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**An exploration of the experience of birth mothers who relinquished a child for adoption between 1960 and 1990 and who subsequently initiated contact with the relinquished child: The clinical implications for practitioners.**

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**A joint programme between Middlesex University and Metanoia Institute**

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**2018**

*For Niamh*

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Finally, I am indebted to the women who shared their stories with me – without them, this would not have been possible.



## Abstract

This is a phenomenological study exploring the experiences of seven birth mothers who relinquished a child for adoption between 1960 and 1990. The aim of the study is to understand the depth and breadth of the experience of relinquishment and to establish whether the impact of relinquishment is long-term. This study explores the relationship between the moral values and social policies that existed during the era of the study and how these factors influenced the birth mothers' decision-making. The objective of the study is to use the findings to develop therapeutic guidance for practitioners working with birth mothers who have lost a child through adoption. The data was gathered through semi-structured interviews and was analysed using Interpretative Phenomenological Analysis. The women provided compelling accounts of lives consisting of secrecy, shame and loss, harsh treatment by family and professionals, and an absence of any emotional support. Additionally, most of their stories had not been heard before. Three master themes emerged from the findings: 1) *The power of social stigmatisation*; 2) *The unique experience of relinquishment*; 3) *Experiencing psychological distress*. The study shows that the impact of the experience of relinquishment is indeed long term, with a diminishing of the intensity of emotions over time. The lack of acknowledgement of the experience was a significant contributory factor in the longevity of the impact.

Clinical implications and recommendations for practitioners who support birth mothers in Adoption Support Agencies are presented. It is anticipated that the recommendations will also be useful for practitioners currently supporting birth mothers whose children have been, or are presently being, taken into care and subsequently adopted. Many of the themes identified in this study, such as loss and stigmatisation, have been shown in the literature to be also present for this group. The findings and clinical implications would therefore have some relevance in supporting these birth mothers.

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# 1. Introduction

## 1. 1 Introduction

Within academia, there is very little literature that specifically addresses the nature of therapeutic support required for birth mothers to address the psychological impact of relinquishing a child to adoption. This paucity of commentary has created a noticeable knowledge gap in the literature, which in turn impacts upon therapeutic practice for birth mothers who have relinquished a child. Relinquishment, in the context of adoption law, refers to a birth parent voluntarily giving up his or her parental rights so that the child may be adopted. Therefore, this thesis seeks to further academic understanding of the factors that influenced women to make the decision to give up a child for adoption and the psychological impacts of relinquishment on birth mothers. This is to be achieved by utilising empirical research to explore the experiences of women who gave up a child for adoption between 1960 and 1990 and who subsequently engaged in the process of looking for their child later in life in what is known as the 'searching process'. In gaining this insight, the research sets out to inform the development of clinical guidance for therapists and other practitioners working with this client group.

This chapter will outline the structure of the thesis and explain the use of reflexivity in qualitative research. Additionally, it will seek to place the research within context by providing an historical overview of 20th century adoption in the UK and summarising the existing relevant literature. Furthermore, it will illustrate the expected contribution of this research to our current understanding of the experience of birth mothers, and how this can inform therapeutic guidance for practitioners working with this client group. This introductory chapter will first address the research aims and my personal interest and motivation.

## 1.2 Title and research aims

An exploration of the experiences of birth mothers who relinquished a child for adoption between 1960 and 1990, and who subsequently engaged in the searching process.

The research aims are as follows:

- To understand the depth and breadth of the experience of relinquishment for the birth mother.
- To establish whether the impact of the experience for the birth mothers is long term.

The objective of the research is to use the findings to develop therapeutic guidance for practitioners working with this client group. The aims will be achieved by:

- Undertaking a critical review of the relevant literature to establish a knowledge base and identify gaps that may exist.
- Conducting semi-structured face-to-face interviews with seven birth mothers who gave up a child for adoption between 1960 and 1990 to develop rich descriptive accounts of their experiences of relinquishment, including the implications of their decision.
- Categorising the findings into themes to identify the key issues and analysing the results using Interpretative Phenomenological Analysis (IPA).
- Using the themes to support the formulation of appropriate therapeutic support for practitioners who work in this area.

Whilst the research addresses the issues of relinquishment for birth mothers from 1960 to 1990, there may be themes extracted from the study that are relevant to



birth mothers today whose children are taken into care and subsequently placed for adoption.

A qualitative approach was taken in this research and IPA was the method of choice. IPA offers a distinctive approach to conducting qualitative research in psychology, offering a theoretical foundation and a detailed procedural guide (Brocki and Wearden, 2006). As well as focusing on an individual's experience, it recognises the researchers' centrality to the research, which was particularly significant for this study. The study is underpinned by the theory of interpretation known as hermeneutics, which facilitated the researcher's own perspective through a process of reflexivity.

### **1.3 Personal motivation for this research**

My motivation for carrying out this study stems from my own experience of relinquishing my daughter for adoption when I was just 17. When I became pregnant, I lived in a small town in rural Ireland where Catholicism had a significant influence on every aspect of life. I had often heard my parents talk in hushed tones about girls who 'got into trouble', or of girls who 'had to' get married, and was acutely aware of the stigma that was attached to pregnancy outside of marriage. On discovering that I was pregnant, I decided never to tell my parents, as I could not bear to burden them with the stigma. And so I concealed my pregnancy as best I could. As my baby grew inside me, I became deeply ashamed of myself, ashamed of my changing shape and my growing stomach, evidence to the world that I had sinned by having sex before marriage and was now about to have an illegitimate child. I perfected the art of holding in my stomach to hide my shame, a practice that still remains with me. I went to London when I was five months pregnant, on the pretext of finding work, and eventually gave birth to my daughter in a large grey Victorian hospital on 21st May 1971. The birth was traumatic; I was alone and more frightened than I have ever been in my life. I had no understanding of what was going to happen to my body and had no one to reassure me. I remember calling out

for my mother but no one answered. My parents didn't know of my experience and never met their granddaughter.

I spent ten days getting to know my daughter – days filled with love, adoration, and amazement, interspersed with fear, isolation, pain and confusion. I never for a moment considered that it might be possible for me to keep my baby. I didn't think I had a choice. I didn't know of any young girls who were single parents and I felt like a child holding a child. I was overwhelmed and frightened, not only for myself but also for my daughter, and I thought it would be better for her to have 'proper' parents. I never for a moment considered the personal impact of giving my child away. This idea was reinforced for me by the professionals at the Catholic adoption agency who assured me that my daughter would have a good home and that I could continue with the rest of my life. I was compliant. I did what I believed was the right thing to do and handed my daughter over to strangers when she was eleven days old – her absence already as palpable as a darkening bruise. In doing this, I added additional layers of shame to those already existing within me.

This experience has had a profound impact on my life: I have lived with shame and been shadowed by loss for most of my adulthood. I pretended that the experience never happened and I allowed myself no room for grief or loss; it was less painful that way. In reality, I could not forget, and the memories haunted me for many years. I fantasised about my daughter: what she might look like; what she might sound like; what would make her laugh. I tried to believe that she belonged to a perfect family and I learnt to conjure up an image to help me maintain that belief. However, I also worried about her and whether she would know of my existence. I worried that she might be unhappy, that she might get ill or that she might not be properly cared for. The memories faded somewhat over the years but would turn up unexpectedly and overwhelm me with their intensity. Legally, I had no rights to obtain details about my daughter or her whereabouts, but I was allowed to provide the agency with my contact details should she wish to find me. However, I felt intuitively that my daughter would seek me out.

I went on to get married and subsequently had a son, yet the secret remained deeply hidden. When asked by people how many children I had, I replied 'one', and each time I said that, I experienced an internal jolt, as I felt I was denying the very existence of my daughter. This feeling of denial was so intense that it felt comparable to the denial of Jesus by Peter the Apostle, whose emotional turbulence as a result of the denial has been the subject of major art for many centuries. It felt, to me, like the ultimate denial.

And then, when I was aged 40, my daughter found me and we were reunited. Such joy – two strangers, mother and daughter, analysing one another for similarities and being delighted on finding them, reminiscent of Jackie Kay's words:

*We are both shy, though our eyes are not  
They pierce below skin  
We are not as we imagined....*

*We don't ask big questions even later by the shore.  
We walk slow, tentative as crabs  
Not, so what have you been doing the last 22 years  
Just what are you working at, stuff like that.  
(Kay, 1991:33)*

The joy was followed by such sadness at the loss of what might have been: a daughter denied a mother, a brother denied a sister and a mother denied a family. And then began the slow process of getting to know each other. With that came the stark realisation of the strange and sometimes fragile nature of such a complex relationship. My secret was now out in the open and I was happy to introduce my daughter into the lives of my family, who were very accepting of her. However although my daughter was now part of my life, which filled me with happiness, my experience remained an emotional, almost toxic secret. My shame remained deeply buried and I continued to tell people that I had only one child, for fear of having to explain my story. On some occasions, I believed my shame was visible to others.

*Maybe the words lie  
Across my forehead  
Headline in thin ink  
MOTHER GIVES BABY AWAY  
(Kay, 1991: 17)*

In 2004, aged 50, I made a career change and commenced my training as a cognitive behavioural therapist. I noticed during my training how easily my colleagues appeared to acknowledge and access their own emotions. I was envious and wondered why I couldn't do the same. I noticed how empathic I could be when connecting with my clients, but I couldn't connect with part of myself. I had personal therapy as part of my training but managed to avoid talking about my 'secret'. I went on to study therapy at Master's level and in 2013 commenced a Doctorate in Psychotherapy at Metanoia Institute with the intention of exploring differences and similarities within specific psychotherapy modalities. The first assignment required writing about my personal experiences and professional learning. As usual, I made no mention of my experiences in relation to my daughter

– a well-rehearsed practice – but focused instead on my achievements and learning. My assignment was rejected, as my paper required '*...more references to emotional experiences...showing greater attention to emotional processes*'. Having fully expected to pass this assignment, I had a strong reaction when reading the feedback. My head was pounding and I felt sick: it was as if I had been found out. My skilful avoidance of my own emotions had been identified for the first time ever, and I felt very vulnerable. I now felt that I had no choice but to talk about the source of my angst, which I had so expertly hidden within the depths of my psyche.

And so I started the process of properly reflecting on my life and the impact of a hidden pregnancy and subsequent relinquishment. I recognised how stoic I had been in my life, ignoring vulnerabilities and developing coping strategies to suppress my emotions. Significant emotional events in my life, on occasions, failed to touch me: I couldn't feel the pain. I looked at how difficult I found emotional intimacy with partners, which impacted significantly on my personal relationships. My experience burdened me with the need to appear capable at all times and it taught me the art

of self-reliance. It helped me in many aspects of my career, as I constantly felt the need to work harder than anyone else and prove that I was a good, worthwhile, and competent person, because, deep down, I believed I had done something very bad.

Whilst I was initially distressed at what I was uncovering, I began to feel a sense of empowerment at finally being able to talk openly about my experiences. My sense of shame began to ease as I acknowledged for the first time the impact of what had happened to me. Following this process of reflection, I decided to undertake research in the very area that I had avoided for my whole life. My thoughts turned to other mothers who had had the same experience as me. In 1971, the year I gave my daughter away, approximately 21,000 (Registrar General's Adoption Data (1940-1980) women in England and Wales also relinquished a child. I wondered how many of those women were holding their secrets as closely as I had held mine. I now believe that if I had sought help earlier, I would have been better able to identify and manage the tsunami of emotions connected to my experience. I hope that by giving these women a voice through my research, some of their pain might be eased.

Another element in my motivation for carrying out this research is linked to the work I carry out as an independent member of an Adoption Panel with a Local Authority. As a panel, we recommend the suitability of prospective adopters and approve matches between approved adopters and children available for adoption. Most children who are adopted today come from within the care system and normally have been removed from their parents without their consent. There is very limited psychological support available for these parents, who, although they may be deemed unfit to be good parents, are likely to experience emotions such as grief and loss, similar to that of a mother giving up her child for adoption. So, whilst the primary focus of the research is on birth mothers who relinquished a child between 1960 and 1990, themes may emerge from the study that might be useful for birth mothers today who have their children taken from them and placed for adoption. It is, however, important to place the experiences of birth mothers who relinquished children in the 1960s, 1970s and 1980s into context by examining the history of UK adoption within the 20th and 21st centuries.

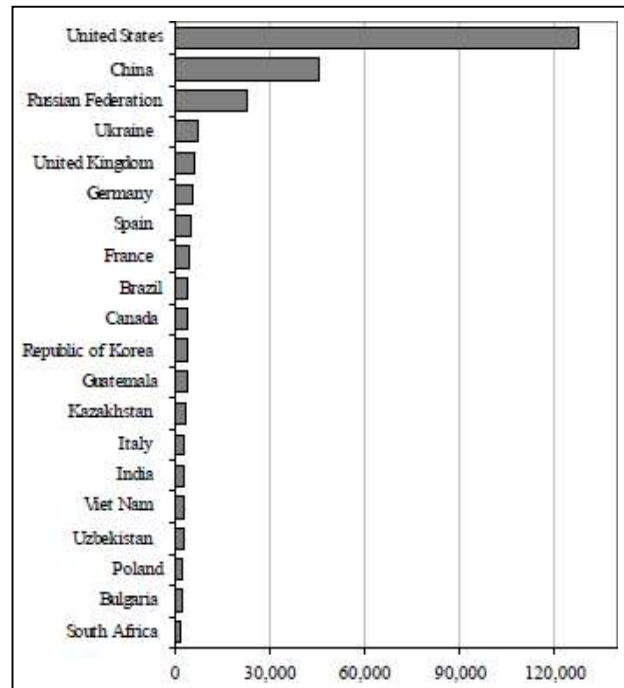
#### **1.4 Definition of adoption**

Adoption is a social relationship created by law, severing one legal relationship and creating another. Adoption law defines and deals with the practical realities of names, inheritance and legal responsibilities (Rowe, 1970). Once an adoption order is made, the law considers the adopter as the child's parent in every respect. The adopted child no longer has automatic inheritance rights from their birth family, but may be named as a beneficiary in a will. There is no provision for annulment, and according to law, the natural parents are parents no longer (Rowe, 1970). It is a single act with enormous consequences, as it separates family, removes identity and changes biological strangers into family.

Not all countries in the world approach adoption from the same perspective. Amongst the 195 countries worldwide, adoption is permissible in 173. However, 20 of these countries do not have legal provisions relating to child adoption. Where legal provision is in place, the paramount concern is ensuring that the best interests of the child are served by adoption (United Nations, 2010).

**Figure 1**

**Countries with the largest number of adoptions: most recent available data (1999-2005)**



Source: United Nations (2009), cited in United Nations (2010) Child Adoption: Trends and Policies

In countries where there is no adoption legislation, alternative procedures such as guardianship or the placement of children with relatives are permitted. In such countries, the termination of natural ties between birth parents and their children is viewed as culturally unacceptable (United Nations, 2010). These informal adoption practices contrast markedly with the secrecy and finality that have come to characterise adoption in the western world.

Adoption in the U.K. is regulated by statutory provision and administered through the courts in line with these principles. It is solely administered through adoption services and agencies approved by the Secretary of State: consequently, private adoption is prohibited in the UK. Initially, the focus of adoption law was on

providing help to unmarried mothers and satisfying the needs of the childless couple; however, this later shifted to the interests and welfare of the adopted child (Sandhu, 2012).

### **1.5 Overview of adoption in the U.K. in the 20th and 21st Centuries**

The first adoption legislation in England and Wales was enacted in 1926, following recommendations from the Government-appointed Hopkinson committee. The committee believed that children who could not be cared for by their birth parent should be placed in homes with a family as opposed to an institution (Gheera, 2014). Prior to this, informal adoption was commonplace, although it is difficult to establish how much openness existed before the Act was passed because of the lack of legal regulation. Informal adoption often occurred within the extended family or within communities, as a means of helping those who could not care for their own children. However, it was shrouded in secrecy and the adoptive parents had no legal rights whatsoever, as the biological parent could reclaim an adopted child at any point (Keating, 2008).

After the First World War, different factors came into play, as many children were left fatherless or orphaned as a result of the conflict. Alongside this, families had fewer children and the emphasis was on the parent's ability to provide a greater investment in the children they had (Rossini, 2014). The idea of a family unit became widely promoted, with images of the ideal family being regularly featured in women's magazines. It was common for newly married couples to keep the top tier of their wedding cake for the arrival of the baby. But what if there was no baby? Fertility treatment was in its infancy and any informal adoption arrangement carried risks. Adopting a baby from strangers was seen as the solution: those who could not have children would become parents and a displaced baby would get its own family and the opportunity to lead a new life. This allowed society to relieve itself of a problem and a burden in the form of the single mother and her baby, and form a new family in the process (Rossini, 2014).



Against this background of surplus children and couples aspiring to be the perfect family, campaigners were pressing to formalise adoption in England and Wales (Richards, 1989). There had been a growth of adoption agencies after the First World War and the dominant thinking at this time was about protection of the family. This was linked to the belief that people would be happier to adopt if there were guarantees around issues such as confidentiality, anonymity and protection of the new family (Keating, 2008). These factors, coupled with the concern for children and the desire to regulate family placements, led to the passing of the Adoption of Children Act 1926, which heralded the beginning of the secrecy linked to adoption that still exists in our society today. This Act did not make adoption completely confidential, as was requested by the adoption societies, but it made tracing of all parties difficult. The Act did not give the child the right to inherit from their adopted parent’s estate, but this was subsequently reversed in 1949. Once the Act was in force, the number of adoption orders granted in the U.K. rose from 3,000 in 1927 to a peak of around 27,000 in 1968 (Richards, 1989:2).

### Figure 2

Number of adoptions in England and Wales:  
Specific years between 1940 - 2010

Year	Number of adoptions
1940	7,775
1950	12,739
1960	15,099
1970	22,373
1980	10,609
1990	6,533
2000	5,977
2010	4,550

Sources: Registrar General’s Annual Statistical review on Adoption Data 1940-1970:  
Office for National Statistics Adoption in England and Wales 1980 – 2010.

However, despite the 1926 Act, children were still being moved overseas, prospective adopters were rarely interviewed, and money was still being exchanged between agencies and adoptive parents (Elliot, 2005). Following these concerns, the UK government published a report highlighting abuses in practices and calling for changes to be made to the law. This resulted in the Adoption of Children Act in 1939, which saw local authorities taking responsibility for the regulation of adoption. However, although the local authorities had a supervisory role, most of the work was carried out by denominational voluntary organisations that employed Christian moral welfare officers to deal with the casework associated with adoption (Elliott, 2005). In the early 1950s, additional legislation was introduced to ensure that the birth mother would have no way of finding out the whereabouts of her relinquished child. Whilst this was intended to maintain confidentiality, it made it almost impossible for birth parents to reconnect with children they had given up for adoption.

