Representations of the Adoptive Mother, the Birth Mother, and the Self in Adult Adoptees

by

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Abstract

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Twenty-seven American-born adults adopted in infancy who had had no contact with their birth families completed the Object Representation Inventory (ORI) by describing their adoptive mothers (AM), their birth mothers (BM) as imagined, and themselves. These descriptions / representations were evaluated in terms of conceptual level (CL), personal attributes, and articulation level (SA). The degree of discrepancy (splitting) between AM and BM representations in terms of their personal attributes was also measured. Subjects also completed the Brief Symptom Inventory (BSI).

Subjects with higher conceptual levels for their AM representations showed significantly higher conceptual levels for their self-representations, but not for their BM representations. Subjects with more highly articulated AM representations did not show more highly articulated BM representations. The study expected negative attributes in the AM representation to be associated with positive attributes in the BM representation, but two analyses yielded mixed results: one supported that expectation and the other did not.

The study also compared CL and SA of the AM representations to the degree of discrepancy between AM and BM representations. It found that subjects whose AM representations were at a higher CL tended to have significantly less discrepancy between AM and BM representations. However, no significant correlation between discrepancy and the articulation level of the AM representation was found.

A post hoc test grouped subjects according to degree of negativity in their AM representations. These groups were then compared by the articulation levels of their BM representations. Subjects whose AM representations contained many negative attributes (group I) tended to have BM representations significantly better articulated than subjects whose AM representations contained few or no negative attributes (groups II and III). A second post hoc test compared subjects' symptomatology to the degree of discrepancy between their AM and BM representations, indicating significant positive correlations between discrepancy and the three global indices of the BSI.

Findings strongly suggested that adoptees' perceptions of their AM relate to aspects of their BM fantasies and self-perceptions. Furthermore, adoptees' symptomatology and AM CL related to the degree of splitting between AM and BM representations. Suggestions for future research and clinical implications are discussed.

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CHAPTER I

Introduction

Every child takes in his parents. That is, every child internalizes his relationships with his parents — for instance, his parents' personalities, their ways of interacting with the child, or of managing emotions — in order to form unconscious models of his parents and of himself in relation to them. These unconscious models, or object representations, are derived from a multitude of real-life experiences along with the child's fantasies, conflicts, temperament, and psychosocial and cognitive levels of development. They are therefore both reality-based, and colored by psychological processes. According to object relations theories, a child bases his expectations of others, of himself, of relationships, as well as his patterns of interpersonal behavior on these unconscious models. Object representations shift with internal changes, such as cognitive and emotional maturation, and with external influences, such as ongoing interactions with people (Blatt & Lerner, 1983; Diamond, Kaslow, Coonerty, & Blatt, 1990; Mahler, Pine, & Bergman, 1975; Priel, 2000).

For adopted children, the formation of object representations is more complicated. Adoptees have the uncommon task of having to integrate two sets of parents into their representational world: the adoptive parents who are raising them, and the birth parents who are often absent and unknown. As the child's awareness of his adopted status develops, so do representations of the birth parents based on a combination of available

information and the child's conscious and unconscious fantasies. At the same time, numerous variables related to the adoption affect the child's representations of himself and both sets of parents, such as the age of the child at adoption (and consequently, whether the child remembers his birth parents), the number of parents in the home, the cultural and ethnic match between the child and adoptive parents, and whether the adoptive parents are same sex or heterosexual. But for all adoptees, knowledge of the adoption is a central influential factor in the ongoing formation of parental and self-representations (Deeg, 1989; Glenn, 1985; Hodges, 1990; Rosenberg & Horner, 1991).

The adoption literature generally addresses the unique stressors and difficulties faced within adoptive families. From an object relational point of view, it often focuses on how the child's awareness of his adoption shapes, and at times distorts, his sense of self and others. A number of articles and clinical case studies, for instance, have explored the common tendency for adopted children and adolescents to form idealized representations of one set of parents and devalued representations of the other set in order to defend against painful feelings of ambivalence about the adoptive and birth parents. (Brinich, 1995; Brinich, 1990; Glenn, 1985; Hodges, 1990; Rosenberg & Horner, 1991; Wieder, 1977a; Wieder, 1977b). Similarly, when discussing the adoptive parent-child relationship, the literature often addresses the way adoption taints the relationship, as, for example, when unconscious fantasies related to the adoption are projected by the adoptive parent onto the child and vice versa. The literature notes the importance of the adoptive parent's availability and sensitivity in discussing adoption-related issues with the child, in order to minimize distortions in the child's conceptualization of his relationships to both sets of parents (Blum, 1983; Brodzinsky, 1987; Hoopes, 1990;

Nickman, 1996). While the literature on adoption paints a rich, complex picture of the psychological impact of adoption, particularly on children and adolescents, some areas remain for further examination.

This study explores the way in which adult adoptees have internalized central relationships into their object representational world. Specifically, this study investigates three questions: First, how is the overall quality of the representation of the adoptive mother — in terms of various structural and qualitative dimensions — linked to the quality of other significant representations, specifically those of the birth mother and the self? Second, are the birth parent representations imbued with personal attributes that are absent or deficient in the adoptive parent representation? Put another way, are the birth parent representations complementary, mirror images of the adoptive parents, fantasies constructed by the adoptee to help him manage his ambivalence toward the parents who raised him? And finally, is there a relationship between the overall quality of the adoptive parent representation and the degree of splitting between the adoptive and birth parents?

By shedding some light on these areas, this study will contribute further insight into how the adopted individual represents his relationships with known (adoptive) and unknown (birth) parents. Given the prevalence of adoption and the complex psychological issues involved, any further knowledge about the adoptee's experience of these central relationships will have substantial value for clinical understanding and clinical practice.

CHAPTER II

Literature Review

Adoption is an optimal solution for children whose birth parents are unable or unwilling raise them; it is also a benefit for the birth parents and for adoptive parents unable to have biological children of their own. At the same time, adoption arises out of a loss for everyone involved. Birth parents lose their child; children lose their parents. Adoptive parents who adopt due to infertility lose their potential biological children and the associated fantasies of raising them (Hajal & Rosenberg, 1991, Brodzinsky, 1987). This mixture of gain and loss, joy and grief, contributes to the complexity of adoption.

For the adopted child, the knowledge of adoption impacts on his developing object relations, defensive functioning, and identity formation. The child integrates facts and fantasies about his birth parents and about the adoption scenario, along with his adoptive parents' attitudes (conscious and unconscious) about both the child and the birth parents, into his sense of self and others. Over time, the child's understanding of his adopted status matures, but the fact of his adoption remains prominent in many age-appropriate tasks and conflicts (Brinich, 1980; Rosenberg & Horner, 1991).

Outcome Studies

Numerous studies have explored the psychological challenges for adopted children and their families, and many conclude that adoption places children at risk for psychological difficulties. For instance, a number of studies have shown that adopted children are over-represented among referrals for psychological or psychiatric services

(Brodzinsky, 1987; Brinich, 1980; Brinich & Brinich, 1982; Hajal & Rosenberg, 1991; Haugaard, 1998; Hoopes, 1990). A review of studies examining the types of symptoms presented in clinic-referred children (Brodzinsky, 1987) indicates that adopted children exhibit many similar symptoms. Those studies conclude that adopted children are more likely than non-adopted children to present with problems with aggression, acting out, low self-esteem, and various learning difficulties, including hyperactivity and Attention Deficit Disorder.

Studies of nonclinical samples are less conclusive regarding adopted children's risk for psychological problems. Indeed, Haugaard (1998) questions the assumption that adoption is a risk factor for children, citing methodological problems in a number of adoption outcome studies. For instance, he points out that many studies do not differentiate between children adopted at birth from those adopted later; nor do they differentiate between children who had optimal versus depriving caretaking situations prior to adoption. By combining the data from such mixed samples, studies may overestimate the risk for some adopted children while underestimating it for others. He argues that while clinical studies suggest an association between adoption and increased adjustment problems, for nonclinical samples, "the link between adoption and adjustment problems is modest or nonexistent" (p. 48). His review further suggests that there is inconclusive evidence of the prevalence of specific psychiatric symptoms in hospitalized adopted children. Finally, he hypothesizes that adopted children are overrepresented in the clinical population because they are over-referred for treatment. This hypothesis is also raised by Brodzinsky, Brodzinsky, and Smith (1998), who suggest that adoptive parents may be more likely to refer their children for treatment because of their own

anxiety, heightened vigilance about potential psychological problems, and their access to adoption-related social services and/or mental health agencies.

In contrast to some of the studies criticized by Haugaard (1998), Brodzinsky et al. (1998) divide their review of outcome studies according to various adoption conditions. They summarize, among others, clinical studies pertaining solely to children adopted in infancy into same-race families under closed adoption conditions. In their review, they find evidence that adopted children and adolescents are more at risk than their nonadopted peers for learning problems and externalizing disorders (i.e. aggression, substance abuse, and hyperactivity), but point out that results are inconsistent across studies, perhaps due to sampling or methodological differences. They also cite apparently undisputed findings that compared to nonadopted children, adopted children are placed in psychiatric hospitals at a younger age (for their first admission) and for longer and more frequent stays. In terms of presenting symptomatology in clinical settings, Brodzinsky et al. conclude that although adopted children and adolescents appear more prone to externalizing behaviors and academic difficulties than nonadoptees, "they clearly manifest a wide range of behaviors and are probably more similar than different from their nonadopted counterparts" (p. 43).

Brodzinsky et al. (1998) find that cross-sectional, nonclinical studies report few, if any, differences between adopted and nonadopted infants, toddlers and preschoolers in terms of quality of infant-mother attachment, temperament, motor functioning, and language development. However, nonclinical studies of adopted children and adolescents present a mixed picture. Some studies indicate few or no differences between adopted and nonadopted children in terms of adjustment problems, personality characteristics and

behavior patterns; others show increased risk for adjustment problems in adopted children. For instance, Brodzinsky et al (1987) reanalyzed data from a previous study of a nonclinical sample of adopted and nonadopted latency-aged children (Brodzinsky et al., 1984) to determine the prevalence of clinically significant symptoms. They found that a higher percentage of the adopted group exhibited such symptoms. In particular, adopted boys were more likely to display clinically significant symptoms related to hyperactivity and uncommunicative behavior, whereas adopted girls were more likely than their non-adopted peers to display symptoms related to depression, hyperactivity, and aggression. Other studies suggest comparably higher rates among adopted children and adolescents for conduct disorders, personality problems and attention deficit hyperactivity disorder. Based on their review of the literature, Brodzinsky et al. (1998) conclude, "Although adopted children may show a small, but significant, increase in adjustment problems compared with their nonadopted peers, there clearly is substantial variability in patterns of behavior and development among these youngsters, with most falling well within the normal range of functioning." (p. 45).

It is worth noting that many cross-sectional and longitudinal outcome studies point to a *decrease* in psychiatric and behavioral problems in late adolescence and/or adulthood, suggesting that adopted children are most likely to experience psychological problems during their school-age and early adolescent years (Brinich & Brinich, 1982; Brodzinsky, 1987; Brodzinsky et al., 1998; Hajal & Rosenberg, 1991; Haugaard, 1998). Furthermore, studies find that adopted adults are not as over-represented in the mental health system as are adopted children (Brinich & Brinich, 1982). Again, findings are somewhat inconsistent. In reviewing studies comparing psychological adjustment in

adoptees and nonadoptees, Wierzbicki (1993) found that effect sizes (for poorer adjustment in adoptees) were larger for adolescents than for either children or adults. Hoopes (1990) reviewed three studies on identity development in adopted young adults ages 18-30, one of which found that the adopted group had more difficulties related to identity development than the nonadopted group, and two of which found no differences between groups.

Developmental Challenges of Adopted Adults

Although adopted adults are not notably prone to psychological problems, adoption-related issues remain prominent in their lives as they move through the developmental phases of adulthood. Rosenberg and Horner (1991) view adulthood as a time of integration for the adoptee who must reconcile facts about his birth family with his upbringing in his adoptive family and accept both his biological and his adoptive roots as legitimate aspects of his identity. And according to Hajal and Rosenberg (1991), the young adult adoptee, after the turbulence and ambivalence of adolescence, is now faced with the challenge of reaffirming his bond with his adoptive family. At the same time, he may pursue more intently his search for his biological origins to strengthen his sense of identity and to connect with his genealogical heritage. Those who do not search maintain the fantasies connected to their roots. In either case, write Rosenberg and Horner, "The degree to which adult adoptees are able to achieve a cohesive integration of self-dynamics may depend on how well they are able to accept the facts as simply facts and to tolerate the ambiguity of their origin" (p. 76).

As the adoptee enters into sexual relationships, he must deal with the risk of incest (the risk being greater the more ignorant he remains about his biological family). Subsequently, becoming a parent allows the adoptee to have a relationship with a biological relative, perhaps for the first time. At the same time, biological parenthood may rekindle feelings of loss and discontinuity associated with adoption. As a parent, the adoptee must also deal with the possible risk of passing unknown genetic characteristics on to his children. Hajal and Rosenberg (1991) add that as parents and romantic partners, adoptees must grapple with decisions about disclosing their adoptive status, just as their adoptive parents did. Additional milestones in adulthood may stir adoption-related issues and/or conflicts and intensify the adoptee's desire to learn about his origins. Losses (for example, of an adoptive parent or of a spouse through divorce) may be experienced as abandonment echoing past feelings about the original relinquishment by the birth parents. And as the adoptee moves into middle age, he may feel a sense of urgency to find his now elderly birth parents who may be in need of support (Sorosky, Baran, & Pannor, 1975).

Protective Factors in the Development of Adoptees

While adoption outcome studies suggest that adopted children are somewhat more prone to psychological disturbance than non-adopted children, the majority of adopted children do not develop psychiatric problems (Brodzinsky, 1987; Frankel, 1991; Hoopes, 1990; Wierzbicki, 1993). "Most adopted children are well within the normal range with respect to behavioral, emotional, and academic adjustment," writes Brodzinsky (1987). Likewise, Hoopes' (1990) review of research on adoption outcome indicated a "70%

success rate," the percentage of adopted children who "demonstrate functioning within the normal range and show no significant differences from biological children" in cognitive and emotional areas (p. 153). So what are some protective factors for adopted children? Among factors that appear related to future psychological health are the ages at which children are adopted and caretaking conditions prior to adoption. Children adopted after infancy suffer a more palpable loss than those adopted at birth in terms of the caregivers to whom they've become attached. And for children who have been placed first in foster homes before adoption, losses may involve multiple caregivers. Studies have shown that age at adoption and caretaking conditions prior to adoption are related to the presence or absence of pathology in adopted children (with children adopted later, and those with early deprivation in pre-adoptive homes faring worse those adopted early and/or with stable, loving, pre-adoptive care) (Sorosky et al., 1975; Frankel, 1991; Haugaard, 1998; Priel, 2000).

