Unlocking the Maternity Experience by Accepting the Identity Dimension Ensured by the Biological Mother in Adopted Young Women who are New Mothers. A Case Study

Silvia-Carmen Mikulović[i]
Hyperion University, Faculty of Psychology and Educational Sciences, Bucharest
Craiova County Emergency Clinical Hospital, Romania

Abstract

Introduction: *Often those who have been adopted feel rejected and abandoned by their biological parents, particularly their mothers. Adopted children must integrate both their birth and adoption experiences, as living with adoptive families. In the case of pregnant women who have been raised by adoptive parents, they oscillate between loyalty towards the adoptive mother and unconscious debt in relation to the biological mother.*

Objectives: *This case study aimed to achieve the assumption of the maternal role and reconnection to the biological roots, by a pregnant woman, hospitalized at the time, who was preparing for the birth of her second child, by working on accepting the identity dimension ensured by the biological mother, building awareness and expression of her emotions, processing the personal adoption experience, as well as the understanding of the biological mother and forgiving her.*

Methods: *The methods used were projective: Draw-a-Family Test, DASS 21-R, the Tree Test, as well as Experiential and Unification psychotherapy means.*

Results: *The therapeutic approach managed to help the client give meaning to and process the event of meeting her biological mother and its influence in the current childbirth, to clarify the client's expectations, and understand her behavior, and her fear to consciously participate in the birth.*

Conclusions: *The psychotherapeutic intervention of maternity patients contributes in the integration of painful experiences, in the acceptance of recent or more distant traumatic experiences, thus helping clients maintain emotional balance, reactivate resources, optimize body functioning, build and strengthen the attachment relationship with the fetus, assuming one's identity and improving the decision-making process.*

Keywords: pregnancy, abandonment, loss, adoption, identity, loyalty, duty, gratitude, forgiveness

[i] Corresponding author: Silvia-Carmen Mikulović, PhD, Faculty of Psychology and Educational Sciences, Hyperion University, 169 Calea Călăraşilor, district 3, 030615, Bucharest, Romania, email: psiho_rot@yahoo.com.

I. Introduction

As children grow, they develop a positive sense of identity, a sense of psychosocial well-being (Brodzinsky, 1990). They build the concepts of self (how they see themselves) and self-esteem (how much they like what they see), and learn to feel comfortable with themselves (Okun & Anderson, 1996). Adoption may complicate the normal processes/ themes of attachment, loss and self-image in childhood. Adopted children must integrate in their development, both the context of their birth, abandonment and adoption, as well as their adoptive families.

Children who have been adopted as infants are affected by adoption throughout their lives. Individuals who have been adopted later in life can understand adoption according to the stage of development they were in when it happened. Those who have suffered trauma or neglect may remember such experiences, which further complicates building their self-image (Brodzinsky, 1990). All adopted children experience the loss of their biological family, heritage and culture (Brodzinsky et al., 1992). Adoptive parents can facilitate and help children go through this painful process, and feel more comfortable with the existence of adoption (Jewett Jaratt, 1994).

In adolescence, adopted persons need to establish an identity, while actively seeking independence and family separation (Okun & Anderson, 1996). Adopted adolescents need to understand both sets of parents, and this may lead to contradictions and conflicts activated by the feeling of loyalty (Pavao, 1998). In early teen years, individuals face the loss of childhood, a loss which can become problematic. The adopted teenager has already suffered losses, fact which makes the transition to adolescence even more complicated. This period of development can be difficult and confusing. Adolescents may experience shame and loss of self-esteem, especially since society's perception on biological parents is often a negative one (Okun & Anderson, 1996).

Teenagers who have gone through adoption need to know details about their history, about what happened to their biological parents, on how the decision to give them up for adoption was taken, about how they entered into the adoptive family. They will reflect on themselves, on the adoptive family, trying to identify the similarities and differences. They may try to find out where they come from (Pavao, 1998). It is normal for teenagers to have a natural reluctance to talk to their adoptive parents, and not to want to share with them their need to get to know the biological family. They may keep their thoughts to themselves, or talk to friends, and adults whom they feel can understand and support them. Finding information about the family of origin is very understandable, but most of the time, parents see this as a threat. The willingness of adoptive parents to accept the child's double inheritance (biological and environmental legacy) helps the child accept that reality (op. cit., 1998).

In the last two decades, research into the psychosocial needs of adopted children and adolescents has advanced. Evidence suggests that the psychological adjustment of adopted adults is more challenged (there have been reported higher levels of depression, anxiety, personality and behavioral disorders, neuroticism) than in the individuals raised up in their biological origin families (Melero & Sánchez-Sandoval, 2017).