The 1960s saw the highest number of adoptions ever reached in England and Wales peaking at 24,831 in 1968 (Registrar, General Adoption Data, 1940-1970). There were a number of reasons for this. The first teenage generation free from conscription had emerged in Britain and television dominated the decade as the most important entertainment medium, as it brought the outside world into people's homes. Furthermore, the pop music of this era promoted the idea of protest, freedom, and liberalism (Black, 2011). This emerging culture spawned new ways of thinking about social issues (Rossini, 2014). Traditional values were overturned and moral codes that had existed since the Second World War broke down, a process formalised by legal changes (Black, 2011). These included the legalisation of homosexuality and the availability of the contraceptive pill on the NHS. It appeared as if the attitudes of society were becoming more liberal. However, not all traditional values were inverted: back-street abortions continued to wreak havoc on women's bodies until 1967, when the Abortion Act made abortions legal up to 24 weeks (Rossini, 2014). Howe, Sawbridge, and Hinings recognised this tension and stated that:

*tolerance and the promotion of sexual freedom conflicted with intolerance and the stigmatisation of illegitimacy and created a recipe for producing more children outside marriage without making it any easier for unmarried mothers to care for them (1992:15).*

In 1972, following the Houghton Report on adoption, which reported on the issue of allowing adopted children greater access to information about their birth families, changes were incorporated into the Children Act 1975 and the Adoption Act 1976 (Gheera, 2014). The most significant change was that adopted adults in England and Wales were given the right to obtain a copy of their original birth certificate. The Act acknowledged that people who had a personal connection to adoption '*should have a right to a service if they had unresolved issues or counselling needs*' (Gheera, 2014:6). This legislation began to unravel the veil of secrecy that shrouded the adoption process, but only for adoptees and not the birth parents. The new century brought more change and, in 2005, the Adoption and Children Act 2002 was fully implemented, replacing the Adoption Act 1976 and modernising the legal framework for adoptions in England and Wales (Ball, 2005). For the first time ever, legislation recognised the needs of birth relatives who wanted the opportunity to let their adult adopted relative know of their interest in contact. Under Section 98 of this Act, birth relatives of an adopted adult, and adoptees themselves, have the legal right to ask a local authority, voluntary adoption agency or registered adoption support agency to provide them with intermediary services so that their adopted relatives or birth relatives are informed of their willingness for contact. This was significant in that it allowed adoption agencies to disclose otherwise protected information about an adopted person to a birth relative (Ball 2005). The information could only be provided through a recognised Adoption Support Agency (ASA), which could also offer support to the birth relative in areas such as searching, requesting contact, counselling, or leaving information on file for the adopted persons. However, the decision to engage with the contact remains solely with the adopted person.

## 1.6 The current landscape of adoption in the UK

From the peak of nearly 25,000 adoptions in 1968, the annual number of adoptions has fallen steadily, with only 3,450 children adopted in 2011-12 (Select Committee on Adoption Legislation, 2014). This decline in the quantity of adoptions is attributed to contraception and abortion becoming available, together with a supportive welfare system. It appeared as if the sexual revolution and the impact of the contraceptive pill took time to permeate the whole of society (Rossini, 2014).

The 21st century has not only seen a significant reduction in the number of children being adopted in the UK, but the profile of children who are being adopted has changed dramatically. In 2012, 77% of the 4,000 children adopted were children who had been taken into care. This contrasts starkly to 1952, when only 3.2% of all adoptions were from children taken into care (Keating, n.d.)

Howe, Sawbridge and Hinings (1992) estimated conservatively that there are at least half a million women in the UK who have given up a child for adoption. Elliot (2005) states that one in four families in Britain has direct experience of adoption. It is theorized that the large-scale adoption of illegitimate babies by childless couples in recent history will probably prove to have been a transient phenomenon of a few decades when permissiveness was rapidly increasing and social policy could not keep up (Dunne, 1979). It was a product of its time, created by a particular set of circumstances, and is unlikely ever to be repeated. In this time, adoption became a significant social intervention to improve the lives of children and childless couples and thereby to relieve unmarried mothers of an economic and moral burden (Elliot, 2005). Nonetheless, it has left a legacy of secrecy and shame for many involved in the process, and raises fundamental questions about the importance of nature versus nurture and the development of each individual's sense of personal identity.

The women who relinquished their children during the 1960s to 1990s are now likely to be between their mid-50s and mid-70s. As a group, they have not been vocal about their experience due to the historical stigmatisation associated with

unmarried pregnancy and illegitimacy. It is only in recent history that high-profile films about child relinquishment such as *Secrets and Lies* (1996) and *Philomena* (2013), and major TV series such as *Long Lost Family* (2016), have encouraged these women to come forward to tell their story. Such programmes indicate that many of the women who gave up their children for adoption during this era felt pressurised into doing so by the prevailing attitudes and practices. Although these portrayals are not accurate evidence as such of birth mothers' feelings, they are illustrative of the prevalent culture. The prominent images of such media portrayals have resulted in some governments recognising the implications of past social practices. In 2013, the Irish Government apologised to the women who were sent to the notorious Magdalene Laundries up until the 1980s to hide the shame of unwanted pregnancy. A fund was set up by the Irish Government to ensure that the women who attended these institutions could have access to therapeutic support. The Taoiseach (Prime Minister) Enda Kenny stated:

*The existence of these institutions cast a long shadow over Irish life and, in a society guided by the principles of compassion and social justice, there would never have been a need for such institutions.* (Kenny, 2013: n.p.)

Similarly, in Australia in 2013, Prime Minister Julia Gilliard issued an apology to the people affected by Australian adoption policy between the 1950s and the 1970s, stating that it was a shameful policy that had created a legacy of pain and suffering. The government agreed to provide £3.4m to help affected women access specialist support, including mental health support (BBC, 2013).

In 2011, an organization called Movement for an Adoption Apology (MAA) was set up in the U.K. with the following mission statement:

*We seek recognition and acknowledgement of the pain and grief suffered by many birth parents and their children because of the unethical adoption practices of the past. We believe that this can only be achieved by a full Parliamentary apology with cross party support.* (MAA, 2011: n.p.).

On 9th November 2016, ITV screened a documentary at peak viewing time called 'Britain's Adoption Scandal – Breaking the Silence'. This documentary showed women breaking their silence to reveal how they had been systematically pressurised into relinquishing their babies for adoption and talked about the injustices they had experienced and the difficulties of dealing with the impact of their decisions. Following the screening, MAA delivered a letter to Amber Rudd, the Home Secretary, accompanied by evidence statements from a number of those affected, asking for a public inquiry into Adoption Practices and Policy, and this was scheduled to be raised on Prime Minister's Question Time on Thursday November 16th 2016 (MAA, 2017). The Government expressed sympathy for the plight of the women and stated that the area of adoption practice was completely transformed by current legislation (BBC, 2016).

Furthermore, on 3rd November 2016, Cardinal Vincent Nichols, Archbishop of Westminster, apologised to women in the U.K. who were pressured into handing over their babies during the 1950s to the 1980s, acknowledging the grief and pain caused by this practice (BBC News, 2016).

Adoption as an institution has faced many challenges over the years. In the past, it offered a solution to a social problem, a child for infertile couples and a home for children who could not be looked after by their parents. However, it continues to raise highly emotive issues because of its fundamental implications for the meaning of familial ties. There are some voices calling for a move away from the secrecy of adoption to a more open solution. The Law Commission of New Zealand and the State of Victoria in Australia are moving towards abolishing the legal concept of adoption and replacing it with a modified version of guardianship (Triseliotis, Feast and Kyle, 2005).

The social stigma of unmarried motherhood and the punitive moral and religious climate of this period legitimised practices that would be considered intolerable today (Elliott 2005). We live in a society that features public discussion about reconciliation and forgiveness, with social media being used to highlight past

injustices. It is encouraging to see today an acknowledgement of past injustices, but the consequences of those practices still exist and continue to impact on the lives of those who have had this experience.

### **1.7 Contribution to knowledge**

Whilst the adoption triad consists of birth parents, adopted children and adoptive parents, few research studies specifically research the experience of birth parents in this triad (O'Leary Wiley and Baden, 2005). This may be attributed to the limited access researchers have to this population in comparison to other members of the triad, with birth parents often seem as the invisible member of the triad. Additionally, Lee (2003) asserts that birth parents are silent as a result of the cultural norms and structures related to relinquishing their children. Zamostny *et al.* (2003) believe that there is limited understanding of adoption experiences and the use of theoretical models for clinical practice, with many questions regarding the impact of adoption left unaddressed and a lack of detailed and empirically tested theoretical models of adoption.

Wegar (1997) identified that, predominantly, research on adoption has been the preserve of social care professionals. He argued that this might be because the scarcity of sociological research on adoption has allowed scholars in other disciplines, such as psychiatry and social work, to dominate the study of adoption. The trend for research on adoption by the social work profession appears to have continued into the 21st century in the UK. In 2005, a major study by Triseliotis, Feast and Kyle on the experiences of all parties of the adoption triad included two authors who had a background in Social Care. Wegar (1997) stated that such scholars usually approach the study of adoption in predominantly individual terms, without taking into account the social factors and processes that affect adoption experiences and policies. Perhaps there is an irony in the fact that the social work profession, which acted as the main agent in implementing adoption practices and processes, has become the expert in researching the implications of its own practices. A recent

study by Sandhu (2012), also with a background in social work, which explored the experiences and motivations of birth mothers who relinquished a child, relied on archival materials collated from adoption case files and adoption panel meetings. Additionally, it included interviews with social work professionals who worked in the arena of adoption. No interviews were carried out with birth mothers, which limits the use of the research and is a missed opportunity to gather primary data.

Since 2000, the focus of much of the literature has shifted to other members of the adoption triad, namely the adopted child and adoptive parents. Perhaps there is a view amongst researchers that that the passage of time has lessened the impact on those who relinquished a child, as until recently, these women have not been visible or vocal about their experience. Or perhaps these women have simply been forgotten about, like some victims of sexual abuse, who until recently have not been visible. Therefore, because of the passage of time, this research will add an additional dimension to the existing literature by identifying the long-term impact of the experience of relinquishment on the birth mother. It will provide a historical background detailing how social policy and cultural and religious beliefs influenced mothers into giving up their children, with little consideration given to the impact of this act on the birth mother. The study will have a distinctive element because it is coming from the perspective of someone who is not influenced by the social work profession but has had experience of the phenomenon being researched and is accessing directly the women who have also had this experience.

As the study seeks to provide a current psychological perspective on the long-term impact of child relinquishment, the outcomes will be helpful for therapists working with this client group. O'Leary Wiley and Baden (2005) state that despite the recognition of the effects of relinquishment on birth parents, clinicians have virtually no empirically validated guidelines for practice with birth parents. Clinical practice with birth parents has relied on best practice generated from case studies, theoretical guidelines and a few treatment programmes developed with sensitivity to relinquishment and adoption-related issues. Novac *et al.* (2006) state that none of the studies asked the birth mothers what would have been helpful for them within



that situation and that many birth mothers reported that they did not receive acknowledgment of their loss from the professionals in their care. Many therapists working with this client group today will not have lived through the era in question and thus may not fully comprehend the cultural factors that existed at the time. This may limit their understanding of, for example, specific shame associated with illegitimacy and an understanding of how such shame can permeate every aspect of the client's life. Therefore, the current research, based on data from the birth mothers' own experience, will provide an authentic insight into the depth and range of emotions linked to the experience of relinquishment, and in doing so, will provide an incremental contribution to the existing literature.

### **1.8 Reflexivity in research**

In qualitative research, it is now accepted that the researcher is inevitably implicated in both the research process and its findings; there is no longer a requirement for the researcher to be hidden. Instead, there is an acknowledgement that the researcher '*is a central figure who influences, if not actively constructs, the collection, selection and interpretation of data*' (Finlay, 2002:212). Despite this acknowledgment, Mruck and Breuer (2003) believe that many empirical studies render the researcher invisible in order to simply mirror the phenomenon being studied. This results in research resembling photographs that apparently need neither camera nor photographer to exist.

Reflexivity means different things to different people; however, it is generally understood as an awareness of the researcher's influence on what is being studied, and simultaneously, on how the process affects the researcher. Probst and Berenson assert that reflexivity serves as a:

*dual-lensed critical consciousness; the awareness of oneself engaging in experience, like an arrow pointed at both ends, or an eye that sees itself while gazing outwards at the world. (2014:815)*

They differentiate this from reflection: a conscious observation of one's own world, with the arrow pointing solely at oneself, as opposed to the reciprocal interplay in reflexivity between the archer's inward and outward viewpoints within reflexivity.

This, of course, raises the question 'why do we need to know about the researcher and what relevance does the motivation and position of the person carrying out the research have on the outcomes?' The answer may be in the level of trust that the reader has in the author of the study. If the reader understands why a particular study was chosen, what philosophical stance underpins the study and how the process impacted on the researcher, then the trustworthiness of the study is enhanced. Reflexivity therefore can be viewed as a crucial aspect of knowledge construction (Probst and Berenson, 2014).

This study focused on what Finlay (2002:215) describes as an '*introspective reflexivity*', which involved examining my own experiences and insight gained from my reflections, and using this to form the basis of a more generalised understanding and interpretation of my data. Woolgar describes this as the researcher moving beyond '*benign introspection*' (1988:2) to a more explicit link between knowledge claims, personal experiences of both participants and the researcher, and the social context.

This introspective reflexivity initially felt uncomfortable and self-indulgent, but over the course of the writing, became more like a companion. I was guided by Etherington, who points out that the judicious use of our selves in research needs to be essential to the argument and not just a '*decorative flourish*' (2003:37) for it to be described as reflexivity. However, it has resulted in me feeling naked: I have had to strip away my protective layers and allow the world to see into the very deepest part of me. Although the research is not about me, I am deeply situated within it. It is not about my daughter, but she is also present; she may read my words and experience sadness whilst gaining a greater understanding of my experience. The remainder of my family may also be impacted and I acknowledge that it may cause them pain.

However, my hope is that it will add a new and positive dimension to all of our relationships.

I cannot claim to be unbiased in my research and I have acknowledged that fact throughout the thesis by adopting a transparent reflexive stance throughout.

### **1.9 Outline of thesis**

This thesis is made up of 8 chapters, including this introduction. Chapter 2 will review the existing literature on the experience of relinquishment for the birth mother, including motivation and impact. It will also explore the social and cultural factors that were present during the era in which the study was situated, and discuss the role of stigma within adoption and how psychotherapy has been viewed in relation to relinquishment. Chapter 3 will outline the chosen methodology, including the underpinning philosophical perspective. It will describe in detail the methods used within the research and the ethical considerations, and also demonstrate the rigour employed in the research. It will conclude with a reflexive paragraph on how this part of the process impacted on me. Chapter 4 highlights the key themes from the findings and includes verbatim comments from the participants to support the themes. Chapter 5 will relate the findings back to the existing literature and highlight incremental contributions to knowledge. Chapter 6 will discuss the clinical implications for therapists and will identify the key skills required by practitioners when working with birth parents. Chapter 7 will allow my voice to be heard through the use of a reflexive summary on how the overall process has impacted on me. Chapter 8 will provide a concluding statement on the outcomes of the research.

## **2. Literature Review**

### **2.1 Introduction**

This chapter offers a critical review of the existing literature relating to the experiences of birth mothers who gave up a child for adoption between 1960 and 1990. The review will explore the prevailing cultural and social factors that contributed to birth mothers' decision-making in relation to relinquishment and explore the literature relating to the stigma surrounding illegitimacy and pregnancy outside marriage. Whilst the main focus will be on the birth mothers' experience, literature relating to Attachment Theory and the impact of separation on the adopted child is also explored. Although the predominant literature on Attachment Theory relates to the impact that severing the mother-child bond has on the child, it may also contribute to our understanding of the impact of this separation on the mother. Finally, this review will explore how the experience of relinquishment has been viewed from a psychological perspective prior to and throughout the era of the research. It is first necessary, however, to understand how adoption is defined in professional and public circles.

### **2.2 Overview of literature**

Adoption is a social and legal construction that has been shaped by social trends and problems, cultural values and conflicts, historical events and forces, as well as public policy and legislation (Carp, 2002). It is conceptualised as a life-long process, rather than a single act, and involves three sets of participants, collectively known as the adoption triad - the adoptee, the birth family, and the adoptive family (Brodzinsky, Smith and Brodzinsky, 1998). The experience of adoption is often thought to be parallel to the genetic birth experience and biological family life (Zamostny *et al.*,

2003). However, Herman states that in a society where the dominant measure or realness in family life is blood, the:

*struggle to make adoptive kinship look and feel as real as the real thing has been a virtual obsession in law, language and literary presentation, as well as in the particular social practices that make families up.*  
(2002:11)

Interest in adoption is widespread and touches numerous disciplines, including social work, psychology, psychotherapy, medicine, sociology, genetics and the legal and justice system. The topic arouses curiosity, with an aura of intrigue and mystery stemming from the fact that things are not what they appear to be. It raises questions about the social construction of families, questions the concept of identity and has the potential to uncover legacies, which may or may not be welcome. Brinich (1990) states that adoption is an essential component of many myths, as old as the story of Moses and as tragic as that of Oedipus. This operation, which turns strangers into family, can elicit emotional response in the mass media (Henney *et al.*, 2011) and has become a visible feature of the social landscape, with adoption becoming:

*as familiar as Angelina Jolie and Madonna; as poignant as a baby girl arriving on a plane from China; and as dramatic as a reunion between adoptees and their birth family* (Herman 2008:4).

But what is it about this theme that grips our attention? Brinich (1990) proposes that we could turn to psychoanalysis for an answer and asserts that the fantasy of adoption allows us to reclaim early images of our parents when we wish to discard the parents we now see. Such fantasies are an expression of every child's ambivalence towards their parents, allowing feelings of both love and hate. Brinich (1990) suggests that many people will openly admit that at some point in their youth, they believed or wished they were adopted whenever they felt

misunderstood by their parents. These fantasies could be described as the romance of adoption; however, as this study shows, the reality of the adoption experience for some of the triad members holds little romance.