Other protective factors pertain to the adoptive family. Numerous authors stress the role that adoptive parents play in helping their child to understand and accept his adopted status and in protecting their child's self-esteem as best they can in the process. Some point out the importance of the adoptive parent's availability and sensitivity in discussing adoption-related issues and in offering information related to the adoption and birth parents (Brodzinsky, 1987; Nickman, 1985). Studies of adopted adults indicate that when adoptive parents are communicative with their children about adoption issues and provide them with information about the birth parents, their children fare better in the long run (Nickman, 1985). Nickman (1996) suggests that it is not enough that parents answer questions about adoption raised by the child, but that parents should also

periodically initiate related discussions, in a sense checking in to see if such discussion is needed while also letting the child know that the subject is not taboo. Another theory about the impact of the adoptive parents has to do with their tendency to either acknowledge or deny difference in terms of their family being adoptive rather than biological. The theory, introduced by Kirk in 1964, states that adopted children are more likely to have adaptive development when their parents are able to acknowledge difference, and that parents who deny difference inhibit open communication about adoption issues, leading to adjustment problems for their children (Brodzinsky, 1987; Hoopes, 1990).

Brodzinsky (1987) argues that Kirk's model, while useful, is too static. Instead, he asserts that at different stages in the child's and the family's development, varying degrees of denial versus acceptance of difference are optimal. For instance, during infancy and toddlerhood, parents may downplay difference in order to establish strong attachment relationships with the child. As the child matures and begins to explore the meaning of his adoption, parents may shift toward greater acknowledgement of difference in order to help their child make sense of the adoption (Brodzinsky, 1987). Other authors such as Hajal and Rosenberg (1991) focus on developmental tasks of the child and the family, stating that adoptive parents must help their children integrate their understanding of, and feelings about, their adoption at each stage of their cognitive and emotional development. Likewise, Nickman (1985) suggests that adoptive parents be attuned to their child's need for clarification, discussion and support pertaining to the adoption at different points in development as adoption-related issues crop up for the child.

Adoption Family Romance Fantasy

Another prominent issue — one that is particularly relevant to this study — involves the birth parents and their psychological presence in the adoptive family. These phantom (but very real) parents are present as fantasies in the minds of the adoptive parents and their children, impacting individuals and relationships in the adoptive family (Hajal & Rosenberg, 1991; Sorosky et al., 1975).

Adopted children's fantasies about their birth parents are frequently compared to Freud's theory of family romance fantasies in nonadopted children. In his 1909 paper "Family Romances," Freud described a common phenomenon in which the latency age child fantasizes that he is adopted and that his true birth parents are extraordinary people who will one day rescue him from his mediocre adoptive family. According to Freud, as the child begins to separate psychologically from his parents, he inevitably comes to recognize his parent's faults and weaknesses. The family romance fantasy helps the child to manage his disappointment in his parents by replacing them with better ones in his imagination. At the same time, the child preserves his original idealization of his parents by transferring it onto fantasied, perfect parents. The fantasy enables the child to hold onto positive feelings and manage negative feelings until he develops the capacity to integrate them in his view of his parents (Brinich, 1995; Freud, 1909; Rosenberg & Horner, 1991). Brinich (1995) writes, "Fantasies of adoption allow us to express both love and hate at the same time and to direct these feelings toward different aspects of our parents — these aspects being represented by the two sets of parents included within the 'family romance'" (p. 194). The fantasy is pleasurable in the moment, and the child

ultimately feels secure that the parents he lives with are, in fact, his biological parents (Rosenberg & Horner, 1991).

Rosenberg and Horner (1991) term the adopted child's version of the family romance fantasy — the fantasy of the birth parents — the "birthparent romance." According to Rosenberg and Horner, the birthparent romance is based on a combination of fact (what the child has been told about the birth parents) and fantasy; it is elaborated over the course of development and becomes part of the child's self-representation and identity. While there are similarities between the family romance fantasy and the birthparent romance, there are also important differences. As with the family romance fantasy, the adopted child may imagine another set of parents "better" than the ones she lives with. But this fantasy is far more complicated and emotionally fraught for the child because he has in reality absent, original parents (Rosenberg & Horner, 1991). Unlike the family romance fantasies of the biological child that in effect preserve his idealization of his parents, birth parent fantasies in adoption may be disturbing to the child, experienced as an attack on his adoptive parents (Hodges, 1984). And rather than facilitating the integration of ambivalent feelings, fantasies of the birth parent can have the opposite effect, keeping such feelings polarized. Clinical writers have also reported cases where adopted children reversed the family romance fantasy by imagining a blood tie to the adoptive parents (Priel et al., 2000).

Often the adopted child's birthparent romance becomes split, as the biological parents are either idealized or devalued. Negative images of the birth parents may develop based on information about their lives and about the adoption itself or overt or unconscious communications from the adoptive parents regarding the birth parents'

promiscuity or other flaws (Wieder, 1977a, Glenn, 1985, Deeg, 1989). Wieder (1977a) suggests that in the child's mind, the birth parents are ultimately associated with the act of abandonment, therefore idealized fantasies about the birth parents cannot be sustained and soon turn negative. Rosenberg and Horner (1991) agree that negative qualities are often assigned to the biological parents, but suggest that it is also common for the biological parents to be idealized as adopted children attempt to deny the painful reality of their parents' decision to give them up. Likewise, Brinich (1995) observes that children's fantasies about their birth parents are often reparative, embellishing the story of the relinquishment (i.e. imagining that their birth parents are anguished or miss them). Whatever the quality, good or bad, of the birth parent fantasy, the child often sees the opposite quality in his adoptive parents (Brinich, 1995; Wieder, 1977b).

A study of the Fantasies of the Birth Mother in Adopted Adult Women

Miller-Havens (1996) studied the birth mother fantasies of adult women who were adopted during infancy or childhood, and who had reunited with (or were in the process of searching for) their birth mothers. The majority of subjects reported searching because of a wish to connect to their birth origins, and almost all reported having had fantasies about their birth mothers. In analyzing her data, Miller-Havens divided fantasies into two types: fantasies of "disconnection" having to do with the relinquishment and fantasies of "connection" having to do with the characteristics or activities of the birth mother (p. 276). She found that only 25% of her subjects fantasized that their birth parents were better parents than their adoptive parents, and only a few imagined that their birth parents were famous or from royalty, findings she interpreted as evidence that

adoption fantasies do not fit into Freud's construct of the family romance. One problem with this reasoning is that clinical evidence of family romance fantasies in adoptees generally comes from work with children (for whom family romance fantasies are theoretically present). One would not necessarily expect family romance fantasies (at least as described by Freud, 1909) in adults.

However, in this sample there appeared to be evidence of a tendency toward idealizing rather than devaluing fantasies, though Miller-Havens does not discuss this tendency. The fifty-seven subjects reported over one thousand fantasies, so it is not clear whether the examples given reflect the data as a whole. Still, a majority of the fantasies presented by Miller-Havens either idealize the birth mother as a person, or describe the birth mother as not responsible for the relinquishment and/or anguished over her lost child. The examples from this study suggest a prevalent fantasy of a perfect bond with the birth mother, if not an idealization of the birth mother herself. The following is an example of a idealizing fantasy from her study:

> She was very much life to me. I fantasized that she looked like me. She was very musical, passionate, intelligent, educated, religious, and a victim. She is very sad as I am very sad. I fantasize she is me; she is my soul mate. She is the me that I have lost. She is the presence beneath this huge sense of loss that I have always lived with . She is home, a place of beginning and return, the wholeness that I have never been able to acquire. She is my mother, a connection, a belonging that I have never had. She is the child in me, my spirit. I hope that she has come to terms with this loss and pray that she is happy. But I think that we are both very sad, I want to find her, touch her more than anything else (p. 291).

In contrast, other subjects are able to articulate the pull to idealize the birth mother in order to manage their ambivalence toward her. "'I wanted to believe she was a warm,

caring person so I wouldn't hold it against her for giving me up for adoption'" writes one subject. Another states "'Perhaps I built her up in my mind as someone famous and beautiful to compensate for how I really saw her deep inside'" (p. 285).

Miller-Havens reports that subjects described twice as many fantasies of connection than of disconnection, and she interprets this finding as reflecting the wish to be in a relationship with the birth mother, a wish she sees as consistent with theories stating that relationships are central in women's development. The finding may also reflect a tendency in adoptees to deny (or avoid thinking about) the initial relinquishment and possible negative characteristics of the birth mother. (Miller-Haven's discusses the tendency toward denial when describing fantasies of subjects who say that as children, they avoided thinking about the relinquishment.) Miller-Havens also found that the content of fantasies did not necessarily correspond with what subjects had been told about their birth mothers. This finding supports Hodges' (1984) observations that birth parent fantasies stem from internal processes as much as, if not more than, external fact. One limitation of the study is that Miller-Havens did not differentiate between subjects who had met their birth mothers and those who had not, so it is impossible to know what the impact of a reunion with the birth mother would be on their reported fantasies. In addition, subjects do not describe their relationships with their adoptive mothers, so it is unknown how (or whether) these relationships are connected to the birth mother fantasies in this sample.

Adoption and the Development of Object Representations

Birth parent fantasies exist on both a conscious and unconscious level in adopted children. For instance, Hodges (1984) notes that only some aspects of adoption fantasies remain conscious — and at times consciously hidden from the adoptive parents — while the unconscious aspects emerge in psychoanalytic treatment, first in "defended, distorted, and derivative forms" that are gradually recognized as stemming from underlying fantasies (p. 49). Clinical writers on adoption often discuss birth parent fantasies in terms of the adopted child's object representations — representations of both sets of parents and of the child in relation to her parents — that function on both a conscious and an unconscious level.

Though the adopted child lacks the daily interactions with her birth parents that typically constitute a child's internalized object representations, she nonetheless develops representations of the birth parents out of the knowledge that they exist and related fantasies (Glenn, 1985; Hodges, 1984). "What our observations seem to show is the child's *wish* for a mental representation, without, as it were, enough bricks to build it. It is as though the information that other parents existed creates a gap needing to be filled by a representation," writes Hodges (1984, p. 49). The adopted child's construction of representations of the birth parents has been compared to a bereaved child's need to form a representation of a parent who died. "In both cases a person has powerful emotions and detailed thoughts about an individual who is not present," writes Nickman (1996), adding that like all object representations, birth parent representations function consciously and unconsciously and influence affect and behavior. These representations are colored by information the child has received about his birth parents, his fantasies about the

adoption, his adoptive parents' conflicts and attitudes regarding the birth parents and adoption, and his psychosocial level of development (Glenn, 1985; Hodges, 1984). "When the child is told of the biological parents, they are introduced as an idea, with more or less information given by the parents, but to which the child attaches feelings and fantasies of his or her own," writes Hodges (1984, pp. 49-50.) Without an actual, day-to-day relationship as its basis, the birth parent representation is primarily shaped by internal processes, "a locus for feelings and fantasies, not modified by everyday reality experience" (Hodges, 1984, p. 50).

Thus, the adopted child is in a unique position in terms of his developing object relations. He has two sets of parents (one present, one absent) and two sets of corresponding representations (one based on lived relationships, one based primarily on fantasy) to integrate into his sense of self and others. Polarization between adoptive and birth parents is difficult to overcome, and ambivalence toward them difficult to master (Brinich, 1980, Rosenberg & Horner, 1991). "The fact that the adopted child has two sets of parents makes it relatively easy for him or her to direct loving and hateful feelings toward different sets of parents," writes Brinich (1995), "Love may be focused on the adoptive parents, whereas hate is directed outwardly, toward the biological parents, or vice versa" (p. 193). Likewise, Priel et al. (2000) note that adopted children have difficulty resolving emotional conflicts with their adoptive parents, due to the fact that they have two sets of parents.

Whether idealizing or denigrating, the child's feelings regarding one set of parents continually color his attitude toward the other set. In this way, the representations of the birth and adoptive parents are connected. Negatively tinged images of the birth parents

may derive from representations of the adoptive parents, as disappointments in the adoptive parents are projected onto the fantasied birth parents. Alternatively, negative characteristics of the fantasied birth parents may be transferred in the child's mind onto the adoptive parents (Glenn, 1985; Priel, 2000). Hodges (1984) suggests that the representation of the birth parent may stem from the child's feelings about the adoptive parents as well as "defensive distortions" (p. 50). Perhaps one example is a case described by Nickman (1996) of an adult patient who reported the childhood fantasy that her birth family was warm and harmonious in contrast to her adoptive parents who were aloof and prone to conflict; the idealizing fantasy comforted her when she felt distressed in the context of her adoptive family.

According to Deeg (1990), the child's representations of the birth parents are more likely to become polarized and distorted when development has been maladaptive in some way. In such cases, these representations function as a defense against intolerable feelings or states. For instance, the child may fantasize about a birth parent who provides limitless gratification in order to undo the narcissistic injury of the original abandonment. Or the child may defend against aggression toward his adoptive parents by minimizing his feelings toward them, declaring his birth parents to be his "real parents." In situations where the adoptive parents are overly gratifying or engulfing, the child may intensify his fantasied relationship with the birth parent in order to delineate a clearer boundary between himself and his adoptive family. Or the child may defend against an adoption-related fear of abandonment by unconsciously provoking significant others to be punitive and/or rejecting. In this way, the child projects the representation of the relinquishing

birth parent onto others, and through re-enactment, brings experiences of abandonment under his control (Deeg, 1990, pp. 147-155).

In response to Deeg (1990), Michaels (1990) asserts that in healthy development, the adopted child's representations of birth parents may also function defensively in ways that are adaptive and appropriate. She argues that the representation of the birth parent may serve a "structure-building purpose," to aid in the development of a self-representation as a "wanted child to counterbalance the image of not being kept" (pp. 158 & 160). In order to foster healthy adaptation, Michaels writes, the representation of the birth parent must be fluid, its meaning and function changing along with the child's needs and cognitive and emotional levels of development. In discussing the changing functions of the representations of the birth parents, Michaels seems also to be referring to the child's capacity to employ a range of defenses. Therefore, like Deeg, she highlights the connection between the child's level of functioning and the quality of his parental representations. As Deeg (1989) states, "the relative success of the adoptee in adapting to the full range of his or her particular human experience is commensurate to the quality and maturational level of this object relation [the internal relationship between the adopted child and the birth parent]" (p. 155).

A Study of the Representations of the Birth Mother and the Adoptive Mother in Adopted Children

Priel et al. (2000) evaluated the representations of the birth mother and the adoptive mother in a nonclinical sample of adopted latency age children and the representations of the birth mother in a comparable, nonadopted sample, in order to

explore the impact of adoption on object representations. They evaluated the structure and content of these representations using the Object Representation Inventory. In comparing the adopted and nonadopted groups, Priel et al. found that the adopted group's representations of the adoptive and birth mothers were less benevolent, and their representations of the birth mother were more punitive, than the birth mother representations of the nonadopted group. In addition, the adopted children's representations of both mothers were at a lower conceptual (cognitive-developmental) level and more concrete than the birth mother representations of the nonadopted children. Representations of the birth mother in adoptees were also notable for their focus on physical characteristics; in other words, these children described their birth mothers primarily in terms of their appearance more often than did the nonadopted children. In examining the data from within the adoptive group, Priel et al. found no difference in conceptual level between the representations of the birth and adoptive mothers. This finding, according to Priel et al., supports previous findings that conceptual level is a relatively constant dimension that correlates with the individual's level of maturity, but not with the content of the representations. There were, however, differences of content within the adopted group. Representations of the birth mother were significantly less benign than those of the adoptive mother, suggesting that, according to Priel et al., the birth mother representations contained split off, negative characteristics of the adoptive mother. Priel et al. also found that greater discrepancy in content between the representations of the birth and adoptive mother was associated with greater symptomatology in the adopted children (specifically externalizing behaviors), indicating

that the disjunction between the two maternal images created psychological stress. Priel et al. write:

> The association found between latency adoptees' splitting on the basis of two maternal representations and externalizing behaviors corroborates basic psychoanalytic assumptions about the importance of an integrated internal world of representations for normal development, as well as the relations between splitting and aggressive behavior. (p. 143).