Not only abandoned children face difficulties, biological mothers also pay for the decision to give up the child, certain consequences being present throughout their lives. Clinical symptoms experienced by biological parents include: unresolved pain, isolation, difficulties in future relationships, and trauma. Some recent research has found that a proportion of the mothers who give up their children, compared to those who do not do so, tend to have poor indicators of well-being criteria (e.g., high school graduation rates, etc.). There appear to be long-term psychological consequences too, related to giving newborns for adoption: the analysis of 163 mothers who gave up the child after birth, showed that the adopted child remains psychologically present for them (Fravel et al., 2000).

The findings suggest that the adoptive mother-daughter relationship has an obvious effect on the relationships tied by adopted children with biological mothers (Richardson et al., 2013). Loyalty towards the adoptive mother seems to influence the evolution of the relationship and closeness shown to the natural mother. Adult women from closed adoptions have reported difficulties in managing the relationship between the two mothers and need clinical help to be able to meet their own emotional needs.

The individuals who have been adopted often feel rejected and abandoned by their natural parents. This comes accompanied by feelings of pain and loss. There is no precise time or age when these feelings surface, but sooner or later it happens.

Feelings of loss and rejection are often accompanied by a deteriorated sense of self-esteem. There is a tendency to believe that "something must be wrong with me because my parents left me". These feelings and thoughts are not related to the amount of

love and support received from adoptive parents and family (op. cit., 2013).

The desire to know, to find out about biological parents generates guilt. Guilt accompanies loss and pain, because adopted adults believe that they are disloyal to the parents who adopted, loved and raised them. They do not want to hurt or betray them. Feelings of guilt and the need for loyalty prevent the adopted individual from asking questions.

According to the great psychologist Erik Erikson (1968), adolescence involves a search for self-identity. This process is difficult for most teenagers, but especially for those who were adopted. If they have never met their natural parents and have no idea about their genetic origin, they are left with a big gap in their quest to answer the question "Who am I?". The more information available to them, the better they can be helped to build their self-image.

Many adults who have been adopted struggle with the fear that they prove disloyal to their adoptive parents if they look for their natural ones. The only exception is when adoptive parents make deliberate and conscious efforts to inform and encourage their children to go and look for them. But there are adoptive parents who discourage such searches and even lie to their adopted children about their origin. Finally, lies and distortions are detected and often lead to angry feelings towards adoptive parents.

Adoptive parents may hide the truth because they live the fear of losing their child. This fear of loss, often irrational, is a strong motivator to keep the adopted child as close as possible.

The truth is that adopted children who are looking for their natural parents have no reason to change their loyalties and feelings. They are looking for their biological parents, especially their mother, because, like the vast majority of people, they need to know as much as possible about their life history, including racial, cultural, personal and genetic backgrounds.

The transition to motherhood begins in the prenatal period and is influenced by a number of factors, such as life circumstances of the parents, social environment and details around their conception. It is not only the support provided by the partner and the woman's family that is important to adopted women expecting children. In the case of pregnant women who have been adopted, their experiences with the biological families, as well as with the adoptive families are important, and any unresolved conflict, loss or rejection may affect, disrupt this transition (Mares et al., 2011).

Attachment issues are brought to the surface during the transition period (Symes, 2017). As the mother begins to build a relationship with the unborn child, during pregnancy (but also later with the newborn), the history of attachment (or relationship) is highlighted. Relationship problems can be strongly reactivated, potentially reprocessed and passed on intergenerationally from mother to child. The mother's ability to respond to her child is influenced by her experience in relation to the biological mother, but also to the adoptive mother. This ability can compromise the assumption of motherhood, the healthy confrontation with unresolved conflicts.

II. Description of the case study

As a psychologist in the Obstetrics-gynecology department, I was sent to see a pregnant woman with high imminence of abortion. Because she could not move, I had to work with her in the medical ward. She was sharing the ward with 3 other pregnant women. Under these conditions, due to confidentiality requirements, it was not possible to explore the specific issues of each case, that is themes that derive from the personal life history. In such cases, I propose certain general experiential techniques, which contribute to muscle relaxation, decrease anxiety, regulate psycho-emotional balance, thus improving the functioning of the body and helping to reduce somatic symptoms and activate psychological resources.

When I use such techniques, I invite all pregnant women from the medical ward to participate. While working with the pregnant woman who asked for my intervention, I observed, at one point, that another participant was crying. Before leaving the room I approached her: "I noticed that you are crying and that you were also crying during the exercise."

She replied that she resonated with her colleague, that she felt like the same. She also told me that when the exercise prescription mentioned forgiveness she could not do it. That she could not apologize.

"P: I understand that it is difficult for you to apologize because you feel...

A: I'm self-conceited, that's the reason I can't apologize.

P: You're self-conceited. You are saying that when you ask for forgiveness what you feel is...