In its early history, adoption was simply seen as a solution to a social problem and minimal attention was given to the impact it had on members of the adoption triad. The main body of adoption literature relating to relinquishment was written during the 1970s to 1990s, when relinquishment was still an occurring phenomenon, albeit a decreasing one (Figure Two). The nature of adoption has changed significantly since 1990, with most children since this date being adopted from the care system, and the literature on adoption reflected this change. The main themes featured in the adoption literature during the late 20th and early 21st century has focused on the needs of the adopted child and its integration into the adopted family. There is now, however, a body of academic work focused on the impact of adoption, including some major studies in the UK in the 21st century that focus on the impact as experienced by the relinquishing birth mothers (Triseliotis, Feast and Kyle, 2005; Sandhu, 2014). It should be noted, however, that none of these studies included face-to-face interviews with birth mothers, which therefore limits the impact of the research.

Additionally, Zamostny *et al.* (2003) state that the nature and scope of adoption research varies considerably, as a function of the professional concerns, research interest and social values inherent in adoption practice. They point out that outcomes in adoption research have largely addressed pragmatic questions and have not been based on theory, *'thereby limiting the empirical understanding of the psychological processes underlying adjustment to adoption'* (Zamostny *et al.*, 2003:666).

The traditional view of adoption is that it simultaneously meets the needs of all parties in the triad, and ideally their interests harmonise with each other for the benefit of all. But Keating (2008) suggests that as three distinct groups are being accounted for in this view, the potential for a conflict of interest exists. She believes

that this harmony is not possible and the interests of the relinquishing parent are usually the least considered of the three. Zamostny *et al.* (2003) also acknowledge the paucity of empirical research on birth parents, the often-invisible members of this triad. For some, this invisibility is their choice; for others, it is the artifact of the adoption system and its historical legal requirements of full relinquishment, secrecy and anonymity (Winkler *et al.*, 1988). Coleman and Garratt (2016) support this view and wonder why birth mothers' experiences are so private and of so little apparent interest and value to mainstream society, particularly when many of these women have unmet psychological needs arising from their decision to place their child for adoption.

### **2.3 Attachment and adoption**

Attachment is the strong emotional bond that develops between an infant and a caregiver, providing the infant with emotional security. Bowlby describes attachment as follows:

*To say of a child that he has an attachment to someone means that he is strongly disposed to seek proximity to, and contact with, a specific figure, and to do so in certain situations, notably when he is frightened, ill or tired. (1982:371)*

Although the tendency to form attachment relationships is innate and universal, Van den Dries *et al.* (2008) recognise that individual differences can occur in the quality of attachment. They elaborate by saying that attachment relationships can be classified as secure or insecure, based upon the strategies children use when they face stressful situations. Secure children seek contact with their attachment figure and are easily comforted, whereas insecure children show signs of avoidance or resistance.

The importance of the attachment bond is generally acknowledged in the literature. Bowlby (1998) sees the bond as the key to psychological security. The mother-infant attachment responses keep the child safe from threat and help regulate his emotional state, in the same way that the antibody-rich colostrum the mother provides keeps micro-organisms at bay. Similarly, Holmes (2001) believes that attachment theory takes as its starting point a comparable need for psychological security, and sees much psychological ill health as resulting from compromised safety systems: If the attachment bond is severed, sadness and depression result, if it is under threat, the result is anger and anxiety. If there is good self-esteem based on secure attachment, people can cope. But without a secure base, the threat remains. In fact, Bowlby (1973) believes that gnawing uncertainty about the accessibility and responsiveness of an attachment figure is a principal condition for the development of unstable personality:

*There is a strong case for believing that an unthinking confidence in the unfailing accessibility and support of attachment figures is the bedrock on which stable personality is built. (1973:366)*

Winnicott (1965) holds an even stronger position, asserting that there is no such thing as an infant, only a mother and infant together. The baby and the mother, although physically separated, are still psychologically one.

But what happens if this attachment is disrupted, if a child is separated from its mother and placed with adoptive parents, within moments, days, or weeks after it is born? Brodzinsky (1990) informs us that although adopted children constitute *'approximately 2% of the total population of children in the United States, they account for 4-5% of the children referred to outpatient mental health facilities'* (1990:3). Research on the symptomatology presented by these children indicated that adoptees are more likely than their non-adopted counterparts to display a variety of problems such as aggression, hyperactivity and low self-esteem (Brodzinsky, 1990). However, Brinich (1990) states that although adoptees may have more psychological problems than non-adopted children, there does not appear to



be *'any one-to- one relationship between adoption and particular psychiatric categories. Nonetheless, when they are referred for psychological help, adoption often seems to have played a significant part in the origins of their difficulties* (1990:420).

Many different perspectives have been offered for the adjustment problems of adopted children but Brodzinsky (1990) identifies a common thread amongst them – namely that adoption is experienced as stressful, and consequently results in a variety of coping efforts, some of which are successful while others are not. He links such struggles to the child's realisation that he is different, and that there is a flip side to his beloved adoption story - that in order to be chosen by his adoptive parents, he first had to be given away by his birth parents. While Fisher (2003) agrees that adopted children struggle with problems related to their relinquishment, he also attributes these problems to other key factors, including adverse prenatal experience such as exposure to drugs or alcohol, or the inheritance of genetic traits such as bipolar disorder or depression.

Some adoption professionals have come to appreciate the unique role played by loss in the psychological adjustment of children who were adopted as infants (Brinich, 1980; Nickman, 1985). There is, however, recognition that the impacts of relinquishment on an infant may be different than those of relinquishment of an older child for adoption. Nickman (1985) suggests that the loss associated with early adoption is covert and subtle, emerging slowly with time in conjunction with the child's growing awareness of the meaning and implication of having being adopted. He believes that this form of loss is less traumatic, and less likely to lead to psychopathology by itself, although it increases the child's vulnerability to other pathogenic experiences. On the other hand, Verrier (1993) strongly disagrees with the idea that differences occur as a result of the age of the adoptee and states that some clinicians working with adoptees recognise that the children essentially have the same issues regardless of the age of separation. Verrier (1993), who is a clinical psychologist and an adoptive parent, does not believe that it is possible to sever the tie with the biological mother and replace her with another primary caregiver, no

matter how caring she may be, without psychological consequences for the child and the mother. She believes that the child will attach with the caregiver, but the quality of that attachment may differ from that of the birth mother and bonding may be difficult, if not impossible. She differentiates between attachment and bonding and sees attachment as a kind of emotional dependence. Bonding, on the other hand, implies a profound connection that is experienced at all levels of human awareness and instils in the child a sense of well-being and wholeness necessary for healthy emotional development. Verrier asserts that a severing of this bond causes a *'primal or narcissistic wound, which affects the adoptees' sense of self and can lead to many emotional difficulties throughout life'* (1993:16).

Conversely, a study by Bakermans-Kranenburg *et al.* (2003) concludes that children who were adopted in the first months of their life usually develop normative attachment relationships. They state that although attachment theory maintains that children's healthy cognitive, social and emotional development needs depend on their attachment in infancy to a stable and permanent caregiver, this need not necessarily be the mother. However, the study concluded that children who are adopted after their first birthday are less capable of developing secure attachments. However, Haugaard (1998) describes a British study of people born in 1958, which found that the greater adjustment problems that adoptees had shown in adolescence had shrunk to insignificance by the time the adoptees had reached the age of 23. Fisher (2003) also notes that studies of adoptees after they have reached adulthood are more favourable than those of younger adoptees. However, he does point out that even if adoptees no longer show comparatively higher rates of problem behaviour when they reach adulthood, the fact that they were adopted is something that they have to confront anew at each stage in their life: for example, getting married, having a child, or losing adoptive parents. Correspondingly, Brodzinsky, Schecter and Marantz (1992) conclude that for the adoptee, the meaning of their adoption experience does not stay the same and can create fresh pain as the adoptee moves through his or her life.

It is clear from the literature that the severing of the mother-child bond can have a significant impact on the child. However, attachment theory does not consider the impact of the separation on the mother. Furthermore, most mothers who relinquish their children understand the impact of separation on their child and this realisation could contribute to the mother's emotional distress. Coleman and Garratt assert that the '*biological and psychological bond is not easily severed for what may be a majority of women and indeed may not be, in reality, severable*' (2016:156).

## 2.4 Whose child is it anyway?

Howe, Sawbridge and Hinings note that there is no word in the English language for a woman who surrenders her child for adoption. They suggest that this is unusual in the world of human relationships, which has a rich and evocative vocabulary – '*lovers and mistresses, lotharios and strumpets, putative fathers and stepmothers, single parents and orphans*' (Howe, Sawbridge and Hinings, 1992:2). They suggest that the absence of a name is symbolic of the woman who gives birth as no longer being needed.

*Instead, her silence is required. Once the baby has been surrendered, she has no role and therefore is left without a name. She is a mother with no baby, and that is no mother at all.* (Howe, Sawbridge and Hinings, 1992:2)

The terminology relating to birth mothers and to other members of the adoption triad has changed over the years and has included 'natural parent', 'biological parent', 'genetic parent' and 'real parent'. Rowe (1970) believes that such adjectives are clumsy and unsatisfactory, as they have implicit value judgments. For example, many adopters object to the wording *natural*, as it implies that they, the adoptive parents, are *unnatural*. Turski (2002) points out that the term 'natural mother' was also problematic for some, as it recognised that the sacred mother-child relationship extended past birth and even past surrender, indicating respect for the mother's 'true' relationship with her child. Andrews (2009) describes the term 'birth mothers'

as a contemporary construction, devised by adoption professionals to '*reduce a woman to a biological function*' (2009:1). Andrews believes that for the adoption myth to work effectively, birth mothers had to be perceived '*as uncaring non-mothers, their babies unwanted*' (2009:2). Otherwise, they could be viewed sympathetically, which could prevent potential adopters from engaging in the adoption process. Therefore, binaries of natural/unnatural, real/not real, abandonment/rescue continued to permeate adoption discourse. Over time, as the public perception of adoption changed, so too did the language used to talk about adoption. As in the case of other areas of social progress, the lexical changes came about '*largely through advocacy and public relations engineering*' (Jensen and Stvan, 2007:1). Advocates of adoption, wishing to avoid terms that marked out members of an adoptive family as different, advised that adoptees and adopters be referred to much as other parents and children are: that is, without making reference to adoption. At the same time, the mother who had given birth to the child came to be known as the 'birth mother', which to some reduces the mother's relationship with her child to that of simply giving birth. For this reason, of all the adoption terms in general use, 'birth mother' is the one most consistently and ardently challenged by those birth mothers opposing adoption, as it reduces a woman to a biological function (Jensen and Stvan, 2007). Despite this, the terms 'birth parent' and 'birth mother' have become accepted nomenclature for referring to the mother who gave birth to a child who was placed for adoption (Brodzinsky 1990). Swain (2011) asserts that the very need to label the different types of mothers involved in an adoption transaction serves to highlight the way practice differentiates from the true motherhood, which it claims to replicate.

## **2.5 Stigmatisation and adoption**

In Greek society, *Stizein* was a mark placed on slaves to identify their position in the social structure and to indicate that they were of less value than others. The modern derivative, stigma, is therefore understood to mean a social construction whereby a distinguishing mark of social disgrace is attached to others in order to identify and to

devalue them.

*Thus stigma, and the process of stigmatisation, consists of two fundamental elements, the recognition of the differentiating mark and the subsequent devaluation of the person. (Arboleda-Florez, 2002:25)*

In relation to adoption, Link and Phelan (2001) describe stigma as a social identity which is devalued in a particular social context. Weegar (1997) purports that there is a stigma attached to all members of the adoption triad: the birth mother who gives away her child, the child who is not being brought up by his or her real parents, and the adoptive family who are rearing a child who is not their own. He argues that social scientists studying adoption have neglected the impact of the social stigmatisation of adoption on members of the triad. He notes that the difficulties that adoptive parents face have often been attributed to psychological pathologies, such as their inability to resolve the humiliation of their infertility, when in fact, those difficulties may be caused by negative societal attitudes about adoption. Similarly, Zamostny (2003) states that researchers have generally failed to recognise the impact that the social stigmatisation of adoption has on the psychological adjustment of triad members. Friedlander (2003) concurs, contending that in western culture, where blood ties between people are extolled, adoption is considered to be second best. Birth parents, adopters and their children struggle for self-acceptance against stigma and marginalisation, despite the fact that adoption for the vast majority is a solution, rather than a problem. Coleman and Garrett (2016) support this view and state that adoption is generally perceived as non- normative and less preferable to biologically-based families and, as a result, all parties of the triad often bear the effects of being stigmatised, with the role of the birth mother being the most strongly stigmatised.

To understand how stigma came to be so closely associated with the birth mother in relation to adoption, it is necessary to look at how it developed in the 20th century. From colonial times until the 1930s, Brodzinsky (1990) asserts that society's view of

unplanned pregnancy and childbirth reflected puritan and religious philosophies, and *'mental retardation and genetic inheritance became customary ways of explaining illegitimacy'* (1990:296). Howe, Sawbridge and Hinings describe how, in the 1940s and 1950s, elaborate psychological models existed which sought to explain why some unmarried mothers had babies - the daughter was acting out her mother's promiscuous wishes, or the adolescent girl was testing her body's sexual potency. Her pregnancy therefore was a symptom of *'emotional disturbance'* (192:13). This thinking led to two assumptions by those involved in adoption practices:

*The first assumption was that as the baby was the product of an intrapsychic turmoil experienced by an emotionally disturbed woman, the child was not wanted for his or her own sake, and therefore it was unlikely to make the woman a good mother. The second assumption that followed closely was that the baby would be better off adopted. The mother who relinquished her child for adoption was mentally healthier than one who did not.*

(Howe, Sawbridge and Hinings, 1992:15)

Bernstein (1966) and Herzog (1966), however, put forward a different view and cautioned against putting too much emphasis on the psychological causes of pregnancy outside marriage by suggesting that a large share of the causation could be ascribed to chance, particularly among young girls getting pregnant for the first time. Pannor, Baran and Sorosky (1978) added to the debate by stating that the most likely explanation would be that children conceived outside of marriage are the result of neither a stork nor a desire for an out-of-wedlock child, but rather the result of sexual intercourse. However, the stigma of pregnancy outside marriage, regardless of why it occurred, still existed. Cohen (2013) asserts that among respected folk in the 20th century, illegitimacy was imagined as a heritable moral weakness, passed down through the blood like a tendency to drink or thievery. Sexual immorality in a parent predicted depravity in a child. Therefore adoption was designed to remove public evidence of illegitimacy for all members of the adoption triad.

This stigma prevailed during the 1960s to the 1980s, and impacted upon how the

unexpected pregnancies of unmarried mothers were dealt with during those decades. Premarital pregnancy was still excoriated and provoked issues around sex, morality, religion and authority, both parental and societal. If a young girl found herself pregnant, she would have had little choice but to tell her parents, as most would still have been living in the family home, with few other means of financial support. The focus of attention would immediately shift to the most expedient way to deal with the pregnancy before it became visible. A number of parents turned to their local parish for guidance, whilst some made use of social workers. Most parishes had listings for Mother and Baby Homes and the priest or vicar would recommend a home, normally of the same faith as the family but always geographically distant. In the UK, Mother and Baby Homes became prominent at the beginning of the 20th century and were created to provide support to unmarried pregnant women. These were an essential component of the UK system of dealing with unmarried mothers during this era and were often a vehicle in enshrining the secrecy surrounding adoption (Elliott, 2005). The majority of these homes were run by religious organisations: '*Church of England (58%), Roman Catholic (11.6%), Salvation Army (7.6 %), Methodist Church (3.5%) as well as other churches and religious organisations*' (Bell, 2013: n.p.). Local authorities, including health and welfare departments, ran the remaining homes. The homes were rarely purpose- built: instead, they were converted old-fashioned houses, which barely indicated their institutional function, frequently with dormitory accommodation and communal living areas for the residents.

These homes were pre-dated by residential institutions known as penitentiaries or reformatories, which aimed at reforming penitent prostitutes (Bell, 2013). Whilst the 20th century homes no longer followed the penitentiary model, they still retained much of the reputation of their forbears. These Mother and Baby homes arose from the Church of England Moral Welfare Council, which was founded in 1880 with the stated aim of '*the co-ordination of thought and action in relation to the place of sex, marriage and family in the Christian life*' (Jones, 2015:144).

The Moral Welfare Council was explicitly grounded in a religious world-view and

conducted religiously-inflected educational and social work, particularly amongst sex workers and single mothers, up until the 1960s. It was characterised by a particularly religious perspective on sexual welfare which '*emphasised traditional Christian virtues of chastity and valorised heterosexual marriages and families*' (Jones, 2015:147). Many of the institutions engaged in this work ended up becoming incorporated within the institutional structures of the Church of England. By the 1950s, the focus of moral welfare work had shifted from rescue work associated with the sex industry to work with single mothers. The people carrying out this work were mostly female, and carried the title of '*Moral Welfare Officers*' (Elliott, 2005:150). They worked for Mother and Baby Homes, providing assistance with pregnancy, birth, postnatal care, and the arrangement of adoption. Although the welfare state had existed in Britain since the 1940s, most of the work with unmarried mothers continued to be done by voluntary agencies, largely under the auspices of the churches. In 1970, the Moral Welfare Workers Association merged with six other organisations to form the British Association of Social Workers (Jones, 2015). Although social workers gradually replaced the moral welfare officers, it is not difficult to see how the influence of the church and its view on the chastity and sanctity of the family remained deeply embedded within the ethos of such organisations. Jones believes that moral welfare officers had a degree of critical awareness of their power over the women they supported, but viewed their own work and selves as having included '*theological values that transformed understanding of power relationships in moral welfare work*' (2015:151). It is easy to see, therefore, how their ability or desire to empathise with unmarried mothers, who had breached religious or moral codes, could be comprised. Ironically, this appears as a total contradiction to the basic tenets of most organised religions: compassion and forgiveness.

Unmarried pregnant girls entered these homes for many reasons - lack of alternative services, a fear of social ostracism that required their pregnancy to occur in secret, or at the insistence of their parents who feared being socially disgraced. The normal pattern was for the mother to go to the home before she became visibly pregnant, stay till the baby was adopted, and then resume life, ostensibly as normal. The



practice of the unmarried mothers wearing large duffle coats to hide their pregnancy, and wedding rings when entering the hospital to give birth, was commonplace, and added to the shame and secrecy experienced by birth mothers (Bell, 2013). Triseliotis, Feast and Kyle (2005) assert that the birth and surrender of the child was surrounded by a conspiracy of silence, both in the family home and in the Mother and Baby's home. Bell (2013) maintains that there appeared an almost complete ignorance about other existing services, which might have helped them to keep their child, such as fostering or financial support.