Based on their findings, Priel et al. (2000) suggest that the experience of having been relinquished for adoption may negatively skew the development of object representations in adoptees. They interpret the finding that latency-age adoptees' representations of the birth mother tended to be concrete, focusing on physical features, as indicating that adoptees are comparatively delayed in the development of symbolic maternal representations. In addition, this delay may reflect their difficulty in integrating the loss of the birth mother into their object representational world (Priel et al., 2000).

The Development of Self-Representations In Adoptees

The adopted child's sense of self is uniquely shaped by her adopted status. As the child struggles to integrate the fact of her adoption into her self-representations, a variety of defensive processes aimed at maintaining self-esteem may come into play. As Rosenberg and Horner (1991) write, "The children feel that they were either 'not meant to be' or 'intolerable,' and may spend a large part of a lifetime struggling with whether this means that the biological parents were bad (inadequate) parents, or that they themselves were bad children, causing their unhappiness, thereby deserving abandonment, and so on" (Rosenberg & Horner, 1991, p. 71). As previously mentioned,

the child may enact the view of himself as unwanted, and the accompanying fear of abandonment, by misbehaving with the adoptive parents to test their commitment. According to Brinich (1995) this can lead to a destructive cycle in which the child's anxiety and acting out behaviors increase with each "test" until the parents are provoked to reject her. However, some latency-age children exhibit the opposite behavior, developing the need to be excessively good for fear of being rejected or given away (Rosenberg & Horner, 1991).

The adopted child's sense of self is also shaped by the meanings that she and her adoptive family make of her adoption — by her representations of significant others (and herself in relation to them) and by her adopted parents' representations of her and her biological family. Moreover, because the child identifies in various ways with both the adoptive and birth parents, her self-representation is tied to all of her parental representations (Glenn, 1985). As demonstrated by Priel et al. (2000), representations of the adoptive and birth mothers may become polarized with one containing primarily negative characteristics, and the other containing primarily positive characteristics. Likewise, the adopted child may develop a parallel split in her self-representation (Glenn, 1985; Wieder, 1977a). In one common scenario, the representations of the biological versus the adoptive parents are divided in terms of instinctual urges, the biological parents being seen as sexual and aggressive while the adoptive parents are viewed as asexual and nurturing (Wieder, 1977b, p. 19). Negative qualities assigned by the child to the biological parents inevitably add to the child's sense of her own low self-worth. Any qualities that may be considered "bad," such as sexuality and aggression, "become the

child's 'evidence' of his or her own endowed badness" (Rosenberg & Horner, 1991, p. 73).

To further complicate matters, the adoptive parents' fantasies and conflicts about the adoption influence the child's developing sense of self and others, and in some instances, can fuel splits in related self- and object representations. Adoptive parents may attribute the child's positive characteristics to their caretaking skills and his negative characteristics (again, such as sexuality and aggression, which are often viewed as negative) to the birth parents (Brinich 1980; Deeg, 1989; Hodges, 1984). Thus adoptive parents may develop "good" and "bad" representations of their child that the child then internalizes as good and bad aspects of himself (Brinich, 1980). "The situation is complicated indeed," writes Glenn (1985), "The representations of the biological parents, the adoptive parents, and the child all affect one another" (p. 310).

Assessment of Object Representations

Freud described the process of superego formation in which significant others are identified with and taken into the ego to become part of the individual's internal world. Subsequent theorists expanded on Freud's ideas about internalization to include all interactions with the environment that are then transformed into regulating, psychological structures (Blatt & Lerner, 1983). According to Blatt and Lerner (1983), early, formative relationships are internalized as representations of self and other (and self and other in interaction) that become the framework for the individual's behavior in interpersonal relationships. They write:

> Broadly defined, object representation refers to the conscious and unconscious mental schemata – including

> cognitive, affective, and experiential components – of objects encountered in reality. (p. 194).

Representations of self and other begin in infancy as "vague, diffuse, variable, sensorimotor experiences of pleasures and unpleasure" and become increasingly differentiated, consistent and realistic over the course of development (Blatt & Lerner, 1983, p. 194).

Projective measures, because of their ambiguous, open-ended nature, allow for the elucidation of unconscious processes such as object relations. As the individual attempts to organize and make sense of projective test material, his responses are shaped by "the organizing characteristics of [his] representational world" (Blatt & Lerner, 1983, p. 195). For instance, in describing the Rorschach test, Mayman (1967) writes, "a person's most readily accessible object-representations called up under such unstructured conditions tell much about his inner world of objects and about the quality of relationships with these inner objects toward which he is predisposed" (p. 17). Thus projective measures have been the primary tool used to assess object representations (Fishler, et al., 1990).

Two research groups in particular are frequently cited for their development of projective methods for assessing object representations: Blatt's research group at Yale University and Mayman's research group at the University of Michigan (Blatt & Lerner, 1983; Fishler, 1990; Kelly, 1997). Mayman and his colleagues have developed assessment techniques and scales focussing on the thematic qualities of object representations using early memories, Rorschach responses, and the manifest content of dreams. Their research has shown, among other things, that projective data is reliably rated using an empathic-intuitive method in which skilled, trained clinicians evaluate

projective data according to their understanding of psychological functioning (Blatt & Lerner, 1983). Furthermore, studies have shown one or more of these measures to discriminate between clinical diagnostic groups and between clinical and nonclinical samples, and to correlate with level of psychopathology, with the ability to enter into a psychotherapeutic relationship, with therapist-supervisor ratings of subjects' object relations, and with long-term outcome in child patients. (Blatt & Lerner, 1983; Stricker & Healey, 1990; Tuber, 1992).

While Mayman's group has focussed primarily on themes and content in object representations, Blatt and his colleagues have focussed on the structural dimensions of object representations. Based on cognitive-developmental and psychoanalytic theory, they assert that during the course of development, an individual's representations of self and others become increasingly articulated, integrated and realistic (Blatt & Lerner, 1983). Their examination of the structure of object representations has included the study of boundary disruption in Rorschach responses, human responses on the Rorschach, and spontaneous descriptions of significant others (the Object Representation Inventory). Blatt and Ritzler (1974), as cited in Blatt and Lerner (1983), found that various levels of boundary disruption in Rorschach responses correlated to levels of functioning in psychiatric patients. In terms of assessing human responses on the Rorschach, the Developmental Analysis of the Concept of the Object Scale (DACOS), developed by Blatt, Brenneis, and Schimek (1976), has been shown to differentiate between diagnostic categories and between clinical and nonclinical samples (Stricker & Healey, 1990). In addition, Blatt et al., 1976 (as cited in Stricker & Healey, 1990) found that in a normal sample, human responses on the Rorschach became increasingly well articulated,

accurately perceived and fully human over a 20 year period, validating the developmental basis of the DACOS. (See Methodology for a complete description of the Object Representation Inventory and related research findings).

In sum, researchers and clinicians studying adoption present an exceedingly complex picture, with multiple factors shaping, enhancing and/or undermining the adopted child's adjustment and development. Some influential factors pertain to the circumstances of the adoption, such as age at adoption, pre-adoption caretaking conditions and the adoptive parents' capacity to manage adoption-related issues with their children. The adoption literature also contains many more studies focussing on adopted children than on adopted adults.

Research indicates (and common sense would suggest) that relationships within the adoptive family will influence how well the adopted child integrates the knowledge of his adoption and his related ambivalence and conflicts. Furthermore, object relations theorists note the centrality of early caretaking relationships in the formation of self- and object representations. As Blatt & Lerner (1983) write, "The development of the representational world into a cohesive and integrated sense of reality initially occurs within the context of the primary caretaking relationship. Eventually this context expands to include significant others." This study therefore examines the quality of the adoptive mother-child relationship *as it has been internalized and represented* in the minds of adults who were adopted in infancy, using a projective measure, the Object Representation Inventory, to elucidate relevant object representations. It is this author's expectation that there will be a connection between the adoptee's representation of the

adoptive mother and other significant representations, specifically that of the birth mother and that of the self. "There can be considerable variation among children" in their experiences of parental behavior, write Blatt and Lerner (1983), "(...)Although we need objective assessments of parental behavior and family interactions, it is essential to assess the phenomenological world — how individuals experience, remember, and represent their parents and their family interactions." (p. 232).

CHAPTER III

Method

This study explores the connection between adopted adults' representations of significant early care-taking relationships, their fantasies of their birth parents, and their views of themselves. In order to examine this connection, this study compares the representations of the adoptive mother, of the birth mother, and of the self in a group of adults who were adopted in infancy.

Subjects

The subjects in this study were 27 American-born adults between the ages of 18 and 35 who were adopted within the first 18 months after birth by parents who shared the subjects' race and ethnicity. Ages of subjects were confined to the early to middle adult years to limit the range of adult developmental changes that can influence object representations. Because parenthood impacts one's feelings and attitudes towards one's own parents — and thus presumably impacts one's representations of one's parents — adult adoptees who had had children were excluded from the study. And because contact with birth parents likely alters their representations, these subjects had neither met nor corresponded with their birth parents.

Subjects who currently lived with their adoptive parents were excluded from this study, because the content of parental representations, as measured by the Object Representation Inventory, has been shown to be unstable over time for individuals who

live with their parents (Bornstein, Galley, Leone, & Kale, 1991). In addition, except for one subject who reported having been hospitalized for depression at age sixteen, participants in this study had never been hospitalized for major psychiatric illness nor currently suffered severe psychiatric symptoms. Finally, the study was limited to subjects whose adoptive mothers were still living.

Procedure

The author recruited subjects directly by posting advertisements at local universities, in local newspapers, at adoption-related agencies and support groups, on adoption-related Internet sites, and by word of mouth. The investigator briefly screened potential subjects by phone to determine their suitability for the current study. Subjects then received by mail a packet containing a letter of introduction, consent form, a stamped envelope to return the packet to the author, and a set of self-report measures including:

1. demographic questionnaire
2. Brief Symptom Inventory (Derogatis)
3. Object Representation Inventory (Blatt, Wein, Chevron, & Quinlan, 1979) with an additional item asking for a description of the birth mother, as imagined.
4. Assessment of Self Descriptions (Blatt, Bers & Stein, 1985)

In two instances, subjects who initially failed to give written descriptions of their birth mothers subsequently gave descriptions by phone when contacted by the author. Subjects received a modest payment for their participation.

Measures

Brief Symptom Inventory

The Brief Symptom Inventory (BSI), was used as a screening measure to assess subjects' overall level of psychopathology. The BSI is a self-report measure of psychiatric symptoms that is a comparable, shorter version of the Hopkins Symptom Checklist – Revised (SCL-90-R) (Derogatis et al., 1976). (The SCL-90-R, which consists of 90 items, was developed for use in both clinical and research situations as a measure of symptomatology in psychiatric and medical adult outpatients.) The BSI consists of 53 items, reflecting the nine symptom dimensions of the SCL-90-R. Each checklist item is rated on a five-point scale according to the level of distress the subject has experienced in the past seven days related to that item, from "not at all" to "extremely." The nine symptom dimension scores indicate severity of symptoms in the following areas: depression (DEP), anxiety (ANX), phobic anxiety (PHOB), somatization (SOM), interpersonal sensitivity (I-S), paranoid ideation (PAR), psychoticism (PSY), obsessive-compulsive (O-C), and hostility (HOS). In addition, the BSI yields three global scores also generated by the SCL-90-R: the Positive Symptom Distress Index (PSDI), the Positive Symptom Total (PST), and the Global Severity Index (GSI). The PSDI indicates overall intensity of symptoms, the PST indicates the total number of symptoms, and the GSI combines the information on intensity and number of symptoms to give a sum indication of severity of pathology (Derogatis & Melisaratos, 1983). According to Derogatis & Melisaratos, of the BSI scores, the GSI is the best overall indicator of current levels of distress.

Research has demonstrated that the BSI has good test-retest and internal consistency reliabilities and convergent and construct validity, and that it correlates highly with comparable dimensions of the SCL-90-R. The nine-symptom dimensions' internal consistency has been shown to range from .71 to .83 and test-retest reliability from .68 to .91. Furthermore, they have been found to have very high convergent validity with their counterparts of the MMPI. Test-retest reliability for the global indices has been demonstrated to range from .80 to .90. In addition, there are three published norms available for the BSI, based on psychiatric outpatients, psychiatric inpatients, and normal (nonpatient) samples (Derogatis & Melisaratos, 1983).

According to Derogatis and Melisaratos (1983), when interpreting the BSI, the investigator should first examine the global scores in order to get a sense of the degree of overall distress experienced by the subject. Next, evaluation of the nine symptom dimensions helps to delineate specific areas of psychopathology. Finally, the investigator may focus on responses to individual items in order to discern the presence and level of the subject's particular symptomatic experiences.

Object Representation Inventory

The Object Representation Inventory (ORI) was used in this study to evaluate representations of adoptive mothers and birth mothers in a sample of adopted adults. The ORI, developed by Blatt, Wein, Chevron, and Quinlan (1979) and revised by Blatt et al. (1988 & 1992), is a self-report measure in which the subject is asked to give spontaneous descriptions of significant others. These open-ended descriptions may be written by the subject or tape-recorded and transcribed verbatim by the investigator. In this study,

subjects were given one blank piece of paper with the heading "Describe your adoptive mother" and a second piece of paper with the heading, "Describe your birth mother as you imagine her to be."

Descriptions were evaluated according to the Assessment of Qualitative and Structural Dimensions of Object Representations scale (Blatt, Chevron, Quinlan, Schaffer, & Wein, 1992). According to this scale, descriptions may be rated in five areas: conceptual level of the representation (CL), qualitative characteristics, degree of ambivalence, length, and degree of articulation (SA). Conceptual level is scored on a nine-point scale divided into five gradations that range from the most primitive and undifferentiated to the most developed and integrated. At the Sensorimotor-Preoperational level (score 1), the most primitive conceptual level, the individual (significant other) is described primarily in terms of how she gratifies or frustrates the subject. At the Concrete-Perceptual level (Score 3), the individual is described primarily in terms of her physical traits. The Iconic level (Scores 5-7) has two phases: At the External Iconic Level (Score 5), the individual is described in terms of her activities. (Unlike the Sensorimotor-Preoperational level, however, the actions described are not related to the subject's gratification.) At the Internal Iconic level (Score 7), the individual is depicted in terms of her internal states — i.e. what she values, thinks and feels. Finally, at the Conceptual level (score 9), the individual is described in a manner that cohesively integrates attributes from all previous levels, often indicating the subject's appreciation of the how the individual has changed over time or insight into the individual's conflicting characteristics. Even numbered scores (2,4,6,8) are given to representations that fall between levels. Thus at each subsequent level, the representation is increasingly

differentiated and better articulated, reflecting greater recognition of the represented individual's inner states in addition to her physical attributes and actions.