A: I don't know, it's unpleasant because I'm self-conceited.

P: Hmm... It's unpleasant. How do you expect the person you apologize to react?"

She thought about it and answered.

"A: I expect them not to forgive me.

P: Not to forgive you, would mean they would do what?

A: They would reject me.

P: They would reject you? Do I understand correctly that it is not because of the self-conceit that you cannot ask for forgiveness, but because of the fear that you will be rejected?"

She replied in tears: "Yes".

Then I invited her to come to my office, because she had no physical limitation concerning movement. She accepted and we continued to work together in the counselling office. I learned that her name was Adela (for confidentiality reasons, I use a different name in the case study, specially chosen to reflect the fact that her name derives from the one given by the biological mother, a potentially significant aspect in the history of the case). Adela was 38 years old at the time, had been adopted at the age of one month, and was hospitalized with the diagnosis: 34-35 weeks pregnancy, central placenta previa. She was divorced and was currently involved in a civil partnership for 4 years. From her experience she considered remarriage was not necessary. She also had a 10-year-old daughter. She got along very well with her partner. She did not expect to get pregnant again. She believed that this pregnancy was sent to her by her (adoptive) mother, who died 10 months before, because she had not been able to get pregnant in the last 8 years. The parents, after adopting her, had had another daughter, her sister, and as she remembered, they never treated them differently. She had wonderful parents, who loved her and supported her unconditionally. She did not understand how a mother can leave her child, but she forgave the woman who gave her life. She recounted how she got in the hospital, after a spontaneous hemorrhage started, while in a gas station, as people called for help and she was hospitalized in emergency ("There was blood on my pants and on my sneakers."). She shared the experience of the first child birth. She told me about her concern that she would have to undergo spinal anesthesia, and how during the first childbirth she underwent cesarean section, but with general anesthesia. She was concerned that she would have to listen to doctors speak during the intervention and wanted to know whom to talk to, to be performed a cesarean section under general anesthesia, as she feared having to hear about potential health problems of the child.

Following the clinical interview in which I found out the client's life history, the context of the hospitalization, the present existential conditions, the fears and conflicts she was facing, I applied a psychometric tool, the DASS 21-R test, to measure Anxiety, Depression and Stress and I asked her to draw a family.

The psychometric results revealed: depression – moderate score; anxiety – severe score; stress – moderate score.

The Draw-a-Family Test results – Adela drew her family, including the unborn baby girl. She explained that among the family members she was the happiest because she had a family and that no one was unhappy. It was noted, on a graphic level, that the family members were distant, she was positioned higher than the others, the whole drawing was childish, primitive, she omitted body parts (hands and soles), the arms of the characters were up, the attitude was casual; there was slight asymmetry, all characters smiled, she was placed further away from the children compared to the father, the characters seem to have the same-sex. The absence of the hands indicates the lack of contact with the entourage, the lack of trust in social contacts, the feet and soles give information about the connection with the environment, personal security, and difficulties in relation with family members.

We can interpret that the quality of attachment is poor, that this quality was specific to the adoptive family, that her relationship with her father was more affectionate than with her mother; we have indications of emotional immaturity, good intelligence; a certain separation/ distance from others could symbolize an imaginary refuge, but it could also indicate taking distance from oneself, disconnection from the environment, from action, others, or the future. It could show an instability experienced in the family.

The lines of the drawing can indicate anxiety, uncertainty, anguish, self-dissatisfaction, conflict,

insecurity, rigidity, aggression, as if devaluing the family, putting distance could be the expression of hostility, defense, symbolic removal from the family as it generated anxiety. Omissions can bear an important meaning revealing the patient's problems at social and emotional level. Arms show intense emotion, joy but also a call for help. The only more elaborately drawn element was the head of the characters, as it is the representation of the Ego.

Afterwards, we began to explore the identified conflicts. We started with the request for general anesthesia by reminding her that she said she did not want to hear medical staff involved in the childbirth talk.

"P: What is it exactly you do not want to hear?

A: I don't want to hear doctors talk, should something happen, I don't want to know about it.

P: What could happen?

A: I could hear them talking.

P: And what would it be like for you to hear them talking? What do you think they would talk about?

A: About what's going on in there.

P: What could be going on in there?

A: I don't know, something could happen...

P: What do you think could happen?" (She froze and did not answer.)

We considered that the fear of childbirth, of something bad happening to the baby, were common fears, specific to the last trimester of pregnancy, that can intensify near birth.

In Adela, her fear that something bad could happen to the baby was naturally accentuated given the medical diagnosis related to the pregnancy (placenta previa), and the massive hemorrhage that occurred in the gas station. I set out to work with her on processing such justified fear, to express it, to understand it, to accept it and this way to be more prepared for the caesarean section without general anesthesia.