Elliott (2005) claims that practices in some religious based Mother and Baby Homes were distressingly unorthodox, if not illegal, and that there were enough stories of coercion, particularly of young mothers, to support this claim. The feelings of coercion might have been experienced from parents or professionals, or such feelings might have their origin in perceptions of violating cultural norms by having a child at a young age without a partner. A study by Deykin, Campbell and Patti, that was carried out with 334 relinquishing parents using questionnaires, supports this view and reports that *'69% of the respondents experienced pressure from families, doctors and social workers who were opposed to keeping a child'* (1984:273). Elliott believes that

*Unmarried mothers 'got it in the neck' from two powerful forces: religious moralists talking about sin and punishment, and psychologists talking in pathological terms about deviant and dysfunctional behaviour. (2005: 150).*

However, she also recognised that whilst for some, the homes were bleak and brutal, for others, they were a sanctuary.

A good example of how stigma remained attached to unmarried mothers until the late 20th century is the introduction of the Magdalene Asylums in Ireland. These asylums were set up from the late 18th century as reform homes for prostitutes, *'with the religious aim of constructive reform and training designed to enable women to return to their communities'* (Clough, 2014:11). As control of the homes was given

to the Catholic Church, they increasingly became a means of containing unmarried mothers and girls who had been raped or sexually abused (Clough, 2014). These institutions became known as the Magdalene Laundries and the young girls who were sent there were commonly known as 'Maggies'. These homes were in existence in Ireland until the late 20th century. The girls were expected to perform continuous penance for their sins, and *'to labour in the laundries without a wage to help provide income to the convents that housed them'* (Clough, 2014:11). Clough goes on to describe how in such homes, the girls were deprived of their freedom, their name (they were often referred to as numbers or given a religious name), their babies who were given up for adoption, and crucially, their identity. Clough believes that this behaviour testifies to the fact that the Catholic Church did not have reconciliation as its goal, but instead, the *'theological emphasis was on lifelong penance, a life spent atoning, with no hope of a restored relationship until death'* (2014:23). The shame and stigma attached to a stay in a Magdalene Laundry added to the shame already felt by these women.

From the 1970s onwards, moralistic social attitudes about unplanned pregnancy appeared to be declining (Brodzinsky, 1990). Deykin, Campbell and Patti (1984) suggest that this was rooted in the 1960s sexual revolution, an increasing social regard for women, increased financial benefits for single parents, a rise in the divorce rate making single-parent families more common, and the option of legalised abortion. By the late 20th century, it would have been reasonable to think that adoption would no longer carry as much of a stigma as it did in the earlier part of the century when all three members of the adoption triad – *the unwed mother, the bastard child, and the barren couple* (Brown, 1992, cited in Fisher 2003:351) – were often made to feel embarrassment and shame. But was this in fact the case? Weinreb and Murphy (1988) assert that in parts of America, sex is still partly considered in a Victorian manner, in that sex is disgusting, evil and strictly for procreation. Seen in this light, girls who find themselves pregnant outside marriage in such communities feel ashamed, because their pregnancy confirms their obvious sexuality, and whether they choose adoption or keep their child, their behaviour is judged immoral. Whilst this commentary focuses particularly on America rather than

the UK it is indicative of the lingering of traditional views and the perpetration of the stigma of illegitimacy within the Western world. The portrayal of birth mothers in literature and the media also adds to the stigma. Kline, Karel and Chatterjee (2006) posit that when stories about adoption were in the news, birth parents were less likely to be mentioned than any other triad member, but when they were mentioned, the portrayal was more likely to be negative than positive.

To summarise, March (2012) believes that the great majority of birth mothers who gave up a child under a closed adoption have been shamed and silenced for their illegitimate motherhood. Secrecy confounded this shaming process, by denying them social affirmation of birth as a significant life-altering event for themselves, and presented the loss of their child to adoption as self-inflicted and unworthy of being recognised socially.

*Nobody would ever guess  
I had no other choice  
Anyway it's best for her  
My name signed on a dotted line*

(Kay, 1991:17)

## **2.6 Motivation for relinquishment**

Relinquishment in the context of adoption suggests a voluntary 'giving up' of the child; however, O'Leary Wiley and Baden (2005) point out that the distinction between voluntary and involuntary relinquishment should be seen more accurately as a continuum, rather than a dichotomy. They state that this has not been addressed in the literature and has only been raised as an ethical issue in more recent adoption literature. Is a woman who disagrees with the decision to give up her child, but is disempowered and cannot speak, a relinquishing or non- relinquishing mother? It is important to remember, therefore, when looking at the literature on motivation for relinquishment, that authors may have different interpretations of the meaning of relinquishment.

A study conducted by Pannor, Baron and Sarosky in 1975 of interviews with 38 birth parents outlines a number of reasons mothers gave for relinquishing their child for adoption, with many attributing the decision to several reasons. These included: *Unmarried and wanting a child to have a family (68%); Unprepared for parenthood (26%); Influenced by parents (21%); Could not manage financially (18%); Pressurised by social worker, doctor or cleric (15%); Did not believe in abortion (8%); Never considered keeping the baby (8%); and Other (3%)* (1978: 331). This study reinforces the fact that fitting into society and wanting a traditional model of the family in which to raise a child was paramount in the decision-making process.

Similarly, a more recent study by Sandhu (2012) illustrates that the motivations of birth mothers to give up a child are complex. The study was based on adoption records and documents, and interviews with adoption agency professionals. The reasons have been broken down into four categories: moral reasons, circumstantial reasons, aspirational reasons and others. It covers two distinct periods of time: 1950-74, and 1975-2012.

**Figure 3**

Reasons for Relinquishment  
(Source: as cited in Sandhu 2012:173)

Reasons for relinquishment	Percentages of birth mothers stating as reasons for adoption	
	1950 - 74	1975 - 2012
<b>Moral reasons:</b>		
Mothers unmarried/no prospect of marriage	38	22
Breakdown of relationship/not wanting to be single parent	-	20
Extra-marital affair	22	-
Best interests of the child	12	60
Abandonment of child	-	2
<b>Circumstantial reasons:</b>		
Financial/housing/material/practical constraints	22	24
Father killed/cannot be found/not interested	20	6
Lack of parental support/parents do not know	42	10
Birth mother mental illness	2	4
Rape/incestuous relationship	2	4
Did not want more children	-	4
No ready/too young for responsibility of parenthood	6	43
<b>Aspirational reasons:</b>		
Continue education	4	2
Pursue a career	-	6
<b>Other:</b>		
Mother died at birth	2	-
No information	16	-

*In most cases, birth parents stated more than one motive for relinquishment. As a result, percentages were worked out based on the number of birth mothers stating that particular reason for adoption. (Sandhu, 2012:173)*

Figure 3 illustrates that the motivation for relinquishing a child for adoption are varied and have changed over time. What is significant from this data is that lack of parental support was shown in the period 1950-1974 as being the single highest factor in reasons for birth mothers relinquishing their child. However, it is worth noting that these findings are not based on the direct voice of the birth mother, but rather on what was reported to the agency or social worker. This is evident from the terminology used in the table: 'Best Interest of the Child', a term

commonly used by social workers when considering adoption issues but seldom used by birth mothers. Indeed, it may even have been based upon the assumption of the agency worker, in the absence of forthcoming information from the birth mother as to her true reasoning, which she might have felt unable to admit to. Many birth mothers during this era were at the receiving end of other people's strong and opinionated views about sex and pregnancy and therefore it is no wonder that they felt the full forces of social and moral stigmatisation. The coercion they experienced may not have been overt, or from a single source – but perhaps a more constructed coercion built on secrecy, shame and stigma. Howe, Sawbridge and Hinings (1992) remind us that the circumstances and reactions that give rise to a woman's experience of being a birth mother are manufactured by the people around her. To a large extent, what she thinks and feels about being a birth mother is socially constructed and not a natural feature of being an unmarried mother who places her child for adoption. They state that feelings of distress and of being at fault are soon followed by shame and guilt: in other words, the net result of so many moral strictures adds to the normal stresses and strains of any woman having a baby.

*The mother is acutely aware of how the world is viewing her and it is within this highly charged emotional arena that she works out the meaning of what she has done (become pregnant as an unmarried girl), what she must do (relinquish the baby; forget all about the unfortunate episode and make a fresh start), and what kind of woman she is (one who has had sex and a child outside marriage and who gives that child away. (Howe, Sawbridge and Hinings 1992:36)*

It may seem improbable to some today that a birth mother would think this way in the perceived liberated society that existed in the 1960s-1980s. But the stigmatisation of illegitimacy was so entrenched in the views of society, both in the parents of the birth mother and the practice of professionals, that the birth mother was rendered powerless: she had no voice. Many birth mothers have reported that at the time of the surrender, they felt a lack of agency, a stifling, or silencing of their voice (Samuels, 2006).

Keating (2008) suggests that although establishment attitudes to secrecy in relation to unwanted pregnancy changed from the 1950s onwards, the change in practice was probably less marked. The adoption societies were quite open about the need for secrecy and indeed it was part of the marketing strategy to attract potential adopters. It was a dominating doctrine among adoption professionals. Elliot (2005) acknowledges that many adoption specialists at the time were aware that if birth mothers had had more financial, housing and parental support, many would not have given up their babies. She states that they did their best and many were pragmatic about accepted practice and adapted it in a sympathetic way to suit the situation. Elliot (2005) also points out that Britain was in the economic doldrums following two world wars, the welfare state was in its infancy, and inflexible moral attitudes prescribed a very narrow range of choices for unmarried mothers. For many of these girls, adoption was upheld as the only option because of a lack of financial and other support. These factors, coupled with the stigma associated with illegitimacy and single parenthood, provided all the motivation necessary for relinquishment.

## **2.7 The impact of relinquishment**

*A man, a lawyer for the adoptive family, called. He told me which day they were coming to pick up the baby and about the papers I needed to sign. Yes, Sir. No, Sir. Whatever you say, Sir. I signed the papers. I still don't know what they said. It's impossible to read through eyes blinded by tears.*

(Anon. Cited in Weinreb and Murphy 1988: 26)

Clinical and empirical research relating to the experience of relinquishing birth parents has been undertaken within a wide variety of professional and academic disciplines and in a number of western countries (O'Leary Wiley and Baden 2005). However, in an Australian study, Higgins (2010) points out that there are very few research studies that explore the effects of past adoption practice, based on theoretical models. The main theories that have shaped understanding of the

impacts of relinquishment were devised by Winkler and van Keppel (1984) and detail the impact in terms of grief and loss, in comparison to other bereavement experiences, and as a stressful life event encompassing shame, lack of support, isolation and the separation from the child. O'Leary Wiley and Baden (2005) identified grief as the strongest emotion driving pathological behaviour and there is recognition within the existing literature that the grief experienced by birth mothers is a different kind of grief, some describing it as a disenfranchised grief. Doka (1989) suggests that disenfranchised grief might occur when the loss is not socially validated or recognized and the emotions associated with such grief are intensified and complicated. Aloi (2009) notes that the absence of recognition by nurses, hospital staff and society and a lack of general support have been identified as key factors in the disenfranchised grief experienced by the birth mother.

A study by Pannor, Baran, and Sorosky in 1975, mentioned earlier, explored the experience of relinquishment by interviewing 38 birth parents. This research explored varied relinquishment experiences, with the number of years since the interviewees had relinquished a child ranging from one year to thirty-three, with a median of nineteen. The authors of this study reported that *'50% continued to have feelings of loss, pain and mourning, with 82% stating that they wondered how their child was growing up'* (1978:332). Perhaps surprisingly, 30% expressed feelings of comfort about their decision despite everything noted in this research. However, without knowing the circumstances of their relinquishment, it is difficult to draw conclusions from this figure.

Furthermore, an influential study by Silverstein and Kaplan (1982) in America identifies that adoption triggers seven lifelong or core issues for all triad members. The specific experiences vary, but *there is a commonality of affective experiences, which persists throughout the individual's life* (Silverstein and Kaplan, 1982:1). They state that the presence of these issues does not indicate that the birth mother is pathological; rather, these are expected issues that evolve logically out of the nature of adoption.



**Figure 4**

**Core issues in adoption  
(Silverstein and Kaplan, 1982)**

<b>Loss</b>	<input type="checkbox"/> Ruminates about lost child <input type="checkbox"/> Initial loss merges with other life events <input type="checkbox"/> Leads to social isolation <input type="checkbox"/> Changes in body and self-image <input type="checkbox"/> Relationship losses
<b>Rejection</b>	<input type="checkbox"/> Rejects self as irresponsible and unworthy <input type="checkbox"/> Turns those feelings against self as deserving of rejection <input type="checkbox"/> Comes to expect and cause rejection
<b>Guilt/Shame</b>	<input type="checkbox"/> Party to guilty secret <input type="checkbox"/> Shame and guilt for placing child <input type="checkbox"/> Feelings of being judged by others <input type="checkbox"/> Not okay to keep child – not okay to place child
<b>Grief</b>	<input type="checkbox"/> Grief acceptable for only a short period <input type="checkbox"/> Grief may be delayed for 10-15 years <input type="checkbox"/> Lacks ritual for mourning <input type="checkbox"/> Sense of shame blocks grief work
<b>Identity</b>	<input type="checkbox"/> Child as part of identity goes on with knowledge <input type="checkbox"/> Diminished sense of self and self-worth <input type="checkbox"/> May interfere with future parental desires
<b>Intimacy and Relationships</b>	<input type="checkbox"/> Intimacy may equate with loss
<b>Controls and Gain</b>	<input type="checkbox"/> Relinquishment seen as an out-of-control, disjunctive event <input type="checkbox"/> Interrupts drive for self actualisation

A later study by Wells (1993) based on a survey of 262 birth mothers in the UK found some similar outcomes in relation to unresolved grief and an inability to make a fresh start. Almost all said that they had been adversely affected emotionally and psychically and that the effects were profound and long-lasting. Given the same circumstances today, most would decide against adoption because of the deep and long-lasting emotional effects. In accord with Wells' (1993) findings, some studies

demonstrate that mothers who had placed their child for adoption often experienced both short-term trauma and long-term anguish. A study by Edwards (1999) showed that the 56 women he interviewed over a three-year period consistently described the experience as the most difficult and significant thing they had ever had to do. Any material advantages of the adoption did not make up for the multiple trauma and losses of separation. De Simone (1996) found that higher levels of grief were associated with birth mothers' perception that they had been coerced by others into relinquishing their children, with further feelings of guilt and shame associated with the decision to relinquish.

An Australian study by Higgins (2010) showed that a number of common themes linked the mental well-being of birth mothers involved in relinquishment to the dominant social view and the subsequent treatment of single pregnant women, which include shame, silence, and blame. Robinson (2016) describes how many parents wrote bitterly about being parted from their illegitimate babies, about the awful impotency of not knowing whether their child was happy and about being ashamed and lacking the confidence to attempt contact.

*Almost all of the mothers mentioned the obduracy of social attitude in the past: how damaging maintaining an illusion of respectability could be, and how lives are corroded by secrets... 'In those days, you were inclined to do what you were told by your parents, even if that meant losing your child, their grandchild. Why didn't I stand up for myself, why did I acquiesce?' (Robinson 2016: 270)*

Some less common findings of the impact of relinquishment revolve around marital relationships and secondary infertility. Deykin, Campbell and Patti (1984) carried out a study by questionnaire of 339 women who had relinquished a child, and reported that '71% of the 280 women interviewed stated that their earlier birth experience had coloured their marital interaction' (1984: 276). They noted that this resulted in problems such as allegiance, commitment and jealousy. Regarding telling a romantic partner about the relinquishment, Henney *et al.* recognise that birth mothers are sometime reluctant to disclose that they have placed a child for adoption due to 'the

*social stigmatization of birth motherhood as a violation of the tenets of motherhood'* (2011:621). They carried out research with a group of birth mothers who had told a partner that they had placed a child for adoption. The reactions were '*generally positive (43.5%), neutral (41.1%), with some reporting that their partner's first reaction was negative (15.5%)*' (Henney *et al.* 2011:622). The conclusion of their study was that adoption introduces a complex interpersonal factor that may increase or decrease perceptions of support and intimacy.

Additionally, regarding subsequent fertility and based on the 308 responses received from birth mothers, Deykin, Campbell and Patti (1984) reported that '*64% had been successful in having at least one successive child. 14% had tried but been unable to have another child, and 17% had chosen to remain childless*' (1984:276). They state that this rate of secondary infertility is '*significantly higher at 14% than the 6% general population rate of secondary infertility among couples that had one child and desired another*' (1984:276); however, they acknowledged that it is not known what proportion of secondary infertility may be due to deficiencies in the partner and not the subject of the research. Furthermore, in a more recent study by Andrews (2010), which used questionnaires to gather the data, it was found that between '*13-20% of birth mothers do not go on to have other children*' (2010:81). For a few, this was a conscious decision; however, for the majority, there was no known reason for infertility. Andrews asserts that birth mothers who were later found to be infertile had two traumas to deal with – the trauma of relinquishment and infertility – and believes that the ability to heal following relinquishment is lessened if the mother experiences subsequent infertility.

Not all studies found negative results regarding the impact of relinquishment. In a study of birth mothers who had placed a child for adoption and a control group who decided to keep their child, Donnelly and Voydanoff (1996) found that both groups of birth mother were firmly convinced, two years after giving birth, that they had made the right decision. Friedlander (2003) also identified that not all feelings are negative and states that as well as the mother experiencing lifelong grief, regret, anger, guilt and shame, these feelings alternate with relief, pride and satisfaction at

having carried through a difficult choice. He argued that for the majority, adoption is the solution, not the problem. However, in both of these studies, it is not clear whether the decision to relinquish was voluntary and therefore it is difficult to draw any general conclusions. Fisher (2003) supports this view and states that adoptions have favourable outcomes for all members of the adoption triad. However, the literature overwhelmingly rejects this view in relation to birth mothers and instead acknowledges the significant negative impact of relinquishment on this member of the triad. As noted by O'Leary Wiley and Baden, *'No data was found in either the clinical or empirical literature on birth parents that suggest that birth parents cope well with their decision to relinquish'* (2005:30.)

