UNSANCTIONED GRIEF AND ITS RELATIONSHIP TO THE ADOPTION PROCESS

by

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ABSTRACT

The purpose of this study was to examine the relationship between adult dysfunction and unresolved grief and loss as experienced by birthmothers and adoptees. Two questionnaires were presented to adoptees and birthmothers on several different internet adoption forums. Responses were collected via E-mail and analyzed for content related to the issues of grief and loss in their adoption experience. The questionnaires were developed specific to each group yet were similar in order to compare the responses between groups. Respondents were asked open ended questions to assess their feelings about adoption circumstances and whether maladaptation in adult life (with special emphasis on alcoholism) results from unexpressed grief. The findings indicated that both birthmothers and adoptees experienced intimacy problems, self esteem issues and addictions in their adulthood. Both groups also reported they had sought out therapy at different life stages, but nearly all respondents reported their grief issues had not been addressed adequately, if at all.
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CHAPTER 1
THE PROBLEM

Introduction

Adoption out of one family and into another is a major developmental interference that has immediate and delayed onset repercussions. Those repercussions are triggered at each stage of the life cycle. Members of the adoption triad may seek therapy for different reasons at different developmental stages. At the time they seek treatment these clients are usually unaware that current lifestyle dysfunction is related to their adoptee, birthmother, or adoptive parent status. Rosenberg (1992) states that birthparents, adoptive parents and adoptees share common themes of loss and anxiety, attachment and separation, and identities that involve paradoxical qualities.

This study examines issues involved in uncovering and resolving grief related to the losses that occur during the adoption process. The study demonstrates disenfranchised grief to be at the core of several areas of dysfunction that a client may bring to therapy. Because the most significant bond is usually between a mother and her children, this study focuses on birthmothers and adoptees. This bond becomes the prototype for other kinds of bonding throughout life (Feinberg, Feinberg & Tarrant, 1978).
Through several questionnaire responses from birthmothers and adoptees who shared their stories for this research on the Internet, the study reviews the lifelong impact of adoption on the birthmother and adoptee.

Development of the Problem

Two issues often permeate adoptive families--loss and control. For children who have lost their birthparents, and whose fate was dictated by strangers, the issue of control is paramount. For the adoptive parents, a sense of loss of control comes from being subjected to surveillance by caseworkers and not knowing if they will meet the criteria to adopt, or if the right child will become available for them to take home even if they do pass inspection. The birthparents have relinquished a child that they may never see again due to circumstances of traumatic loss (Roles, 1989a).

For all members of the adoption triad there is a special kind of on-going grief because no adoption circle member forgets the existence of the others. Yet they are often held to secrecy due to the shame associated with adoption. This makes it difficult for members to grieve the loss of these significant people in their lives.

Silverstein and Kaplan (1986) stress that the sense of shame blocks the grief work. They support the conclusion that if a person is entrenched in feelings of shame and subsequent denial, it is only by acknowledging their
adoption story that triad members can reduce enough shame to begin to feel again.

On the subject of grieving Lee (1996) states that most people would do anything to avoid looking closely at their losses and feel the grief resulting from those losses. Grieving techniques are frequently not included in university counseling curricula. A reason for the lack of emphasis on grief stages relates to the therapist being untrained in grief work. Another reason may be the therapist’s own issues of abandonment, birth rights, disempowerment, and social issues that stir up emotions for her/him and prevent therapeutic efficacy with clients.

The grief issue for the adoptee is profound, the most profound that any child can experience. She lost her parents, who gave her life. She was never held by the mother, who carried her in utero. Infants adopted as newborns often report a feeling of loss—and a need to grieve this loss—at adolescence, young adulthood or when other significant losses occur (Walsh, 1993).

A growing body of research indicates that, from the years of denial and numbness to the building of post-reunion relationships with their children, the birthmother is a hurting person, numb and powerless. In 1988, Winkler, Brown, van Keppel, and Blanchard commented:

The reported incidence of birthmothers who suffer long after relinquishment appears to be low, and this is largely because of the “conspiracy of silence” and the prevalent mythology surrounding birthmothers. Adoption
legislation and practice have traditionally underplayed the role of the birthparent in the adoption process... It is only in more recent years that birthparents have "come out" and talked publicly of their private anguish. (Stiffler, 1991, p.48)

In much of the literature, the birthfather is strangely absent—for the adoptee an even more enigmatic character than the birthmother (Brodinsky, Schechter, 1990). The adoptee’s fantasy is often that the birthfather impregnated the birthmother, then abandoned her. Often the only access to information about him is through the birthmother. If she is unavailable, the adopted child has no choice but to fill in the blanks with his/her own fantasies. When the birthmother is found, there is often reluctance on her part to talk about the birthfather due to her shame and her wanting to keep the secret, or the lack of knowledge about him.

Need for the Study

In the United States, there are few psychotherapeutic supports for grieving. From early childhood people are taught to pull themselves up by the bootstraps, to keep a stiff upper lip, to count their blessings instead of their losses and to avoid self-pity at all costs. These admonitions teach people to avoid facing their losses and to remain uninvolved when faced with others' losses. The purpose of this study is to add to the body of knowledge on helping clients process their losses by grieving them, with
special emphasis on the complexities of the unsanctioned
grief situation called adoption.

Jan Waldron's (1995) prosaic memoir Giving Away Simone
reports the following statistics:

There are approximately 6 million adoptees in the United
States. By extension, there are 12 million birthparents
and 12 million adoptive parents--30 million people
directly involved in adoption. Add to that number the
untraceable millions of other birth and adoptive
relations, and the percentage of our population touched
by the act of adoption grows beyond imagination... (p.
xvi)

Waldron (1995) also stresses that open support for this
large segment of society comes at a time when,

The upside of the current confessional climate in this
country...is the undoing of a conspiracy to erase
ourselves and the effort to give life to the stories
we've been expected to hide. (p. xvii)

There are millions of birthmothers in the United States,
but most people will say they have never met one.

**Purpose of the Study**

The purpose of the study was to examine the
relationship between adult dysfunction and unresolved grief
and loss as experienced by birthmothers and adoptees.

**Research Question**

What is the relationship between adult dysfunction and
unresolved grief and loss as experienced by birthmothers
and adoptees?
Definition of Terms

Adoption Circle/Triangle/Triad/Family: For this study, these terms describe family members involved in the adoption—the birthmother, adoptee, and adoptive parents. It also includes the social worker, any foster parents, and the absentee father.


Guilt: An evaluation of behavior rather than being, which leads to changing that behavior. Guilt is emotionally healthy when not chronically excessive (Harper and Hoopes, 1990).

Emotional Abuse: Any act that diminishes the emotional/feeling worth of a child. This abuse may be random or passive, which is the case in the adoption process. For example, the birthmother experiences as unselfish her decision to relinquish her child, but once the child has reached maturity and understands what happened, he/she may do self-blame and feel devalued or unwanted as a result of being relinquished.
Alcoholism: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following DSM IV Criteria:

(1) tolerance
(2) withdrawal
(3) the substance is often taken in larger amounts or over a longer period than was intended
(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
(5) a great deal of time is spent in activities necessary to obtain the substance
(6) important social, occupational, or recreational activities are given up or reduced because of substance use
(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (American Psychiatric Association, 1995).

Disenfranchised Grief:

The grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported. The concept of disenfranchised grief recognizes that societies have sets of norms—in effect, grieving rules—that attempt to specify who, when, where, how, how long, and for whom people should grieve. Such policies reflect the fact that each society defines who has a legitimate right to grieve, and these definitions of right correspond to relationships, primarily familial, that are socially recognized and sanctioned. In any given society these grieving rules may
not correspond to the nature of attachments, the sense of loss, or the feelings of the survivors (Doka, 1989, p. 5).
CHAPTER 2

LITERATURE REVIEW

Introduction

The literature review includes five sections: (1) background of adoption process, (2) separation, loss and identity issues, (3) shame and its relationship to adoption process, (4) adult dysfunction resulting from unsanctioned grief issues (with special emphasis on alcoholism), (5) grieving the losses and healing from unsanctioned grief, (6) summary.

Background of Adoption Process

Adoption is a process whereby a child is removed from one family and placed into another family through a legal process involving one or both birthparents; a private agency using an attorney or other intermediary; or an agency and the adoptive family (Roles, 1989a).

Agency adoption refers to social agencies that are licensed and regulated by the state to facilitate the adoption process. In the United States, a licensed adoption agency can be located by contacting a state
department of social services, the Child Welfare League of America, or the Family Service Association (Roles, 1989a).

Private or independent adoption refers to adoptions that take place as the result of collaboration between the birthparents and a private intermediary. They act primarily on behalf of the adoptive parents. According to Roles (1989a),

Adoptive parents may be paying a substantial sum of money to the intermediary to facilitate adoption. It is an offense to give or receive payment either directly or indirectly for the procurement of a child for adoption. (p.6)

Roles (1989a) also says that some birthparents may prefer to use private agencies because they have more control over the process, but she warns that birthparents should also have their own lawyer to represent their interests in the process.

The birthparent(s) have made a choice to relinquish their child due to a perceived inability to care for that child. This situation is paralleled with another couple, facing their inability to reproduce but wanting a child, considering the adoption of someone else’s unwanted, relinquished child. This prerequisite stage then leads to what Hajal and Rosenberg (1991) state is often a frustrating, sometimes agonizing, waiting period, a time of
expectations raised and often dashed. This is a public time for the expectant adoptive parents due to the scrutinizing of their lives by the private or public adoptive agency. It is an ambivalent experience for the relinquishing parent as she realizes "adoption is like an organ transplant with the same serious risks as well as hope of full recovery" (Rowe, 1989, p. 11).

Rowe states,

Adoption is a lifelong process for all involved; it does not end when the adoption is legalized. Those involved are all subject to generalizations, stereotypes, and myths. It is important for every party involved to be sensitive to the others' feelings, needs, positions, and roles. Adoption is a powerful experience that touches upon universal human themes of abandonment, parenthood, sexuality, identity, and the sense of belonging. (cited in Reitz & Watson, 1992, p. 3)

Jan Waldron's prosaic memoir Giving Away Simone (1995) accurately states the following statistics:

There are approximately 6 million adoptees in the United States. By extension, there are 12 million birthparents and 12 million adoptive parents--30 million people directly involved in adoption. Add to that number the untraceable millions of other birth and adoptive relations, and the percentage of our population touched by the act of adoption grows beyond imagination. (p. xvi)

Waldron (1995) also stresses that open support for this large segment of the population comes at a time when, "the upside of the current confessional climate in this
country...is the undoing of a conspiracy to erase ourselves and the effort to give life to the stories we’ve been expected to hide.” (p. xvii)

According to Roles (1989a) the adoption triad (adoptee, birthparents and adoptive parents) are all linked in an experience of loss. This loss hits at the core of people’s self-worth and is not an easy adjustment to make. There are other clinical issues involved as well. The Adoption Forum Library (America On-Line, 1994) identifies Silverstein and Kaplan’s (1986) seven core issues of adoption:

Loss: Each member of the triad has been involved in at least one major loss before becoming involved in adoption. Loss is a very natural thing that occurs in many of our human experiences and is sometimes necessary to gain new experiences and relationships (America On-Line, 1994). While losses are painful, they are a part of who people are and how they deal with various issues in their lives. Society encourages those in the adoption triangle to ignore their losses rather than confront them. Members of the adoption triad often participate in “behaviors that are designed to retrieve and replace losses” (Silverstein and Kaplan, cited by America On-Line, 1994). According to
Feinberg, Feinberg, and Tarrant (1978), the ways in which people encounter these leave-takings have consequences for their self-esteem, their general well-being and their emotional integrity. For adoptees, it is extremely valuable for them to know they can feel sad about the loss of their birth family and still be happy about being with a new family.

**Rejection:** One way in which people deal with their loss is to try to figure out what they did wrong to cause the loss. The message that many people believe is that they were unworthy of having what was lost, and they feel rejected. Members of the triad fear rejection more than anything else and will do almost anything to prevent it from happening. To counter their feelings of unworthiness (shame), they may become people pleasers, or may reject others before they are rejected themselves. In other words, rejection may be anticipated, therefore setting the scene for it to happen in their future relationships.

**Guilt/Shame:** Shame occurs when someone takes on the responsibility of the loss and personalizes the experiences as something wrong with themselves (America On-Line, 1994). The shame comes from knowing that others know about the adoption. It comes from the secrecy that often surrounds
adoption processes. Shame is a deep emotion having to do with feeling that one is intrinsically bad.

Guilt is related to the action that caused the loss. Guilt is about ones' behavior. While a person may regret their behavior, it doesn't diminish their sense of self worth.

**Grief:** It is difficult for the members of the adoption triangle to grieve when the premise of adoption is seen as a way for everyone to gain. According to Roles (1989a) "society does not recognize the right of birthparents to grieve." (p. ix) Roles (1989b) also states that there are volumes of books on loss and grief related to death, divorce, and separation, but only a chapter or article here and there about birthparents' grief. Research regarding grieving the loss of a child through adoption, were found only in the category of unsanctioned grief.