For the qualitative ratings, descriptions are rated for each of twelve characteristics or attributes on a seven-point scale reflecting the degree that each characteristic is present in the described individual. Characteristics include: affectionate, ambitious, malevolent-benevolent, cold-warm, constructively involved, intellectual, judgmental, a negative or positive ideal, nurturant, punitive, successful, and strong. When there is not enough information or detail in a description to rate a particular attribute, that attribute is rated "9", essentially meaning "no score". In addition, the following three factor scores based on the twelve attributes may be derived: Benevolent (comprised of affectionate, benevolent, warm, constructive involvement, positive ideal, nurturant, successful and strong), Punitive (comprised of judgmental, punitive, and ambivalent) and Ambitious (comprised of ambitious and intellectual).

Descriptions are also rated for the degree of ambivalence the subject expresses toward the individual described. Specifically, the Ambivalence subscale measures the degree to which the subject expresses unresolved, conflicting, confused or inconsistent feelings toward the described individual. Verbal fluency is also scored based on the length of the description. Finally, representations may be rated for their degree of articulation based on the number of scorable attributes (SA), out of the possible twelve, used to describe the individual.

A number of studies have found the ORI to have sound psychometric properties. In a study of the ORI's reliability and validity using a nonclinical sample of college students, Quinlan, Blatt, Chevron, and Wein (1992) reported inter-rater reliability for the

twelve character traits as ranging from .917 (for Warm) to .449 (Affectionate), and reliability of .88 for length. Reliability for Ambivalence was .413. However when the Ambivalence scale was subsequently increased from three to five points, reliability increased to .87 (Blatt et al., 1992). Blatt et al. (1992) further reported reliability of .88 for Conceptual Level. High inter-rater reliability has also been found in studies by Bornstein, Galley, and Leone (1986) and Bornstein, Galley, Leone, and Kale (1991). According to Quinlan et al., four factors account for 71% of the total variance: Benevolent, Punitive, Ambitious and Length. Inter-rater reliability for these factors have ranged from .77 (Punitive) to .92 (Benevolent).

ORI scores have been shown to correlate significantly with parental ratings on the Semantic Differential by Osgood, Suci and Tannenbaum (1957) (Quinlan, et al., 1992) and with parental ratings on Parker, Tupling, and Brown's (1979) Parental Bonding Instrument (Schaffer & Blatt, 1990). Quinlan et al. (1992) further reported significant relationships between ORI scores and scores on measures of depression such as the Zung Self-Rating Depression Scale (Zung, 1972) and the Depressive Experiences Questionnaire (Blatt, D'Afflitti, & Quinlan, 1976). Studies further found ORI scores to be unrelated to intelligence, education and socioeconomic or marital status (Blatt et al., 1979; Bornstein, Galley & Leone, 1986; Bornstein & O'Neill, 1992).

The ORI has been utilized in studies of clinical and nonclinical samples. For instance, studies of inpatient populations have shown ORI scores to be related to clinical functioning over the course of intensive therapy (Blatt, Wiseman, Prince-Gibson, & Gatt, 1991; Blatt, Stayner, Auerbach, & Behrends, 1996) and to the presence and level of pathology (Bornstein & O'Neill, 1992). Studies of nonclinical samples have

demonstrated relationships between ORI scores and depression (Blatt et al., 1979), attachment styles (Levy, Blatt, & Shaver, 1998), and measures of orality (Bornstein et al., 1986).

ORI dimensions of the representation have also been found to correlate with each other. For instance, Bornstein et al. (1992) found that the two original factor scores (nurturance and striving) correlated with each other in a sample of male and female psychiatric patients and nonpatients. Bornstein et al. further found that both factor scores negatively correlated with degree of ambivalence. Length of description, on the other hand, has been found to be unrelated to conceptual level and ambivalence (Bornstein et al, 1992). Conceptual level, qualitative ratings, and degree of ambivalence of parental representations have been found to discriminate between inpatient and nonpatient samples and to correlate with level of psychopathology within an inpatient sample (Bornstein et al, 1992). In addition, qualitative ratings of parental representations have proven to be unstable over a six week period for adults living with their parents but stable for those living away from home, while conceptual level, degree of ambivalence, and length remain stable over time in both circumstances (Bornstein et al, 1991).

Assessment of Self Descriptions

The Assessment of Self-Descriptions is a modified version of the ORI developed by Blatt, Bers, & Stein, (1985). As in the ORI, the subject gives a spontaneous description of himself that is then scored for quality and conceptual level using scales and standards similar to those of the ORI. Additional features of the representation may also be scored, including level of tolerance for contradictory characteristics within the self,

level of differentiation between self and other, level of relatedness, level of self-definition, and quality and coherence of mood states. Inter-rater reliabilities range from .74 to .99 according to Blatt et al. (1991). In a study of normal college students, Bornstein (1988) demonstrated a relationship between self-description ratings and level of orality. Moreover, in a study of psychiatric inpatients in long-term treatment, positive changes in self-descriptions paralleled independently rated treatment gains (Bers, Blatt, Sayward, & Johnston (1993). For this study, subjects were given a blank piece of paper with the heading, "Describe yourself." Descriptions were then scored according to the procedures developed by Blatt et al. (1991).

For this study, representations of the adoptive mother, the birth mother and the self were scored for conceptual level by a doctoral student in clinical psychology who had proven in prior studies to be reliable with the Assessment of Qualitative and Structural Dimensions of Object Representations scale of the ORI. Qualitative dimensions were scored by a clinical psychologist who, with the author, trained in scoring to achieve reliability. The author scored one third of the sample's written descriptions (9 adoptive mother descriptions and 9 birth mother descriptions) and these scores were used along with those of the primary scorer to calculate interrater reliability. When either the primary scorer or the author gave a rating of 9 (meaning "no score") for any characteristic on a given description, that pair of scores was not included in calculating reliability for that characteristic. For 10 of the 12 qualitative characteristics, reliability coefficients ranged from .91 to .98. The primary scorer and author did not achieve reliability on Judgmental or Intellectual, because unlike the other 10 characteristics, Judgmental and Intellectual were rarely scored in the 18 descriptions used

to determine reliability. Therefore, reliability for Judgmental was calculated based on the scores from only two descriptions, and reliability for Intellectual could not be calculated because there were no descriptions for which both scorers gave a rating for Intellectual. Given the strong reliability demonstrated for the other 10 characteristics, it is likely that reliability for Judgmental and Intellectual would have been equally strong if more cases had been available for calculation.

Main Hypotheses

This study explores the connection between adoptees' representations of early care-taking relationships and other significant object representations by examining the representations of the adoptive mother, the birth mother, and the self in a sample of adopted adults. In this study, the Object Representations Inventory (ORI) is used to measure the quality of these representations in terms of the following dimensions: conceptual level (CL), qualitative characteristics, and degree of articulation (SA).

Hypothesis One

Hypothesis 1A: We expect that subjects whose representations of their adoptive mothers are at a higher conceptual level than those of other subjects will also have representations of their birth mothers and of themselves that are at a higher conceptual level than those of the other subjects. The conceptual level subscale of the ORI will measure conceptual level.

Hypothesis 1B: Likewise, we expect that subjects whose representations of their adoptive mothers are better articulated than those of other subjects will also have representations of their birth mothers that are better articulated than those of other subjects. Degree of articulation will be determined by the number of scorable attributes or characteristics, out of a possible twelve, used to describe the adoptive mother and the birth mother on the ORI (SA subscale).

Hypothesis Two

While the first hypothesis focuses on the conceptual level and degree of articulation of representations, the second hypothesis focuses on their qualitative characteristics (the personal qualities assigned to the represented individual). The second hypothesis is based on clinical findings that adopted children and adolescents often form polarized representations of their adoptive and birth parents, with one set of parents idealized and the other devalued. The assumption here is that the representations of the birth parents function to help the adopted individual manage his ambivalence toward the adoptive parents by providing fantasied (but existent) parents who are "flawless" specifically in the ways that the adoptive parents are flawed. Therefore, for the adopted individual, the fantasy of the unknown birth mother will be complementary to his view of the adoptive mother, in a sense making up for the real-life disappointments in the adoptive mother.

Hypothesis 2: We expect that in a sample of adopted adults, the description of negative attributes in the adoptive mother will be associated with the description of complementary, positive attributes in the birth mother. In order to measure the occurrence of this complementary relationship between attributes assigned to the adoptive versus the birth mother, each subject's qualitative ratings for the adoptive mother will be examined for negatively skewed scores. When a negatively skewed score is found for a particular attribute, it is expected to be associated with a positively skewed score on the same attribute in the representation of the birth mother.

For the purposes of this study, the following attributes will be considered positive: affectionate, benevolent, warm, constructive involvement, positive ideal, nurturant,

successful, and strong. (These attributes, that comprise the benevolent factor score, are described by Blatt et al (1992) as "positively valued aspects of parental roles," (p. 21)). For the above positive attributes, scores of 4 or more will be considered positively skewed and scores of 3 or less will be considered negatively skewed. (Attributes are scored 1-7.) Likewise, the following attributes will be considered negative: punitive and judgmental. (These attributes have been labeled "negative" here because they comprise the Punitive factor score). For the above negative attributes, scores of 3 or less will be considered positively skewed and scores of 4 or more will be considered negatively skewed. The remaining two attributes, intellectual and ambitious, will not be examined here as their positive/negative valence is too ambiguous for the purposes of this study.

Hypothesis Three

The third hypothesis explores the relationship between the quality of the representation of the adoptive mother and the degree of discrepancy between the representation of the adoptive mother and that of the birth mother in terms of their qualitative characteristics. Discrepancy here refers to how disparate the adoptive and birth mother representations are in terms of the positive or negative valence of their qualitative characteristics. Using the Euclidean Distance Metric, a discrepancy variable will be calculated based on the qualitative scores to signify the disparity between the adoptive and birth mother representations. Quality here refers to conceptual level and degree of articulation — discrete dimensions that contribute to the overall quality of a representation (Blatt et al., 1979, 1991, & 1996; Bornstein et al., 1986, 1991, & 1992; Quinlan et al., 1992; and Priel et al, 2000). This study will examine the conceptual level

and level of articulation of the adoptive mother representation as they relate to the degree of discrepancy between the representations of the adoptive and birth mother.

The literature is mixed as to how the qualitative characteristics and conceptual level of a representation correlate with one another. For instance, while one study found that certain qualitative factor scores tended correlate positively with conceptual level (Bornstein et al., 1992), another study found that various qualitative characteristics correlated either positively or negatively with conceptual level, depending on the attachment styles of the subjects (Levy, Blatt, & Shaver, 1998). Because previous research does not show consistent correlations between the conceptual level and qualitative characteristics of a representation, this study will explore, rather than attempt to predict, the relationship between conceptual level and qualitative characteristics (in terms of a discrepancy variable) in this sample of adopted adults. Similarly, the relationships between discrepancy and degree of articulation will be explored but not predicted.

CHAPTER 1V

RESULTS

Subjects

The subjects for this study were 27 American-born adults who had been adopted in infancy and who had no contact with their birth families. Their ages ranged from 18 – 35, averaging 25 (Median = 25, SD = 5.48). As shown in table 1, the subjects were predominantly female and white. They were generally well educated— more than half had begun or completed college and more than one quarter had begun or completed a postgraduate degree.

All of the adoptive mothers of the 27 subjects were still living. However, three subjects' adoptive fathers were no longer living: in two cases, the adoptive fathers died when the subjects were 8 years old; the remaining subject's adoptive father died approximately one year prior to this study when the subject was 26 years old. Twenty-four subjects (88.9%) reported having been raised by both adoptive parents. In terms of adoptive parents' levels of education, 1 adoptive father had not completed high school, 7 (25.9%) were high school graduates, 7 (25.9%) had begun or completed college, and 12 (44.4%) had completed postgraduate degrees. Of the adoptive mothers, 1 had not completed high school, 9 (33.3%) were high school graduates, 11 (40.7%) had begun or completed college, and 6 (22.2%) had completed postgraduate degrees.

Table 1
Subjects' Demographic Data

	N	Percentage
Gender	27	
Male	8	29.6
Female	19	70.4
Race	27	
White	24	88.9
African-American	2	7.4
Asian-American	1	3.7
Employment	27	
Full-time student	12	44.4
Employed full time	7	25.9
Employed part time	5	18.5
Self Employed	2	7.4
Unemployed	1	3.7
Education	27	
High school graduate	2	7.4
College degree, begun or completed	18	66.7
Postgraduate degree, begun or completed	7	25.9
Marital Status	27	
Single	25	92.6
Married (or partnered)	1	3.7
Widowed	1	3.7

Only one of the 27 subjects reported currently being in psychotherapy (this subject's cognitive-behavioral treatment had begun less than 6 months prior to participation in the study). However, 11 subjects (40.7%) reported having been treated previously in psychotherapy. Of these 11, 10 reported treatments that had lasted for less than one year, while the remaining subject reported treatment that had been "off and on for an extended period of time." Eight of the 11 subjects had received treatment between the ages of 12 and 17, the remaining three between the ages of 19 and 27. Only one subject had been hospitalized for psychiatric reasons (at age 16), and five had been on medication for psychiatric reasons at some point during treatment.

Most of the 27 subjects did not know whether their birth parents were deceased or living (23 or 85.2% with respect to their birth mothers and 25 or 92.6% with respect to

their birth fathers). While none of the subjects had had contact with either birth parent, 7 (25.9%) had taken steps to contact their birth mothers and 4 (14.8%) had taken steps to contact their birth fathers. Of the 23 subjects who reported on future plans to contact their birth parents, 3 planned to take steps to contact them, 8 did not plan to take such steps, and 12 were undecided.

It should be noted that subjects were also asked to report their household income and number of people in the household. However, in reviewing responses to those questions, it seemed they reflected subjects' varying frames of reference. In particular, some full-time students seemed to respond based on their families of origin while others seemed to respond based on their current living situation. These apparent inconsistencies were due to a lack of clarity in the questions themselves. Because responses were based on varying interpretations of the questions, data for household income and number of people in the household will not be reported.

Brief Symptom Inventory

Table 2 presents BSI T-scores for the total sample as well as for male and female subjects. It also presents Derogatis' (1979) normative scores for nonpatient men and women. As shown in table 2, our total sample and our female subsample had BSI mean T- scores that were very close to those of the normative samples. This was not the case, however, for our male subsample that had BSI mean T- scores above those of the normative sample.

According to Derogatis (1982) if a respondent has a GSI score greater than or equal to 63, that respondent is considered to be a "positive diagnosis or a case" (p. 32).

Nonpatient adult norms developed by Derogatis (1979) indicate that approximately 10% of men and women have GSI scores of 63 or higher. Of the 27 subjects in our sample, 7 (25.9%) had GSI scores greater than or equal to 63. Six of the 8 male subjects (75%) had GSI scores greater than 63, while only 1 of the 19 female subjects (5%) had a GSI score greater than 63. Therefore, as compared with Derogatis' nonpatient norms, it appears that a smaller percentage of this study's female subjects would be considered "positive diagnoses," while a greater percentage of its male subjects would be considered "positive diagnoses." However, given the relatively small number of male subjects in this study, it is not possible to draw conclusions from the relatively high level of symptomatology in this group of adopted men. In terms of the total sample, a higher percentage of this study's subjects would be considered "positive diagnoses" compared to Derogatis' normative nonpatient samples.