The impact of the trauma of relinquishment is often noted to be long lasting, as illustrated by Fravel *et al.* (2000) in a study of 163 birth mothers in America, which used a somewhat different outcome measure to assess the psychological presence of the relinquished child within the minds of birth mothers. They found that the adopted child remained psychologically present for mothers, both in their daily lives and on special occasions. O'Leary Wiley and Baden view this finding as *'an empirical discrediting of the "happily ever after" myth in which birth mothers are supposed to forget their children and get on with their lives'* (2005:32).

The psychological presence of relinquished children subsequently leads to a noticeable number of women attempting to search for their child when they reach adulthood. The literature has been unanimous in its support for search and contact as a means of addressing needs long expressed by both birth parents and adopted people (Winkler and Van Keppel, 1988; Howe and Feast, 2001). Howe and Feast suggest that the subject of reunion is not only of practical interest to the parties to adoption but also taps into deeper themes to do with *'biology and upbringing, nature and nurture, identity and belonging, connectedness and family relationships'* (2001:351). On the other hand, it is acknowledged that many birth mothers choose not to search because they feel and believe that they have signed away their rights to do so (Triseliotis, Feast and Kyle 2005).

This is reinforced by Higgins (2010), who acknowledges that in attempting reunion, one of the main motivations for mothers is to know about their child’s welfare, but this is tempered with concern about how such an approach would be received. A study by Triseliotis, Feast and Kyle in 2005, using postal questionnaires with 93 birth mothers, identified the initial fears that were expressed by birth mothers and how many of them viewed their initial fears as their main fears.

**Figure 5**

**Fears on reunion**

***All and main* initial fears about contact expressed by birth mothers**

(Source: Triseliotis, Feast and Kyle, 2005:105)

	<b>All fears</b> %	<b>Main fears</b> %
Finding he/she has been unhappy	77	23
Not being liked	68	36
Being angry with mother	64	13
Making it difficult for the adoptive family	63	-
Not getting on	56	-
Overwhelmed by emotion	36	6
Making it difficult for the birth family	35	22
Not liking him/her	24	-
He/she might want more than I can offer	24	-

These findings demonstrate the complexities of the emotions experienced by the surrounding contact with a relinquished child. The popular media portrayals of contact and reunion on TV programmes such as *Long Lost Families* (2016) tend to focus on the initial joy of the reunion between mother and child and do not alert the viewers to the implications of such a reunion. Affleck and Steed (2001) suggest that such a reunion, while offering the freedom for birth parents and adoptees to find their lost family, also carries potential threats in that *‘it may lead to the unintended disclosure of secrets; consequently, the thought of reunion evokes a myriad of mixed emotions and is driven by a wide diversity of motivations’* (2001:38). They assert that many birth mothers perceive themselves as having been victimised by the societal

standards of the time and by the bureaucratic adoption system, which in turn gives them a determination to reclaim the right of reunion with their child. They cautioned that such reunion relationships where expectations and desires are expressed in terms of right are likely to be *'fraught with difficulty'*, as when rights such as these are being claimed, it is easy for the right of one to be experienced as a demand by the other *'with little room for negotiation'* (Affleck and Steed, 2001:42).

March (2014) notes that many birth mothers who do accept contact with their child describe a tremendous sense of relief from knowing about their child's situation. They also report feelings of fear: fear of losing contact once it has been established, fear of rejection from their child and fear of upsetting the adoptive parents. March (2014) also states that some of the birth mothers express a sense of betrayal by the adoption process if the adoption did not go well or if the child encountered abuse or neglect. Furthermore, all reported emotional pain from resurrecting memories of their past pregnancy and adoption experience (March 2014).

In Affleck and Steed's (2001) study of the expectations and experience of participants in ongoing adoption reunion, they identify that reunion relationships are fraught with difficulties for the following reasons:

*They are associated with a unique set of beliefs and experiences to which all parties bring their own set of expectations; there is little societal support for the existence of the relationship; The relationship is rooted in a situation that may have been tainted with a sense of stigma or shame; Some level of anxiety is likely to be experienced by extended family members; There is no ideal model of relationship for the participants to emulate.*  
(2001:47)

They concluded by saying that ongoing reunions are uncharted territory, but despite the difficulties, the desire for connection and a relationship between biological parents and children is often so great that these difficulties are ignored.

Additionally, within exploration of birth parents' experiences of relinquishment, those of birth fathers tend to be dismissed. Current literature suggests that birth fathers are less affected than birth mothers by the act of relinquishing their children (Novac *et al.*, 2006). Following a study of 30 birth fathers in Australia, Cicchini (1993) found that 66% had minimal or no say in the adoption decision, which may eliminate some of the guilt. Most remembered it as a distressing experience and only 17% reporting feeling positive about the experience. The most frequently cited reason for searching was to make sure that the child was doing well, which, in the highlighted literature, is similar to the motivation of birth mothers. A study conducted by Whitesel (2009) concurred, finding that birth fathers displayed comparatively different emotions when triggered by adoption than birth mothers. Birth fathers experienced high levels of anxiety but did not experience elevated levels of depression. Birth fathers reported that they felt relieved afterwards, knowing that they could offer their children better life conditions with families that were emotionally, financially and physically prepared for parenthood. However, O'Leary Wiley and Baden (2005) concludes that fathers did retain emotional and psychological feelings of responsibility for the child and challenged prevailing assumptions that birth fathers are irresponsible, uncaring and uninvolved. It must be noted, however, that these ideas about birth fathers are based on limited research.

## **2.8 Psychotherapy and the birth mother**

Literature from the 1960s and 1970s paints a damning picture of the emotional state of the unmarried pregnant woman. In fact, Hartley (1975) states that the array of generalisations about unmarried mothers would lead anyone to a state of depression, adding that '*some researchers needed several categories of labels to adequately diagnose such women*' (1975:75). Zamostny *et al.* (2003) state that early psychodynamic models viewed the unwed mother as using her pregnancy to regressively act out unconscious unmet needs towards her own mother. On the

other hand, early family system theory was used to describe the unplanned pregnancy as a statement of ambivalent feelings and powerlessness in the family.

Cattell's (1954:340) study of 54 unwed pregnant women awaiting delivery in a New York Hospital found that '30 were classified as having character disorders, 17 were people diagnosed with schizophrenia and the remainder as having neurotic reactions. Hartley (1975) makes the point that as none of the mothers was found to be normal and pregnant simply as an unintended consequence of sexual intercourse, 'all of the diagnostic studies must be seriously questioned' (1975:71). An earlier American study by Strand and Larson (1960) articulates that social workers regarded counselling as an essential requirement for all unmarried mothers, as they believed that illegitimate pregnancy was a symptom of personality disorder and that success in dealing with it depended on the diagnosis and treatment of the basic emotional problems of the mother. The views of unmarried mothers by professionals in psychology have not changed much in the subsequent decade. In 1979, a study by Straker and Altman concluded that:

*The implication of the present study is that un-wed pregnancy, regardless of whether or not the mother keeps the baby, is symptomatic of deep-seated unmet needs, and, as such, represents a rather severe form of pathology. Intensive ongoing counselling, rather than short-term intervention is therefore indicated. (1979:57)*

Many authors have stressed that therapy can be of value to birth parents before and after relinquishment (O'Leary Wiley and Baden, 2005). Throughout the literature, different theoretical models have offered varied clinical interpretations of the issues faced by birth mothers and the support they need (O'Leary Wiley, Baden, 2005). Deykin, Campbell and Patti (1984) acknowledged that the needs of birth mothers should be considered more fully at the time of adoption and the subsequent signing of the adoption papers. Specifically, they recommended that adoption workers should facilitate, rather than discourage, the mourning of the surrendered child. They state that since grief over a surrendered child appears to remain undimmed with time, present knowledge of the dynamics of mourning might only partially



apply to the birth mother's situation. A study by Condon (1986) identified four unique psychological aspects of the experience of birth mothers who place their child for adoption: 1) the feeling of being coerced; 2) the possibility of a reunion leaving no sense of finality; 3) lack of knowledge leading to disturbing fantasies about the child; and 4) information from the authorities about their child being blocked.

However, there is little written in the literature about the frequency and nature of the therapy provided to birth mothers during or after the experience of relinquishment. The majority of those sampled in a study by Condon (1986) stated that they had received little help from family, friends or professionals and that more than half used alcohol or sedative medication to cope after placing their child for adoption. Weinreb and Konstam (1999) reported that seven out of eight birth mothers they interviewed were dissatisfied and disappointed with the services provided by helping professionals: *'four of the eight women said that the mental health practitioner had not provided validation of their feelings, had not recognised that the crisis was of immense proportions and had not helped them examine themselves and their decision'* (1999:322). Additionally, O'Leary Wiley and Baden (2005) state that clinicians report that the birth mothers they meet in therapy alternate between denial of the relinquishment of their child and feelings of continuing shame, depression and negative self-image: many felt that they carried a serious secret and that they were unacceptable and unlovable. March (2014) supports this view and recognises that birth mothers who experienced secrecy and silence as part of the adoption process require particular attention. They assert that *'many of these women lacked emotional support and suffer considerable stigmatisation during one of the most significant events of their life – the birth and loss of a child'* (2014:417). Weinreb and Murphy (1988) believe that *'in order to grieve, the client needs to remove this shroud of denial and secrecy concerning the birth and surrender. Often this occurs for the first time within the safety of a caring therapeutic relationship in which the client is encouraged to talk about her experience'* (1988:34). But they point out that the therapist-client relationship often contributes to the reproduction of societal beliefs and expectations about

motherhood and women's sexuality, and state that it is imperative that the therapist recognises his or her own prejudices before engaging in therapy with a birth mother. It is only through a mutually affirming relationship, rather than labelling her behaviours as narcissistic or masochistic, *'that the birth mother may come to see her decision as the caring act that it was often meant to be'* (Weinreb and Murphy, 1988:34). Zamostny *et al.* (2003) believe that lack of attention to adoption issues in the training and practice of psychologists limits the ability to meet the mental health needs of members of the adoption triad.

However, public and professional approaches to adoption are changing. Adoption was included for the first time at the world conference in Holland of the International Society for Traumatic Stress Studies in 1992. This demonstrated that serious attention was being given to the traumatic separation of the loss of the mother and child relationship through adoption (Wells, 1993). Wells (1993:30) also asserts that *'many of the symptoms of Post-Traumatic Stress Disorder (PTSD) in long-term sufferers could be applied to birth mothers'*. Many birth mothers say they cut themselves off from their trauma as a coping mechanism. This avoidance as a strategy is one of the key symptoms of PTSD, which may be caused by the trauma being internalised to avoid pain (Allinson, 1991).

The distress associated with the loss may also cause psychogenic amnesia (Wells, 1993). Many birth mothers have verified this, saying that they are unable to recall important events associated with the birth or adoption. However, Connor and Higgins (2008:297) express some caution, and state that although social science researchers have used a trauma framework to understand the impact of similar phenomena, such as the effects of child maltreatment, *'it has not been explicitly posited or tested empirically in relation to mothers affected by past adoption practices'*. Friedlander (2003) points out that because the psychological experiences of members of the adoption triad are as diverse as those of people from any other cultural group, practitioners must understand that adoption is not a *'diagnostic formula for traumatic loss any more than being female is a formula for passivity'* (2003:745). Therefore, the competent therapist, faced with knowledge of a client's

adoption history, should keep an open mind about the meaning of this event in a person's life. Friedlander continues by stating that well-meaning but naïve therapists can:

*unwittingly damage their clients by promulgating the same myths and stereotypes about adoption that abound in popular culture, for example by assuming that the loss of a birth family is universally experienced as tragic or that reunions are essential to psychological wholeness.*  
(Friedlander 2003:747)

Mothers in the 21st century whose children are taken into care and are subsequently adopted share some of the emotional experiences identified in the literature on relinquishing mothers. A study by Smeeton and Boxall (2011) relating to non-relinquishing birth parents' experiences of adoption proceedings where the children had been taken into care found several themes consistent with the literature on relinquishing parents. These findings are supported by Memarnia's (2014) study on seven non-relinquishing birth mothers whose children had been removed from their custody and either fostered or adopted. The most notable of these themes is '*the trauma of saying goodbye to their child, feelings of isolation, and a lack of support*' (Smeeton and Boxall, 2011: 449-450). Other themes included '*a disconnection from emotion; experiencing disenfranchised grief; and feelings of being marginalised*' (Memarnia, 2014:63). A common theme from her study was the lack of support and a sense from the birth mothers that they were left alone to cope with their loss. This study highlights the need for clinicians to '*recognize, understand and respond to the complex needs of the birth mother*' (Memarnia, 2014:88).

There is a growing awareness today, partly driven by popular culture and social media, of the impact of relinquishment on birth mothers and the recognition of usefulness of therapy to these women. This was evidenced by the fact that both the Australian (BBC, 2013) and Irish Governments (Kenny, 2013), following their apology to birth mothers, set aside considerable sums of money to provide therapeutic support to those impacted by the experiences of relinquishment. Coleman and Garratt believe that:

*professional recognition of the complexity of the adoption decision, and awareness that the birth mother's abilities to achieve comfort, requires integration and re-integration of the experience into one's personal identity throughout life, are vital to developing adoption protocols that honour and respect birth mothers. (2016:142)*

## **2.9 Summary of findings**

When reviewing the extant literature on the motivation and impact of relinquishment, it is noticeable that the findings from the earlier studies in the 1960s-1980s have much in common with the findings of later studies from the 1990s onwards. In relation to the motivation for relinquishment, one of the most common reason identified was 'being unmarried', which demonstrates the importance attributed to complying with social norms and the stigma attached to non-compliance. Secondary reasons that were heavily noted in the literature included pressure from parents and professionals and lack of financial support. This pressure in some cases significantly affected how the birth mothers felt about the voluntariness of their decision.

In terms of the impact of relinquishment, the picture that emerges from the literature is one of long-term pain for birth mothers. The recurring themes of shame, loss, guilt, coercion and a desire for reunion are present in most of the studies. The literature is consistent in acknowledging the social attitudes of the time as the reason for the treatment that single mothers receive. The birth mothers' feelings of loss and grief, anger and despair were shaped by a climate of censure and punishment (Howe, Sawbridge, and Hinings, 1992): not only have they lost a baby, but also a place in society. The literature also found that higher levels of grief were associated with the birth mother's perception that others had coerced her into relinquishing her child. Other impacts were identified, such as secondary infertility, difficulties in intimacy, and an interruption to the drive for self-actualisation. One study, carried out 12-20 years after relinquishment, illustrated that 46% of women were still experiencing feelings of sadness, anger and grief. In terms of psychological impact, a recurring theme is the lack of acknowledgement of the experience and

subsequently the lack of emotional support available, commonly resulting in depression. The experience, on occasions, caused some of the birth mothers to view themselves as morally or psychologically flawed. Significantly, there was recognition in the literature that the relinquished child was always psychologically present. The review identified the complexities of reunion and recognised that despite these complexities, the drive for the mother to find out about her child's welfare is so visceral and potent that the dangers are ignored in favour of the possibility of being reunited.

March (2014:410) acknowledges that many birth mothers' biographies suffer from '*retrospection, subjective analysis and lack of measurement standardization*'; however, she states that the close similarity of material in both biographies and research studies, especially in the description of the long-term psychological impact of secrecy and shame for birth mothers, is '*compelling*'. Additionally, March (2014) points out that both types of narrative match the clinical experiences of practitioners working in the field of adoption and tells us to pay attention to

*The feelings of humiliation and despair for birth mothers created by incidents of birth mother shaming from authority figures such as parents, teachers, religious figures, social workers and medical staff, and the impact such occurrences had in blocking her ability to grieve in a socially accepted manner (2014:410)*

Nonetheless, she reminds us that the dysfunctional impact of post-surrender for birth mothers may be overestimated, as anxiety, depression, and internalised anger are also symptomatic of other life crisis events such as separation, divorce job loss, or death of a loved one.

## **2.10 The current study**

This chapter has reviewed the existing literature on voluntary relinquishment, and in doing so, has provided a backdrop to the current study. The literature is consistent as to the psychological factors that relinquishing birth mothers experience and the

need for support for birth mothers. However, there is a notable gap as to the nature of such support. This study seeks to expand on the findings in the existing literature and specifically seeks to understand whether the impact of relinquishment, some forty years after the event, is consistent with previous findings carried out at shorter periods after relinquishment, or whether new themes have emerged. In doing so, it will provide an up-to-date exploration of the experiences of relinquishment, which in turn will inform the training and ongoing development of practitioners working with this client group. The review of the literature has been helpful in shaping the research design, as it provides a solid foundation to facilitate the development of the questionnaire. It has also served to highlight an existing gap in terms of how to deal with the psychological impact of relinquishment in the clinical treatment of birth mothers. The next chapter will explore in great detail the methodological approaches taken within the study.

## **3. Methodology**

### **3.1 Introduction**

This chapter will describe the various stages involved in the research methodology, including interview design, participant recruitment and data collection. It will also outline the ethical considerations that were prioritised throughout and explore how validity and reliability were applied to the research. It concludes with a reflexive statement describing the impact as experienced by myself as the researcher during this stage of the research process. Due to the reflexive element of this research, it is important to first examine my epistemological and philosophical perspective to highlight how this impacted upon the research process and to explain the rationale behind the research methodology.

### **3.2 Theoretical framework**

All research is anchored to basic beliefs about how the world exists, which in turn informs our view of what constitutes valid knowledge (Etherington, 2004). This required me to have not only a clear understanding of the creation of knowledge, but also an understanding of my values and beliefs in relation to this knowledge. As a psychotherapist and a researcher, I acknowledge that my discussions about the creation of knowledge are not likely to be as scholarly as that of a philosopher; nonetheless, I realised the importance of understanding how my view of the world has framed the research process from design through to dissemination.

This chapter will focus on two types of epistemology – objectivist and constructive – and also look at differing ontological positions. Epistemology is described by Hamlyn as dealing '*with the nature of knowledge, its possibility, scope and general basis*' (1995:242). The first, objectivist epistemology, holds that all meaning, including

meaningful reality, exists independently from human consciousness; therefore, *'a tree in a forest is a tree, regardless of whether anyone is aware of its existence or not. When human beings recognise it as a tree, they are simply discovering a reality that has been lying there in wait for them all along'* (Crotty, 1998: 8).

On the other hand, constructivist epistemology discards objectivism and dictates instead that the tree in the forest has actually been construed as a tree by humans and indeed may have different connotations in different cultures. Crotty (1998) therefore asserts that *'truth, or meaning, comes into existence in and out of our engagement with the realities of the world'* (1998:8). I identify with Crotty's view, and for the purpose of this research, I will engage with a constructionist perspective and hold the belief that truth happens as a result of our engagement with our world.