**Identity:** Simply defined, this is the knowing of who one is and who one is not (Walsh, 1993). Adoption threatens a person's sense of knowing who he/she is, where he/she came from and where he/she is going. Each person in the triangle has experienced some loss of identity; such as identifying oneself as a caretaker of a child, being able
to birth a child, and, for the adoptee, not really belonging to their families. These missing identities, or roles, may cause them to behave in extreme ways to gain a sense of belonging. They may become people pleasers or be inclined to join cults or gangs (America On-Line, 1994).

**Intimacy:** If a person has difficulty with identity, it is likely he/she will have difficulty developing close relationships. A person who has experienced significant losses may fear getting close to others because of the risk of experiencing more losses (Silverstein and Kaplan, 1986). Both the adoptee and the birthparent may associate intimacy with loss, causing them to avoid intimacy in their relationships.

**Control:** The loss of control in the context of adoption can cause human beings to feel less secure and can have long term effects on each member of the adoption triangle. According to Silverstein and Kaplan (1988) the relinquishment is seen as an out-of-control disjunctive event which can interrupt the drive for self-actualization. Kaplan and Silverstein write that "recognizing and working through these seven core issues in adoption can be an enriching experience for members of the adoption triad" (cited by American On-Line, 1994).
According to Roles (1989a) a major shift has taken place in the adoption picture over the past twenty years influenced by: "(1) decreased stigma on single parenting as divorce rates increase; (2) decreased stigmas on out-of-wedlock births; (3) the civil rights movement; (4) the women's rights movement; and (5) legalized abortion" (p. x).

A new reality about adoption has emerged that validates both sets of parents; the birthparents as the ones who nurtured the child during pregnancy, gave birth to the child, and provided the child’s genetic and hereditary traits; and the ones who raised the child to adulthood and provided the nurturing environment and relationships. As Roles (1989a) observes, "both are valuable, essential contributions to the child's life. Neither parent is the more real parent. They are just different kinds of parents. Neither set of parents owns the child." (p. xi)

Another developing theme in adoption is open vs. closed adoptions. The notion of open adoption is relatively new and was catapulted into prominence in 1982 by a book, Dear Birthmother, by Kathleen Silber and Phyliss Speedlin. Open adoption refers to the exchange of information (usually identifying) between birthparents and
adoptive parents, and to the possible opportunity for face-to-face contact among birthparents, adoptive parents and child (Role, 1989a).

McRoy, Grotevant, and White (1988) identify three points on an openness continuum: (1) closed adoption, in which all identifying information about the other parties involved is kept confidential; (2) semi-open adoption, in which there has been mutual disclosure of information between the adoptive family and the birthparent, or a one time meeting, or both; and (3) fully open adoption in which the two families have continuing contact. (cited by Reitz & Watson, 1992, p. 260)

The extent of openness may include:

1. receiving identifying information  
2. meeting each other  
3. having adoptive parents present at the delivery  
4. actually handing the child into the arms of the adoptive parents  
5. continuing exchange of information after placement (letters and photos)  
6. continuing contact with the child (Role, 1989a p. 4)

By contrast, the traditional closed adoption refers to the maintenance of confidentiality of both the birthparents and adoptive parents. No identifying information is exchanged, though both parties are able to obtain
non-identifying profiles of a number of adoptive families and be offered their preference. Role (1989a) claims, in many states the opportunity now exists to sign a waiver of confidentiality at the time of the adoption. This permits identifying information to be released if the adopted child, upon reaching the age of majority, seeks information about the birthparents. (p. 4)

Currently there is no empirical evidence to support or refute open adoption as the adoption plan of preference. There are anecdotal accounts of preferences for both open and closed adoption processes. Several of these reports are cited by Reitz and Watson (1992, p. 260-261). They also report (1992) that, in their clinical experience, triad members who have been involved in confidential adoptions often experience several identified critical issues: "the unresolved loss of both the adoptee and the birthparent; the denial of the adoptee’s dual family ties by all members of the triangle; and the diminished self-esteem of the adoptee and the birthparent" (Reitz & Watson, 1992, p. 261).

Silber and Speedlin (1991) present four prevalent myths of adoption:

1. The birthmother obviously doesn’t care about her child or she wouldn’t have given him/her away.
2. Secrecy in every phase of the adoption process is necessary to protect all parties.
3. Both the birthmother and the birthfather will forget about their unwanted child.
4. If the adoptee really loved his adoptive family, he/she would not have to search for his birthparents. (p. 75)

These four beliefs represent the primary issues that bring members of the adoption triad into therapy.

Separation, Loss and Identity Issues

Silverstein & Kaplan (1986) say that adoption is created through loss, and that without losses there would be no adoption taking place. The loss touches each member in the adoption triangle; the birthparents lose the child born to them, the adoptees lose their birthparents, and the adoptive parents lose the child they hoped to bear. All of these losses loom large in the lives of each adoption participant, and how those losses have been dealt with or not dealt with is examined carefully in this study.

Separation anxiety is the feeling of distress. It is felt when the threat of loss presents itself and at the time of actual loss (Lipinski, 1980).

It’s most poignant visible expression is possibly the restless search of an animal separated from an offspring or the aimless pacing of a bereaved widow as she yearns and pines for a lost spouse. (Lipinski, 1980, p. 5)

One of the earliest attempts to examine separation anxiety was done by Otto Rank (1957) in his book The Trauma of Birth. Rank’s theme was that the trauma of the moment
of birth contained overwhelming fear and shock that had inevitable significance for the entire span of one's life. He describes a momentary sense of primitive fear as infantile anxiety and as fear of being left alone, abandoned, yearning for the comfort and security of the known. The term separation anxiety is most often used relative to young animals and infants (Smith, 1975). Smith (1975) states

the construct seems to have undeniable bearing on the understanding of the formation of relationships; the development of dependence, and autonomy; the need for intimacy and warmth; and the adaptation to life-threatening illness and loss of important persons. (p. 5)

These processes represent affectional bonding (Feinberg, Feinberg, & Tarrant, 1978). Affectional bonding may have its origin in the evolutionary past. The most significant bond is usually between the mother and her young. This bond becomes the prototype for other kinds of bonding throughout life (Feinberg, Feinberg & Tarrant, 1978).

"Both psychoanalytic and attachment theories that have emerged regarding mother-infant relationships and early separations present very persuasive interpretations concerning bonding" (Lipinski, 1980, p.6). Bowlby (1958, 1960a, 1960b) postulates an extension of Darwin's theory of
evolution and claims these early attachment bonds have survival value for the species. Freud's (1957) view supports a drive reduction theory. Lipinski (1980) states that the most reasonable compromise of theories may be found in the concept of arousal. "When confronted by separation or threat of separation, the infant, the young child, and the adult all show signs of emotional and physiological arousal" (p. 7).

Bowlby (1960a, 1960b) claims when a child is separated from the mother to whom an attachment has developed, there is a separation protest of crying, reaching, following, and making attempts to regain her. If the mother does not return, the child appears to give up until there is a loss of interest, and detachment.

Bowlby (1961, 1973) and Spitz and Wolf (1946) both present adverse effects of maternal separation and deprivation. Lipinski (1980) concludes, "although they may be challenged, their descriptions of withdrawn, apathetic children, suffering from 'affect hunger,' ring true as the precursors of the lack of trust and the inability to be close to others." (p. 7)

Bowlby (1958) has posited that separation anxiety may be generated by unconscious hostility toward the mother.
This hypothesis gained support by Gold (1971) in his findings with 200 children that “early hostility and separation anxiety are precursors of the anger toward the lost love object that is often evident in later life” (cited by Lipinski, 1980, p. 7).

In most contemporary studies of separation anxiety researchers agree that “separation anxiety is a dynamic and essential force propelling us along the path of finding and relating to objects and of developing our self-concepts” (Sternschein, 1973, cited by Lipinski, 1980, p.7).

The literature review above concerns primarily the concept of loss from the infant’s perspective. This researcher wishes to stress the same concept from the birthmother’s perspective.

Birthmothers have been traditionally encouraged to sign the relinquishment papers, to go home and to get on with their lives. This prevailing attitude is reflective of what Heather Carlini (1992) states are adoption laws from the 1920s. There was a great deal of stigma placed on a child and its mother when the birth occurred outside the confines of marriage. Carl (1995) states that unmarried mothers had to bear shame not only from their families and friends but from society as well. Birthmothers were
expected to place their child for adoption even though they wanted to keep their child. Carl (1995) says as a result, many birthmothers felt as though their child had been taken from them. Birthmothers were encouraged to never speak of the child again, and their families did not either, because of the shame and the pain of their loss.

The effects that relinquishing a child can have on the life of the birthmother is profound. Silverstein and Kaplan (1986) point out that relinquishment is seen as an out of control disjunctive event which interrupts the drive for self-actualization. A birthmother may have difficulty resolving issues with the birthfather which may interfere with future relationships. “Intimacy may equate with loss to the birthmother” (Silverstein and Kaplan, 1986). The self-worth and sense of self of a birthmother “may be diminished and interfere with future parental desires” (Silverstein and Kaplan, 1986). “The child as a part of the identity of the parent goes on without knowledge” (Silverstein and Kaplan, 1986). Birthmothers “may reject self as irresponsible, unworthy because they permitted an adoption” (Silverstein and Kaplan, 1986). A birthmother may “turn these feelings against her self and see herself as deserving rejection; she may even come to expect or
cause rejection" (Silverstein and Kaplan, 1986). Carlini (1992) believes there are eight core issues of relinquishment: low self esteem, grieving the loss of your child, forgiving self and others, being out of touch with your feelings, difficulty giving and receiving love, co-dependency, self-hatred, and dysfunctional sexual problems. She believes these issues remain as problems for the birthmother for years after the adoption.

Roles (1989b) states, "an irrevocable decision on the part of the birthmother is necessary, and this leaves little incentive to acknowledge the pain in the loss" (p. vi). To acknowledge and encourage the reality of loss and subsequent need for grieving might jeopardize the signing of adoption papers. Roles (1989b) says the

two major differences between the loss in adoption and other losses have contributed to its lack of public acknowledgement and sanction: (1) the social stigma attached to out-of-wedlock births and teenage pregnancies; and (2) the traditional view that adoption simultaneously meets the needs of all three parties in adoption. (p. vi)

The adoption decision creates a body vs. mind struggle for the birthmother. As she rationalizes her decision to herself she can be attempting to suppress her sense of loss and end up finding physiological outlets for the emotional pain. The longer these feelings remain unexpressed or
suppressed, the greater her fear of losing control. If she is unsuccessful in finding an outlet she may develop secondary symptoms of repressed emotions such as nightmares, phobias, sleep disturbance, panic attacks, depression, alcoholism, or drug abuse. Roles (1989a) says that the birthmother may use anger to avoid facing her loss and that the stimulation of intense affect such as anger keeps birthmothers connected emotionally to the child.

Shame and Its Relationship to the Adoption Process

Winkler, Brown, Van Keppel, and Blanchard, cited in Stiffler (1991) commented:

The reported incidence of birthmothers who suffer long after relinquishment appears to be low, and this is largely because of the "conspiracy of silence" and the prevalent mythology surrounding birthmothers. Adoption legislation and practice have traditionally underplayed the role of the birthparent in the adoption process... It is only in more recent years that birthparents have "come out" and talked publicly of their private anguish. (p. 48)

Shame is defined as an emotional response to a negative evaluation of one’s self (Harper and Hoopes, 1990). His sense of being worthless and unlovable that affects self-esteem and the ability to deeply care for oneself.

Adoption triad members often try to figure out where they went wrong. Their own sense of unworthiness is
reinforced in the adoption process because their designated role as adoptee, birthmother or adoptive parent imply a less than normal status. The adoptee views himself or herself as unworthy of being parented by their birthparents. The birthparents view themselves as unworthy of fulfilling their destiny to parent a child. The adoptive parents decide they are defective due to their inability to produce a fertilized egg and procreate as nature intended. These feelings are then compounded by the secrecy that often surrounds adoption. When people identify with a loss to the extent that they feel there is something intrinsically wrong with themselves that caused the loss, they often feel they did something wrong, or they feel shame that others may know (Silverstein & Kaplan, 1989). Since all are frequently asked in public settings to reveal information about birth, birthparents, children, etc. the shame is revisited throughout the triad member’s lifetime. Triad members will sometimes fabricate their truth to avoid further rejection from society, which leads to a chronic state of denial--complicating shame and grief. Denial is maintained through unresolved feelings of shame and grief (Jones, 1993).
Carlini (1992) studied the birthmother trauma based on interviews of relinquishing mothers. She claims that when these women were asked about their self-esteem, eighty-five percent reported that they suffered from low self-esteem.