Table 2

Subjects' BSI Global Index Scores and Nonpatient Norms: BSI Global Index Scores

Subjects' BSI Global Index Scores	Mean	Median	SD	Nonpatient norms: BSI Global Index Scores	Mean
GSI: total sample	54.13	55	13.13	GSI:	
female subsample	49.05	49	10.19	female subsample	53
male subsample	66.19	66.5	11.71	male subsample	54
PST: total sample	53.63	52	13.5	PST:	
female subsample	48.73	48	11.69	female subsample	52
male subsample	65.25	66	10.3	male subsample	53
PSDI: total sample	52.74	53	7.89	PSDI:	
female subsample	50.63	52	7.17	female subsample	54
male subsample	57.75	59.5	7.63	male subsample	52

Tests for Main Hypotheses

Hypothesis 1A: Hypothesis 1A tests whether there is a relationship between the conceptual level of the adoptive mother representation and the conceptual levels of both the birth mother representation and the self-representation. In order to test for these relationships, subjects were divided into two groups, those with relatively higher conceptual levels for their adoptive mother representations and those with relatively lower conceptual levels for their adoptive mother representations. T-tests were then conducted to evaluate whether subjects in the higher conceptual level group reported significantly greater mean conceptual levels for their birth mother representations and self-representations than did subjects in the lower conceptual level group.

Conceptual level (CL) scores for adoptive mother representations ranged from 1-8. The mean score was 5.43 and the median score was 6 (SD 1.77). Subjects were divided into two groups according to their conceptual level scores for the adoptive mother (AM) representations, using the median score of 6 as the dividing point. The 15 subjects whose adoptive mother conceptual level scores were at or above the median (ranging from 6-8) were designated the higher adoptive mother conceptual level group. The 12 subjects whose adoptive mother conceptual level scores fell below the median (ranging from 1-5.5) were designated the lower adoptive mother conceptual level group.

Two t-tests were then conducted, the first comparing the mean conceptual level scores of the birth mother (BM) representations in the higher and lower adoptive mother conceptual level groups and the second comparing the mean conceptual level scores of the self-representations in the higher and lower adoptive mother conceptual level groups. It was hypothesized that the mean birth mother conceptual level score and the mean self

conceptual level score would be higher for the higher adoptive mother conceptual level group than for the lower adoptive mother conceptual level group. Table 3 presents the t-tests comparing birth mother conceptual level and self conceptual level means of the higher and lower adoptive mother conceptual level groups. As can be seen in table 3, the mean birth mother conceptual level score of the higher adoptive mother conceptual level group was not significantly higher than the mean birth mother conceptual level score of the lower adoptive mother conceptual level group. However, the mean self conceptual level score of the higher adoptive mother conceptual level group was significantly higher than the mean self conceptual level score of the lower adoptive mother conceptual level group. Therefore, hypothesis 1A was partially confirmed.

Table 3

T-test: comparison of higher and lower adoptive mother conceptual level groups on birth mother conceptual level and self conceptual level

	AM GRPS	N	Mean	SD	t	df	Sig. (2-tailed)
Birth Mother Conceptual Level	< Median	12	4.625	1.85	-0.27	25	0.79
	>=Median	15	4.8	1.56			
Self Conceptual Level	< Median	12	6.38	0.48	-2.71	23.85	0.02
	>=Median	15	7.03	0.77			

Hypothesis 1B: Hypothesis 1B tests whether there is relationship between the articulation level of the adoptive mother representation and the articulation level of the birth mother representation. In order to test for this relationship, subjects were divided into two groups, those with relatively higher articulation levels for their adoptive mother

representations and those with relatively lower articulation levels for their adoptive mother representations. A t-test was then conducted to evaluate whether subjects in the higher articulation level group reported significantly greater mean articulation levels for their birth mother representations than did subjects in the lower articulation level group.

Level of articulation (SA) scores for the adoptive mother representations ranged from 4-12. The mean score was 8.67 and the median score was 9 (SD = 1.75). Subjects were divided into two groups according to their articulation level scores for the adoptive mother descriptions, using the median score of 9 as the dividing point. The 15 subjects whose articulation level scores for the adoptive mother representation were at or above the median (ranging from 9-12) comprised the higher adoptive mother articulation level group. The 12 subjects whose articulation level scores for the adoptive mother representation fell below the median (ranging from 4-8) comprised the lower adoptive mother articulation level group.

A t-test was then calculated comparing the mean birth mother articulation level scores of the higher and lower adoptive mother articulation level groups. It was hypothesized that the mean birth mother articulation level score would be higher for the higher adoptive mother articulation level group than for the lower adoptive mother articulation level group. Table 4 presents the t-test results. As can be seen in table 4, the mean birth mother articulation level score was higher for the higher adoptive mother articulation level group than the mean birth mother articulation level score for the lower adoptive mother articulation level group, but this difference was not significant. Therefore, hypothesis 1B was disconfirmed.

Table 4

T-test: comparison of high and low adoptive mother articulation level groups on birth mother articulation level

	AM GRPS	N	Mean	SD	t	df	Sig. (2-tailed)
Birth Mother: Level of Articulation	< Median	12	4.67	2.46	-.51	25	.62
	>=Median	15	5.13	2.26			

In terms of levels of articulation, it is interesting to note that the representations of the adoptive mother were significantly better articulated than those of the birth mother. The mean articulation level score for the representations of the adoptive mother was 8.67 compared to 4.93 for the representations of the birth mother. A post hoc t-test comparing the mean articulation level scores for the representations of the adoptive and birth mothers indicated that articulation level was significantly higher for the adoptive mother representations ($p < .00$). Table 5 shows the results of this post hoc t-test.

Table 5

T-test: comparison of adoptive mother and birth mother articulation levels (SA)

	N	Mean	SD	t	df	Sig. (2-tailed)
AM SA	27	8.67	1.75	7.44	26	.000
BM SA	27	4.93	2.32			

Hypothesis 2: Hypothesis 2 tests for the degree of association between negatively skewed qualitative ratings assigned to the adoptive mother representation and positively skewed qualitative ratings assigned to the birth mother representations on the same attribute. Negatively skewed ratings refers to low scores on positive attributes such as "warm" or "benevolent," as well as high scores on negative attributes such as "judgmental" or "punitive." Conversely, positively skewed ratings refers to high scores on positive attributes and low scores on negative attributes. In an example of the type of association being tested, a subject's adoptive mother representation would be assigned a low rating for "warmth" (negatively skewed) and his/her birth mother representation would be assigned a high rating for "warmth" (positively skewed).

Each subject's ten qualitative ratings for the adoptive mother representation were examined for negatively skewed scores. When a negatively skewed score was found for a particular attribute in the adoptive mother representation, we then examined the score for that particular attribute in the birth mother representation in order to determine whether that score was, in turn, positively skewed. Negatively skewed scores for the adoptive mother representation that were associated with no score on the same attribute in the birth mother representation were discarded as they could not be evaluated due to the lack of a parallel score for the birth mother representation. Therefore, we evaluated only negatively skewed scores for the adoptive mother representation that were associated with an actual score on the same attribute for the birth mother representation. Of the 27 subjects, 13 gave at least one negatively skewed score on the qualitative ratings of their adoptive mother representations. And of those 13, 6 gave negatively skewed scores that

could be evaluated; that is, some or all of their negatively skewed scores were associated with actual scores for the birth mother representation.

In evaluating the scores of these 6 subjects, we designated any negatively skewed adoptive mother score associated with a positively skewed birth mother score on the same attribute to be a "match" and any negatively skewed adoptive mother score associated with a negatively skewed birth mother score to be a "mismatch." According to Hypothesis 2, we predicted that a significantly greater proportion of the 6 subjects would have more matches than mismatches among their qualitative scores. (The null hypothesis, in contrast, reflects the expectation that there will be an equal number of subjects with a predominance of either matches or mismatches, i.e. of the 6 evaluable respondents, 3 will have more matches and 3 will have more mismatches.) The expected distribution of matches and mismatches under the null hypothesis was then compared to the observed distribution of matches and mismatches using a 1-sample goodness-of-fit test. As shown in Table 6, 4 subjects had a predominance of matches and 2 had a predominance of mismatches. While the observed distribution was consistent with our prediction that matches would predominate, the discrepancy between the observed distribution and the expected distribution under the null hypothesis was not large enough to reject the null hypothesis (see Table 7). Therefore, according to a 1-sample Goodness of Fit Chi Square Test, hypothesis 2 was disconfirmed.

Table 6

Distribution of subjects with more matches vs. those with more mismatches

	Mismatches Versus Matches			
	Category	Observed N	Expected N	Residual
1	Mismatch	2	3	-1.0
2	Match	4	3	1
Total		6		

Table 7

Goodness of Fit Chi-Square Test: Subjects with more matches vs. those with more mismatches

	Mismatches V Matches
Chi-Square	.667
df	1
Asymp. Sig.	.414

Looking at the data from another angle, we then performed a paired-samples t-test in order to determine the correlation between matches and mismatches on a per subject basis. We found a significant negative correlation between the number of matches and the number of mismatches on a per subject basis ($r = -.849$, $p < .05$). In other words, subjects who tended to give more matches also tended to give fewer mismatches, a pattern that supports Hypothesis 2. A scatterplot of the 6 subjects (their pairs of matches and mismatches) indicated that there was no outlier skewing this data.

Therefore, the evidence in support of Hypothesis 2 is mixed: while the distribution of subjects with a predominance of either matches or mismatches does not support confirmation of Hypothesis 2, there is some evidence that matches are negatively correlated with mismatches, a pattern consistent with Hypothesis 2. In sum, Hypothesis 2

was not clearly confirmed or disconfirmed in this study; rather, depending on the formulation tested, there is both support and lack of support for this hypothesis.

Hypothesis 3: Hypothesis 3 tests whether there is a relationship between the conceptual level and articulation level of the adoptive mother representation and the degree of discrepancy between the adoptive and birth mother representations in terms of their qualitative attributes. No predictions were made regarding these relationships.

Based on the qualitative scores, a discrepancy variable was calculated to represent the degree of discrepancy using the Euclidean Distance Metric. Because a number of qualitative scores were missing, particularly for the birth mother representations, we first determined for which qualitative attributes subjects tended to give actual scores for both the adoptive mother and the birth mother. We found that two attributes, malevolent/benevolent and negative/positive ideal, were most often scored for both the adoptive and birth mothers; of the 27 subjects, 23 gave scores to both mothers for each attribute. (These attributes also depict the overall positive or negative valence of a representation.) Scores for malevolence/benevolence and for negative/positive ideal were then used to calculate the discrepancy variable. Therefore, the discrepancy variable is based on the data from 23 rather than 27 subjects, as are the subsequent correlations described below (see Table 8).

To calculate the Euclidean Distance Metric, the adoptive mother malevolent/benevolent score was subtracted from the birth mother malevolent/benevolent score and the result was squared. The same calculation was done for adoptive mother and birth mother negative/positive ideal scores. The two results (one for each attribute) were

then added together and the square root was taken of their sum, yielding the Euclidean Distance Metric or discrepancy variable.

Two Pearson Correlations were then calculated, one for the discrepancy variable and conceptual level of the adoptive mother representation (AM CL), the other for the discrepancy variable and articulation level of the adoptive mother representation (AM SA). Table 8 presents these correlations. As can be seen in Table 8, there was a trend toward a significant negative correlation between adoptive mother conceptual level and discrepancy ($p < .10$). In other words, subjects whose representations of their adoptive mothers were at a higher conceptual level tended to have less discrepancy between their adoptive and birth mother representations. The reverse was true for subjects whose representations were at a lower conceptual level; they tended to have greater discrepancy between their adoptive and birth mother representations. In contrast, there was a weak, positive correlation between adoptive mother articulation level and discrepancy, suggesting that as the articulation level of the adoptive mother representation increased, so did the level of discrepancy between the adoptive and birth mother representations. However, this positive correlation was not significant ($r = .26$, $p = .23$).

Table 8

Pearson correlations between discrepancy variable and adoptive mother conceptual level and adoptive mother articulation level

		Discrepancy
Adoptive Mother: Conceptual Level	Pearson Correlation	-.37
	Sig. (2-tailed)	.08
	N	23
Adoptive Mother: Articulation Level	Pearson Correlation	.26
	Sig. (2-tailed)	.23
	N	23

Post Hoc Analyses

Post Hoc Analysis 1: Post Hoc Analysis 1 tests whether there is a relationship between the number of negatively skewed qualitative scores assigned to the adoptive mother representation and the articulation level of the birth mother representation. In other words, is there a relationship between the degree of negativity in the subject's view of the adoptive mother and the degree of elaboration of his/her birth mother fantasy?

First, the 27 subjects were divided into three groups: Group I consisted of the 6 subjects from hypothesis 2 for whom negatively skewed qualitative scores for the adoptive mother representation had been associated with actual qualitative scores (rather than no score) for the birth mother representation. In other words, when these 6 subjects gave descriptions of their adoptive mothers that were negative in terms of particular attributes, their descriptions of their birth mothers included references to some or all of those same attributes. (It had been noted that these 6 subjects also tended to give more negatively skewed qualitative scores for the adoptive mother representation than did the remaining 21 subjects, leading to this post hoc analysis.) Group II consisted of the 7

subjects for whom negatively skewed qualitative scores for the adoptive mother representation were associated with no score on the same attribute for the birth mother representation. So when these subjects gave descriptions of their adoptive mothers that were negative in terms of particular attributes, their descriptions of their birth mothers excluded references to those attributes. Group III consisted of the remaining 14 subjects who gave no negatively skewed qualitative scores for their adoptive mother representations. For Group I the mean number of negatively skewed adoptive mother qualitative scores was 6.8, for Group II it was 1.4, and of course, for Group III it was 0.

The mean birth mother articulation levels for groups I, II, and III were 7.17, 3.86, and 4.5, respectively (Table 9). A one-way analysis of variance (1-way ANOVA) was conducted to establish that there were statistically significant differences between groups I, II, and III in terms of their mean articulation level scores for the birth mother representation ($F = 4.92$, $df = (2, 24)$, $p = .016$). A test of between-subject effects indicated that in at least one pair of groups, there was a significant difference in terms of the mean birth mother articulation levels ($p = .016$) (Table 10). As can be seen in table 11, follow-up pairwise comparisons indicated that Group I had a significantly greater mean birth mother articulation level than both Group II and Group III (7.2 vs. 3.9 ($p=.007$) and 7.2 vs. 4.5 ($p=.013$)). Group II and Group III did not differ significantly from each other ($p = .50$).

In sum, subjects whose descriptions of their adoptive mothers contained a relatively greater number of negatively rated qualitative attributes (and whose birth mother representations contained references to some or all of those particular traits) also tended to give descriptions of their birth mothers that were significantly better articulated

than subjects whose descriptions of their adoptive mothers contained few or no negatively rated qualitative attributes. In contrast, subjects whose descriptions of their adoptive mothers contained only one or two negatively rated qualitative attributes did not differ significantly from those subjects whose descriptions of their adoptive mothers were entirely positive, in terms of the articulation levels of their birth mother representations.