Whilst epistemology asks us 'how can we know?', ontology asks us 'what is there to know?' Willig (2001) discusses the different approaches to ontology, and describes a realist ontological position as one that sees the world as being made up of structures and objects that have a cause-effect relationship with one another. However, Willig states that a relativist ontological position rejects this view, and maintains that the world is not the orderly, law-bound place that realists believe it to be: *'relativist ontology questions the out-there-ness of the world and emphasizes the diversity of interpretations that can be applied to it'* (Willig, 2001:13). I am drawn to the relativist ontological position, as it resonates with my own understanding of truth, in that we construct reality within the social context of our lives and that meaning is influenced by our social and cultural context.

In order to ensure that I fully understood and grasped the relevance of my position as the researcher, I considered my stance on the theory of modernism. Parahoo (2006) describes modernism as:

*A set of ideas that emerged during the 18th century as a reaction to earlier supernatural and metaphysical belief systems, rational thinking began to take hold and people put their faith in the ability of science*



*to improve their life. The aim was to produce theories that would explain everything in the world. (2006:44)*

However, by the end of the 1950s, some of these ideas were challenged by intellectuals and a new movement called postmodernism was born. This movement rejected the notion of truth or reality as objective, and supported the view that *'knowledge is socially constructed or co-created'* (Parahoo, 2006:44). Ashworth (2007) states that postmodernity can be viewed as a cultural movement for which such strong criteria of validity no longer exist, as *'the connection between reality and human construction has been dismissed'* (2007:22). Again, this fitted with my view of the world, and this postmodern approach aligned itself well with my understanding of constructionist epistemology. Therefore I approached and designed this research through my perspective, which sees truth and knowledge as something that is constructed through our engagement with the world around us.

When considering how to carry out my research, my primary concern was to choose a methodology that was fit for purpose. Quantitative research methods are broadly based on the philosophy of positivism, which views the world as definable in terms of certain laws which are open to observation. In contrast, qualitative research methods arise from a different philosophical tradition of interpretivism, which looks for meaning behind social action (Shakespeare, Atkinson and French, 1993). Ashworth (2008) believes that a concentration on human experience as the central topic of psychology or a focus on construction or interpretation seems to lead almost inevitably to qualitative research. Subsequently, as my research question aimed to place special emphasis on birth mothers' experiences of relinquishing a child for adoption, and was not primarily concerned with explaining the cause of events, I considered a qualitative research methodology to be most appropriate.

Denscombe describes qualitative research *'as an umbrella term that covers a variety of styles with a common element, a concern with meanings and the way people understand things'* (2003:267). The logic informing qualitative research is often inductive, in that the task is to describe and understand before developing a more

general theory. This was relevant to my research, as I did not know what I was going to uncover and this brought a dynamic element to the research, which I found challenging and exciting. As a therapist whose work explores unique human experiences, I wanted to embrace this concept in my research. Grimmer and Tribe (2001) assert that this type of approach is similar to the practice of counselling, as it focuses on subjectivity and places emphasis on achieving understanding rather than being a demonstration of truth. This is supported by McLeod (2001), who believes that carrying out qualitative research is highly concordant with the activity of doing therapy, making new meanings, and gaining insight and understanding.

### **3.3 Phenomenology**

Having identified that I wished to pursue an understanding of experiences or ideas that are socially constructed rather than pursuing a positivist objective type of knowledge, I next sought out a philosophy that fitted my research. I was drawn to phenomenology, as I was influenced by the theories of Husserl, Heidegger, Merleau-Ponty and Finlay. Phenomenology as a research approach has its roots in philosophy and was conceived by the German philosopher Husserl at the beginning of the 20th century to investigate consciousness as experienced by the subject (Baker, Wuest and Stern, 1992). Phenomenological research aims to understand everyday life situations, as they are experienced and lived by subjects. Rather than attempting to reduce a phenomenon to a convenient number of identifiable variables, it strives to remain as faithful as possible to the phenomenon and to the context in which it appears in the world (Giorgi and Giorgi, 2008). Applied to research, quite simply, phenomenology is the study of phenomena: their nature and how they are experienced. However, there is nothing simplistic about phenomenology, as it demands that researchers suspend their presuppositions and '*go beyond the natural attitude of taken-for-granted understanding*' (Finlay, 2008:2). Husserlian phenomenology demands that our preconceptions are put aside and bracketed so that the true phenomenon can be revealed. In contrast to Husserl's view, a number of philosophers, including Heidegger, Gadamer and Merleau-Ponty, suggest that we

cannot escape our history and our own personal view of the world, and raise instead the possibility of exploiting our own horizons of experience and understanding (Finlay, 2008).

Additionally, Lester (1999) recognises that epistemologically, phenomenological approaches are based in a '*paradigm of personal knowledge and subjectivity and emphasise the importance of personal perspectives and interpretation*' (1999:1). I believe that a phenomenological approach is a powerful methodology for understanding subjective experience, and whilst I wish to be aware of my preconceptions, I believe that they could be explored and integrated into the research through the use of reflexivity. Therefore, it felt appropriate to use this approach to my study because of its perceived capacity to authentically process the subjective experiences of a small sample group, such as the one I would be researching. The approach facilitated my research aims of seeking to discover how mothers who relinquished their child for adoption experienced the phenomenon.

### **3.4 Interpretative Phenomenological Analysis**

Phenomenological researchers face a rich diversity of empirical approaches from which to choose, with different approaches required according to the type of phenomenon under investigation and the kind of knowledge that the researcher seeks (Finlay, 2008). I explored several research approaches, with special consideration given to heuristic, narrative, and interpretative phenomenological analysis (IPA). I first considered a heuristic approach, which is an adaptation of phenomenological enquiry that explicitly acknowledges the involvement of the researcher to the extent that the lived experience of the researcher becomes the main focus of the research (Hiles, 2002). Whilst I wanted my experience to be part of the study, I did not wish it to be the main focus, as my research aim was to know about the experience of others and I was concerned that an over-focus on my own experience would increase the chance of bias. Narrative inquiry, on the other hand, might well have suited this study, as it seeks to capture the individual's experience

and the context in which they experienced it. However, Marshall and Rossman (2010) point out that narrative inquiry is criticised for its focus on the individual rather than on the social context. As this study is focused not just on experience, but also on how society plays a part in birth mothers' decisions to have their child adopted, this approach seemed too restrictive and might have prevented the exploration of wider issues. Consequently, both of these methodologies were rejected in favour of IPA, which aligned itself well to my research question.

Interpretative phenomenological analysis is concerned with the detailed examination of human lived experiences and particularly focuses on the meaning that those experiences hold for the participants (Smith, Flowers and Larkin, 2009). Denscombe believes that IPA, in its efforts to base its inquiry on the lived experience of people in the everyday world, '*represents a style of research that is far removed from any high minded abstract theorising and allows the researcher to be close to the objects of study*' (2003:106). Additionally, it offers a structured, bounded and rigorous approach to analysis, which is not present in other methodologies. As well as containing a phenomenological component, IPA is underpinned by a theory of interpretation known as hermeneutics. Heidegger was a student of Husserl, but he did not believe that describing the experience of individuals was enough (Parahoo, 2006). In contrast to Husserl (1964), who focuses on the experience itself, Heidegger focuses on the experience of understanding. Thus, for Heidegger (1962), phenomenology is concerned in part with '*examining something which may be latent, or disguised as it emerges into the light*' (Smith, Flowers and Larkin, 2009:24). IPA therefore is a qualitative method:

*which synthesises the phenomenological philosophy of Husserl (1964) with the phenomenological and hermeneutic philosophies of Heidegger (1962) and Gadamer (1976) and recognizes the historicity and situatedness of human existence. (Broadbent, 2013:264)*

IPA recognizes that in trying to gain access to the participant's personal world, access is dependent on the researcher's own conceptions, which are required to make

sense of the other world through a process of interpretative activity. Subsequently, IPA combines a two-stage interpretation – both researcher and participant are interpreting. This is recognised by Smith, Flowers and Larkin (2009), who stress that in attempting to get as close as possible to the personal experience of the participants, it '*inevitably becomes an interpretative endeavour for both participant and researcher* (2009:37). Fade (2004) supports this view and describes IPA as follows:

*IPA is phenomenological in that it seeks an insider perspective on the lived experience of individuals, and interpretative in that it acknowledges the researcher's personal beliefs and standpoints and embraces the view that understanding requires interpretation.*  
(2004:648)

Fade believes that the researchers' beliefs are not seen as biases to be eliminated but rather as being necessary for making sense of the experience of other individuals. Ashworth (2008) identifies that IPA combines an empathic interpretation when questioning participants with the aim of '*faithful disclosure*' (2007:18), with a more critical interpretation when questioning the data collected, aiming to discover a further reality behind the *thing* being analysed.

IPA is inductive – it does not work with a preconceived hypothesis but aims to understand the way in which participants experience a particular phenomenon. As I wished to understand the individual experience of each birth mother, a phenomenon I also have personally experienced, I felt IPA to be the methodology of choice, as it enables me to highlight and engage with the centrality and meaning of each participant's subjective experience of relinquishing her child. I also felt that the importance of the detailed narrative portrayal in IPA and the interpretative analysis of themes would be appropriate in reflecting the participant's unique and individual experience. IPA's status as a new and developing approach allowed me freedom and creativity, and although it offered a structured approach to data analysis, it also exercises a healthy flexibility in its approach to the task (Smith, Flowers and Larkin,

2009). Unlike most of traditional psychology, IPA offers the researcher an opportunity to engage with a research question at an idiographic level. The participant's lived experience is coupled with a '*subjective and reflective process of interpretation in which the analyst explicitly enters into the research process*' (Reid, Flowers and Larkin, 2005:20). As a methodology, Elliott, Fischer and Rennie (1999) believe that IPA contains many of the principles of good practice that add to the production of good qualitative research. Additionally, it is congruent with my approach to therapeutic work, which is to understand the client from his or her own experience.

### **3.5 Research method**

Writing in 2007, Smith and Osborn describes IPA as being a dynamic process with an active role for the researcher, since its purpose is to explore in detail how participants make sense of their experiences, and '*therefore a flexible data collection instrument is required*' (2007:53). Subsequently, I decided to use semi-structured interviews, as this methodology allows both the researcher and participants to engage in a dialogue where questions can be modified during the process, making it adaptable as new information emerges and allowing areas of interest to be explored further if necessary. Semi-structured interviews follow from the phenomenological position as described by Smith, Harre and Langenhove (1995:12):

*The investigator has an idea of the area of interest and some questions to pursue. There is a wish to enter the psychological and social world of the respondent. Therefore, the respondent shares more closely in the direction the interview takes and can introduce an issue the investigator has not thought of. In this relationship, the respondents can be perceived as the expert on the subject and should be allowed maximum opportunity to tell his or her story.*

This method, I hoped, would enable the facilitation of rapport and empathy between me and the participants, thereby producing richer data. This style of interview is sometimes described as non-directive, but Willig (2001) stresses that it is important to acknowledge that *'it is the researcher whose research question drives the interview'* (2001:22). I recognised that a tension might exist for me in my desire to let the participants speak and acknowledge them as being the experiential expert on the topic, whilst trying to keep control of the interview. Smith and Osborn (2007) also recognise this tension and describe a disadvantage of IPA as *'reducing the control the investigator has over the situation, taking longer to carry out the research and having a harder task in data analysis'* (2007:59).

### **3.6 Evaluation of methodology**

The use of qualitative research for this study could be seen as a weakness because qualitative research collects data that is made up of different accounts of experience and events. Subsequently, an outcome is not given: it is constructed. This is in stark contrast to a quantitative study where data is logically and numerically structured. The importance attached to providing a detailed description of events can lead to accusations that they are nothing but descriptions, and some may even consider it mundane, as it deals with the trivial. However, the flexibility of a qualitative method allows the researcher into the personal, intimate and private world of participants and therefore has the ability to elicit rich data. Additionally, qualitative methodology can be perceived as subjective because of the role of the researcher in the interpretation - the researcher interprets what the participant is *saying*, rather than observing *what* she does (Morgan, 2010:45). However, Kvale (1996) believes that the deliberate use of a subjective perspective need not be a negative bias: *'rather the personal perspective of the subject and the interpreter can provide a distinct and sensitive understanding of the phenomena in question'* (1996:291).

Denscombe (2003) points out that there are several disadvantages to phenomenological research, including its emphasis on subjectivity, description and

interpretation in contrast with the scientific emphasis on objectivity, analysis and measurement. Furthermore, qualitative IPA research does not allow the researcher to identify generally applicable laws of cause and effect (Willig, 2008). The studies tend to work on small sample sizes, which means that they cannot generate insight about the dynamics of a particular claim. Instead, they are concerned with in-depth descriptions and explanations, rather than predictions. Whilst an IPA study allows us to enter the world of the participants, it does not allow the researcher to draw firm conclusions about why they experience it in that way. IPA studies do not seek to find one single answer or truth, but rather to provide a coherent and legitimate account that is attentive to the words of the participants (Pringle et al., 2011). Although IPA was the methodology of choice, I recognise that my methodology also could be viewed as including a narrative element, in that narrative research recognises that people use stories to make sense of their lives and to present their lives to others. Indeed Smith, Flowers and Larkin (2009) acknowledge that IPA analysis draws on ideas from discourse and narrative analysis. Any methodological approach incorporating a pluralistic stance can justify more multiple interests and therefore can be viewed in more general terms. However, IPA is coupled with a '*commitment to the experiential*' (Smith, Flower and Larkin, 2009: 99) and is typically looking for knowledge about the individual, rather than generalising. Patterns of similarities as well as the uniqueness of each individual's experience were demonstrated in this research through the use of themes and supporting narrative. Smith (2011:24) believes that this nuanced capturing of '*similarity and difference, convergence and divergence*' is the hallmark of good IPA work

An IPA study cannot test hypotheses or correlations, although Kvale (1996) believes that hypothesis testing is not a necessary criterion or goal for social research. He instead states that the nuanced description of the phenomena being studied has intrinsic value and contributes to the other strengths of qualitative research. There is an acknowledgment in IPA that any insight gained from analysis of a text is necessarily the product of interpretation. This means that the researcher is implicated in the analysis (Willig, 2008). This has inherent dangers in that it is subject to the personal



biases of the researcher and therefore requires a reflexive attitude from the researcher. Furthermore, my use of a reflexive journal, my engagement in bracketing interviews and my inclusion of reflexive statements within this thesis minimised these identified dangers.

### **3.7 Interview design**

Interview research may appear to some to be a simple and straightforward task, almost like a normal conversation. However, this simplicity is illusory and may result in lulling the researcher into a false sense of security (Denscombe, 2003). Consequently, Denscombe believes that interviews are fraught with hidden danger and need careful planning and preparation to prevent failure. As the aim of an IPA enquiry is to describe rather than explain, this was at the forefront of my mind when designing the questions. Coupled with this consideration was an acute awareness that due to the sensitivity of the topic, some of the participants might become distressed or emotional, and therefore careful planning was required (Rubin and Rubin, 1995). An interview schedule (Appendix A) was drawn up to facilitate a comfortable interaction with the participants and to allow the interview to flow freely. The interview questions were developed to contribute to the '*dynamic flow of the conversation*' (Kvale and Brinkmann, 2009:135-138). The number and style of questions was based on guidance for IPA studies (Smith and Osborn, 2007). The questions were deliberately open, with the purpose of allowing the participants to develop ideas and speak more widely on issues that hold meaning for them rather than issues that I, as the researcher, would think of as important. In designing the interview questions, the following approach was adopted:

- Questions were designed to be open and non-judgmental.
- Ethical issues were considered in advance to help identify any potential issues that might arise.
- Prompts were developed to assist the participants if needed.
- The research aims were revisited to ensure that the questions were relevant to the stated aims.

- Sensitive questions were left until later in the interview to ensure that the participant was more relaxed.
- The questions were asked in a chronological fashion to assist the flow of the story.

Following the review of the literature, I was interested in establishing during the research whether the participants' experiences of relinquishment mirrored the findings from the existing studies. The literature had been consistent in describing the impact of relinquishment on the birth mother. I wished to establish whether my study would elicit similar findings, and therefore my questions were informed and constructed using the prevalent understanding of the emotional impact of relinquishment, which were unearthed during the literature review. Specifically, I wished to establish whether the impact of relinquishment was still present despite the passage of time, and this was reflected in the design of the interview questions. As the objective of my research was to develop therapeutic guidance for practitioners working with this group, an open question on this topic was included, with the intention of gaining an understanding of what support the participants might need going forward.

A draft of my questions was sent to my supervisor and a critical friend for review. The feedback from both was similar: they found the questions '*somewhat blunt*' and of a clinical nature. This was an unintended consequence of an emotional reaction that I experienced when devising the questions, and is documented in my reflexive statement at the end of this chapter. I reviewed the questions, paying particular attention to the tone and the use of language. I redistributed the questionnaire and subsequently received positive feedback from both parties. I piloted the interview with an extended family member as the participant, as she had given up her child for adoption but did not wish to be included in my research. I sought feedback from her regarding the clarity, relevance and sensitivity of the questions: her response was positive but she felt that there were too many questions. She reported feeling stressed following completion of the interview but also talked about feeling a sense of empowerment. When I examined what specifically caused the stress, she stated that she could not remember some of the details about the circumstances surrounding the

birth and relinquishment of her child, and this caused her to feel ashamed. She wondered how it was possible that she could forget anything about such a traumatic experience. She also felt that she was letting me down by not remembering these details, as she knew it was important for my research. This highlighted to me that this could be a problem for many of the participants, as the events had taken place many years previously and their memories might have faded. I was also aware of the possibility that some might have blocked out aspects of the experience due to the nature of the trauma. Therefore, to avoid any additional stress for the participants caused by memory loss, I addressed this subject in my preamble before the recording of any interviews.

### **3.8 Recruitment of Participants**

This study used a sample size of seven, which fits with the recommended sample size of IPA research. IPA studies are conducted with small sample sizes, as this approach requires a commitment to a detailed interpretative account of each case, which realistically can only be done on small samples. Smith and Osborn describe this as '*sacrificing breadth for depth*' (2007:56), as the aim of an IPA study is to say something in detail about the perceptions and understandings of a particular group, rather than to prematurely make general claims. This methodology challenges the traditional linear relationship between the number of participants in a study and the value of research findings (Reid, Flower and Larkin, 2005). Furthermore, Smith and Osborn refer to this as an '*idiographic mode of enquiry*' because it has been derived from the examination of individual case studies (2008:56). To use phenomenological interviews effectively, Roulston (2010) states that it is essential to have identified participants who are both experienced and able to talk about the particular lived experience under examination. This was at the forefront of my mind when selecting candidates.