"P: Let's look into what scares you about the cesarean section. I mean, you could hear that... something is happening to the child?

A: Yes...

P: What exactly could happen?

A: I don't know.

P: If something happened to the child, would it be bad for you or the child?" (The intention being to put her in touch with any fear that she might lose the baby.)

"A: It would be bad for the child.

P: I understand that you don't want to know if it could be bad for the child, for the little girl? If something happened to her, you wouldn't want to know, you would like to sleep? Is that what you mean?

A: Oh, no. I want to know.

P: Would you want to know? If you do want to know, does that mean you shouldn't be asleep? Or do you want to be asleep?

A: I wouldn't want to sleep.

P: Then what do you want to do?

A: I don't think it would be bad for the child.

P: Then for whom do you think it would be bad?

A: I don't know.

P: Maybe it would be bad for you? What could be bad for you?

A: I don't know.

P: Let's see how it would be like for you. How do you imagine it would be for you? Look, at the first cesarean you didn't know how it was like for you, because you were sleeping. What do you think it would be like for you this time?

A: I don't know. […] Something might happen to me.

P: Something could happen to you?

A: No, I don't think anything could happen to me." (She already had an experience with a previous cesarean, an experience that confirmed that nothing bad would happen.)

As she was stuck and could not continue, I added, starting from the hypothesis that it was not the fear of death, but rather the fear of hearing how the child was born, a fear that was a transgenerational information transmission, taken from the biological mother (who gave birth to her and abandoned her in the hospital). I tried to help her understand, be aware of the unconscious influences, the psychological impact the feelings of the biological mother could have on her in the birth process. Projections work in many ways. Projection games are especially complex when they refer to the only event that connected Adela to her natural mother. People are built by acts of mimesis and by identifying with others, with family members (Van Eersel & Maillard, 2011). Even the adoptive mother's feelings before receiving her into their family were important to explore. And especially, the birth of a child by the adoptive mother, after Adela was adopted, had a certain symbolism in the patient's life history. The biological mother was unable to contain her, during pregnancy, in a subjective unavailability to give birth. I considered that she was following a transgenerational scenario, pendulating between loyalty towards the adoptive mother and the debt to the biological mother, a scenario transmitted unconsciously, thus ensuring the non-assumption of maternal identity, in hospital conditions, as did the biological mother. Thus, Adela maintained the same

fears, the same needs, self-sabotaging her assumption of the maternal role, self-locking in a repetitive behavior.

I wanted to create the possibility for her to get out of this scenario, facilitating the authentic contact with her own needs, but one session was not enough to achieve such goal. I considered it a maladaptive behavior, which was generated by the debt towards the biological mother.

"P: You mean you could hear that... they're getting ready to take the baby out?

A: Yes.

P: What do you think it would be like to hear when she comes into the world? Would that be bad?

A: No, I don't think so.

P: How would that be like?

A: I think it would be good...

Q: How do you imagine it would be like to hear your child's birth?

A: I think I would like it.

P: How do you imagine you will feel when you hear the baby girl?

A: I think I will be happy.

P: What do you think about what you said? Do you think you will be happy, do you think you will like it? From what you said previously, it seems to me that you don't want to feel happy that you give birth to a child, a baby girl.

A: Oh, no. I'm happy. I haven't thought about that. I want to hear her.

P: Do you want to hear what the doctors are doing, what they are talking about, to hear when the baby girl is born?

A: Yes, I want to."

In the end, she expressed that she felt calm and that she was fine with the anesthesia.

I found that she did not know, did not relate to a specific experience, as usually happens (pregnant women imagine catastrophic experiences about them or the child, influenced by what they heard from other pregnant women), but she was afraid. As I stated, fear is natural to some extent, because the fear that something can occur during childbirth is normal for pregnant women, especially if they give birth with surgery. But she already had a previous experience with cesarean delivery and knew it was normal. Because of that big hemorrhage, I found it natural for her to be afraid. But she did not verbalize anything to portray these natural fears. That was why I did not express them either, not supporting her to explore herself from that point of view, because I considered that, in her case, the fear of cesarean section intervention, the need to sleep while the baby was born, could have another meaning. I was prepared to return exploring that fear if she required total anesthesia or before birth. It was not the case. She also talked to the surgeon and I found out that she did not ask to give birth under general anesthesia.

We processed the experience lived in the gas station – she identified the fear, the helplessness "that left in my mind a feeling of danger". She became aware of the fear and expressed her emotions about the danger.

"P: That danger that you felt then, do you also feel it now? Do you still feel the danger?

A: No, I don't feel it anymore. Now I feel safe in the hospital. The bleeding stopped. I'm fine."