Jones (1993) identifies the birthmother syndrome in which the following characteristic related to shame typically appears: Dual identities, divided into outer pretenses of perfection and secret inner feelings of shame, self-condemnation, and isolation. (Jones, 1993, p. 272)

"Each time you talk about your experience it will get easier, but there will always be some situations that will be particularly uncomfortable" (Roles, 1989a, p. 52). If members of the adoption triad continue to keep the secret, they continue to reject the notion that they are redeemable and it will be difficult to feel good about themselves. This pain must be continually measured against the pain of disclosing the secret. Roles (1989a) quotes Pauline:

I ask myself now, “How did I manage to keep this painful secret for so long?” I blocked it out as if it just didn’t happen. However, when family or friends had a discussion about babies or pregnancy, my secret wasn’t as deeply buried as I thought. My pain would start to surface, and I would have to leave. (p. 53)

Pauline was at that painful place of acknowledging her secrets and letting the pain out or, once again, leaving
and choosing further denial. Gradually letting go of the secret is a release from the "bondage of shame and embarrassment" (Roles, p. 53). "It can actually build your confidence as you find the courage to talk about this part of your life" (Roles, p. 53).

**Adult Dysfunction**

Maladaptation in adult life (with special emphasis on alcoholism) resulting from unexpressed grief.

Referring again to Jones (1993), identifying the birthmother syndrome, the additional following characteristics typically appear:

1. Signs of unresolved grief, such as a lingering denial, anger, or depression.

2. Symptoms of posttraumatic stress disorder, such as flashbacks, nightmares, anxiety, avoidance, or phobic reactions.

3. Diminished self-esteem, passivity, abandonment of previous goals, or feelings, or feelings of powerlessness, worthlessness, and victimization.

4. Dual identities, divided into outer pretenses of "perfection" and secret inner feelings of shame, self-condemnation, and isolation.

5. Arrested emotional development, typified by the sense of being "stuck" where they were when they relinquished.

6. Self-punishment, often inflicted through participation in abusive relationships, abuse of drugs or alcohol, eating disorders, or other self-destructive behaviors.
7. Unexplained secondary infertility.

8. Living at, or vacillating between various extremes. (Jones, 1993, p. 272)

Jones (1993) reports that most of the women she interviewed stated that the bulk of their problems began after their relinquishment, and some reported a predisposition to emotional problems before the relinquishment (cited in Carl, 1995).

Silverstein & Kaplan (1986) claim the members of the triad often participate in "behaviors that are designed to retrieve and replace losses." This theme of loss has powerful effects on the subsequent relationships for triad members. Adoptees may fear abandonment to such a degree that they cannot utilize healthy boundaries in relationships--they will not know when to let go and when to hold on. They may develop codependency through people-pleasing behaviors. Their shame over feeling intrinsically defective may lead them into abusive relationships that they cannot get out of. All the triad members may react to abuse similarly due to overwhelming fear of rejection. They may get caught in a pattern of avoiding intimacy due to this fear.
Adoption threatens a person's sense of knowing who he or she is, where he or she came from, and where he or she is going (Silverstein & Kaplan, 1988). Identity issues are confusing for both adoptees and birthparents. The adoptee loses his/her biological heritage, which impedes his/her sense of self (Carl, 1995). This can lead to having a sense of not belonging anywhere, which can lead to a life lived in extremes (Jones, 1993).

Whatever extremes or other signs of the birth mother syndrome have emerged in their individual life patterns, many had been driven by an underlying theme of hopelessness and loss that has colored the entire fabric of their lives. Indications of the syndrome appeared among birthmothers of all ages, in all parts of the country, and within open and closed adoptions. (Jones, 1993, p. 273)

Those extremes cover a wide range of behaviors. "Their romances and intimacies, family relationships, child-rearing practices, career, goals, and self-images often reflected extremes with absolute either/or motifs" (Jones, 1993, p. 273). Examples of these extremes are: having no other children or having many in quick succession, behaving promiscuously or being sexually anorexic, being very controlling or very passive, isolating or joining a cult to satisfy that need to belong somewhere.

Self-punishment, states Jones (1993), is often inflicted through participation in abuse of drugs or
alcohol. The body has a memory, and the birthmother may struggle to divest herself of that memory because it arouses pain. She may choose to numb the body with alcohol, to survive until she is able to find a way to let go of her past. Roles (1989a) accurately states that

the longer these feelings remain unexpressed or suppressed, the greater the fear of loss of control becomes. If you never find an outlet for these feelings, you risk developing symptoms such as nightmares, phobias, sleep disturbances, panic attacks, depression, alcoholism, or drug abuse” (p. 22).

There are numerous somatic disorders related to repressed emotions as well (Roles, 1989a).

Your body might find physiological outlets for the emotional pain, such as headaches, allergies, muscle tension, digestive disturbances, back pain, or abdominal pain... Your body and mind are inseparable... It takes a tremendous amount of physical and mental energy to keep feelings masked. (Roles, 1989a, p. 22 & 23)

Innumerable clinical studies have linked alcoholism and adoption, concluding that there is inheritability of alcoholism through genetics. Dinwiddie & Cloninger (1991) state, “alcoholism has been shown repeatedly to be much more common among relatives of alcoholics than in the general population” (p. 206). Reich, Cloninger, van Eerdewegh, Rice and Mullaney (1988) have recently applied
Rice's (1986) model, which states that the degree to which traits are passed from generation to generation can be quantified and modeled. In doing so, they have shown that the "transmissibility of the disorder appears to be increasing over time, an indication that purely genetic factors cannot fully explain the etiology of the illness" (Reich, et al., 1988, p. 458). Nonetheless, adoption and twin research results strongly favor the existence of inborn factors contributing to the development of alcoholism (Dinwiddie and Cloninger, 1986).

In 1996 the Archives of General Psychiatry presented a group of articles on alcoholism. Much of the research described in the article was supported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The resulting commentary by Dr. E. Gordis highlights a "significant fraction of vulnerability to alcoholism is inherited" (Gordis, 1996, p. 199). Research scientists "have bred strains of rats over many generations that reliably demonstrate strong or absent alcohol preference" (Gordis, 1996, p. 199). In 1994 Cutrona, Cadoret, Suhr, Richards, Troughton, Schutte, & Woodworth tested adoptees for both genetic and environmental factors implicated in the etiology of alcohol abuse. Their results indicated an
unexpectedly high incidence of alcohol abuse and/or dependence among the adoptees; however, these results failed to interpret the biological parent alcoholism as the predictor of adoptee alcoholism.

There is no easy explanation for the high rate of abuse/dependence in the sample. One possibility is that adoption is itself a risk factor for alcoholism, although no literature was located to confirm this hypothesis. (Cutrona, et al., 1994, p. 177)

In this same study by Cutrona et al. (1994), consistent with their predictions, significant interactions were obtained between alcoholic biological background and two of the environmental variables among women. “Adoptive family conflict predicted the probability of adoptee alcohol abuse/dependence only among women with an alcoholic biologic parent” (Cutrona, et al., 1994, p. 178).

In another adoption study, done in 1986 by Cadoret, Troughton, O’Gorman & Heywood three etiological relationships with drug abuse were found:

1. Drug abuse was highly correlated with antisocial personality, which in turn was predicted from antisocial biologic background;

2. A biologic background of alcohol problems predicted increased drug abuse in adoptees who did not have antisocial personalities; and

3. environmental factors of divorce and psychiatric disturbance in the adoptive family were associated with increased drug abuse. (p. 1131)
Peele (1985) suggested that "multiple addictions to a wide variety of substances constitute evidence against a genetic interpretation of addiction" (cited in Cadoret et al, 1986, p. 1136). But the data of Cadoret et al (1986) refutes that position and actually suggests there is some underlying biochemical foundation involved in all of the substances abused or some common psychosocial factor leading to polysubstance abuse.

Goodwin (1977) states "the strongest predictor of future alcoholism in adolescents is a family history of alcoholism" (p. 171). He states every study shows that about one of every four or five sons of alcoholics (in North America and Western Europe) became alcoholic; about 5% to 10% of the daughters became alcoholic. Alcoholism runs in families. It runs in families even when the children are separated from the alcoholic parents and raised by nonalcoholic adoptive parents.

In the Stockholm Adoption Study by Cloninger, Bohman, Sigvardsson & von Knorrin (1984) the inheritance of alcohol abuse and other psychopathology was studied in 862 men and 913 women adopted by nonrelatives at an early age in Sweden. Cloninger et al. found several new findings about alcoholism. First, they showed that genetic factors
are important in the risk of alcoholism in both men and women. Second, they found that in some families the same genetic factors that lead to alcohol abuse in men are expressed as somatization in women (1984, p. 49).

Somatization disorder, also known as Briquet's syndrome or chronic hysteria, has been described by Guze (1967) and cited by Sigvardsson, von Knorring, Bohman & Cloninger (1984) as:

a chronic syndrome of recurrent symptoms in many different organ systems that begins before age 30 years and is associated with psychiatric distress but no physical disorder. Characteristic symptoms include frequent body pains, gastrointestinal tract symptoms, complications of pregnancy and menstruation, anxiety and depressive symptoms, conversion symptoms, and a belief on the part of the patient that she has been sickly most of her life. The disorder is thought to affect women almost exclusively, but rare cases in men have been reported. (p. 854)

In the Sigvardsson et al. study (1984), somatizers accounted for 36% of all cases of psychiatric disability and 48% of all sick-leave occasions in adopted women. "Compared with nonadoptees, there was an excess of somatizers in adoptees, a population known to have an excess of biologic parents who are criminal and/or alcoholic" (p. 853). There may be a relationship between female somatizing and predicting alcoholism. As noted by Cloninger et al (1984) "nearly 30% of the high-frequency
somatizers had registrations for alcohol abuse and/or criminality. This is more than an eleven-fold excess compared with nonsomatizers” (p. 871).

In a 1981 study involving cross-fostering analysis of adopted women, Bohman, Sigvardsson & Cloninger conclude

There was a threefold excess of alcohol abusers among the adopted daughters. In addition, there was an excess of alcohol abuse among the daughters of biological fathers with alcohol abuse that was mild and not associated with criminality. (p. 965)

In a 1970 study of males done by Cadoret, Cain & Grove “significant associations were found between adoptee alcoholism and an alcoholic background and between childhood conduct disorder and the development of alcoholism as an adult” (p. 561). Cadoret et al. also conclude

the association of alcoholism in adoptees with a history of alcoholic biologic relatives suggests a genetic component in alcoholism. This interpretation is likely, given the early separation of the adoptees from biologic relatives, thus minimizing learned behavior. (p. 563)

Bohman & von Knorring (1979) studied psychiatric illness among adults adopted as infants and found there was a “significantly high frequency of psychiatric illness among the adoptees compared with nonadopted controls” (p. 106). The nature of the psychiatric illnesses tested significant were personality disorders and abuse (mostly to
alcohol). They also showed an over-representation of neurotic disease among adopted males.

In the older studies from the 1970s, much less research was done on females so less is known about genetic factors in female alcoholism. One 1977 study done by Goodwin, Schulsinger, Knop, Mednick & Guze on alcoholism and depression in adopted-out daughters of alcoholics suggests that environmental factors may be important in both alcoholism and depression in women, since both were correlated with psychopathology in the foster parents. In this study Goodwin et al. (1977) did not find that daughters of alcoholics had any more depression than controls (daughters of nonalcoholics) and that both groups had the same number of problem drinkers and that all girls were at least light drinkers.

A study of male adoptees in 1973 by Goodwin, Schulsinger, Hermansen, Guze and Winokur looked at drinking practices and problems and a wide range of other life experiences in a group of 55 men who had been separated from their alcoholic birthparents early in life.

Compared to a matched control group of adoptees, significantly more of them had a history of drinking problems and psychiatric treatment. The two groups did not differ with regard to other forms of psychopathology, such as depression or character
disorders. Children of alcoholics had three times the divorce rate of the controls. (p. 238)

Grieving the Losses and Healing from Unsanctioned Grief

Viorst (1986) states:

When we think of loss we think of the loss, through death, of people we love. But loss is a far more encompassing theme in our life. For we lose not only through death, but also by leaving and being left, by changing and letting go and moving on. And our losses include not only our separations and departures from those we love, but our conscious and unconscious losses of romantic dreams, impossible expectations, illusions of freedom and power, illusions of safety—the loss of our own younger self, the self that thought it always would be unwrinkled and invulnerable and immortal. (p. 2)

In Western culture, grief has become an emotion that is hidden from view. After a grief event people are expected to pull themselves together, get back to work and do their mourning briefly and quietly, if at all. “The outright expression of grief frightens us and leaves us feeling helpless” (Seeland, 1990, p. 53). This expectation that people maintain control over their emotions even when they are overwhelmed with feelings takes its toll. What is the price when one hides one’s pain over a loss that cannot be publicly acknowledged? Seeland supports the notion that unresolved grief frequently leads to long-standing negative consequences, and also states that the grief over the loss
of a child through adoption or abortion is often hidden and repressed.

The following quote describes how this happens in an adoption scenario.