Because of the specificity of the subject, which required a particular type of participant, I decided to use purposeful sampling. Denscombe (2003) describes this as interviewees being selected with a specific purpose in mind, and that purpose '*reflects*

*the particular qualities of the people or events chosen and their relevance to the topic of investigation'* (2003:15). In order to reach a wide population of potential participants, I devised a website (Appendix B), which provided the details of my research and invited participants to take part as interviewees. The criterion for inclusion was that they had given up their child for adoption between 1960 and 1990 and had subsequently initiated contact with the adopted child. I specifically chose this era, as previously discussed, because it saw a peak in the number of UK adoptions, which subsequently declined in the following two decades (see Figure 2). Therefore, studying the period 1960-1990 would enable me to understand the nature and influence of social pressures on birth mothers to have their child adopted. Additionally, it would allow me to gain an understanding of how these pressures might have changed over the period in question. I disclosed on the website that I had given up my own child for adoption during this era.

As I had contact with a Local Authority through my work as a member of an adoption panel, I considered this to be a good source for recruitment of participants. I visited a team of social workers who worked in the area of adoption and also contacted various adoption organizations by email, forwarding details of my website. All were supportive but yielded no results. I had not anticipated this and quickly realised that I would have to broaden my search. Lee (1993) understands this difficulty and states that sampling becomes more difficult the more sensitive the topic under investigation, as potential participants will have more incentive to conceal their activities. Because of the difficulties encountered in finding participants, I change from my initial plan of purposeful sampling to a sampling method known as snowballing. This is a method where the sample emerges through a process of reference from one person to the next and is an effective sampling method '*when used as part of a small scale research process'* (Denscombe, 2003:16). A colleague of mine who knew about my research indicated that a friend of hers would be interested in talking to me, and following a lengthy email exchange, she agreed to be interviewed. She also put me in touch with a relative of hers who expressed an interest in my research, and who agreed to be interviewed also.

I placed an advertisement in *'Therapy Today'* which included a link to my website and received two responses from that source. I contacted an organisation called Natural Parents Network, which is a registered charity for natural parents who had lost their children to adoption. Following my contact, they agreed to put a link to my website on their front page. Within two hours of my advertisement appearing, eleven participants contacted me requesting to take part. I was overwhelmed, as many of these women included parts of their stories in their emails to me:

*I gave away my son in 1971; I was aged 14 at the time.*

*I was later diagnosed as having autism; I did not even know what part of my body my baby would come out from.*

*It was a concealed pregnancy – no one knew until a few hours before birth.*

*I later found out the child I had given away had been abused.*

Many also included words of encouragement about my research – *'Good luck, I hope this project can remove some of the pain, ongoing, for so many'*.

These responses moved me deeply whilst increasing my motivation to carry out the research. I had the website withdrawn on the same day, as I realised that I would now be faced with the difficult task of rejecting some participants who had had the courage to come forward. In selecting participants, I tried to minimise bias by ensuring that I had a geographical spread. I identified suitable participants from all countries within the United Kingdom and one who, although now living in the Irish Republic, had been brought up in the UK. Additionally, I looked for the widest year range possible between 1960 and 1990 to enable me to establish through my research whether there had been any change in attitudes towards illegitimacy during the specific decades. I wrote to the remaining participants who had put themselves forward to thank them for their interest.

Although I had set out to interview six women in total, one woman contacted me after I had turned her down, saying how disappointed she was at not being chosen and how much she needed to be heard. I agreed to interview her, as I believed I understood

how she felt. My final selection was therefore seven participants. I realised later how my own experience had influenced this decision, possibly in a good way, because it made me empathise with the women's desire to tell her story, but it also highlighted to me the danger of bias and made me more aware of how it could influence me. The women I had chosen were white UK citizens, ranging in age from 54 to 65. All of them had relinquished their child for adoption between 1960 and 1990. Five of the seven described themselves as Catholic at the time they became pregnant and five out of seven had attended a mother and baby home. All of the participants remained with their baby for a period after birth, ranging from five days to several weeks, and all had been reunited with their child, with one exception.

### **3.9 Bracketing**

As I had personal experience of the phenomenon being researched, it was imperative for me to fully explore my degree of subjectivity and unearth any assumptions prior to the research. This was important in order to understand how my assumptions could impact on the research, and to add rigour to the process by facilitating transparency in my position as researcher. Barber (2006:6) made the following point:

*I feel I cannot stress too strongly the need for you to describe the mental-set you are starting from, for changes to this will provide evidence of how the research field is impacting you.*

On a personal level, there were other considerations. Although I felt strong in terms of my ability to carry out the research from an emotional perspective, I felt I needed access to support, as I was aware that the cumulative effects of the emotion surrounding the interviews could become overwhelming for me. Drew (1989) argues that while it is the researchers' emotional investment that fires the inception of a study, emotion is a source of potential bias because it affects the perception and interpretation of data. Tufford and Newman (2010) acknowledge that preconceptions arriving at any stage may filter to other stages and thereby impact on the entire research process. Therefore, I needed to make sure my thoughts, feelings, experiences

and unconscious agenda would not intrude on my capacity to listen to the participants (Rolls and Relf, 2006). This, I believed, could be achieved through a series of reflexive bracketing interviews that would allow me access to my unconscious thoughts, which could shape my data and thereby prevent me from accurately describing my participants' experience.

The term 'reduction' or bracketing was first articulated by Husserl as a radical self-meditative process in which the philosopher puts aside the natural world and the world of interpretation in order to see the phenomenon in its essence (Finlay, 2008). The term has mathematical roots in that it refers to the idea of separating out certain contents of an equation into brackets, thus keeping it separate from the main body (Smith, Flowers and Larkin, 2009). This involves setting aside prior assumptions about the nature of the phenomenon being studied. Reflexive bracketing developed from phenomenological philosophy and represents a more modern development in qualitative research (Gearing, 2004). The researcher attempts to identify his or her internal suppositions, values and judgment, which allows him or her to reduce the influence of his or her own experience on the topic under investigation. However, Gearing states that:

*This form of bracketing acknowledges that a phenomenon can be investigated and understood from multiple perspectives. No single truth exists. Furthermore, it is improbable for a researcher to hold in abeyance their suppositions in investigation of any phenomenon. However, a researcher can acknowledge his or her suppositions and become consciously self-aware of the influence on the phenomenon under investigation (200:1445).*

Tufford and Newman assert that '*the evolving and amorphous nature of bracketing has given rise to a number of tensions*' (2010:81). These tensions include a lack of consensus as to when bracketing should occur, who should engage in it and how it should be conducted. Beech (1999), however, believes that regardless of any tension, in order to advance legitimacy as a research method, the researcher needs to be '*explicit about the process of bracketing so that others can observe and understand the rules of the game and the researcher can legitimately use the word*' (1999:44).

Ahern (1999) argues that the ability to put aside personal feelings and preconceptions is more a function of how reflexive one is rather than how objective one is because it is not possible for researchers to set aside things about which they are not aware. She believes that the process of bracketing is *'an iterative, reflexive journey that entails preparation, action, evaluation, and systematic feedback about the effectiveness of the process'* (Ahern, 1999:408).

Prior to carrying out my research, I approached a therapist colleague and explained to her what I was trying to achieve and my reasons for embarking on the process of bracketing. I explained to her that I was not looking for therapy, but rather for an opportunity to explore, in a loosely structured manner, any preconceptions that I held in relation to my research topic. I explained that the advantage of this process is that the researcher's energies are spent more productively in trying to understand the effects of his or her experiences, rather than engaging in futile attempts to eliminate them (Porter, 1993). Paradoxically, Heidegger (1962) recognises that these preconceptions actually enable identification of issues or situations because they enable researchers to be alert to themes in common with the broader human experience. My colleague agreed to engage in this process and we arranged to carry out two interviews: the first at the beginning of the research and the second on completion of the research. Each interview would last an hour and I agreed to come prepared in terms of what I had identified as possible preconceptions. We agreed to record and transcribe the interviews on the understanding that I would use them to enhance the rigour of my data analysis.

I prepared myself for the initial bracketing interview by noting down what assumptions I might hold, what concerns I had about the forthcoming research, and most importantly what might trigger my own distress. My colleague allowed me the space to articulate my views and questioned me further where appropriate to try and draw out any personal perceptions or biases. We identified that a tension existed between the many parts of me that would be present at the interview: researcher, therapist, and birth mother. Although recognising that I would not be working as a therapist during the interview process, I worried about how I could possibly leave this



role aside, particularly due to the sensitive nature of the topic. As a therapist, I have learnt to contain my emotion when a client becomes distressed, but I was worried about whether I could do the same under such unique circumstances. We spent some time talking about what particular triggers might create the most emotion for me: this was useful, as it brought these triggers into the forefront of my consciousness and allowed me to better prepare for the interviews. I identified some of these emotions that I had experienced, such as shame and loss, which I thought might be similar for everyone, and this process alerted me to the potential for bias when analysing the interviews. The most significant outcome from this process was the realisation that the narratives I would hear were likely to have similarities to my own story, but that this did not mean that the emotions experienced by the participants would be the same as mine.

The final bracketing interview felt less emotional, as there was no longer a fear of the unknown. It provided me with a very useful space to explore my feelings in relation to what I had experienced during the interviews and how it had impacted on me. It allowed me to check any assumptions that I had identified in the earlier interviews and to fully acknowledge that my experience had been of use in the service of the research and therefore contributed to the outcome. Rolls and Relf (2006: 304) assert that this bracketing model:

*engages the researcher in a two-stage process that involves both feeling and thought, and utilizes two forms: a narrative form through conversation with the other and a textual form that can be analysed and made available, as part of the audit trail, lending authenticity and credibility to the social construction process and to the knowledge generated through it.*

This process of bracketing was invaluable in helping me to silence, for a while, my own voice, which in turn allowed me to give precedence to the voice of the participant.

### 3.10 Analysis of data

The analytical focus in IPA is on the participant's attempt to make sense of their experience. Morgan (2010) acknowledges that there is a set of common approaches, moving from the specific to the shared and from the descriptive to the interpretative. There is also a set of common principles, which include a commitment to understanding events from the participant's perspective and a psychological focus on personal meaning-making: *'the researcher enters a dialogue with the data and with the knowledge of what it means to the participant'* (Morgan, 2010:41). With that understanding in mind, I commenced my analysis, following the principles of IPA suggested by Smith (2007) and Willig (2008), which involved the identification of pertinent themes in each of the interview transcripts through a staged process. I chose to analyse the transcripts independently from each other. The first stage involved me gaining familiarity with the text – this I did by carefully listening to the recordings and reading and re-reading the transcripts, and this process allowed me to pick up any audible cues in the analysis (Appendix C, Doreen's transcript). I made some brief initial notes during this stage on the left hand side of the transcript and re-read my field notes and reflexive journal to remember what my thought processes were during the interviews. At this point, there was no attempt to omit or select particular sections from the transcripts. Willig (2008) states that notes produced at this stage constitute *'the most open form of annotation'* (2008:58). The next stage involved re-reading the transcript, examining the language and content used and annotating in the right hand column any emerging themes. I found this process very challenging, as I was aware of the content in its entirety and struggled to isolate and attach meaning to individual lines or words, whilst remaining close to the participant's stated meaning (Appendix D, Doreen's transcript: Excerpt with Stage 1 and 2 annotations). Smith, Flowers and Larkin (2009) recommend to take time with this stage and to avoid our habitual propensity for *'quick and dirty reduction and synopsis'* (2009:82).

Stage 3 (Appendix E: Doreen's emerging themes) involved the identification of emerging threads and themes that were drawn primarily from my transcript notes

whilst remaining close to the overall text. In doing this, the original whole of the interview becomes a set of parts and is described by Smith, Flowers and Larkin (2009) as '*one manifestation of the hermeneutic circle*' (2009:91). The emerging themes were then typed out and examined to identify connections and commonalities. This stage, although still challenging, was useful, as it allowed me to introduce some structure into the analysis and prevented me from becoming overwhelmed by the sheer quantity of data involved.

Once connections had been established between the themes, it was possible to move towards the next stage, which involved the identification of superordinate themes (Appendix F: Doreen's superordinate themes). Again, this was done by clustering and analysing, noting which themes acted as magnets, drawing others to them. To ensure that the emerging themes were grounded in the text, instances where they occurred were noted and were checked against the transcript. This form of analysis was iterative and required me to work closely with the text. Once superordinate themes were identified for the first transcript, a template approach was employed, where the same themes were used to help orient the subsequent analysis. Biggerstaff and Thompson (2008) recognise this as an acceptable method when moving on to the other transcripts, provided the researcher is alerted to the possibilities of new themes emerging.

Once this process was complete for each transcript, a process of integration took place where a final list of master themes was constructed (Hatton, 2010). Themes were not selected purely on the basis of their prevalence within the data, but also because of their richness and relevance to the research question. Other factors I considered when identifying themes included repetition, emphasis and commonality between interviews. This process, therefore, could be described as largely an inductive or bottom-up approach, starting with sections drawn from the transcripts and moving towards concepts that organised and integrated the participant's account.

I next turned to my bracketing interviews to test whether any preconceptions that had been previously identified had influenced my choice of emerging themes or prevented

me from critically examining the data. For example, I had a strong belief that shame would be a dominant theme, as that had been my personal experience. Therefore, when I identified it as a superordinate theme, I checked and rechecked the transcripts to make sure that the participant's narratives supported the theme. I also had considered in my bracketing interviews that many of the participants' stories would be similar to mine and I was concerned that this could result in my story infiltrating theirs. In reality, most stories were quite different to mine, although the emotions experienced were similar, but being aware of this in advance allowed me to engage with the data with an increased awareness of any existing bias. In doing this, the bracketing interviews became embedded in the research, which cemented '*their centrality in the research process*' (Rolls and Relf, 2006:294).

### **3.11 Quality of the research**

Research quality, which is synonymous with rigour, '*involves the systematic approach of research design, data analysis, interpretation and presentation*' (Hays *et al.*, 2016: 173). Rolfe (2006) believes that judgments of research quality are usually based on a reader's confidence in the findings, according to what is presented in the report. Therefore, it is important for researchers to convey comprehensively, within the report, the research process and the strategies used to establish trustworthiness.

I have chosen Lucy Yardley's (2007) four broad principles of assessing qualitative research to demonstrate the quality of my research. Smith, Flowers and Larkin (2009) believe that their suggested criteria are broad-ranging and suitable for IPA studies, as they '*offer a variety of ways of establishing quality and are presented in an accessible style*' (2009:179).

These criteria are: sensitivity to context, which is concerned with the sensitivity of the approach to the topic, the quality of the interviews, and sensitivity to the data; commitment and rigour, which seeks to demonstrate the degree of attentiveness to the process; transparency and coherence, which is concerned with how the study

has embraced the principles of IPA, including its philosophical underpinning; and lastly, impact and importance, which seek to demonstrate the importance or usefulness of the study (Smith, Flowers and Larkin, 2009).

### ***Sensitivity to context***

By providing a comprehensive literature review and clarifying what was already known from research and theory, a detailed background was provided which set the study in context and highlighted the cultural factors that prevailed at the time that influenced mothers in making decisions about giving up their child for adoption. My disclosure about my own experience of relinquishing a child featured on the website I set up to recruit participants and I feel that this was a strong indicator of my sensitivity to context. I also believe that it was instrumental in attracting people to the study and brought a non-judgmental and transparent quality to the interviews.

My approach in relation to how I communicated with my participants before, during and after the interviews, the use of private rooms, the discussions about my own experience, and my offer of sharing of transcripts underpinned my own sensitivity to the nature of the research and created an environment that enabled participants to speak openly. Additionally, open-ended questions were used to encourage people to talk about what was important to them. My management of any residual distress of the participants by providing contact numbers for available support enhanced my sensitivity to context. All of this, I believe, added to the depth and richness of the data obtained, whilst safeguarding the participants involved. This was reflected in a comment written to me by a participant following the interview.

*You made the whole process so smooth and easy and I salute your mix of professionalism and genuine compassion. (Maisie)*

### ***Commitment and rigour***

My commitment toward constructing an unbiased and comprehensive study is evidenced through my choice of participants and through the thoroughness of my data collection and analysis. To enhance the representativeness of my sample, I deliberately chose participants who lived in different parts of the country: this involved extensive travel within the UK and one visit to Ireland and demonstrated my personal commitment to the study. Additionally, I chose the widest time span possible within the decades specified for this study, to try to establish whether the passage of time made any difference to the research findings. The purpose of this careful selection was to ensure that I gained as broad a view as possible in order to minimise bias and add depth to the research. I used an inductive approach to focus on the narratives of the participants, rather than coming to the research with any theories.

Furthermore, I carried out two bracketing interviews with a colleague therapist to identify any pre-existing biases in order to gain an understanding of any potential emotional vulnerability I held in relation to the research. This proved invaluable in preparing me for the research interviews, equipping me to deal with whatever might emerge. I also used the insight gained from these interviews at the analysis stage to check the validity of my emerging themes.

Rigour was evidenced by following a detailed structured method of analysis suggested by Smith (2007), which involved identification of pertinent themes in each of the interview transcripts using a four-stage process. This was a lengthy, iterative process but ensured an in-depth engagement with the data. Themes were not selected purely on the basis of their prevalence within the data, but because of their richness and relevance to the research question. Once the themes had been established, an additional check was carried out by an independent researcher who audited the analysis of two of the transcripts. The purpose was to validate that the themes I had identified did actually emerge from the original interviews and to

ensure that a logical progression ran through the chain of events. This was achieved by reading the transcripts, noting the categorization and emerging themes, and reviewing the final identified table of themes. Whilst validity was enhanced through agreement about the themes identified, I was also aware that just because there is agreement between two researchers about the use of a theme, this does not necessarily mean that the theme is significant within the research. I was aware that all researchers have the opportunity to manipulate their data to reflect any underlying agenda they might have. McLeod (2001) describes this as *'a crisis of representation – the challenge of conveying on paper the richness of understanding what the researcher has developed, and the various voices of the participants'* (2001:138). Throughout the analysis, I focused directly on the themes emerging from the participants' accounts rather than trying to ensure that the themes fitted any pre-existing theoretical perspective. I used a process of disconfirming instances, which involved searching for data that did not fit within the themes and patterns that have been identified, as is described by Cresswell (1998) as the qualitative equivalent to testing one's emerging hypothesis. In line with social constructionist epistemology, I tried to remain aware of and acknowledge any influence of my own assumptions on the analytical process through use of my reflexive diary.