Table 9

ONE-WAY ANOVA: Comparison of articulation level of birth mother representations for groups I, II, and III

Dependent Variable: birth mother articulation level

Groups	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Group I	7.17	.83	5.45	8.88
Group II	3.86	.77	2.27	5.44
Group III	4.50	.54	3.38	5.62

Table 10

Source Table:

Dependent Variable: birth mother articulation level

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	40.66	2	20.33	4.91	.016
Intercept	632.6	1	632.6	153.06	.000
Group	40.66	2	20.33	4.91	.02
Error	99.19	24	4.13		
Total	795	27			
Corrected Total	139.85	26			

Table 11

Pairwise Comparisons of mean birth mother articulation levels of Groups I, II, and III
Dependent Variable: birth mother articulation level

(I) Group	(J) Group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence for Difference	Interval
Group I	Group II	3.31	1.13	.01	.98	5.64
	Group III	2.67	.99	.01	.62	4.71
Group II	Group I	-3.31	1.13	.01	-5.64	-.975
	Group III	-.643	.94	.501	-2.59	1.3
Group III	Group I	-2.67	.99	.01	-4.71	-.62
	Group II	.64	.94	.501	-1.3	2.59

Post Hoc Analysis 2: Post Hoc Analysis 2 tests whether there is a relationship between subjects' level of symptomatology as reported on the Brief Symptom Inventory and the level of discrepancy between adoptive and birth mother representations. As in Hypothesis 3, the discrepancy variable and subsequent analysis are derived from the data of 23, rather than 27 subjects.

Three Pearson correlations, presented in table 12, were conducted comparing the discrepancy variable to the Global Severity Index or GSI ($r = .37$, $p = .09$), to the Positive Symptom Total or PST ($r = .39$, $p = .07$), and to the Positive Symptom Distress Index or PSDI ($r = .52$, $p = .01$). As can be seen in table 12, all three correlations were positive and of moderate strength. The correlations between discrepancy and GSI, and between discrepancy and PST, were significant at the less than .10 confidence level, while the correlation between discrepancy and PSDI was somewhat stronger, significant at the less than .05 confidence level. In sum, as the number of symptoms and associated levels of

distress reported on the BSI increased, so did the degree of discrepancy between the adoptive and birth mother representations.

Table 12

Pearson correlations between discrepancy and BSI Global Index Scores

		GSI	PST	PSDI
Discrepancy	Pearson Correlation	.37	.39	.52
	Sig. (2-tailed)	.09	.07	.01
	N	23	23	23

Summary of Results

Statistical analyses of the main hypotheses yielded some significant results. Tests of hypothesis 1A, which compared subjects with higher versus lower conceptual level scores for their adoptive mother representations, confirmed that subjects in the higher group also had significantly higher conceptual level scores for their self-representations but not for their birth mother representations. In contrast, a test for hypothesis 1B comparing subjects with higher versus lower articulation level scores for their adoptive mother representations found no significant difference between the higher and lower groups in terms of the articulation levels of their birth mother representations. Analyses of hypothesis 2 yielded mixed results: one test disconfirmed an association between negatively skewed qualitative scores for the adoptive mother representation and positively skewed qualitative scores for the birth mother representation, but another test supported such an association. While no predictions were made for hypothesis 3, a significant negative correlation was found between the conceptual level of the adoptive mother representation and the degree of discrepancy between the adoptive and birth

mother representations. A weak positive correlation was found between articulation level of the adoptive mother representation and discrepancy; this correlation was not significant.

Two post hoc analyses yielded significant results. The first post hoc test confirmed that subjects whose adoptive mother representations contained a greater number of negatively skewed qualitative scores had significantly higher articulation levels for their birth mother representations than subjects whose adoptive mother representations had few or no negatively skewed qualitative scores. (No significant difference was found between subjects with few negatively skewed qualitative scores for their adoptive mother representations and subjects with no such scores.) The second post hoc test confirmed a significant positive correlation between subjects' reported levels of symptomatology and the degree of discrepancy between their adoptive and birth mother representations.

CHAPTER V

Discussion

This study explored adult adoptees' representations of the adoptive mother, the birth mother, and the self. Underlying the study was the idea, set forth in object relations theories, that primary care-taking relationships are internalized by the child and that the resulting parental representations form the major basis of the child's object relations and object representations. Based on this assumption, it was expected that connections would be found between the representation of the adoptive mother and representations of the birth mother and of the self. The above representations were examined in terms of their cognitive-developmental levels, their content, and their degree of elaboration as measured by the Object Representation Inventory's scales of conceptual level (CL), qualitative attributes, and degree of articulation (SA), respectively. In addition, this study examined the disparity in content (splitting) between the adoptive and birth mother representations using a discrepancy variable based on the qualitative attributes assigned to these maternal representations.

Subjects

The subjects in this study represented a demographically narrow group. They were predominantly female, white, and college educated (most were either college students or college graduates, and one quarter had begun or completed postgraduate degrees). Their educational achievements suggested that as a group, they were

functioning relatively well and with success. Moreover, their average level of symptomatology as measured by the BSI was similar to those of normative, nonpatient samples, further indicating that subjects were generally functioning as well as their nonadopted peers. This is consistent with the literature that suggests psychological distress in adoptees is more prominent in childhood but tends to diminish in adulthood. It is interesting to note that when the subjects were divided by gender, the women were slightly less symptomatic than the BSI's normative sample of women, but men were far more symptomatic than the BSI's normative sample of men. (Six of the eight male subjects' BSI scores qualified them as "positive diagnoses" according to BSI standards, compared to one of the nineteen female subjects.) Therefore, in this sample of adoptees, the men were experiencing much higher levels of symptomatology than the women, though the sample is too small to generalize from this finding. Also noteworthy, as well as encouraging, was the generally positive view these subjects held of their adoptive mothers. More than 75% of them described their adoptive mothers in mostly positive terms. So overall, this sample of adoptees seemed to be relatively successful, asymptomatic, and fond of their adoptive families.

Discussion of Findings

Hypothesis One - A: Conceptual level of the representation of the adoptive mother compared to conceptual levels of the representations of the birth mother and of the self.

We hypothesized that the conceptual level of the adoptive mother representation would be consistent with both the conceptual level of the self-representation and the conceptual level of the birth mother representation. Results indicated that there was a

significant relationship in terms of conceptual level between the representation of the adoptive mother and the representation of the self, in which relatively high-level adoptive mother representations were associated with relatively high-level self-representations, and relatively low-level adoptive mother representations were associated with relatively low-level self-representations. However, a similar relationship was not shown between the representation of the adoptive mother and the representation of the birth mother. In fact, the conceptual levels of the birth mother representation were very similar between the two groups (those with higher versus lower conceptual levels for the adoptive mother representation).

In interpreting these findings, it is helpful to revisit the meaning of conceptual level. According to Blatt et al (1992) the conceptual level of a representation reflects the degree to which the represented individual is seen as separate and distinct, embodying qualities that are external (physical traits, actions), internal (values, emotions), and coherently integrated, even if these qualities are contradictory. Conceptual level further indicates the degree to which the representation is stable and realistic. One explanation for this study's findings (one that is consistent with object relations theories) is that the similarity between the conceptual levels of the adoptive mother representation and the self-representation reflects both the internalization of the adoptive mother – adoptee relationship and the influence of the resulting adoptive mother representation on the adoptee's self-representation. However, it may also be that the convergence of the two conceptual levels reflects the adoptee's general level of psychological health and maturity rather than a connection between the two representations. Future research investigating

the impact of early object relations on the adoptee's self-representation is needed to verify the first interpretation of these findings.

Whether the convergence between conceptual levels of self- and adoptive mother representations reflects the influence of early object relations or general psychological health, it is noteworthy that the conceptual level of the birth mother representation did not follow the same pattern; it did not appear to be related to the conceptual level of the adoptive mother. In fact, it was surprisingly consistent between the two groups of subjects, those with higher versus lower adoptive mother conceptual level scores. This finding suggests one of two things: either the conceptual level of the adoptive mother representation influences that of the self-representation but does not influence that of the birth mother representation, or the general level of psychological health reflected in the representations of the adoptive mother and the self does not extend to, or influence, the conceptual level of the birth mother representation.

The apparent "independence" of the conceptual level of the birth mother representation likely reflects the circumstances that set this representation apart from that of the adoptive mother and that of the self. While the representations of the adoptive mother and the self are drawn from real people and relationships, the representation of the birth mother is primarily based on fantasy. (As Hodges (1984) notes, even when the adopted child is given factual information about the birth mother, his image of her is often largely based on fantasy.) According to object relations theories, in optimal development, day-to-day interactions between parent and child gradually enable the child to integrate various qualities of the parent and to minimize distortions in the parental representation. Over time, the parental representation becomes increasingly accurate with

respect to reality. For adoptees, the lack of actual contact with the birth mother precludes this process; therefore, the representation of the birth mother may follow a unique developmental trajectory, becoming more or less fully developed in conjunction with the adoptee's fantasy life. The finding that conceptual level is not consistent between adoptive and birth mother representations also contradicts Priel et al's (2000) finding that the conceptual levels of the adoptive and birth mother representations were similar in a sample of adopted children. One explanation for the difference in findings between this study and Priel et al's study is that in childhood, both maternal representations are in the early stages of development. By adulthood, these representations have followed divergent developmental paths, with the adoptive mother representation evolving based on reality and the birth mother representation evolving based on fantasy.

In both the higher and lower adoptive mother conceptual level groups, representations of the birth mother were rated on average between 4 and 5, falling between the Concrete-Perceptual and External Iconic levels. These findings not only suggests that the birth mother representation is independent of the adoptive mother representation in terms of conceptual level, but also suggests a general tendency to fantasize about the birth mother and to create a concrete image of her, if not a more in-depth representation, regardless of the level of other significant object representations.

Hypothesis One - B: Articulation level of the representation of the adoptive mother compared to the articulation level of the representation of the birth mother.

We hypothesized that subjects with more highly articulated adoptive mother representations would also have more highly articulated birth mother representations than

subjects with less articulated adoptive mother representations. As it turns out, there was no significant difference in terms of articulation level of the birth mother representation between subject groups with higher versus lower articulation scores for the adoptive mother representation. This finding suggests that the birth mother representation is independent of the adoptive mother representation in terms of the degree of articulation.

As noted above, adoptive mother representations were far better articulated than birth mother representations in this sample. This finding suggests that the real-life relationship with the adoptive mother generally leads to a richer, more elaborate representation compared with that of the birth mother. Another explanation for the relatively lower articulation levels for the birth mother representations may have to do with the fact that subjects gave their birth mother descriptions in writing rather than verbally. As a number of subjects noted, describing their unknown birth mother was a very difficult task. Subjects may have given more elaborate depictions of their birth mothers in an interview, perhaps with probes from the interviewer. The degree of articulation of birth and adoptive mother representations may have been more similar under such circumstances.

Hypothesis Two: The association between negative qualities assigned to the adoptive mother and positive qualities assigned to the birth mother.

We expected specific negative qualities in the adoptive mother representation to be associated with parallel positive qualities in the birth mother representation. When subjects described negative characteristics in their adoptive mothers, we expected them to idealize their birth mothers specifically around those characteristics. While one statistical

analysis disconfirmed our expectation, another supported it. Of the six subjects whose scores could be evaluated, four had adoptive and birth mother representations whose qualitative ratings conformed to the pattern described above. But these subjects did not comprise a significant majority of the total six. Confirming our expectation, however, subjects who tended to ascribe more qualities to their adoptive and birth mothers that fit the above pattern also tended to ascribe fewer qualities that did not fit the pattern. Our inconsistent results may suggest that when adopted adults see faults in their adoptive parents, they do not tend to fantasize about birth parents who do not have those particular faults. But because the subjects in this sample generally gave positive descriptions of their adoptive mothers, there were very few representations on which this hypothesis could be tested. Results may have been stronger with more cases to examine.

The finding that a significant negative correlation existed between the number of qualities that fit the pattern and the number of qualities that did not, was clearly reflected in those representations on which it was based. Namely, for the four subjects who were critical of their adoptive mother and idealizing of their birth mother in terms of specific attributes, the disparity between the two representations was striking. One such subject characterized his adoptive mother as "cold" and "unloving," and described feeling like "property...like something bought and expected to work a certain way." In contrast, he wrote of an unseen bond between himself and his birth mother whom he imagined to be concerned for his well-being and anguished over their separation. Another subject wrote of feeling "discriminated against" by his mother who favored his biological siblings, and wondered if she had adopted him for the stipend she received. He imagined his birth mother as "passionate and human, someone who might have been caring but had some

problems." A third subject reflected on the pull to idealize his birth mother in reaction to disappointments in his adoptive mother. He wrote "Whatever is wrong at that moment with my adoptive parents I imagine my birth mom the opposite."

In a particularly poignant example, the fourth subject in this subgroup described her relationship with her adoptive mother as completely lacking in warmth or support. "I feel as though there has been no feeling of love between us, ever," she wrote, describing her adoptive mother as "incapable of expressing 'motherly feelings'" and as constantly critical, viewing even the subject's achievements with resentment rather than pride. Writing of her fantasy of her birth mother, she described the following recurring dream:

> I am in my room, and I wake up afraid, of what I do not know. I shake a little and I feel a tear run down my face. I think, "Mommy I'm tired and I don't feel well, please come take care of me." So after crying for quite some time, I always imagined a calm creep over me, and a feeling that someone was sitting on the bed next to me. I could almost feel my forehead being touched and my hair being stroked to calm me down. The "it's okay, everything will be fine my princess" is whispered again, and the crying subsides. The humming starts, I can never remember the tune, but I always remember that it is so pleasant to the ear. She came to me several times, and the last thing I remember is a gentle kiss on the forehead.

She goes on, "So basically, I always envisioned my birth mother to be caring, loving, attentive, gentle, and so devoted that I could tell her anything, cry to her about anything, get hugged and be praised." For this subject, it seemed her idealized birth mother fantasy was not simply a result of her adopted status. Rather, her yearning for a "loving" birth mother grew out of her feelings of emptiness and deprivation with regard to her adoptive mother. Her maternal representations illustrate how the fantasy of the birth mother may be used to manage feelings of disappointment, anger, or grief in relation to the adoptive mother.

In sum, because most subjects in this study characterized their adoptive mother in positive terms, there were few cases on which to test this hypothesis, and results were mixed. Of the six subjects whose maternal representations were evaluated, four described negative qualities in their adoptive mothers and parallel, positive qualities in their birth mothers. The maternal descriptions of these four subjects provide vivid examples of birth mother fantasies that seem to grow out of, and compensate for, disappointments in the adoptive mother.

Hypothesis Three: The association between the overall quality of the adoptive mother representation and the degree of discrepancy, in terms of content, between the adoptive and birth mother representations.

Two dimensions that contribute to the overall quality of the adoptive mother representation, conceptual level (CL) and degree of articulation (SA) were examined to see if either was related to the degree of discrepancy between the adoptive and birth mother representations. A third dimension, content, could not be evaluated in terms of its relationship to discrepancy, because content (qualitative) ratings were used to calculate the discrepancy variable and therefore were not statistically independent of it. A discrepancy variable was calculated to symbolize the degree to which the two representations were polarized or split (i.e. the adoptive mother characterized as predominantly negative and the birth mother characterized as predominantly positive or vice versa). Because of missing qualitative ratings, the discrepancy variable and the following analysis were based on the data of 23 of the 27 subjects. No predictions were made about how the conceptual level or degree of articulation of the adoptive mother

representation might be associated to the discrepancy variable. A significant negative correlation was found between the adoptive mother representation's conceptual level and the discrepancy variable: as the conceptual level of the adoptive mother representation increased, the tendency to maintain split representations of the adoptive and birth mothers decreased. In contrast, a weak positive correlation was found between the adoptive mother representation's level of articulation and the discrepancy variable, but this correlation was not significant.