Joan, a 40-year old, single executive, sought therapy for recurrent episodes of serious depression and frequent job changes. She would usually quit just prior to an anticipated promotion and end up with another job below her professional potential. It took a whole year of therapy before Joan was able to reveal, for the first time in her life, that while in college, at the age of 18, she had become pregnant by her teenage boyfriend and had given her child, a girl, up for adoption (sic). Her desire not to spend her life like her parents—as a blue collar worker—and her fear that her boyfriend would “never amount to anything either” were some of the factors leading to her decision. She was finally able to admit her long-standing sadness over the loss of the child and her unconscious “searching” anytime she met a woman of the age of her daughter. She also began to recognize her self-destructive work behavior as an unconscious attempt to punish herself for her previous ambitiousness, which had led to the adoption. (Seeland, 1990, p. 55)

In this circumstance hidden grief resulted in long-standing depression, an incomplete stage of yearning for the lost person, and self-destructive behavior to punish the person responsible for the loss (Seeland, 1990).

When people grieve openly and consciously it allows them to experience their pain, anger, shame, fear, guilt, remorse, loneliness and other related feelings. It is an essential factor in healing and shedding a cloak of shame.
To share one's grief with others allows one to be comforted and to give comfort. It confirms the knowledge that one is not alone and that it's possible for life and love to continue (Seeland, 1990).

Worden (1982) outlines the tasks of grieving:

1. To accept the reality of the loss.

2. To experience the pain of grief.

3. To adjust to an environment in which the deceased (or relinquished) is missing.

4. To withdraw emotional energy from the past and reinvest it in the future (cited in Seeland, 1990, p. 54).

These steps are impossible to resolve in an acceptable loss situation and their incomplete status can lead to:

1. Delayed grief reactions where new grief may draw on the power of old unresolved grief.

2. Chronic grief reaction where grief is never resolved, life becomes stagnant, and new emotional growth cannot take place.

3. Masked grief reactions where grief may express itself in physical illness, psychological problems, or aberrant or self-destructive behavior (Seeland, 1990, p. 54 & 55).

Silverstein and Kaplan (1986) state, "Where relinquishment is involved, the grief process can be delayed as much as ten to fifteen years. American society 'lacks' rituals for mourning the loss of a child through adoption" (cited in Carl, 1995, p. 6).
Jones (1993) discusses the fact that all cultures establish methods for helping people survive traumatic loss or grief. This often includes "formal rituals and structured practices that allow people to face their losses, grieve, and heal" (Jones, 1993, p. 74).

Jones (1993) claims that adoption is not a loss that qualifies as a legitimate reason to grieve in American society.

When losses are socially acceptable, occurring within the basic guidelines of social structure, they evoke emotional support that assists the process of grief and, thus, the progress of affected individuals. However, when losses occur outside its norms, society withholds its mechanisms of comfort from those who grieve. Having broken society’s rules regarding pregnancy and motherhood, most birthmothers found little support in grieving and healing. Ironically, many who endured the losses of their children in order to regain social acceptance found that society turned its back on them, denying them the very rituals and tools that might have helped them recover, afterward. (Jones, 1993, p. 75)

Due to the unsanctioned grief surrounding adoption most birthmothers have been left alone to manage their own grief, which has usually meant they remained in stage one of Kubler-Ross's (1969) five stages of grief. That stage is one of denial and isolation. The other stages are anger (stage two), bargaining (stage three), depression (stage four) and acceptance (stage five) (Kubler-Ross, 1969).
Birthmothers may remain in a stage of denial for a long time because of the secrecy of their relinquishment.

Roles (1989a) writes:

Loss and grief in adoption are like other kinds of loss but are also unique, particularly because the element of decision making is an important aspect of the grief process. First, the more clear it is that the decision is your own, the more you can take the responsibility for it and the less you will get caught up in blaming others. Blaming someone else will block or hinder your ability to get through the grief process. Second, the element of choice in the decision seems to be a factor in society's lack of recognition of the grief that relinquishment causes" (p. 18).

Jones (1993) claims relinquishing birthparents experience a loss similar to the death of a loved one, but the need to grieve that loss goes unrecognized, so "many claim that they never experience certain phases, skipping denial and anger and proceeding directly to depression" (p. 79).

Roles (1989a) presents other issues for the birthmother after relinquishment:

1. Adoption lacks the finality of loss through death, which leads to fantasy created by the unknown.

2. Hopes for a reunion in the future can inhibit the acknowledgement of loss and impair the grief process.

3. No rules on how to behave after relinquishment.
4. Family and friends do not acknowledge the loss either.

5. Other simultaneous losses can make her feel more vulnerable and overwhelmed. (pp. 20-21)

Roles (1989a) reminds birthmothers that they grieve because they loved. She says many people love and try not to grieve. They try to block out mourning because the feelings can be uncomfortable and overwhelming. Experiencing loss is a huge part of life and expressing pain is nature’s remedy for those losses. Without the expression of these deep feelings they will remain hidden and other, less direct, expression may manifest through self-destructive behaviors, physical illness or psychological distress.

Summary

The review of literature, related to various issues surrounding the adoption process and members of the adoption triad, strongly supports the necessity for a grief-oriented type of treatment model that recognizes, as Rowe (1989) states, “adoption is a lifelong process for all involved; it does not end when the adoption is legalized” (p. 57).

Waldron’s (1995) memoir Giving Away Simone points to adoption statistics, “...30 million people directly
involved in adoption" (p. xvi), suggesting there is a need for therapists to be aware of adoption issues because the likelihood of their encountering one or all members of the adoption triad at some point is quite high.

The issue of loss links all members of the triad, and since society encourages them to ignore their losses rather than confront them, members often participate in "behaviors that are designed to retrieve and replace losses" (America On-Line, 1994). Those behaviors include self-destructive life styles that may involve relationship dysfunction, addictions, eating disorders, depression, somatization (female adoptees and birthmothers) and some degree of sociopathy (male adoptees). They also must deal with other adoption issues, including rejection, guilt & shame, grief, identity problems, intimacy and control difficulties.

Unresolved grief is often at the core of these adoption issues, and that this grief needs expression and resolution. The grief is unsanctioned because society rejects adoption as a legitimate reason to grieve. For this reason therapists may be called upon to validate a triad member's feelings of loss in order for him/her to begin coming out of denial and telling the adoption story.
Therapists may encounter clients who present a variety of signs of unresolved grief such as a lingering denial, anger, or depression. There may be symptoms of posttraumatic stress disorder, diminished self esteem, passivity, abandonment of previous goals, or feelings of powerlessness, worthlessness, and victimization. A client may possess dual identities, divided into outer pretenses of perfection and secret inner feelings of shame (Jones, 1993, p. 272). Therapists may observe self-punishment inflicted through abusive relationships, abuse of drugs or alcohol, eating disorders or other self destructive patterns. Masked grief may also present itself as physical illness.
CHAPTER 3

METHODOLOGY

Introduction

The purpose of the study was to examine the relationship between adult dysfunction and unresolved grief as loss as experienced by birthmothers and adoptees.

The research question is: what is the relationship between adult dysfunction and unresolved grief as loss as experienced by birthmothers and adoptees?

Research Design

A descriptive research design was used to draw attention to the degree to which adoptee and birthmother dysfunction phenomena were related to unresolved grief issues. "In descriptive research, the researcher does not manipulate variables or control the environment in which the study takes place" (Merriam & Simpson, 1995, p. 61). A questionnaire was used which focused on adoption-related issues in these adoptees' and birthmothers' lives.
Population and Sample

The study population were birthmothers and adoptees who have either relinquished children or have been relinquished. The sample was from America-On-Line adoption forums' listings. The sample were asked to respond via e-mail to a questionnaire about their adoption experience and whether they were currently in any kind of therapy. No demographic information was requested from the participants other than their status as a birthmother or adoptee. The participants were informed in a cover letter from this researcher that their responses would remain anonymous. There were thirty-eight responses from adoptees and ninety from birthmothers. Thirty-eight birthmother responses were selected randomly to match the adoptee number.

Procedure

A series of questions were presented to adoptees and birthmothers on several different Internet adoption forums such as the Open Adoption mailing list. The list servers distributed the questions to their mailing list and adoptees and or birthmothers responded directly to an e-mail address included with the questionnaire. This researcher provided a brief explanation about how the research results would be used. The researcher explained
that she too was a member of an adoption triad (as a birthmother) and that participation was strictly voluntary and anonymous. Completed questionnaires from the respondents were collected and analyzed for content relating to the issues of grief and loss in their adoption experiences.

Instrumentation

The instruments used in this study were two questionnaires, one used for the adoptees and the other for birthmothers. The questionnaires were developed specific to each group yet were similar in order to compare the responses. The first group of questions asked the respondents about their memories of the adoption experience. Both groups were asked if adoption was something they would recommend. Another group of questions asked about adult behaviors that were self destructive in order to identify addictive disorders. The last question was to discover if members of either group had sought out therapy related to their adoption status. The two questionnaires can be found in Appendix A.

Assumptions and Limitations

A limitation of this study is that the respondents were selected only from the Internet, and may represent a
higher socio-economic group. Therefore, the sample may not be representative of the birthmother and adoptee population in general. There was no identifying information requested from the respondents other than their adoptee or birthmother status. Therefore, it is assumed that the responses were honest to the degree that respondents were capable of at the time of their participation.

Method of Analysis

As information from the respondents was received, the researcher aggregated the responses to identify common themes and patterns of response. The frequency and percentage of response was reported for all items on the questionnaire whenever possible.
CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

Findings

The responses to adoptee/birthmother questionnaires are summarized in this chapter. Direct quotes are used to illustrate the predominance of issues of loss and grief throughout the data.

Adoptee Findings

The information received from the 38 adoptees who responded is summarized as follows:

1. Briefly describe the circumstances when you found out you were adopted.

Seventy-six percent of respondents were informed of their adoption by their adoptive families at an early age. Of that seventy-six percent about half stated they always knew they were adopted or they did not remember the particular circumstances when they found out, but the adoptive parents did verify their adoptive status later in their lives. Although they were given limited information,
they were assured of their equal value with other siblings and were told they were chosen children and were special.

2. Do you remember what you felt at the time?

There was a range of general responses to this question, from feeling special at being the chosen child to feeling betrayed. The negative responses came exclusively from those adoptees in the twenty-four percent who were not told of their adoption until they were much older. From that group responses were shamed-based in nature. Included in this twenty-four percent were four respondents who wrote they were never told they were adopted but they found out by “mistake.” This signifies the secret nature of their adoption situation. From that group of four were comments like the following: “I felt confused,” “I felt curious.” “I felt different my whole life,” “I do not belong to these people.”

3. What were your thoughts as you continued on with your life knowing you were adopted?

This question elicited a variety of responses, and they seemed contingent on how the adoptee was treated by adoptive family, peers and teachers. About half of adoptees created fantasies about their birthparents in response to their own curiosity. Ninety percent felt a
strong curiosity and, of that percentage, about half felt a longing to connect with birthparents. They were sometimes conflicted due to their loyalty to their adoptive families. "With hesitation and fear, I searched out more details of my biological genealogical history".

Shame was a dominant theme for about ten percent of the adoptees as they reflected on messages from teachers, peers and, sometimes Adoptive parents.

"One of my teachers was telling the class how adoption was a horrible thing, etc...and I stood up to her, thus being removed from the class."

"I was teased by other children and told my birthmother did not want me."

"My a-mom was alcoholic and mentally ill and I grew up in a dysfunctional household."

Twenty-four percent of adoptees who found out about their adoption either much later in their lives or through a mistaken discovery experienced feelings of anger and rage. All adoptees expressed some degree of rage toward the adoption system that did not allow them to have information about their birthparents.

Eighty percent of adoptees experienced a loss of identity while the remaining twenty percent felt "more connected--just knowing there was someone out there, somewhere who was like me." One adoptee wrote, "It really
bothered me when we were doing the family tree thing at school. I didn't have a family, I had to pretend that my folks were my family.”

Identity and shame issues surfaced for about half of the adoptees as they were asked by physicians for medical histories. The teenage years, when Who am I? questions naturally come up, were particularly difficult for about half of the adoptees. The adoptive parents' secrets were very frustrating to teen adoptees. The adoptees had legitimate questions and felt they could not get straight answers, or they would avoid asking questions because they did not want to hurt their a-parent's feelings.

Thirty percent of the adoptees denied they felt different as an adopted child until they became parents. Once initiated into parenthood, they began to question their adoptee status, particularly regarding identity issues—“How can I tell my child about their familial history (genetics, medical, etc.)?” Some adoptees wrote, “Being adopted is part of who I am.” “I thought my adoptive parents would send me back, if I was not a good girl.” “The subject was not discussed.”
4. What thoughts did you have about your birthmother? The common responses reported by about thirty percent were that she was self-sacrificing. There was curiosity and subsequent fantasy about the birthmother and her circumstances. If the adoptive mom was abusive toward her adopted child, the adoptee tended to fantasize about birthmother and how she would be more understanding and "love me more."