We worked on clarifying Adela's fears (I thought she actually wanted to not even hear the birth of her daughter, as she did not participate in the first childbirth). Cesarean section is the intervention in which in a way the woman does not 'give birth', does not participate in the birth of her child, only attends the process. During childbirth a woman meets her own mother, "she becomes her mother, as an extension of her mother, differentiating herself from her mother at the same time. [...] To give birth means to recognize one's own mother in her interior" (Bydlowski, 1998, p. 69).

During the first birth, using general anesthesia, she felt safe. Ghosts and unconscious conflicts were annihilated by anesthesia. She woke up after giving birth.

She made sure that even in the second childbirth case she was safe, although the method of anesthesia could not be changed, as in the maternity hospital where she was admitted that was the procedure. She lowered her anxiety, understood and accepted the procedure. She certainly secured herself because in the following days and until the time of the procedure, she did not mention the fear of anesthesia, the fear of the cesarean procedure, she did not express the desire to sleep during birth.

Clarifying these aspects, making sure that she was not invaded by catastrophic scenarios, I considered it would be beneficial to assist her in the issue of rejection, a problem found during the first meeting with her.

She had always known she was adopted. We would talk about adoption just like we would talk about any trivial event. She was very happy that she "had them as adoptive parents". Her parents were wonderful. She told me about her adoptive mother, who died 10 months before. She claimed that her mother must have brought her the baby girl, because she had not got pregnant for a very long time. As if it were natural for the mother to give her a child, because she, through her existence, also 'gave' the adoptive mother the maternal role, that is,

helped her become a mother, paved the way for the experience of motherhood, thus helping her to unlock fertility by giving birth to her own child (her sister).

Most people are just born into the families in which they were born and do not think thoroughly about it. For adopted people there are always the possibility of another life and many unanswered questions.

I found that she was haunted by a question. Why did her mother give up on her? (As mentioned above, it is a natural need of adopted children to answer such question.) The need to know one's biological parents, which occurs in many adopted children, is a natural part of the process of self-search. Regardless of the moment when the adopted persons want to establish a contact, whether direct or indirect, with the biological family, it is very important that the adoptive families understand, accept them and, if they can, help them in this process. The emotions that can be triggered in this process of searching and reuniting are very deep and painful. Therefore, they need the support of their adoptive parents and their validation. Just because they are looking for their biological parents does not mean that they do not love their adoptive parents, but that they need to understand that part of their life that is missing, they need answers to so many questions. Establishing, mediating and managing the contact between the adoptees and their biological parents is a process that requires a lot of attention (Melero & Sánchez-Sandoval, 2017).

Adela recounted how she looked for her biological mother, how the only person she talked to was her grandmother, who encouraged her. "Only Grandma knew about this visit." The adoptive parents did not know about her need to see where she came from, who gave life to her, what her mother looked like. She found out where her biological mother lived, went to her hometown, asked around, and found her home. Her mother did not look happy to see her. She was upset that her mother was not happy to see her. For Adela, who had waited for her biological mother to see her, to be glad to see her, it was a disappointing experience. Why did she not hug her? She was waiting to be hugged, and that woman did not do that. Why didn't she show any emotions?

I saw her pain as she told the story.

She told me that during the exercise in the ward, an exercise aiming to express forgiveness for those who have mistaken them, she felt a painful sensation in her body.

I challenged her to understand her body. "What does your body say?" She failed to explore body language.

"A: I can't forgive because I'm self-conceited... because I feel rejected.

P: When did you feel rejected?

A: Once when I was abandoned in the hospital and then, a second time, when I went to see my mother and she rejected me."

We further worked on rejection and abandonment.

During that meeting she wanted to tell me that when she gave birth to her eldest daughter, she wanted to leave the hospital with her immediately after birth... "I didn't want to stay." Another new mother, a ward colleague, told Adela that she was selfish, that she didn't think about her child's best interest. She shared with her that she had a child in intensive care, while Adela could visit her baby, breastfeed her, and hold her in her arms. That woman told her "I can't do any of these, and yet you want to leave". She wanted to leave (ignoring the baby's needs) and no one understood her desire to leave the hospital as soon as possible. A nurse explained that for the child, she had to stay admitted in the hospital for a few days more. She understood, but she still did not stay as long as was planned to be hospitalized, she talked with the doctors, and left the hospital two days before her discharge, without a ticket to leave the hospital. This was how her own mother, who abandoned her in the hospital, certainly left.

"Through birth, and especially through the first child, a woman settles her debt to her own mother" (Bydlowski, 1998, p. 71). I considered that during the first birth she oscillated between the hatred towards the biological mother and the duty towards her, thus explaining her need to sleep during the birth, not to have contact with the process, and then, the need to leave as soon as possible from the hospital with her little girl. Certainly, such need was intensely experienced by her own mother after she gave birth to her. Usually, mothers who abandon their children in maternity hospitals leave after two, maximum three days, after birth, not waiting for the child to be ready for discharge. She could not clarify these issues for herself at that time.