The finding that subjects with higher conceptual levels for their adoptive mother representations tended to report less discrepancy between their two maternal representations may reflect the impact of the subjects' overall level of psychological health and maturity. A psychologically healthy adoptee will presumably form an integrated, coherent and stable representation of his adoptive mother and will also use a broad range of defenses to manage his ambivalence toward his two mothers rather than revert to splitting. Another interpretation of this finding, however, is that the conceptual level of the representation of the adoptive mother actually influences the adoptee's defensive functioning, i.e. whether or not the adoptee relies on splitting in order to manage negative feelings toward the adoptive and/or birth mother. Put another way, something about the relationship with the adoptive mother leads the adoptee to develop a more fully formed representation of her (with a high conceptual level) as well as healthy defenses, including the capacity to maintain balanced rather than distorted maternal representations. It may be that the adoptee's experience of the adoptive mother (as generally positive or negative) is the "something" in the adoptive mother-adoptee relationship that is connected to both conceptual level and the degree of splitting between

the adoptive and birth mother representations. But because we could not statistically

the adoptive and birth mother representations. But because we could not statistically

compare the qualitative ratings of the adoptive mother representation to the discrepancy variable, this connection remains speculative. Our results further indicated that there was not a significant relationship between the number of personal attributes that the adoptee referred to in describing his adoptive mother (SA) and the degree of splitting between his two maternal representations (discrepancy).

Post Hoc Analysis I: The relationship between the number of negatively skewed qualitative scores assigned to the adoptive mother representation and the articulation level (SA) of the birth mother representation.

In order to test this relationship, subjects were divided into three groups: Group I consisted of the six subjects whose adoptive mother representations contained many negative personal attributes and whose birth mother representations also contained those same attributes in either positive or negative terms. Group II consisted of those subjects whose adoptive mother representations contained only one or two negative personal attributes, but whose birth mother representations did not refer to those same attributes. And Group III consisted of those subjects whose adoptive mother representations were entirely positive. We noted that Group I had assigned a far greater number of negative attributes to their adoptive mothers than did Group II (an average 6.8 as compared to 1.4). (It is important to note that the qualitative attributes rated in the ORI are not independent of one another; for example, a parent who is described as "warm" is also likely to be described as "affectionate." So adoptive mother representations that had a greater number of negative qualitative ratings did not necessarily contain a greater number of distinct

faults, but did have a more negative valence overall.) Our results showed that Group I had a mean articulation level for the birth mother representations that was significantly higher than that of Group II or Group III, while the mean articulation levels of the birth mother representations in Groups II and III did not differ significantly.

In sum, subjects who described their adoptive mothers in mostly negative terms tended to describe their birth mothers in greater detail than subjects who described their adoptive mothers in mostly positive terms. This finding suggests that adoptees who have generally unfavorable views of their adoptive mother — which likely reflect negative experiences of their relationship with her — put more energy into fantasizing about their birth mother than adoptees who have generally favorable views of their adoptive mothers.

It is also noteworthy that in Group I, birth mother representations contained references to some or all of the traits that were negatively skewed in their adoptive mother representations. This was not the case for Group II. So in addition to being comparatively happier with their adoptive mothers, subjects in Group II did not have fantasies about their birth mothers that related specifically to their (few) criticisms of their adoptive mothers. Perhaps they had such fantasies as children but became less invested in them over time. Or perhaps they did not develop such fantasies to begin with. Our results suggest that for those adoptees who are highly ambivalent about, or intensely disappointed in, their adoptive mothers, the fantasy of the birth mother is used to manage these difficult feelings.

Post Hoc Analysis II: The relationship between subjects' levels of symptomatology and the degree of discrepancy between their adoptive and birth mother representations.

The discrepancy variable, which signified the degree of polarization between the adoptive and birth mother representations, was compared to the Global Index scores of the Brief Symptom Inventory: the Global Severity Index (GSI), the Positive Symptom Total (PST), and the Positive Symptom Distress Index (PSDI). All three indices correlated positively with the discrepancy variable, indicating that as subjects' symptomatology increased, so did the degree of discrepancy between their two maternal representations.

According to this finding, adoptees who suffer more psychiatric symptoms (or more related distress) tend to maintain a greater split between their adoptive and birth mother representations. This result is consistent with Priel et al.'s (2000) study of adopted children that found that the greater the degree of symptomatology (specifically externalizing behaviors), the greater the degree of discrepancy between the representations of the adoptive and birth mothers. Priel et al. suggest that split representations may impede normal development and/or result in higher levels of symptomatology. While this causal relationship is possible, the association between discrepancy and symptomatology may also reflect, once again, the adoptee's overall level of psychological health. The finding that adoptees with lower conceptual level of the adoptive mother representation have greater discrepancy between the two maternal representations (Hypothesis Three), along with the finding that adoptees with greater symptomatology have greater discrepancy between the two maternal representations, seems to point to some underlying psychological disadvantage for adoptees who fall into

either category. However, one would have to examine the data further — for instance, to see whether those subjects with lower conceptual level scores for their adoptive mother representations also had greater symptomatology — in order to explore the connection between the general level of psychological health and variables such as discrepancy, conceptual level of representations, and symptomatology.

Limitations of the Study

The homogeneity of the subject pool is one prominent limitation of this study. Subjects represented a narrow demographic group in terms of race, gender, and education. The predominance of white subjects may have to do with the fact that we included only subjects born in the United States, ruling out international adoption, and required that subjects share the same race and ethnicity as their adoptive parents. According to a 1993 overview of adoption statistics in the United States, data on children within the welfare system whose adoptions were finalized indicated that 60.7% were white, 23% were black, 9.4% were Hispanic, and 5.7% were of other racial backgrounds. The overview also cites a 1987 National Health Survey of adoptions in which the child was still living with the adoptive mother; the survey indicated that in 92% of all such adoptions, the adoptive mother and child were of the same race, and that 85% involved mothers and children who were white, 6% involved mothers and children who were black, and 1% involved mothers and children of other races (Stolley, 1993). These statistics suggest that the majority of formalized, noninternational adoptions in the United States involve white children and may explain the predominance of white participants in this study. (Interestingly, none of the college students who responded to advertisements

for the study were from public universities, which have a greater percentage of minority students, even though fliers were posted at an equal number of public and private institutions.) This study was advertised predominantly at colleges and universities, hence the majority of participants were at least partially college educated. In terms of gender, it is unclear why there were more female than male participants.

The small sample size of the study is another limitation. Moreover, this study focussed only on closed adoptions in which adoptees had no contact with their birth families. Other types of adoption are also common including international, transracial, open (in which adoptees remain in contact with their birth parents), and informal adoptions that are not legalized, such as adoptions by relatives of the birth family. Because this study involved a small sample, a specific form of adoption, and a relatively narrow demographic group, results cannot be generalized to the broader adoption community.

Finally, the format of the study may have affected subjects' responses. Specifically, the descriptions of the adoptive and birth mothers may have been more elaborate had they been elicited in an interview, perhaps with probes by the interviewer, rather than in writing. Furthermore, in reviewing the birth mother descriptions, it is possible they would have been richer and more highly detailed had additional instructions been given. For instance, along with the instruction "describe your birth mother as you imagine her to be," the author may have asked subjects to "describe your birth mother as you imagine she would have been as a parent." This may have elicited a more direct comparison to the adoptive mother and illuminated any otherwise hidden splits between the two maternal representations.

Suggestions for Future Research

The results of this study point to a number of areas for related research. For instance, similar studies might focus on different types of adoption. It would be interesting to investigate the impact of open adoption (and continuous contact with the birth mother) on the adoptive and birth mother representations. Such a study might examine whether birth mother representations were, on average, at a higher conceptual level than those in this study. It might also explore the associations between the representations of the adoptive mother, the birth mother, and the self, as well as the degree of discrepancy between the two maternal representations. Similarly, studies of international and transracial adoptions might explore these associations in circumstances where there are more obvious ethnic differences between the adoptive mother and the adoptee. International adoptions would be additionally interesting in terms of the adoptees' fantasies of the birth mother, according to the various circumstances prior to the adoption (i.e. was the child living in an orphanage or with a family? What were the circumstances of the relinquishment or abandonment by the birth mother?) In sum, similar studies of open, international, and transracial adoptions might compare their results to those of this study in order to explore differences between adoption scenarios in terms of maternal and self-representations.

The results of this study also point to future research regarding closed adoption and object representations. For instance, we found that male subjects were significantly more symptomatic than female subjects. In addition, three of the four subjects from hypothesis two (whose highly negative adoptive mother representation were associated with positive birth mother representations) were men. With a larger sample, it would be

interesting to explore gender differences in terms of symptomatology and discrepancy to see if the trends suggested in this author's study are significant. Likewise, it would be interesting to replicate the study with a clinical sample of adoptees in order to investigate the link between symptomatology and maternal representations in adoptees.

While this study found connections between the adoptive mother representation and the self-representation, the birth mother representation, and the degree of discrepancy between the two maternal representations, it did not prove causality between these variables. Future research might focus on early adoptive mother-child relationships and object representations in order to examine the possible causal link between the representation of the adoptive mother and those of the birth mother and of the self. Such research might also attempt to establish whether the adoptee's general levels of psychological health and maturity underlie the above associations. In addition, this author's study did not compare the content of the adoptive mother representation to the degree of discrepancy between the adoptive and birth mother representations because the two variables were not statistically independent. Future research might make such a statistical analysis by using a measure other than the ORI to rate the content of the adoptive mother representation, and then comparing those ratings to the degree of discrepancy (calculated from ORI qualitative scores). In this way, one might investigate the association between positive versus negative views of the adoptive mother and the degree of splitting between the two maternal representations. Finally, the association between negative qualitative ratings for the adoptive mother representation and positive qualitative ratings for the birth mother ratings may be better illustrated by a larger sample

or by a clinical sample (where negative views of the adoptive mother might be more prevalent).

Additional statistical analyses of this study's data could also yield more findings. For instance, the conceptual levels of the birth mother representation and the self-representation could be compared in order to see if an association exists similar to the one found between the conceptual levels of the adoptive mother representation and the self-representation. Likewise, one could rate the content of self-representations and then compare the resulting qualitative scores to those of the adoptive and birth mother representations. This analysis would illuminate the various ways that the adoptee identifies with either the adoptive mother or the birth mother (or both) in terms of personal attributes. Finally, an analysis similar to that of hypothesis two could look at instances in which positive qualitative ratings assigned to the adoptive mother representation are associated with negative qualitative ratings assigned to the birth mother representation — instances in which the adoptive mother is idealized and the birth mother devalued in terms of specific character traits — the reverse of the type of splitting examined in this study.

Summary and Conclusions

This study explored relationships between the representations of the adoptive mother, of the birth mother, and of the self in a sample of adult adoptees. Underlying this exploration was the assumption that the adoptee internalizes his relationship with the adoptive mother, and that the resulting representation of her impacts both his view of himself and his birth mother fantasy. While a causal link was not proven between

dimensions of the adoptive mother representation and those of the self-representation and the birth mother representation, significant and provocative associations were uncovered.

First, in terms of cognitive-developmental (conceptual) level, there appeared to be a link between adoptees' capacity to view their adoptive mothers as complex and multidimensional (yet coherent and stable individuals) and their capacity to view themselves in a similar manner. Because the content of the adoptive mother representations was not examined in terms of this association, it is unclear whether qualitatively positive experiences with the adoptive mother are also associated with high conceptual levels of these representations. Still, this finding suggests that when the adoptee's adoptive mother representation evolves more fully, the adoptee's view of him or herself is more likely to reach optimal levels of development.

This study further explored the relationship between the representations of the adoptive mother and of the birth mother. In reviewing our results, a complex picture emerged of the possible connections between these two object representations. Namely our findings suggested that the conceptual levels of the representations of the adoptive and birth mother are not directly connected, but that the conceptual level of the adoptive mother representation *is* connected to the degree of discrepancy or splitting between the two representations.

In terms of conceptual level, each maternal representation appears to evolve according to its own distinct course of development. Optimally, the adoptee's representation of his adoptive mother is continually refined by, and increasingly reflects, the reality of his relationship with her; in contrast, the adoptee's representation of his birth mother is primarily based on fantasy. These two representations seem to diverge in

their conceptual levels because of their distinct conditions for development. Nevertheless, the degree to which the adoptee forms a differentiated, coherent, three-dimensional representation of his adoptive mother (as measured by conceptual level) appears tied to his capacity to integrate ambivalent feelings toward both mothers rather than revert to splitting (as measured by discrepancy).

Moreover, in terms of their content, evidence was inconclusive as to whether there is a complementary relationship between the two maternal representations (with the adoptive mother devalued and the birth mother idealized). However, our results strongly suggest that adoptees who have highly negative views of their adoptive mothers tend to develop far more elaborated fantasies of their birth mothers than adoptees who have primarily positive views of their adoptive mothers. So when the adoptee is intensely unhappy with his adoptive mother, he puts more energy into imagining what his birth mother is like. This author began the study with the question of whether the birth parent representations are complementary, mirror images of the adoptive parents, fantasies constructed by the adoptee to help him manage his ambivalence toward the parents who raised him. Although the data does not confirm the existence of this complementary relationship between the two maternal representations, it does validate the notion that the representation or fantasy of the birth mother is used by the adoptee to manage intensely negative or ambivalent feelings toward the adoptive mother.

How can these findings ultimately be applied to clinical practice and to greater understanding? It is this author's opinion that these complicated associations — between the representations of the adoptive mother, the birth mother, and the self — have strong clinical implications for psychotherapists working with either adoptees or adoptive

parents. In therapeutic work with an adoptee, one must pay attention to issues related to the adoption (including the relinquishment by the birth parents and the possibility of searching for them). But one must pay equal attention to the adoptee's relationship with the adoptive parents and to the complex array of feelings — i.e. of affection, ambivalence, disappointment — the adoptee may have toward them. Such complicated feelings (normal in any parent-child relationship) are likely to be reflected in, or illuminated by, the adoptee's birth parent fantasies, but could easily be overlooked if issues around the loss of the birth parent were the sole focus of treatment. In psychotherapy with adoptive parents, treatment should validate the fact that adoptive parents are taken in by the adoptee, just like biological parents are taken in by their biological children. It is this process of internalization that likely influences the adoptee's capacity to form integrated, balanced, and realistic views of his adoptive and birth families and of himself.

APPENDIX A

VOLUNTEERS WANTED

FOR STUDY ON
ADOPTED ADULTS

WANTED: American-born adults between 18 and 35 who were adopted during infancy,
who have had
no contact with their birth families,
and who are not parents themselves.

For a clinical psychology doctoral research study
on adoptees' thoughts about
their adoptive and birth families.

Brief questionnaires to be completed by mail.

Approximately one hour required.

All information will be kept confidential
and treated in a sensitive manner.

You will receive $20 for you time.

If interested, please contact Liz Gertner at
(917) 531-4990

APPENDIX B
Object Representation Inventory

I.D. Number
Please respond to the following questions with whatever comes to mind:
1. Describe your adoptive mother.