Four adoptees asked themselves, Why? "I wanted her to know who I was, and I wanted to know her and her reasons for giving me up." "I wondered why she didn’t come get me. Was I so bad at my birth that she hated me?" The remaining adoptees either accepted the stories they were told by their adoptive parents or created their own fantasies about what happened that caused their birthmother to relinquish them.

About twenty-five percent reported having a range of feelings about their birthmothers, one adoptee wrote, "Sometimes I think she’s a witch and other times I think she’s a saint." "I thought she didn’t want me and it made me sad." "When I became a mother I realized how hard it must have been for her to give up her baby. I admired her for being able to do it." "I’m glad she had me
because I have a good life.” “My mother died two days after I was born from a brain aneurysm. I feel extremely sad that my life brought on her death.” Of the thirty-eight total adoptees, seventy-five percent reported compassion and empathy for their birthmothers.

5. Did knowing you were adopted change how you felt about yourself?

Thirty two out of thirty eight adoptees answered this question “yes.” They wrote that being adopted has made it difficult to trust people. They are often unable to feel secure in themselves. A sense of shame affects their self-esteem. Some of the responses from this group were “I realized why I was so different, and the knowledge of my being a ‘bastard’ underlined my not-wantedness.” “I felt unwanted.” One adoptee wrote that she was “always waiting for others to get mad and leave.” This group wrote that a lack of identity negatively affected their lives--“I was always on the outside looking in to the world of true family.” “...I felt like a phony much of the time because I didn’t really know who I was.” “It made me feel empty somehow, with this deep lack of identity.”

Fear of abandonment was represented in many of this group’s responses. “When I’m in a relationship I’m always
thinking it will end tomorrow, and because of that my relationships don’t last.” Another response, “I have worked to overcome this (low self-esteem) and very few people realize that for me I live with a fear of being ‘found out’ of being a ‘pretender’.” “I’ve always felt like an oddity...the bland wall, alien even. No past history. Like an amnesiac who walks through life without really knowing it.”

The other eight respondents reported that they did not change how they felt about themselves, “...because I always knew, there was nothing to change.” One adoptee said knowing she was adopted did not change how she felt about herself, “I always felt very loved by my adoptive family.” Another continued to identify with the “chosen child” feeling, “I was special, my parents hand-picked me, and I think that because of that I always tried to make them proud of that choice.” She later admits to fearing abandonment.

6. Have you experienced difficulties with intimate relationships, self esteem, strong feelings of anger, depression, addictions to drugs or alcohol, eating disorders, or other self destructive life patterns? Please describe any symptoms you have had.
Figure 1 indicates the types of dysfunctions and/or destructive patterns the responding adoptees described. The Figure shows that intimacy and self-esteem issues are the most frequent dysfunctions reported by all thirty-eight adoptees.

![Figure 1: Self-Destructive Life Patterns Adoptees]

7. Was your adoption closed and how do you feel about that now?

Of thirty-eight responses, thirty-five adoptees stated their cases were closed. One did not know. She said, "I have been told that my mother came to visit up
until I was about age four/five, but everyone has lied so much." Two adoptions were semi-closed—the adoptees had some identifying information about their birth families.

The feelings associated with the closed status of these adoptions ranged from neutral, where the adoptee had no opinion, to extreme anger regarding their inability to get vital information about themselves for identity purposes. One adoptee commented, "I am angry about that because my birth mother died when I was almost 7, and if the adoption had been open I might have had the opportunity to meet her and know her personally." Another wrote, "I walked around mad at the world for about 2 years. How dare everyone lie to me. And not a little lie mind you. My entire life was a lie!...and every agency I went to would just pat me on my lil' head and say 'you don't need to worry about that, now go on home like a good boy,' I’m 27 years old, old enough to go to war, but I’m not old enough to know who my natural parents are?"

In capital letters, one particularly angry adoptee stated, "CLOSED RECORDS ARE WRONG, UNJUST, DEMORALIZING, UNFAIR, ILLEGAL, DICTATORIAL IN NATURE AND WORTH FIGHTING TO CHANGE AND ABOLISH BY ANY MEANS NECESSARY, THIS HAS GONE ON LONG ENOUGH AND MUST BE ENDED NOW!!!"
Another adoptee said, "I feel that my medical records and other important information should be available to me because I am a legal adult, but I can understand why my birthmother arranged for a closed adoption--because open adoption was not as widespread and perhaps she wasn't even given that option."

All adoptees who had closed adoptions and attempted to search for identifying information about their birth parents reported feeling a lot of frustration, "...frustrated, annoyed that I can't get information about me. My weight problems and some health problems I really want medical information. I feel the laws are draconian and records need to be open to all adult adoptees. I am a member of Bastard Nation and I have been trying to be active in changing the laws."

"It makes me feel ashamed...like the circumstances of my birth were so horrible that they could never possibly be discussed openly."

"If I could have known the answers as a child maybe I would not have had to spend so much time crying and wondering." (Adoption, my private war)

Suggestions from adoptees for changing those laws were, "although I would not allow physical contact between
my adopted child and the bparents, I would communicate with them via mail and send photos and updates from time to time to let them know how the child is progressing." "I am fortunate that I have been able to access my records under the new TN (Tennessee) law, and I wholeheartedly believe that adult adoptees are entitled to their information."

"Before I got on this list (Open Adoption list through Internet) I just wished I knew about my parents but figured that there was no way I could find out anything. Now I realize that everyone else is allowed this info by LAW except adoptees. It should be our right too."

8. Have you ever received help from a therapist related to your adoption or any other area of your life? Please describe.

There were eight respondents who said they received therapy that was actually helpful to them and that the issues surrounding their adoptee status were addressed. Of those eight, two adoptees did grief therapy, and one of those two went into treatment, initially to deal with her husband's suicide. Two more from this group of eight actually received treatment specific to their adoptee status.
The remaining thirty adoptees either received no treatment or treatment that proved unhelpful for various reasons. One adoptee said, "my therapist did not know anything about adoption in particular and only treated the problem from the 'being abandoned' viewpoint. Never talked about lack of identity, lack of information, fantasies about birthparents. I believe therapy for adoptees should be a specialized field."

Another comment was, "It was very hard for me to talk to anyone as a child. Everyone always told my mother what I said and that would get me into terrible trouble...I never trusted a counselor enough to tell everything."

"I was in psychotherapy from age 18 to 23 and returned after the birth of my child and still see my therapist once a week. (I am now 41.) I wish I could remember what he calls my 'disorder' (I fall into deep depressions and suffer anxiety attacks)...I cover it up...I have friends who cover for me too. I feel loved and yet I NEVER feel secure."

"I tried a couple of times but the therapist I went to had an adopted girl and couldn’t understand why I felt the way I did." "...belong to an anger management workshop to
help me deal with my anger for what seems like unknown reasons.”

An adoptee who lived in an abusive relationship with her husband for many years wrote, “I don’t believe any of this is related to being adopted and neither did my psychologist.”

Another said, “I received help from a therapist back in high school regarding certain relationships that were running me ragged...but the therapist soon began giving me the creeps—he saw a likeness in me that reminded him of his dead daughter—and after that I stopped seeing him altogether. Since then I have not sought any kind of help.” “I was required to spend one hour with a Family Counselor in order to sign up with any adoption registry in the state I was adopted from, but that is the only time I have received counseling.”

“I have been seeing a therapist for about 5 or 6 months for many reasons—including problems with self esteem and my relationship with my wife. I have also had periodic depression...and psychological addiction to marijuana. But I don’t think the depression or marijuana use has anything to do with being adopted.”
"...due to low self esteem and feelings of anger when I was a teenager. I think that may have something to do with adoption, but the subject was never brought up by any therapists."

"While in therapy for issues regarding my relationship at age 22, it was my therapist who suggested (actually confirmed) the possibility that I might be adopted. I promptly told her she was crazy although in retrospect I had been questioning it since I was 13."

"I have been in and out of therapy for many years starting when I was in my late teens, nothing ever helped until I found my b-family three years ago."

"Very limited therapy, but the more I learn of how my problems can be traced back not only to the abuse by my Aparents but to actually being adopted, the more I am considering going consistently."

Birthmother Findings

The following information was received from 38 birthmothers who responded:

1. What were the factors that influenced you to make your decision to relinquish your child for adoption?

The responses to this question related to either parental decision, society’s dictates or the birthmother’s
belief that she was not as capable of providing the necessary care for her infant as an adoptive couple. Fourteen of the thirty-eight respondents stated she chose to relinquish because she believed an adoptive couple could be better providers for her child. Some comments were: "I realized the very night before I went to the hospital that no matter how much I loved her, I could never love her enough for two parents." "We were not ready to get married (referring to the birthfather and herself). We felt that it would be best for the child to relinquish her for adoption--two parents who were already established with their relationship, finances, etc." "I chose adoption for a few reasons, but the most obvious is that I am only fifteen. Because of my young age, I didn't think that I would be a good enough mother. I wanted my daughter to have a normal, two-parent home and all of the other things that I couldn't provide."

Many of the comments contained more than just one reason for choosing relinquishment even though the dominant reason was related to birthmother's inability to care for child. For example, "I was single and 16 years old. My boyfriend, the birthfather, was acting goofy. My mother was acting crazy. Homelife had always felt cold and
miserable to me and I didn’t want to expose an innocent little baby to the atmosphere I had to live in. Catholic Social Services encouraged me to place my child for adoption. I had no money. My parents had no money. I had no one to confide in. Feeling that a child needs two mature parents and some security/stability.”

Another example of multiple reasons for relinquishment:

"...a profound disbelief in my own worthiness—a desperately strong feeling that this baby needed and deserved a good, loving family that could provide for it, and a feeling of absolute certainty that I could not provide it, due to lack of any salable working skills (I was just 18, and had started college), not having a clue how to be a mother, fear for my baby of the lasting stigma of illegitimacy (a biggie in the 50’s!). No support from my parents for keeping—visible relief at my decision to relinquish. Strong negative response from counselor at Flo Crittenden Home when I tried to talk about keeping baby during the last month of pregnancy—obvious maltreatment of only 2 girls out of about 40 residents who were not going to give up their babies—social stigma for me and the
child--knowing I would not be allowed to keep my scholarship and finish college (told so by the dean)."

Not all of the relinquishing birthmothers were simply afraid of financial inadequacy, the following quote alludes to the emotional instability of one young birthmother: "When I got pregnant, I had not matured emotionally enough to raise a child. I was so afraid that if I suddenly lost my temper, I would strike or harm this precious gift from God. I wanted them to have a better life than I could give them at that time."

Nineteen of the thirty-eight stated their parents made the relinquishment decision for them. They were often very young (fifteen to twenty years old), and were told directly to give the child up for adoption, or they were shamed into it. "The decision was made for me, by my parents. In 1968 it was neither accepted not tolerated that someone became pregnant outside of marriage. Shame was probably the biggest factor which led them to their decision and trying to protect 'our name' in the small town in which we lived."

"My parents made me, I took it to court, but lost due to my age." "I was 18 in 1972 and my parents told me what I was supposed to do. Even though I was a wild, rebellious teenager, this one caught up with me. I had shamed them,
sinned against the world, disgraced everyone. After three months in a home, I was whipped, defeated, in despair. I had no choice. I was numb. And, I hated myself for giving in to them." "I was 17 years old. ...my parents refused to help me temporarily, actually at all and refused me returning home from the hospital with, 'that spic's baby,' because my daughter’s father is Puerto Rican (I am Caucasian)."

More shame coming from family: "I was coerced and manipulated to make this decision by my family and the ob/gyn, who handled the private adoption. I was flooded with blame, guilt and shame, and had absolutely no support."

"I was 6 months shy of my 18th birthday, and my parents told me, 'you can't come home with a baby.' I was not given any other alternative, nor told of any programs where I could get assistance." "I was 15...I was forced to relinquish by my patents who thought they were doing the right thing. I never wanted to give them (I had twin girls) up. I was lied to by the nuns and social workers and every adult who told me it would be better this way."

"My parents forced me to relinquish my child (1967). I had never heard of Welfare and was threatened that if I kept my
baby, they would throw me out into the street.” “When I got pregnant, I was 16, it was 1961...I was not allowed to make any decision, it was made for me. I was told that I could not keep my child and was sent out of state to a home for unwed mothers where I gave birth and relinquished alone.”

One birthmother, who was adopted herself by her grandparents, commented: “...I was forced by my adopted parents to give my daughter up for adoption. My granddad wanted me to keep my child, my controlling and alcoholic grandmother said she’d kill her since she did not like my child’s father. I had social services saying they’d just take her away from me and terminate my parental rights anyway, so I might as well sign the paper or go through an even more awful ordeal.”

The last group of five birthmothers responded that society had more of a play in their relinquishment decision: “I signed papers in 1970 and stuffed feelings until now...” “...lack of support from boyfriend, family or society. Encouragement that I was doing the ‘right thing’ (by relinquishing).” “...Catholic upbringing (pro-adoption, anti-abortion), ‘right thing to do,’ best decision for the
child, two parents are better than one...unconscious belief that if I gave her up I would still be loved by my parents, her father, the adoptive parents and God (redemption).”