Attachment is the foundation for the important relationships that the child will have throughout life. The need is fulfilled only by an available caregiver, warm and consistent in behavior with the child. Thus, the child learns to trust their caregiver, they learn to trust their parents, they know that parents will provide them with affection, food and protection, that they will be there when they need them. Children give parents the status of being unique, special adults, "their secure base" in this world. I consider that Adela's first contact with the

biological mother remains imprinted in her unconscious, identifying with the need of the woman to leave, and in fact she really left. Therefore, it was not by chance that at the first child, Adela gave birth under general anesthesia (she did not want to participate, not even by hearing) and she felt the urge to leave the hospital as soon as possible. Moreover, after the first birth, lactation was not possible, so she fed the baby with powder milk, thus identifying with the adoptive mother who had similarly fed her, i.e., with "adoptive" milk.

I asked her if she noticed anything in common between her behavior and the biological mother's behavior. She said no.

"P: You both left the hospital quickly after giving birth, didn't you?

A: Oh, no. There is no resemblance. She didn't want to give birth to me, I wanted the baby girl, she left alone, I left with my baby. I never thought of leaving without the child. What kind of mother does that?"

The need for separation, the need to get out of a scenario that causes suffering, the natural process of individuation made the patient focus on the differences between her and the biological mother, in a process of counter-identification, not expressing her own authentic needs, which could have helped her assuming a personal, authentic identity (e.g., the rush to leave the hospital quickly with the baby girl may be a statement that "I want the girl, I have a family who are feeling happy for me and my child, who are waiting for us at home, that's why I don't want to stay in the hospital, I want to I share my joy with my family as soon as possible", but also "I can't stand this place, I can't stand the hospital where I was abandoned, etc.").

I considered that she could not process the experience in terms of genuinely assuming her own needs. We returned to exploring the visit to her natural mother. Adela stated that "I've never imagined she was the same as me."

Children inherit many traits from their biological parents (for example: eye, hair, or skin color, physical constitution, and even the talents family members have had). The heritage is also the one that determines certain predispositions to certain diseases. Regarding the child's personality, psychologists have established that their temperament is innate, but can be shaped according to environmental and educational factors.

Yet, the biological parents' behavior cannot be assimilated by children in the conditions in which adoptive parents offer the child a different living environment, positive models, safety, trust and availability. Therefore, the relationship that the adoptive parents establish with the child is what determines the child's future evolution and behavior.

"P: What was it that made you want to meet her?

A: I just wanted to see her, to know her. I went there hoping not to have feelings, not to get attached, but I felt outraged at her, I couldn't understand why she didn't show any emotion."

Without realizing it, she responded towards the biological mother in a similar way, as the woman, after having given birth to her, decided not to attach herself to the baby.

"P: What makes you say she had no emotion? What emotion did you expect her to have?

A: I expected her to have a motherly feeling, I expected her to hug me. But from her attitude, I understood that she did not want me.

A: I asked her if she was forced by her parents to leave me in the hospital, not to take me home, and she said no. She told me «I didn't breastfeed you so I wouldn't get attached to you».

P: She didn't breastfeed you so she wouldn't get attached to you? What do you think about that? Was she afraid she would get attached to you?"

She paused and thought about it.

"A: She probably thought she was going to get attached.

P: What do you think about that?

A: She's probably a good woman, I think she's a good woman. She gave birth to me, she could have killed me, she could have aborted me, she was only a child herself." (Her mother was 16 when she gave birth to Adela.)

Adela talked about her finding out that she looked like her mother, having her figure, her eyes, her fingers.

"A: I'm amazed. I don't know what to say."

I perceived her feeling confused by the fact that she discovered she looked like biological mother, she even saw her fingers, she noticed how similar they were, but I could not further explore the resemblance because she did not want to focus on these aspects. The surprise and dissatisfaction that Adela looked like the biological mother, generated her rejection, and maybe, not coincidentally in the family drawing, the depicted members did not have hands or fingers. It would have been interesting to explore how she experienced the resemblance to the biological mother, how it was for her to have the same fingers as her mother. We did not have the possibility to return to these issues. She was concerned and affected by her biological mother's attitude, so I assessed that she needed to explore these feelings, to understand them.

She recounted that she perceived her mother as indifferent, disrespectful, failing to look into her eyes, leaning against the gate and stayed that way throughout the discussion, as if the gate could support her.

"P: Because she didn't look at you, she kept her eyes down, as you say, did it mean to you that she was acting indifferently, disrespectfully? When, in which other situations do other people avoid looking into your eyes?

A: Was she ashamed, did she feel guilty?