I.D. Number

2. Describe your birth mother as you imagine her to be.

APPENDIX C
Assessment of Self-Representation

I.D. Number _____
3. Describe yourself.

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

Date:

Demographics

1) Age at last birthday _____

2) Marital status _____
- 1 Single, never married
- 2 Married
- 3 Separated
- 4 Divorced
- 5 Widowed

3) Religious Affiliation _____
- 1 Catholic
- 2 Protestant
- 3 Jewish
- 4 Muslim
- 5 Other: _____
- 6 None

4) Ethnic/Racial Background _____
- 1 Caucasian
- 2 Black
- 3 Latino
- 4 Asian
- 5 Other: _____

5) Education _____
- 1 <12th grade (years completed ____)
- 2 Completed high school
- 3 H.S. + other training
- 4 Some college (years completed ____)
- 5 Completed college
- 6 Some postgraduate education _____
- 7 Completed postgraduate degree _____

6) Occupation _____

7) Current Employment _____

1 Full-time student
2 Employed full time
3 Employed part time
4 Homemaker
5 Unemployed
6 Disabled
7 Retired
8 Other _____

8) Estimate of current household income per year _____

1. under 10,000
2. 10,000-15,000
3. 16,000-25,000
4. 26,000-35,000
5. 36,000-50,000
6. 50,000-75,000
7. 75,000-100,000
8. more than 100,000

9) Number of people in household _____

10) Adoptive mother is _____

1 alive
2 deceased

11) If adoptive mother is deceased, when did she die? _____(date)
How old were you at the time? _____

12) If adoptive mother is alive, how frequent is your contact with her? _____

1 everyday
2 a few times per week
3 once per week
4 every two weeks
5 once a month
6 once every 2-3 months
7 once every 6 months
8 once a year
9 less than once a year

13) Adoptive father is _____

1. alive
2. deceased

14) If adoptive father is deceased, when did he die? _____(date)
How old were you at the time? _____

15) If adoptive father is alive, how frequent is your contact with him? _____

1. everyday
2. a few times per week
3. once per week
4. every two weeks
5. once a month
6. once every 2-3 months
7. once every 6 months
8. once a year
9. less than once a year

16) Are you currently in psychotherapy? _____

1. Yes
2. No

If yes, for how long? _____

1. less than 6 months
2. more than 6 months, less than 1 year, consistently
3. more than 1 year, less than 2 years consistently
4. more than 2 years
5. off and on, for an extended period of time

17) What type of therapy are you in? _____

1. cognitive-behavioral
2. psychoanalytic/psychodynamic
3. other _____
4. Not sure

18) Frequency of sessions _____

1. 1x per week
2. 2x per week
3. 3x per week
4. 4x per week
5. 5x per week

19) Reason for referral to psychotherapy _____

20) Are you on medication related to psychiatric problems? _____

1. Yes
2. No

If yes, type of medication _____

For what illness _____

21) Were you previously seen in psychotherapy? _____
1. Yes
2. No

If yes, for how long? _____
1. less than 6 months
2. more than 6 months, less than 1 year, consistently
3. more than 1 year, less than 2 years consistently
4. more than 2 years
5. off and on, for an extended period of time

22) What type of therapy were you in? _____
1. cognitive-behavioral
2. psychoanalytic/psychodynamic
3. other _____
4. Not sure

23) How old were you at the time? _____

24) Frequency of sessions _____
1. 1x per week
2. 2x per week
3. 3x per week
4. 4x per week
5. 5x per week

25) Reason for referral to psychotherapy _____

26) Length of time for total psychotherapy _____
1. 1-6 months
2. 6 months to 1 year
3. 1-2 years
4. 2-3 years
5. over 3 years

27) If you've been in psychotherapy, how often was your adoption _____
(or related issues) a focus of treatment sessions?
1 very often and/or for an extended period of time
2 fairly often
3 once in a while
4 rarely
5 never

28) Have you ever been hospitalized for psychiatric problems? _____
1. Yes
2. No

If yes, what was your diagnosis? _____

29) Were you ever on medication related to psychiatric problems? _____

1. Yes
2. No

If yes, type of medication _____

For what illness _____

Adoptive Family Demographics

30) Birthplace: _____

31) Were you raised by _____

1. both adoptive parents
2. one adoptive parent

If raised by one adoptive parent, please specify circumstances _____

_____

32) Adoptive parents are currently _____

1. still married / living together
2. divorced / separated
3. one or both deceased

33) Persons in childhood, adoptive family household (0=absent; # = how many)

1. Mother _____
2. Father _____
3. Siblings (Adopted) _____
4. Siblings (Biological children of your adoptive parents) _____
5. Siblings (Biological siblings adopted into your adoptive family) _____
3 Stepmother _____
4 Stepfather _____
5 Stepsiblings (number) _____
6 Grandmother (M or P) _____
7 Grandfather (M or P) _____
8 Other _____

34) Birth order: # _____ of _____ siblings

35) Adoptive father's occupation _____

36) Adoptive father's highest level of education _____

1. <12th grade (years completed ____)
2. Completed high school
3. H.S. + other training
4. Some college (years completed ____)
5. Completed college
6. Some postgraduate education _____
7. Completed postgraduate degree _____

37) Adoptive mother's occupation _____

38) Adoptive mother's highest level of education _____
(Use numbers from above.)

Birth Family Information

39) Birth mother is _____
1 alive
2 deceased
3 I don't know

40) Birth father is _____
1. alive
2. deceased
3. I don't know

41) Have you had contact with either your birth mother or birth father? _____
1. Yes
2. No
If yes, please specify _____
_____

42) Have you taken steps toward contacting your birth mother? _____
1. Yes
2. No
If yes, please specify _____
_____

43) Have you taken steps toward contacting your birth father? _____
1. Yes
2. No
If yes, please specify _____
_____

44) Have either of your birth parents attempted to contact you? _____
1. Yes
2. No
If yes, please specify _____
_____

45) If you have not taken steps toward contacting either of your birth parents, do you plan on doing so in the future? _____
1. Yes
2. No
3.Not yet decided

46) If you were adopted some time after birth, who took care of you up until the time your adoption took place? _____

1 birth mother
2 birth mother with birth father and/or family
3 foster family
4 Other: _____
5 Not sure

APPENDIX E
Brief Symptom Inventory

Instructions: Below is a list of problems people sometimes have. Please read each one carefully, and circle the number to the right that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example below before beginning, and if you have any questions please contact me to ask about them.

Example:	not at all	a little bit	moderately	quite a bit	extremely
How Much Were You Distressed By					
1. bodyaches	0	1	2	3	4

	not at all	**a little bit**	**moderately**	**quite a bit**	**extremely**
How Much Were You Distressed By:					
1. Nervousness or shakiness inside	0	1	2	3	4
2. Faintness or dizziness	0	1	2	3	4
3. The idea that someone else can control your thoughts	0	1	2	3	4
4. Feeling others are to blame for most of your troubles	0	1	2	3	4
5. Trouble remembering things	0	1	2	3	4
6. Feeling easily annoyed or irritated	0	1	2	3	4
7. Pains in heart or chest	0	1	2	3	4
8. Feeling afraid in open spaces	0	1	2	3	4
9. Thoughts of ending your life	0	1	2	3	4
10. Feeling that most people cannot be trusted	0	1	2	3	4
11. Poor appetite	0	1	2	3	4
12. Suddenly scared for no reason	0	1	2	3	4
13. Temper outburst that you could not control	0	1	2	3	4
14. Feeling lonely even when you are with people	0	1	2	3	4

	not at all	a little bit	moderately	quite a bit	extremely
15. Feeling blocked in getting things done	0	1	2	3	4
16. Feeling lonely	0	1	2	3	4
17. Feeling blue	0	1	2	3	4
18. Feeling no interest in things	0	1	2	3	4
19. Feeling fearful	0	1	2	3	4
20. Your feelings being easily hurt	0	1	2	3	4
21. Feeling that people are unfriendly or dislike you	0	1	2	3	4
22. Feeling inferior to others	0	1	2	3	4
23. Nausea or upset stomach	0	1	2	3	4
24. Feeling that you are watched or talked about by others	0	1	2	3	4
25. Having trouble falling asleep	0	1	2	3	4
26. Having to check and double check what you do	0	1	2	3	4
27. Difficulty making decisions	0	1	2	3	4
28. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
29. Trouble getting your breath	0	1	2	3	4
30. Hot or cold spells	0	1	2	3	4
31. Having to avoid certain things, places or activities because they frighten you	0	1	2	3	4
32. Your mind going blank	0	1	2	3	4
33. Numbness or tingling in parts of you body	0	1	2	3	4
34. The idea that you should be punished for your sins	0	1	2	3	4
35. Feeling hopeless about the future	0	1	2	3	4
36. Trouble concentrating	0	1	2	3	4
37. Feeling weak in parts of your body	0	1	2	3	4
38. Feeling tense or keyed up	0	1	2	3	4
39. Thoughts of death or dying	0	1	2	3	4
40. Having urges to beat, injure, or harm someone	0	1	2	3	4
41. Having urges to break or smash things	0	1	2	3	4
42. Feeling very self-conscious with others	0	1	2	3	4

	not at all	a little bit	moderately	quite a bit	extremely
43. Feeling uneasy in crowds such as shopping or at a movie	0	1	2	3	4
44. Never feeling close to another person	0	1	2	3	4
45. Spells of terror or panic	0	1	2	3	4
46. Getting into frequent arguments	0	1	2	3	4
47. Feeling nervous when you are left alone	0	1	2	3	4
48. Others not giving you proper credit for your achievements	0	1	2	3	4
49. Feeling so restless you couldn't sit still	0	1	2	3	4
50. Feelings of worthlessness	0	1	2	3	4
51. Feeling that people will take advantage of you if you let them	0	1	2	3	4
52. Feelings of guilt	0	1	2	3	4
53. The idea that something is wrong with your mind	0	1	2	3	4

APPENDIX F
Initial Telephone Screening Interview

Name:
Phone Number: (home)
(work)

I am a graduate student in clinical psychology and I am conducting a doctoral research study. I am hoping to learn about how adopted individuals perceive and think about themselves, their adoptive families and their birth families. I need to ask you some questions. Is this a good time?

1. How did you hear about the study?_____

2. Where do you live? _____
   If in NYC area, continue.
   If not, end now.

3. How old are you? _____
   If between the ages of 18 and 35, continue.
   If not, end now.

4. Where were you born? _____
   If born in the United States, continue.
   If not, end now.

5. Who adopted you? _____
   If heterosexual couple, continue.
   If any other situation, end now.

6. How old were you when you were adopted? _____
   If within first year of life, continue.
   If not, end now.

7. Have you had any contact with your birth mother or father? _____
   If no contact with birth parents, continue.
   If contact with birth parents, end now.

8. What is your ethnicity? _____

9. What is your adoptive parent(s) ethnicity? _____
   If same as volunteer's ethnicity, continue.
   If not, end now.

10. Do you have, or have you had, children? _____
    If no, continue.
    If yes, end now.

11. Do you currently live with your adoptive parents? _____
    If no, continue.
    If yes, end now.

12. Are your adoptive parents alive? _____
    If no, when did he/she die? _____
    How old were you at the time? _____

    If parents are alive, continue.

    If adoptive parent died, say, **"I'm not sure if you'll be eligible for the study. If it turns out that you are, I'll get back to you. In the meantime, you have my number if you wish to reach me."**

13. Have you ever been hospitalized for psychiatric reasons? _____
    If no, continue.
    If yes, end now.

14. Are you currently, or have you ever been, in psychotherapy? _____
    If yes, for how long, continuously?
    How long total?

    If less than one year continuously, continue.
    If more than one year, end now. Say, **"I'm not sure if you'll be eligible for the study. If it turns out that you are, I'll get back to you. In the meantime, you have my number if you wish to reach me."**

15. The aim of this study is to better understand how adopted individuals perceive and think about themselves, their adoptive families and their birth families. This study will involve your completing three questionnaires that should take about one to one and a half hours. Questions involve your perceptions/thoughts about yourself and your adoptive and birth families. You will also be asked to fill out a brief demographic questionnaire and to answer some questions about how you've been feeling in the past week. Questionnaires will be mailed to you to be completed and returned to me. When I've received your completed packet, you will receive $20 for your time.

16. Does this sound like something you would like to participate in? _____

17. I would just like to review some things about confidentiality at this time. All questionnaires and responses will remain confidential. Your name will appear only on a consent form that will be given to you along with the questionnaires. There will be

two copies of the consent form, one for you to return to me and one for you to keep. All other forms will be identified by a code number that I'll assign to you.

18. Do you have any questions for me?

19. Let me have your address so that I may send you the research study materials.

Address:

APPENDIX G

The Graduate School and University Center of
The City University of New York
City College

VOLUNTEER CONSENT FORM

Project Title: Perceptions of Adoptive Mothers, Birth Mothers, and Self-Perceptions in Adult Adoptees.

Project Investigator: Lisabeth Gertner

Subject Name: _____

I.D. Number: _____

You are being asked to participate in a doctoral dissertation study on adopted adults and their perceptions of their adoptive mothers, their birth mothers and themselves. I hope to learn more about how these perceptions relate to one another. You have been selected as a possible participant in this study because you were adopted during infancy and have had no contact with your birth mother.

If you decide to participate, I will ask you to discuss in writing thoughts about your adoptive mother, your birth mother, and yourself. You will also be asked to complete one background information questionnaire and one questionnaire regarding how you've been feeling in the past week. These tasks will take about one to one-and-a-half hours to complete. A stamped, addressed envelope has been provided for you to return questionnaires and responses to me by mail.

You may experience some distress from writing about issues related to your adoption. You do not have to answer any question that upsets you and you may decide not to answer further questions if you wish. While some people find it helpful to think about and discuss issues related to their adoption, you may not receive any benefit from participating in this study. If you take part, however, the main benefit is to the community. The results of this study will be used to inform professionals in their understanding of, and work with, adopted individuals and their families.

After your completed packet has been received, you will be paid $20 for your time. If the need arises based on the information you share with me, I will contact you to discuss a referral for psychological or psychiatric treatment. However, this study does not provide compensation for additional medical or other costs.

The information obtained during your participation will be kept confidential. You will not be identified by name in any publication or report. Your name will not be included on any form other than this consent form. Instead, you will be identified only by an identification code. I will keep your code number and name in a locked filing cabinet. Only my advisor and I will have access to this information.

Your decision as to whether or not to participate in this research study will not prejudice your relationship in any way with any professor, the college, or the CUNY system.

If you have any questions at any time, you can reach me by telephone at (917) 531-4990. You may also contact Professor Steve Tuber, Ph.D., Clinical Psychology Doctoral Program, NAC Building, Room 8/101, City College or call him at (212) 650- 5672. If you have questions about your rights as a volunteer, please contact Ethel Breheny, IACUC/IRB Administrator, Office of Research Administration, Shepard Hall, Room S-16, City College or call her at (212) 650-7903. Please feel free to contact us at any time, even after the study is completed if you would like.

You are making a decision about whether or not to participate in this study. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at anytime after signing this form should you change your mind later.

_____ _____

Signature of Participant Date

_____ _____

Lisabeth Gertner, M.A., Investigator Date

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