These five respondents emphasized that the time of their pregnancy; namely, that it was the sixties, and there was no acceptance of pregnancy out of wedlock, played a key role. They are being reflective as they respond to these questions. “Society and parents. In the 1960’s it was taboo to have a child out of wedlock and would bring shame and insult to the family.” “The social climate: 1968. The social worker’s advice. Being Catholic, unmarried 18 years old...”

2. Would you choose adoption again or recommend it to a friend or relative?

Thirty-seven respondents answered “no” to this question. One respondent did not reply to this question. Twenty were adamant in their response stating that they would never choose adoption again nor would they recommend it to anyone under any circumstances. The other twelve respondents answered that they would not choose adoption, but they would recommend it under certain circumstances. One birthmother comments, “I would never recommend adoption as the system is now.” She was typical of the respondents
who advocated for open adoption unanimously. Another one states, “Absolutely not a ‘closed adoption.’ Depending on the circumstances I would advise anyone I know to do everything possible to keep their child…” Another, “…only if a true open adoption was possible, and the birthmother was fully informed about how difficult it is, long term, to have given up a child AND (her caps) the circumstances for that person were extremely difficult.” “I would do it over again only if it was a very open adoption. I wouldn’t recommend that anyone suffer the way that I and all other birthmothers have.”

Other circumstances were identified as valid reasons for relinquishment. One birthmother states, “…I no longer believe in separating a mother and infant unless there are COMPPELLING (her caps) reasons to do so--insanity, drug addiction, a lack of desire to parent.” “I would not choose it again. I would not recommend it at all to anyone, unless their life was a complete mess, or they were abusive, on drugs, etc.” “Never. I am not against it however. There are some for which it is a good choice and I do not hold judgement against them.” “I would never recommend adoption to any person. However, if that was their decision, I would support them in it.”
Five of the respondents stated they would recommend adoption. Three birthmothers from this group experienced open adoptions. The other two indicated that it would depend on the individual's circumstances and whether or not the adoption could be open or semi-open.

3. Do you feel you were prepared for the effects that relinquishing your child had on you later in life?

There were thirty-eight responses to this question and only three birthmothers felt they were prepared to deal with the effects of their relinquishment. All three were involved in open adoption situations. One stated, "Yes, the agency I went through provided me with wonderful counseling and I was encouraged to call 24 hours a day even if just to talk with them. I did call or drop by the agency on numerous times when not even scheduled for counseling and they always made the time to work with me. I was told of numerous books on the subject also." Another commented, "I think the fact that I relinquished in a very open adoption helped tremendously. Many of the fears of the birth mothers who are involved in closed adoptions are not a factor in my situation...I know she is loved and well taken care of."
The remaining thirty-five birthmothers were not so fortunate and expressed openly their anger about not being told by doctors, agencies or counselors what they could expect after giving up a child. All of their adoptions were closed. They were told to go home and forget about it, to get on with their lives and close this shameful chapter of their lives. They were not able to do so and said so many times over in their responses. “If I had known then what I know now, they would have had to kill me to get my baby.” “I kept my emotions deep, very deep inside me. I had no counseling and nobody in my family or the family Dr. ever spoke of it again until she found me, 36 years later.” “I was told the grief would dissipate and that I’d ‘go on with my life.’ This did not happen.” “It was thought that I could ‘forget about it with time.’ That’s impossible! No mother EVER (caps were hers) forgets the birth of her child.”

This response was particularly powerful and validates that birthmothers are not any more prepared for what relinquishing a child means today (1997), than they were in the sixties. “I only relinquished her three weeks ago, so I am still coping, but I am not sure that I was prepared that well. I did see a counselor, but only a few times,
and she focused more on choosing and getting to know my daughter’s adoptive parents. She told me that it would be hard, but she didn’t explain to me just how hard it would be to let her go.”

The comments continued to reveal the birthmothers’ pain at the situation that left them keeping their secret from the world for many years. One birthmother said, “...5 days after my daughter was born, when I returned home, I was told that ‘it’ never happened...I never spoke of it to a soul for the next 35 years.” “I had no idea that my decision to give up my twin sons would cause a downward spiral that would last for about 10 years.” “I was left to cry alone and to be alone with the loss of my son for over 25 years. The effects this had on my whole life continue even today.” “Upon my return to my family, the subject was NEVER (caps are hers) discussed until almost 27 years later. I did not go through a healthy grieving process.” “...Not a single day has passed in 28 years that I didn’t desperately miss my child and want her with me. It was a terrible trauma that changed my life forever.”

One responding birthmother expressed her anger, “There was no discussion of ANY (caps are hers) ill effects for me in my later post adoption life. I am still very angry
about this. I feel that an entity that had been doing adoptions for 50 years had NO excuse to be ignorant of the negative impact this could potentially have upon me and had a responsibility to inform, address, and provide resources for coping with...The institution didn’t give a damn about what might happen to me.” Another took a different approach to deal with her grief, “There was no counseling or help. I turned to drugs for two years, and married a man only to have another child. Was I prepared for the fact it would never go away? That my heart would never heal until I met her? No, not at all.” Another is frightened by the intensity of her feelings, “...My bitterness and anger scare me, and I don’t know what steps to take to deal with the after effects of relinquishment...my anger is carrying over into other aspects of my life, and I trust almost no one. I don’t care for my agency, so going there for help is out of the question...I feel frustrated every day and I hate seeing children.” Another shares that she had “no idea that I would experience so many years of denial, anger and pain for this loss. I didn’t know that I would feel so much shame because I ‘abnormally’ couldn’t forget about this child and move on with my life. I didn’t know that I was
even experiencing such grief because of the denial inherent in such closed proceedings. I believed there was something very wrong with me because of this."

Another birthmother talks about how relinquishing her child affected her ability to relate to other people—"Did I know then that I would never be able to form the kind of fulfilling relationship I wanted but felt I never deserved because I gave my child away?"

More signs of grief are revealed—"Not at all...was told to 'forget it and go on with my life' and that 'I'd get married and have other children' to replace my firstborn. I have grieved for my lost child ever since he was surrendered to adoption."

"...Everyone told me that I would forget. I never did. I feel that I lost a large part of 'ME'."

4. Have you experienced any difficulties with intimate relationships, self esteem, addictions to drugs or alcohol, eating disorders, depression or other self destructive patterns in your life? Please identify which ones have affected you.

Figure 2 indicates the types of dysfunctions and/or destructive patterns the responding birthmothers described.
The data show that intimacy issues and depression rank as the most common dysfunctions for birthmothers.

![Figure 2](chart)

5. Could you briefly respond to the following quote:

The baby’s mother expressed much love and concern for the baby, as did her parent. She felt it was important for a child to be raised by two parents, by a mother and father who love one another and who can offer that security to a growing child. She realized the difficulties she and the child would experience if she kept her and tried to raise her alone in our society today. (anonymous adoption agency, cited in Barton, E., 1996)
There were three different types of responses to this quote. The first type is a negative reaction and twenty of the thirty-eight respondents reacted negatively to this quote implying that it had been, "a lot of crap in my opinion, I was TOLD (her caps) this is how I should feel...not how I REALLY felt!!" Another said, "Yes, this is the litany. And it is B.S.!!! And I could NOT (her caps) have given my daughter the 'upbringing,' the 'status' she enjoyed. When I found her, one of the first things she told me was, 'All my life I have had everything that money could buy and all I wanted was what money couldn't buy, the love of my mother.' Now she has it." Another comment, "I think this is a lot of flowery garbage. She and the child will have more problems being apart. And, there are no guarantees the adoptive parents are/will stay happy or together. No guarantee the child will not be emotionally/sexually abused. Talk to adoptees, some of them have 'horror' stories to tell. It is the greatest myth that couples who adopt are happy, secure, emotionally and financially stable."

Another angry birthmother said, "In 1970 the quote was what we were led to believe, and now I think it was a bunch of bull--families didn't want to be embarrassed, single
moms would have been as ok as they are in 1997, and the kids would be fine.” Another said, “A bunch of crock. I was brainwashed that I couldn’t take care of my child—that if I truly loved her I would give her away—bull. If my family truly had loved me, they would have helped me keep her. That quote still makes me angry.” More anger surfaces, “Bullshit. She may have realized the difficulties if she had kept the child, but she was lied to about the difficulties the child would have later in life, having been abandoned by his biological mother. Did they happen to mention the statistics of the numbers of adoptees now in therapy or mental institutions?” Another birthmother said, “I now realize what a huge con this was!! I don’t think I ever believed it myself, but I went along with this sentiment.”

This next quote summarizes the essence of this study, “Adoption causes many more problems for both the birthmother and adoptee than raising or being raised by a single parent.” More confirmation from a birthmother who had experienced through therapy her own “primal wound,” “I wonder if this mother and her parent were aware of the grief issues and the life-long impact of this decision...Does she know about abandonment issues that
adoptees have? Does she know about primal wound? Does she know how differently adoptive parents are AFTER (her caps) the adoption is final? Does she know how fear-ridden they are, and how our society supports them in staying stuck in their fear..."

Other negative reactions referred to how society has changed since the time they relinquished their child. "Society made us believe that we were unworthy as a single parent to even think of taking care of our child. It would be selfish. Funny how times change and now there are as many single parents raising children as two-parents. We weren’t given the chance to know that we could be mothers..."

Another birthmother comments, "Well, it’s of our time. The lie we were forced into...The changes in society since then have given huge impetus to our collective anger over this. I doubt anyone would disagree two parents in love and security is a great option, but so is a loving and caring trying mother..." Another birthmother states, "These things ARE (her caps) important--but birthmother has a UNREALISTIC view...wanting a perfect family and perfect upbringing--No such animal!--saying this 32 years later!!!"
Keeping your child and raising it in this society now would be the best choice."

The positive responses were from ten of the thirty-eight birthmothers. Of these ten, three cases were open adoptions. One of the open-adoption birthmothers stated, "I think this is very similar to my own feelings and decision to place my child for adoption." Another open-adoption birthmother commented, "That is EXACTLY (her caps) I feel. Couldn’t have said it better myself."

Other positive quotes were as follows:

"The above quote could easily have been made by me at anytime over the past 24 years."

"That is EXACTLY (her caps) how I felt and was made to feel by the social worker, my parents, etc."

"Was this written about me???? This sums up my entire reason for giving up my daughter perfectly. Things were so much different in 1978 than they are now...They labeled us 'unwed mothers' like we were damaged goods! And, I knew it wouldn’t be fair to subject my daughter to the ridiculous standards of 'proper society' at the time, in addition to not having a father in her life."

"I guess she took the words right out of my mouth--yes, I wanted my daughter to be raised in a loving family
with a mother and a father and society in 1970, wouldn’t have made it very easy for me or her to even try--there was such a stigma attached to illegitimate children.”

The following quotes are from the remaining seven respondents (one birthmother simply stated, “no response”). These comments make up the third type of response which contained some negative and some positive reactions to the Barton quote.

This first one may have been read as a negative since it is somewhat ambiguous. “That is exactly what the agency told me to believe in.” The next one is from an open-adoption birthmother, “That’s basically the reasoning behind my decision to relinquish. I don’t care about the stigma that society attaches to unwed mothers. However, I didn’t want to struggle for the rest of my life, and have to give up what little time I had left to be a kid…”

The other responses were a mix:

“This was pretty much my situation. It was really a terrible thing to be unmarried and raising a child, yet four years later I was doing just that. I married within six months of relinquishment and had a child. Then, 1 1/2 years later I was divorced.”
“This was especially true for me in 1968. Now, however, things are different, but I still think a 2-parent family is preferable. If the birthmother is stable and able to provide for physical and emotional needs, I have no problem with birthmother keeping her child. It is such an individual decision.”

“I think it depends what community you live in...”

“When I was 17 years old and in crisis, the above quote made perfect sense. Today, no way. Since finding my daughter I have learned that even though my daughter did have two loving, wonderful adoptive parents, they are not ‘who’ my daughter needed. She needed me. There was no ‘security’ for my daughter. Not until I found her.”

This last quote summates the ambiguity of feelings about Barton’s words.

“First, the concern and love are real and valid. We (birthmothers) love our children; they are not throw away children. We do want what is best for them. Second, society tells us we are not good enough for them, hence the desire to have a two parent home for our babies. To that, I say, ‘Bullshit.’ While I can’t deny the fact that adoption is probably best in some instances, in most, these children belong in their families of origin...Love isn’t
enough to feed and clothe a child, however, that love can motivate us and carry us through tremendous hardships...”

6. Was your adoption open or closed and how do you feel about that now?

There were thirty-five responses to this question. Four of the adoptions were open, two were semi-open and the remaining twenty-nine were closed. Three of the thirty-eight selected respondents chose not to answer this question.

The responses from the open group were:

“I am very happy that I searched for an agency that would offer this and recommend open adoption to everyone thinking of the adoption process.”