P: How about these other interpretations?

A: I've thought about them too, but I don't believe these are correct.

P: What makes you reluctant to believe them?

A: The fact that she was leaning against that gate, like that.

P: You say she leaned against the gate. In which situations do people lean against something?

A: They lean to find their balance.

P: Uhm... To find a balance. Did she need balance?

A: I didn't prepare her for the visit, she wasn't expecting me to come to her gate."

While they were talking at the gate, her mother's mother approached them, that is, her maternal grandmother. Her biological mother turned to her mother and introduced Adela. "Mother, this is my daughter, Adelina" (note: the name has also been replaced for confidentiality reasons). The patient replied: "I'm not your daughter and my name is not Adelina." (It is important to note that the patient's name is derived from the one given by the biological mother. The meaning of the name and of rejecting it when she heard it spoken by the biological mother would have been interesting to explore, but we did not get to address this topic either.)

"P: What does that mean to you, that your mother introduced you to her own mother by saying «this is my daughter, Adelina»? Does that mean that she rejected you, as you say you felt?

A: In her mind she knows that she is my mother, that I am her child. That doesn't mean she rejected me, but she didn't hug me, either.

P: How do you feel in this moment, as you remember how your biological mother introduced you to your maternal grandmother «this is my daughter, Adelina»?

A: That's strange. I haven't thought about it before.

P: If you were to think about it?

A: I can believe she accepted me, but it doesn't feel like that, because she didn't hug me after all.

P: I understand that if she didn't hug you, for you it meant she rejected you. What do you think about this?"

She did not answer.

"P: Would you have needed her to hug you?

A: Yes, but she didn't do it.

P: Could you have hugged her first? I think that sometimes, when children need hugs from their mothers, they go and hug them. Could you have hugged her like this?

A: I could have, but I didn't think about it. It never crossed my mind.

P: Is it possible that the same thing could happen to her? Like, she might have wanted to hug you, but it didn't cross her mind? You say you took her by surprise. She continually leaned against that gate. Could this be possible?"

She waited, thought and answered.

"A: It is possible, but she should have thought about it, because she was the mother.

When I came to the hospital, the doctors tried to save me, but for me I didn't matter, only the baby mattered. For me, my life didn't matter, only the child's life did. That's why I couldn't understand my mother for having left me.

P: Only children matter to you, as it mattered to whom?

A: For my parents."

Probably Adela assimilated the need to focus on parenting children from her adoptive parents, who having no children before her adoption, could fully focus on her as a child. Because she had told me that her biological mother knew that Adela had been adopted by a family of doctors (which denotes the biological mother's interest in her), that she showed her daughter her living conditions (a poorly endowed house), that she also told her that she was having a hard time, that she had two more children, but she was separated from her spouse, I guided her to explore this information, in order to be able to reach other meanings than the known ones, to find other significations.

"P: You've told me that your biological mother said she knew that it was good for you that a family of doctors adopted you, she showed you her house, a poor house... she told you «look, this is where I live». What do you think about this? Whom did she think about when she gave you up for adoption?

A: Is it possible that she thought about me, too?

P: What do you think? She told you she showed interest to know more about you.

A: I think she too may have thought about me. But I would have wanted to grow up there, even if I would have had a hard time, to be raised by my mother.

P: You would have lost the experience with the wonderful parents you told me about and whom you are so proud of. It this for sure what you would have wanted?

A: I don't think I would have wanted that. I had the most wonderful parents.

P: And yet you say that you would have wanted to grow up with your biological mother, without a father.

A: I don't think I would have wanted that. […]

I think she did the best she could for me. If I think about it, I believe she thought it would be good for me, she tried to find out if I was having a nice life. […]

P: What are you feeling right now?

A: I'm at peace."

At the end, she added:

"I would like to thank her for deciding to leave me in the hospital. I had this in my mind, always, how could a mother leave her child, I couldn't understand, I was placing a heavy guilt on her. Now, I would spontaneously embrace her to make her feel that gratitude comes from the heart, that she took a good decision to give birth to me. I am reconciled to the idea and happy that she gave birth to me. Now, I have something to be thankful to her for".

I believe that the desire to counter-identify with the biological mother, because Adela felt hate and rejection towards her, contributed to the absence of catastrophic scenarios (quite common scenarios before childbirth), causing her to focus only on the child. During the session, she stated that after the psychotherapeutic process she understood that she was focused only on the baby's life and health and not on her own, she did not matter at all. "I did not matter, only the child mattered". (Scenarios possibly taken from both mothers, as the biological mother may have thought of the child when she abandoned her).

For Adela (as she stated), only her children were important, children who were born by cesarean section, one with general anesthesia, one with epidural anesthesia.