“The adoption was a VERY (her caps) open one. I met with my daughter’s new parents three months prior to her birth and we clicked immediately...They have been better than I had ever imagined.”

“...I have absolutely no regrets about my decision. When I set out to find an agency that dealt with open adoptions, I never dreamed I would end up in a situation like this!!! Her parents keep in touch with my mom and grandmother too!!! They have become an extended part of my family.”
The semi-open adoption birthmothers commented as follows:

"It was in between. Started out as closed except my daughter could have access to my name with my consent when she turned 18. She is 19 now and supposedly is not interested (according to her adoptive parents). The adoption was opened enough to receive three updates in 18 years. When my daughter was 12 the adoptive parents were contacted by the agency and agreed to send yearly updates (but absolute no pictures). It took seven years for the next update to arrive. These are the same people who described themselves as kind, caring, Christian people in the letter they sent to me through the agency at the time. Right."

The following statement comes from a young birthmother who very recently (7 1/2 months ago) relinquished her child. She is not really certain whether the semi-open adoption status will be honored. "...Due to my agency, I don't think they (she's referring to the adoptive parents) understand how open adoptions can work. I also think they feel threatened by my presence. I asked for my child back 2 times, which really caused me to lose a lot of ground. I am angry with them also, for not telling me what my child
enjoys...They also have another adopted child whose birthmother has little contact. The adoptive parents have a hard time understanding how the b-parents of the two children could want two different relationships."

The responses from the closed-adoption birthmothers were often angry in nature for a myriad of reasons, including that open adoptions were not available to them at the time of their relinquishment. "...This was twenty-seven years ago. There was no such thing as open adoption."

"...I cannot get any information. I am disappointed that I had no choice. How much different it would be if I knew he was alive and could find me if he wanted."

"My adoption was absolute closed, absolutely secret, and never spoken of in my family for the last 27 years. I hate that, but must admit that it was the best way for me...the better to stick my head in the sand."

"It was very closed...although the kind social worker let me see her name and the name of the adoptive parents, but I felt that if I ever looked for her, it would be tantamount to committing a 'mortal sin,' and also illegal!!! I believe that adoption should be in the best interests of the child not the best interests of the adoptive parents"
and their misguided and self-interested feelings of 'ownership' of the child."

"My adoption was closed and was the worst thing that I have ever done to myself."

"Totally closed. I feel that was absolutely wrong, created the shame, rather than relieving it, and was a terrible injustice to my daughter who was adopted, to her half-sisters I later raised, and to me, and even to the adoptive parents. We were all led to hold false beliefs about each other and what 'good' is all about. We need to end this inhumane system."

"...I feel closed adoption records are definitely wrong. I spent 37 years racked with guilt because I relinquished my son, yrs. not knowing anything about his health/happiness. I lost and he lost..."

"Very poor choice for me and my son...Plain and simple the system as it exists now SUCKS (her caps)—full of lies and lack of humanity toward birthmothers. I found him 32 years later. The laws need to be revised and changed."

"In 1961 there was no such thing as an open adoption. How do I feel about that? I have lost her youth, along with my own...I feel that truly open adoption is the only humane solution to a thorny problem."
A contrasting comment from one birthmother, she states, "Mine was a closed adoption. I do not believe in open adoptions because the adoptive parents are the ones raising the child. The birth mother gave up the child in order to give them a better life." In reviewing the remaining responses from closed adoption birthmothers, this was the only birthmother who approved of closed adoptions. The others were often vehement in their comments about the abusiveness of the closed adoption system. "...But I do know the effects of a closed, sealed system. It damages everyone. The adoptive family pretends the child is completely theirs, ignoring the medical, emotional, and other psychological heritage of the child, denying facts, denying sometimes the adoption, and denying the child can have characteristics completely different than the adoptive family. The birthmother never knows what became of that child, and is hurt forever by the lies and secrecy and shame."

Another's similar sentiment, "The adoption was closed. I am currently working with support groups, etc. to change legislation to open records. I had no idea that my child would not be allowed to know her medical history, heritage,
etc. BY LAW! (her caps) I did not learn this until I began searching about four months ago!"

"My adoption was closed. I think open adoption is a wonderful concept and wish it had been an option 19 years ago. I would give my right arm to know anything about my daughter, including what she looks like, that she is healthy and that she has had a good life with two parents who love her more than life itself. That is all a birthmother can hope for when choosing to allow another family to raise her child. I think the most difficult part of the whole experience for me, though, is the fact that I was never allowed to hold my daughter. I never got to touch her or even see her. I didn’t name her because I didn’t feel it was my right to do so. The only thing I have to hold onto is that I heard her cry for the first time in the delivery room."

7. Have you ever received help from a therapist for issues related to relinquishing your child or for any other reason? Please describe.

There were thirty-six responses to this question out of thirty-eight total birthmothers. Two respondees did not answer this question. Nine birthmothers stated they had not received any treatment related to relinquishment or for
any other reason. An open-adoption birthmother stated, “Knowing was the best therapy I could have asked for!!!” Three of the nine simply answered “no.” One birthmother said, “No, I’ve always handled it on my own and by talking with good friends.” She also said that the Internet birthmother support system was a real “Godsend, because it helps more than anything to know I’m not alone in this and someone else really DOES (her caps) know what I have been and am currently going through.”

A young birthmother who just relinquished her child 7 1/2 months ago said, “I thought I could or just would get through this on my own, but my anger is making me exhausted...Basically I don’t know where to go, do I look up someone under grieving or anger or what?” She is in a semi-open adoption situation and says, “I think seeing the child rejuvenates my anger, instead of providing me with joy.” Another states, “No, I am unaware there are therapists that are educated in this subject. It takes a special person to even try to understand the feelings of a birthmother.” The last quote expresses the birthmother’s pain over her inability to face relinquishment issues, “I know I should even today but somehow can’t bring myself to do anything about it. Probably because those issues are
buried so very deep there's a great fear of bringing them too close to the surface."

The first three responses are from three open-adoptions birthmothers.

"I went to see a therapist for a few sessions. She wasn't an adoption expert though and so it seemed useless. YOU REALLY NEED TO HAVE A THERAPIST WHO IS AN EXPERT AT ADOPTION ISSUES IF THEY ARE TO HELP BIRTHMOTHERS OR ADOPTEES (her caps)...therapists are not taught to think being adopted is major--and to think that bparents have a tremendous loss."

"Through the agency I received counseling about the adoption before and after...They did pay for this counseling as well. It was their policy to have ongoing counseling for any of the birthparents for al long as the birthparents felt it necessary."

"I still see my counselor every couple of weeks, and she helps..."

The next group of birthmothers have not been so fortunate with their efforts to get help from therapy.

"I saw a therapist weekly for 18 months in the early 1990's. She could not help with any details related to adoption. At the time I did not think it was an issue
relating to any of my other problems and clearly neither did she."

"I have never felt 'right' since I relinquished my child. I have had years of off and on therapy, group stuff, and 5 years on Prozac."

"Yes, but my therapist was little help concerning my issues relating to relinquishment. She had had little or no training in the area and seemed in awe of most things that I told her, especially my feelings and reactions to the whole situation."

"I have told therapists about the adoption in clinical terms but never discussed it because I would lose control and cry. I have never allowed myself that privilege. The only therapist I went to was with my daughter and her problems."

"Wish I did—but never never got any attention paid to it, much less anything helpful. Yet I brought it up early in every relationship with a therapist."

"I have been in and out of therapy all of my life because of the child I lost. In my early 20's I became suicidally depressed and received 20 shock treatments while being a guest of a private institution for 4 months. I didn't talk about the 'real' reason I was there. How could
I? I was told that I would forget, that it wasn’t important...How could that unimportant incidence in my life be the cause of my dysfunctionality? I only recently decided to really attack this issue and for the first time, I actually talked about what was wrong with my world. I saw a therapist for 3 months beginning in January and finally gave myself permission to grieve, rage...”

“Yeah, psychiatrists and psychologists. No one really understands.”

“I was in therapy at least twice before I finally decided to search for my daughter when she turned 21. Neither time did the therapist place any importance on the relinquishment. Even after my reunion, I had to educate my therapist on the issues.”

“I did seek professional counseling but the 3 therapists had no experience with post adoption concerning birthmothers.”

“I had sought and received counseling for many other issues prior to this...I feel the need to seek help in resolving various adoption related issues once again, however, there is no one available who has the knowledge or expertise in our area to deal with this need...”
"I often went into therapy with relationship issues and would focus on those. I would mention my pain and sadness over relinquishing my son, but we never got very deep into it... But, one day I just told my therapist that I really needed to do the grief work that I never did. So, now I am reliving all the acute pain I experienced while I was pregnant and the pain caused by letting go of my son..."

"I have been in and out of therapists offices for nearly most of the past 19 years. I was put in the psych ward against my will for one of my suicide attempts. I have never received therapy directly for the relinquishment of my daughter, but that is one of the main reasons I have ended up in all these offices and in the psych ward..."

"I have tried my therapists over the years, especially at first. None helped, because they all believed I should get on with my life..."

"Yes, I’ve had 10 years from one therapist, and more. I had very low self-esteem, and little self-empowerment. I was raised in a family where I received abuse...My therapy issues centered around these issues, and did NOT include the relinquishment. I feel that some very important issues
were totally ignored and kept 'secret' even with some quite progressive therapy."

The last two responses were more hopeful. Both birthmothers received help with their relinquishment issues and stated it helped them.

"I finally went into therapy (after 11 years when she became suicidal). I had avoided it because it proved I was doing alright if I didn't need therapy. So to decide I could no longer go this alone was the rock bottom. I found someone with adoption experience...It was a Godsend. I saw her weekly for months then monthly for three years....It changed my life. I wish I had gone into therapy when I was pregnant so I might have understood what was going on--so I might have been in a place where I could have made a different decision."

And, lastly, a healing birthmother states that she did receive therapy relating to "depression because I gave my child away."

Both adoptees and birthmothers report similar frequency of dysfunction in all areas researched with the exception of depression. Birthmothers reported nearly twice the frequency of depression symptoms. The adoptee
and birthmother patterns are highlighted in Figure 3 below which compares the frequency of responses for both groups.

**Figure 3**
Self-Destructive Life Patterns
Adoptees and Birthmothers

- **Frequency of Response**
  - **Addictions**
  - **Depression**
  - **Eating Disorders**
  - **Health**
  - **Intimacy**
  - **Self-Esteem**
  - **Rage**
  - **Other (Incl. Suicide)**

Legend:
- Adoptees
- Birthmothers
CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of the study was to examine the relationship between adult dysfunction and unresolved grief and loss as experienced by birthmothers and adoptees.

The literature reviewed in this study identified seven core issues of adoption: (1) loss, (2) rejection, (3) guilt/shame, (4) grief, (5) identity, (6) intimacy and (7) control (Silverstein & Kaplan, 1989).

The literature indicated that there is no empirical evidence to support or refute open adoption as the adoption plan of preference. However, triad members who have been involved in confidential adoptions often experience unresolved loss, the denial of the adoptee's dual family ties by all members of the triangle; and the diminished self-esteem of the adoptee and the birthparent.

The literature also shows that birthparents, adoptive parents and adoptees share common themes of loss and
anxiety, attachment and separation, and identities that involve paradoxical qualities (Rosenberg, 1992).

The literature supports the notion that unresolved grief frequently leads to long-standing negative consequences. Adoption is not a loss that qualifies as a legitimate reason to grieve. As a result, grief over the loss of a child through adoption or abortion is often hidden and repressed.

In this study, two questionnaires were distributed over the Internet through e-mail to several different adoption forums. One questionnaire was designed for adoptees and the other for birthmothers. The questionnaires were distributed by list servers to their members. The participants were assured their confidentially would be protected and no demographics were requested. Responses were collected and analyzed for content relating to the issues of grief and loss in their adoption experiences. There were thirty-eight responses from adoptees and ninety from birthmothers. Thirty-eight birthmother responses were selected randomly to match the number of adoptee responses.

The findings indicate that the theme of open adoption vs. closed adoptions was present in responses from both
adoptees and birthmothers. This research pointed to advantages in the open adoption situation for all triad members.

The data concurred with the belief that grief is a pervasive issue and that it is frequently disenfranchised by adoptee, birthmother and therapists. This statement is supported in the findings by repeated references by both adoptees and birthmothers to life patterns directly related to loss, such as intimacy and trust issues.

In the cases where grief issues had been addressed in either the adoptee or birthmother’s therapeutic processing there were reports of healing. The findings of this study show that acknowledging and experiencing the grief related to loss is an essential component in healing and shedding a cloak of shame.

The findings also show that, in particular, birthmother grief is not acknowledged by social workers, parents, clergy, doctors, therapists or the birthmothers themselves.

The findings support the claim that therapists may encounter a variety of signs of unresolved grief, such as lingering denial, anger, or depression. A high number of birthmothers reported depression in their adult lives.
Diminished self esteem, feelings of powerlessness, worthlessness and victimization, addiction or eating disorders were frequently present in the adoptees and birthmothers studied.

The findings show a relationship between relinquishing a child and unsanctioned grief that is at the core of several areas of dysfunction. The data validate the shame experienced by both the birthmother and adoptee, and indicate similar dysfunctioning as a result of that shame in the lives of both groups.

The questionnaire contained no specific reference to issues of grief for adoptees. The responses to the last question regarding therapy contained sufficient lack of reference to grief issues to comply with expected results. Namely that, except in two cases, grief was likely not considered either by the clients, therapists, or others involved in adoption process. There were cases cited where the clients requested validation from therapists for the pain they felt regarding adoption status. Their loss was not discussed in an adoption context.

Conclusions

Adoptees may fear abandonment to such a degree that they cannot use healthy boundaries in relationships, they
will not know when to let go and when to hold on. They may develop co-dependency through people pleasing behaviors. Their shame over feeling intrinsically defective may lead them into abusive relationships that they cannot get out of. A person who has experienced significant losses may fear getting close to others because of the risk of experiencing more losses. Both the adoptee and birthmother may associate intimacy with loss, causing them to avoid intimacy in their relationships.

Shame is a dominant theme for about ten percent of the adoptees in this study. The feeling of shame seems to be linked to identity issues. Shame was reported by adoptees who found out about their adoption either much later in their lives or through a mistaken discovery. This indicates that secrets were maintained until later in these children’s lives, which may have also created more reasons not to trust. The shame accompanies feelings of anger and rage. All adoptees express some degree of rage toward the closed adoption system that would not allow them access to medical and other biological identifying information.

Self esteem issues also appear to be linked to identity issues. This researcher’s personal experience supports this premise. The family of origin issues present
in her life just prior to the pregnancy provided sufficient emotional disturbance that the pregnancy and subsequent relinquishment may have only created another layer of dysfunctional beliefs and shame. Adoption threatens a person's sense of knowing who he or she is, where he or she came from and where he or she is going.

The effects that relinquishing a child can have on the life of the birthmother are profound. The responses from birthmothers involved in closed adoptions validate this statement 100% of the time. There were substantially less dysfunctional patterns for the four birthmothers who were in open adoption cases. This would certainly lend support for the current trend toward more open adoptions.

The birthmother data also concurred with Carlini's (1992) eight core issues of relinquishment: low self esteem, grieving the loss of your child, forgiving self and others, being out of touch with your feelings, difficulty giving and receiving love, co-dependency, self-hatred, and dysfunctional sexual problems. The testimonials showed that many of these issues have remained as problems for the birthmothers years after the relinquishment. The issues were on simmer in many women in excess of 10 years. Most reported they had given birth during the 1960's and 1970's.
Unmarried mothers had to bear shame not only from their families and friends but from society as well (Carl, S., 1995). Thirty five of the birthmothers were told to go home and forget about it, to get on with their lives and close this chapter.

Intimacy dysfunction ranked first among birthmothers in this study. Intimacy may equate with loss to the birthmother. Birthmothers may come to reject themselves as irresponsible; therefore, if someone were to attempt a relationship with them, they would anticipate rejection from that person. Shame and self worth dictate how well a person can maintain boundaries in a relationship. It would be reasonable to conclude that a self-blaming birthmother would have difficulty valuing herself in a relationship. This could account for the co-dependency issues confirmed in the literature and this study.

Depression ranked second for birthmothers. It may be useful to contrast this with the anger scores for adoptees. It would appear that adoptees had not shut down their feelings leading to depression. Whereas the birthmothers reporting excessive depression were denied their anger about the relinquishment. It is possible that the
birthmothers believed they had no one to be angry at except themselves.  To distance herself of that emotion, she

The adoption decision creates an internal struggle for the birthmother as she rationalizes her decision. She attempts, therefore, to suppress her sense of loss. The longer these feelings remain unexpressed, the greater her fear of losing control. If she does not find an outlet, she may develop secondary symptoms of repression such as alcoholism, drug abuse, or depression (Roles, 1989a).

The results of this study show that over one third of the birthmothers have dealt with or are dealing with addictions, eating disorders and other self-destructive behaviors. Since alcohol is a depressant and depression is likely to occur as an adoption issue as well (especially for female adoptees), depression can become acute enough to lead to suicidal thoughts. This may often be the time when a triad member decides to seek treatment.

Many of the characteristics of the birthmother syndrome appear as signs of unresolved grief (Jones, 1993). They are lingering denial, anger, or depression, self-punishment, often inflicted through participation in abusive relationships, abuse of drugs or alcohol, eating disorders, or other self-destructive patterns.
The body has a memory, and the birthmother may struggle to divest herself of that memory because it arouses so much pain. She may choose to numb the body with alcohol. Alcohol is a depressant and depression occurs as an adoption issue. The depression can become severe enough to lead to suicidal thoughts and attempts. There were reports of attempted suicides by both adoptees and birthmothers in this study. This issue certainly supports a treatment protocol that addresses adoption grief when it surfaces in therapy.

The lack of grief resolution was paramount in data from birthmothers responding to the last question regarding their therapy experiences. There were only three birthmothers who reported some grief resolution, and two of them were from open adoption situations. It seems that it is difficult for the members of the adoption triad to grieve when the premise of adoption is seen as a way for everyone to gain. It can be concluded that this would be particularly true for the birthmother since her pregnancy is the problem.

Recommendations

It is critical for therapists to do more than simply note that there has been an adoption in the family. When
Self-destructive patterns seem evident early in a client's treatment, inquiry and a genealogy are critical to determine if adoption history exists. There is an urgency involved because the triad members have probably delayed their grief process, waiting ten to fifteen years to get any help with their issues (Silverstein & Kaplan, 1986).

The adoption family must be regarded as unique, which acknowledges the depth and complexity of their issues. The issues of loss and grief must be addressed specifically, yet clients may feel too much shame to acknowledge they feel grief.

For this reason, the treatment recommendations resulting from this study stress that therapists must validate the clients' loss and encourage them to tell their adoption story as often as necessary. Each time the adoption story is told, some shame will be reduced. Clients may be referred to an adoption support group to promote lessening the shame and creating additional support. As triad members talk about the adoption experience, they may be surprised at the number of people who have been touched by the adoption experience in their lives as well. This researcher has found this to be the case repeatedly as she has revealed her adoption story to
others throughout the past few years. When one member tells others, it gives permission for others to tell their secrets as well. It can also be validation of feelings for each person sharing their pain.

Members of the adoption triad are often held to secrecy due to the shame associated with adoption and there is a special kind of on-going grief because no adoption circle member forgets the existence of the others. The presence of shame makes it difficult for members to grieve the loss of these significant people in their lives.

Due to the core nature of grief in the healing process of either an adoptee or birthmother, therapy must address the grief in order to be effective. If the confrontation of a client’s grief issues is not comfortable for the therapist, a referral is appropriate. If the therapist has a strong bias regarding adoption issues, a referral may also be necessary.

The findings from this study emphasize treatment for the grief related to the needs of birthmothers and adoptees. Yet often birthmothers and adoptees show up for treatment of depression and other emotional and physical problems, and they are not aware of and or willing to speak of, their loss related to adoption circumstances. It is
important for therapists to be alert to how the presenting symptoms are frequently signs of unresolved grief in general and in particular with adoption members.

These treatment suggestions evolved from the need for a unique approach to complicated grief resolution due to the illegitimate (shameful) circumstances of the adoptee’s relinquishment. This researcher recalls that her grief was stifled most of her life because her family did not allow her to talk about it.

This study advocates that therapists question clients about adoption issues at the early stages of therapy and, if adoption issues surface, follow grieving protocol throughout treatment. Since the research points to unresolved grief as the nature of many dysfunctions in adult life, including behaviors that can threaten the life of the birthmother or adoptee, it behooves the therapist to expedite therapy and take a complete history early in treatment (Walsh, 1993). Brodinsky & Schechter (1990) refer to this therapeutic narrative as a self-constructive process. Many therapists have found that the core of work done with adoptive families or with an individual is in the telling and retelling of their story.
It is also hoped that this information will be used in a preventative manner in cases where substance abuse may be predictable due to birthparent addiction. This study cites research supporting genetic connections between birthparents' alcoholism and offspring alcoholism. For this reason an addictions behavioral modification step is recommended for treatment if alcoholism is a problem in the adoptee or birthmother and, at the very least, an addiction prevention plan if the client is too young to have experienced addiction difficulties.

The fewer secrets there are about the adoption from the beginning, the easier it will be to reduce shame and do necessary grieving. For this reason, this researcher believes the trend toward open adoption policies may have a positive impact on the ability of triad members to tell their truth. Triad members can then have their issues of loss supported through sanctioning their grief by appropriate counseling practices. They can move into healing through grieving much sooner in their lives. This practice would eliminate many of the self destructive patterns that are often part of a triad member's life.

This researcher believes these patterns play themselves out through addictive behaviors that can lead
the adoptee or birthmother into perilous situations that test the persons' ability to cope or solve problems.

Many of the respondents are involved in searches and stressed the importance of searching for their relinquished children and or birthparents and what the possibility of reunion meant to them. Due to its connection with healing grief, the issues of search and reunion will need to be factored into the treatment plan by the therapist.

The price for hiding our pain and loss over a loss that cannot be publicly acknowledged is shame compounded with feelings associated with grief. When people grieve openly and consciously it allows them to experience their pain, anger, shame, fear, guilt, remorse, loneliness and other related feelings. It is an essential factor in healing and shedding a cloak of shame. To share their grief with others allows them to be comforted and give comfort. It confirms the knowledge that they are not alone and that it is possible for life and love to continue.

It is only through acknowledging the truth that members of the adoption triad can reduce enough shame to begin feeling again. This involves a courageous step that transcends the possibility of further rejection by family,
friends and or other children. The gift of this step is finding a beginning for self-acceptance.

A new reality about adoption has emerged that is validating of both sets of parents: the birthparents as the ones who nurtured the child during pregnancy, gave birth to the child, and provided the child's genetic and hereditary traits; and the adoptive parents, who raised the child to adulthood and provided the nurturing environment and relationships. As Role (1989a) observes, "both are valuable, essential contributions to the child's life" (p. xi).

This researcher believes the trend toward open adoption may have a positive impact on the members of the adoption triad. More research in the area of open vs. closed adoption policy is recommended.

The issues related to the search and possible reunion of adoptees and birthmothers is also an area where more research needs to be done.

The relationship between gender and other demographics and unsanctioned grief among birthmothers and adoptees would be an important area to explore as well.


APPENDIX A

QUESTIONNAIRES
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Birthmother questionnaire:

1. What were the factors that influenced you to make your decision to relinquish your child for adoption?

2. Would you choose adoption again or recommend it to a friend or relative?

3. Do you feel that you were prepared for the effects that relinquishing your child had on you later in life?

4. Have you experienced any difficulties with intimate relationships, self esteem, addictions to drugs or alcohol, eating disorders, depression or other self destructive patterns in your life? Please identify which ones have effected you.

5. Could you briefly respond to the following quote:

"The baby’s mother expressed much love and concern for the baby, as did her parent. She felt it was important for a child to be raised by two parents, by a mother and father who love one another and who can offer that security to a growing child. She realized the difficulties she and the child experience if she kept her and tried to raise her alone in our society today" (anonymous adoption agency, cited in Barton, E., 1996).
6. Was your adoption open or closed and how do you feel about that now?

7. Have you ever received help from a therapist for issues related to relinquishing your child or for any other reason? Please describe.

Adoptee Questionnaire:
1. Briefly describe the circumstances when you found out you were adopted.
2. Do you remember what you felt at the time?
3. What were your thoughts as you continued on with your life knowing you were adopted?
4. What thoughts did you have about your birthmother?
5. Did knowing you were adopted change how you felt about yourself?
6. Have you experienced difficulties with intimate relationships, self esteem, strong feelings of anger, depression, addictions to drugs or alcohol, eating disorders, or other self destructive life patterns? Please describe any symptoms you have had.
7. Was your adoption open or closed and how do you feel about that now?
8. Have you ever received help from a therapist related to your adoption or any other area of your life? Please describe.
BIOGRAPHICAL SKETCH

Roxanne Conolly was born in San Diego, California. She attended several college programs throughout her career beginning at San Diego State University, San Diego City College, and the University of Utah, where she graduated cum laude with a Bachelor of Science degree in Psychology in 1983. She also completed graduate courses at the University of Utah before relocating to San Diego in 1986. She moved to Arizona to make a career change from engineering to counseling in 1992. She began her counseling career as an intern at Sierra Tucson. She later worked as a substance abuse counselor at the Meadows in Wickenburg, Arizona. It was during this time she began graduate school at Ottawa University where she completed her Master of Arts degree in Marriage, Family and Addictions Recovery counseling.

In September, 1987, Roxanne reunited with her daughter, Lisa, whom she relinquished in 1966. Her story is similar to the birthmothers interviewed for this study. Her daughter's story is similar to many of the adoptees' as well.