I believe that this brief therapeutic process that she was able to go through unlocked maternity, changed the meaning of motherhood, helping her accept her biological mother. This hypothesis was confirmed by the installation of lactation before leaving the hospital, Adela being able to breastfeed the baby girl.

At the first pregnancy, she could not activate lactation at all. She shared how after efforts and use of milking devices she still "had no milk". With the help of the therapeutic process, only at the second birth, she could manage to integrate motherhood, her body expressing it through the installation of lactation.

At the end of our intervention, before giving birth, I asked Adela what she understood from everything we had worked on.

She replied:

"I understand that I now have a mother, and I will visit her someday."

She said she had a mother, a living mother, because her adoptive mother had died.

At the end of the process, I re-applied DASS 21-R. The psychometric results indicated Depression, Anxiety, Stress scores within normal limits.

I asked Adela to draw a tree. She drew a blooming tree, surrounded by flowers, because she wanted so.

Unfortunately, the patient's challenges cannot be solved with a short-term therapeutic process, so I wonder how much of what she gained in the therapeutic process would be consolidated, given that when she got home, the guilt towards the adoptive mother could be reactivated and the process of identity assumption, implicitly the assumption of motherhood could be sabotaged, or even be interrupted. But it is important that she changed the scenario she had lived in all her life "my mother did not want me, did not think about me, abandoned me", found another meaning in connection with the actions of the biological mother and expressed her gratitude for it.

The dire material conditions, lack of education, young age of mothers, unmarried mothers, at the time of childbirth, family constraints are just some of the situations that determine biological mothers to leave their children. Irrespective of their reasons, biological mothers or fathers should not be judged or criticized for

the decision to leave their children, as the factors and conditions contributing to such phenomenon could never be fully known. On the other hand, biological mothers leaving their children could be blamed, which could implicitly lead to the child being blamed and not fully accepted by the adoptive parents, as not being theirs, of being born of a woman they devalue.

Many adoptive parents either reject or do not treat the child's history with due importance. Biological parents are also part of this past, and they have an important role in building the child's complete identity. By rejecting the child's biological parents, this topic becomes a taboo, a secret not talked about and/or not allowed to be talked about. In this way, the adoptive parents deprive the child of an important part of their personal history, something that belongs to them, a part of themselves they have the right to know and which contributes to the formation of their identity.

The experience of giving up their own child impacts many biological mothers for the rest of their lives, as a loss and as a trauma. The fact that they chose or were forced to give up the child is not a proof of lack of love. The child's biological parents must be perceived with understanding, indulgence, compassion and empathy, they must be respected. The adopted child needs the adoptive parents to respect the biological parents, as they are a part of his/her past.

III. Conclusions

I considered that the need to talk about adoption, about the event of visiting her biological mother (she also shared it with the other pregnant women in the ward) was a cry for help, a need that her sadness be expressed, about the fact that she could no longer contain it, in the conditions of pregnancy and near birth. It was as if she said "I want to do something with my anger, with my resentments".

Certainly, the natural mother was unable to contain her, during pregnancy, in a subjective psychological unavailability to give birth.

I considered that she was caught in the transgenerational scenario, oscillating between loyalty and duty. In that way, she maintained the same fears, the same needs, self-sabotaging her assumption of the maternal role, locking herself in a repetitive behavior.

I wanted to create for her the possibility to get out of the scenario, facilitating authentic contact with her own needs, but the few sessions were not enough to entirely achieve such goal.

She managed to appreciate what her biological mother gave her – life. The oscillation between the personal unconscious, unconscious transmissions of the biological mother, and those of suffering in relation to the inability to have children transmitted by the adoptive mother, generated confusion in the assumption of the maternal role, in the assumption of childbirth (as the adoptive mother did not give birth, did not participate at birth).

Certainly, as a newborn, she felt the brutal rupture between her and her biological mother, the one who had brought her into the world, making her insecure about childbirth and breastfeeding. She oscillated between debt towards the biological mother and loyalty towards the adoptive mother. During the therapeutic intervention, the cognitive rigidity decreased, she even showed a great cognitive flexibility, but the emotional rigidity only diminished. Although she managed to express certain emotions, she did not become emotionally flexible, not fully accessing the emotions related to abandonment and the biological mother.

The Tree test, administered at the end of the intervention showed that there was still a lack of connection with the unconscious, with the primary themes and beginning. Adela experienced indecision and anxiety, but also had projections related to the future, manifested extroversion, optimism, rationality.

I believe that the Tree test was relevant for the starting of the emotional processing, for the connection between the rational and the emotional aspects of the psyche. The fact that she added flowers next to the tree has good predictive value in terms of acceptance of identity, gratitude towards the biological mother; there is hope that one day, alone, or with the help of a psychotherapist, Adela can succeed in completing the integration of abandonment and adoption experiences.

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