### ***Transparency and Coherence***

The coherence of a study relates to the extent to which it makes sense as a consistent whole (Yardley, 2007). For me, this meant understanding where I placed myself epistemologically; how my philosophy was shaped; why I chose a qualitative method of enquiry; and why I specifically chose IPA as the preferred method. All of this has been detailed within this chapter, which has acted as a natural audit trail and includes an explicit account of the aims of the research, a detailed explanation of the research design and process and the explicit use of reflexivity throughout the process. To aid transparency, I have explained my reason behind the chosen sample selection and size, the use of semi-structured interviews and the choice of IPA for data analysis. A paper trail was kept of the analysis of the data from the initial stages of open annotation to the final stages of theme identification. By audio-

recording the interviews and then having them transcribed, the participants' data was captured verbatim and the transcripts were sent to each participant to confirm accuracy. I chose not to send the participants copies of the themes I had identified from the transcripts, as I was aware that they might not agree with my interpretations. I was reassured by the view of Josselson (2006), who considers that the primary ethical attitude in the report rests in the researcher's authority, stressing that the report is the researcher's understanding or interpretation of the text. She believes that from this point of view, *'the report is not about the participants but about the researchers' meaning-making'* (Josselson, 2006:549).

Reflexivity was used to understand my own position in the research and to help me to objectively question what was happening for me during the various stages. McLeod (2001) believes that the question of reflexivity has special poignancy and significance for qualitative researchers in the areas of counselling and psychotherapy. However, he recognized that it is a contested notion in psychology, with differing views on what constitutes reflexivity. For some, it involves little more than a means of checking against subjective bias; for others, it could be the primary data collection tool. In the light of this study, I have followed the definition put forward by Etherington (2004), as it was the most meaningful in the context of my research: *'the capacity to acknowledge how your own experiences and contexts (which might be fluid and changing), informs the process and outcomes of inquiry'* (2004:31).

I utilised this reflexivity as a tool to minimise bias within the research by keeping a diary of thoughts, which acted as a reflexive journal and helped me to objectively question what was happening for me during the various stages. Within this diary, I tried to look explicitly at the factors that influenced the study at each stage, almost like my own informal enquiry. This included a review of all my documentation with some key questions to ask myself - did I follow the principle of good interview practice? Did I appropriately interpret the data? How might someone else have viewed this? Ely *et al.* (1997) assert that a bias we are aware of may be an entrée into the experience we are studying. They call this an *enabling* bias, as opposed to a



*blinding* bias, and believe that the difference lies in the level of self-awareness. (1997:350). This use of reflexivity heightened my sensitivity to bias and allowed me to acknowledge my perspective and associated assumptions in order to recognise the part they played in the research process.

I initially had the support of three critical friends throughout the process – one with little knowledge of psychotherapy and research but with a keen enquiring mind, one who is both a psychotherapist and a researcher, and a family member with an interest in research and literature. I also had the support of a therapist colleague for my emotional needs. What I didn't know at the time of choosing these people was that each of them had a history of adoption in the family: one had an adopted sibling, one was herself adopted and one had an adopted nephew. I considered this a remarkable coincidence and it demonstrated to me that adoption indeed touches many lives. Of course, it also meant that their views might include bias in relation to the research, and this awareness helped me to adopt an objective stance to their feedback. For this reason, I gained the support of another critical friend who had no experience of adoption, but was interested in my research. Both my research supervisors and my clinical supervisor were used extensively for debate, challenge, feedback and reflection.

### ***Impact and importance***

The objective of this research was to produce guidance for practitioners who support birth mothers who have relinquished a child for adoption. I believe that my own experience of the phenomenon being researched added credibility and authenticity to the study, thereby increasing its impact. The findings from the study produced rich data from which emerged key themes relating to the experience of relinquishment. This enabled identification of the implications for practitioners working with this group, which can be utilised by Adoption Agencies as part of their core training for practitioners working in adoption. Significantly, although the focus of the study was on birth mothers who relinquished a child between 1960 and 1990, similar themes have been identified in the literature as to the psychological distress

experienced by birth mothers today whose children are taken into care and subsequently adopted. These findings, therefore, have relevance to current birth parents and can be adapted to enhance the skills of practitioners working with this client group.

### **3.12 Ethical considerations**

Throughout this research, ethical considerations were prioritized and ethical approval was gained from the Metanoia Institute and Middlesex University. The ethical guidelines produced by both the British Association for Counselling and Psychotherapy (BACP) and the British Psychological Society (BPS) were consulted during the research design and process, but as identified by Valentine (2007), these were only useful as starting points to prepare for interviews of such a sensitive nature. However, they provided a useful structure in relation to ethical considerations.

The role of the researcher as a person of integrity is critical to the quality of the knowledge and soundness of ethical decisions in qualitative inquiry (Kvale and Brinkman, 2009). Therefore, being familiar with ethical guidelines and theories may guide the researcher in weighing up ethical considerations but, in the end, the integrity of the researcher and his or her knowledge, experience, and honesty are the deciding factors. To approach my research with integrity, I drew up a list of ethical considerations with accompanying risks and benefits (Appendix G). Sieber and Tolich (2013) believe that risk-benefit assessments are a major feature of planning ethically responsible research, but recognise that it is not an exact science and therefore it may be difficult to estimate with any real accuracy the likely risks and benefits. The issues I identified included, but were not limited to, my own emotional wellbeing, participants' distress and the challenges of being an inside researcher who had experienced the phenomenon being researched. Additionally, I had identified my research as sensitive because it fitted the description of sensitive topics as defined by Lee (1993): *'those laden with emotion or which inspire feeling of*

*awe or dread'* (1993:2). Lee also states that research may have a sensitive character for situational reasons or because it is situated within a specific socio-political context. As my research was concerned with an era when the Church and State were instrumental in influencing decisions made by mothers in relation to the relinquishment of their child, I felt that this added to the sensitivity.

Before the research was conducted, an information sheet was devised, which included information relating to the purpose of the research, confidentiality and informed consent (Appendix H). These sheets were sent to the participants in advance and included contact numbers if support was needed. These were referred to again at the start of each interview when each participant signed an informed consent form (Appendix I). A private room was booked on each occasion due to the sensitivity of the interviews.

I had a checklist prepared, which I went through prior to each interview. It included items such as the duration of the interview, taking breaks and de-briefing, and included an opportunity for participants to ask questions. There were also informed that they could stop the interview at any point. Most importantly, I sought to reassure them that it didn't matter if they had forgotten details of their story, but asked them to focus instead on remembering how they felt. As they were aware that I was a qualified therapist and therefore might have had expectations as to how I might support them during the interview, I reminded them that on this occasion, my role was that of a researcher. The shortest interview lasted one hour, with the longest lasting two hours. All the interviews were recorded onto a digital recorder and later transcribed by a professional transcription company, with one exception, which I transcribed myself.

Careful consideration was given to both anonymity and confidentiality, with recordings and transcripts not labelled in any way that could compromise anonymity. Furthermore, all data was stored in accordance with the Data Protection Act 1998. The transcripts were stored in a locked cabinet and any confidential information held on the computer was stored in a password-protected folder. This

included the transcripts of both bracketing interviews. I discussed the role of secure storage with the transcription company and was assured that all data was held securely.

A significant challenge I faced was how I would position myself as an inside researcher. To assist the process, I drew up a list of possible options highlighting the benefits and risk of different approaches based on Wilkinson and Kitzinger's (2013) model of considerations on being an insider researcher (Appendix J). I was acutely aware that whilst having the same experience as the participants might engender trust and enhance empathy, it could also lead to false assumptions of commonality and might stop me from identifying the range of experience that exists amongst the participants. As the participants already knew that I too had relinquished a child, I decided to utilise this shared experience in order to establish rapport and trust in the hope of eliciting high quality data. This I did by acknowledging my own experience again, face to face, immediately prior to the interviews and answering any questions when asked. I believe that my own experience helped me to understand the responses in a nuanced way and *'helped me to hear the unsaid'* (Berger, 2013:223). To address any biases in adopting this position, I referred to my bracketing interviews, research supervision and reflexive diary.

As I had shared the experience of all my participants, many were curious as to my story. From an ethical viewpoint, I was concerned about the implications of sharing my information. My daughter and I were reunited and enjoyed a positive relationship; however, that was not the experience of many of my participants. Marshall and Rossman (2010) recognise that reciprocity is a key ethical consideration in research and when participants adjust their priorities to help the researcher or even just take part in the interview, they are giving of themselves: the researcher therefore should be sensitive to this and plan to reciprocate. Knowing this in advance, I was able to prepare which parts of my story it would be appropriate to share with the participants, such as how my daughter and I were reunited, but also which parts I chose not to talk about, for fear of triggering my own emotions or of making the participants envious of my situation, thereby inadvertently creating a

power imbalance. Josselson (2007) supports this view and believes that self-disclosure, as long as it does not embarrass the participants, may encourage a sense of collaboration and build rapport.

I identified an ethical conflict between the need to minimise risk and the need to get results. This tension between pursuit of knowledge and ethics in interviewing is described by Sennett (2004:38) as follows:

*The interviewer all too frequently finds that she has offended subjects, transgressing a line over which only friends or intimates can cross. The craft consists in calibrating social distances without making the subject feel like an insect under a microscope*

Kvale (2009) also recognized this conflict and stated that the dilemma of wanting as much knowledge as possible, whilst at the same time respecting the integrity of the participants, is not easily solved. In my pursuit of information, there was no way of knowing in advance what would unfold in the interviews or how distressed the participants might become as a result of my questioning. However, Harper and Thompson (2011) believe that experiencing distress is not necessarily harmful. They go on to state that there is now considerable evidence that emotional disclosure across a range of settings has the potential to be beneficial. What matters is the researcher's ability to anticipate and deal with the distress. Josselson (2007) believes that the interview itself has an impact on the participant's life, as it stimulates some thinking or rethinking or makes some new meaning as they reflect on their own words. Whilst I recognised that researching such a sensitive area might cause distress to my participants, I believed that it would also be therapeutic in helping the participants to explore their emotions in relation to the experience of relinquishment.

Whilst I was concerned about the difficulty in anticipating the outcomes of the research, I believe that I had prepared well in assessing and monitoring risk and was also confident that my skills as a therapist would assist me greatly at times of difficulty in the interviews. I allowed time at the end of each interview to discuss

any issues of concern with the participants and used this opportunity to remind them of the range of support available to them, already provided in the information sheet.

Finally, a key ethical consideration for me during the data analysis stage was the requirement for me to remain true to the data as a whole to ensure that the participants' accounts were represented accurately. This involved not using only quotes which were extreme or emotive for effect, but ensuring where relevant, that the limitations or shortcomings of the data were made visible.

### **3.13 Ethical dilemma**

An example of how an ethical challenge arose for me was when one of the participants contacted me and requested an audio copy of her interview. The reason given was that she wished to share it with her daughter, whom she had relinquished for adoption and who was the subject of our interview. She believed that if her daughter heard the interview as it unfolded, it would help her to understand the context in which the participant found herself at the time of being pregnant. Her sharing of the recording concerned me, as the interview included some sections that involved the participant speaking angrily about her daughter. Although they had been reunited, their relationship was difficult, and in my view, if her daughter heard the recording, it could further damage further an already fragile relationship. I was unsure what course of action to take. I spoke to my research supervisor, who enquired about what I had written in my consent form with regard to the ownership of the data. As I had not explicitly stated that the recordings were for research purposes only, I was unclear whether I could refuse her on this basis. I discussed my concerns with both my clinical and my research supervisor, and the ethics section of the BACP: this resulted in some discussion and considerations but no clear course of action. I drew then on my own integrity, judgment and values and decided to speak with the participant about my concerns, as I felt that we had established a good relationship during the interview. My intuitive view was that the participant had a

right to have a copy of the recording, as I had already offered her the transcript, which contained the same information in written form. I telephoned her and sensitively expressed my concerns in relation to the use of the recording and the possible damage it might cause to her relationship with her daughter. I suggested that she might wish to listen to the recording before making any decisions as to its use. The participant listened to me carefully and thanked me for my 'wise words'. Following this conversation, I sent her the recording, but I am unaware of whether she shared this with her daughter. This ethical dilemma could be described as '*a contextual or situational model of ethics*' (Mauthner *et al.*, 2002:20) with the emphasis on the researcher's moral values and ethical skills in reflexively negotiating ethical dilemmas. Punch (2014) supports this view and believes that justifying ethical decisions is a matter of principled reasoning – an ongoing process throughout which researchers need to pay attention to the situation and the way it shapes their judgments. In this case, I felt that I had appropriately considered the situation and taken the best action whilst respecting the participant's autonomy and right to make her own decision

### **3.14 Reflexive statement in relation to Methodology**

During the period between the initial bracketing interview and the final bracketing interview, I experienced significant emotional upheaval in relation to my research. This became evident to me for the first time when I began devising the interview schedule. I started by developing open-ended sensitive questions regarding the participants' circumstances, with my first question being, '*Tell me what it felt like when you discovered you were pregnant?*' As I wrote this, I felt an internal jolt; I did not understand what had caused this jolt so I dismissed it and carried on - a well-rehearsed behaviour. However, unconsciously, my style of questions changed to a less sensitive style and became more factual. I sent the draft questionnaire to a critical friend and supervisor for comment and they both commented on the *bluntness* and the *clinical* nature of the questions. Following this feedback, I re-read my questions and realised what the jolt had been: I had never been asked that

question, never been asked what it felt like when I discovered I was pregnant, either at the time of my pregnancy or in the intervening years. What a difference it might have made to me if I had been asked. With that realisation, a tsunami of tears rose from somewhere deep inside me: tears of pain, loss, sorrow, and regret, accompanied by an overwhelming feeling of sadness and aloneness, akin to how I had felt 44 years previously. I was aware that it was my own pain that had caused this outburst but there was a parallel process, in which I was wondering if, during the interviews, the participants would experience the same reaction as me, and if so, how would I, how could I handle it? Would I cry with them, would I comfort them, would I let them cry? It was several days before my emotions allowed me to re-visit the questions again. It was then that I fully understood what I had been doing: by devising questions that were more clinical, I hoped I would receive more clinical replies, replies with less emotion, replies that I could handle. I was afraid to unleash the torrent of emotions that I suspected might still be present for some of the participants, as indeed it was for me. But then my thinking changed, as I considered that the participants might want to be asked this question, as perhaps they had never been asked before either. Perhaps that is why they had volunteered to take part in my research – they wanted or needed to talk about their experience. This awareness was helpful in allowing me to design the questions in a more sensitive manner than previously.

My next strong emotional reaction was at my first bracketing interview. As soon as I switched the recorder on to talk to my colleague, my voice shook and my tears came, with the words, *'I am afraid to talk about this...'* My fear of not being able to contain my own emotions during the interviews was powerful. I expressed fears about being overwhelmed by the participants' stories, fears of mixing my story up with theirs, fears of blurred and shared pain, fears of the unknown. However, as we talked and explored some more, I could feel my worries dissipating: I realised that I had just needed this opportunity to express my fears out loud, to acknowledge my emotional state and to become comfortable with that which was uncomfortable.



The most moving part of the research process for me was the interviews themselves. They were intimate encounters; being with women who had shared my experience and were talking openly about what it felt like for them was profound. I believe they experienced no judgment in the interviews and therefore spoke freely. Their voices rose and dropped as they spoke, and their speech was punctuated with laughter and tears. There were many silences, used to gather themselves up following some painful admission. I laughed and cried with them, although I purposefully kept my crying silent and discreet. I'm not sure whom the tears were for, but as I write this account now, the tears come again, trickling slowly from my eyes and landing on the keyboard of my computer. We shared looks of understanding, encompassing grief, shame and pain. Some brought photographs of the child they gave away – tangible evidence of their loss. My semi-structured interview questions were almost unnecessary – their stories flowed. I felt privileged. I was acutely conscious of the many roles I had in this interaction and the possible blurring of roles. I was primarily a researcher, but was that in fact true? Was I primarily a mother who relinquished her child for adoption, just as my participants had? And what of my therapist's role – had I left this outside the door? I came to the conclusion that what role I had didn't need a name. I was experiencing something special and the data I was gathering was raw, visceral and authentic.

One of the women I interviewed could not recall much of what happened between realising she was pregnant and giving her baby away. I remembered being frustrated, as I was concerned at the lack of data that might be forthcoming as a result of the interview. She was deeply apologetic about her forgetfulness. About a week after the interview, a small parcel arrived at my house. It was a hand-painted card with a message of thanks and alongside the card were twelve sheets of poetry from my participant that she had written following our interview. Although she couldn't express herself well in the interview, she had found a voice through poetry and that allowed her to express her pain. I cried again, both for her pain and for my shame in worrying about my data.

## **Depression**

The word says nothing  
To be de-pressed  
Is to be compressed  
Beaten up  
Exhausted  
Taken to the depths  
Of isolation  
Frustration  
Desolation  
That's what it means  
To be depressed (Excerpt from participant's poem, 2016)

Many of the interviewees asked me questions at the end of the interview about my own experience. As a therapist who is not used to disclosing personal information, this felt strange. However, these women had bared their souls, divulged their innermost thoughts, both good and bad, and had trusted me to receive what they were saying without judgment, mainly because they were aware that I had shared their experience. So it felt right to give them something back about myself, and as the interviews progressed, I felt more comfortable with this sharing of information. Fontana and Frey (2000) believe that interviewers can show their human side by answering questions and expressing feelings. Methodologically, they state that this new approach '*provides a greater spectrum of responses and greater insights into the lives of respondents*' (Fontana and Frey, 2000:658). However, as I had identified vulnerabilities in relation to my own experience of relinquishment during the bracketing interviews, I made the decision to only share factual information about my situation, as I felt that it was safer than sharing any emotional experience which might have impacted negatively on the participants. With all of the women, we embraced when parting, and those embraces felt unique. Their impact will be with me forever.

Excerpt from my reflexive diary during fieldwork:

*Woke up this morning still with the saddest feeling – I feel emotionally drained, and words from my interviews keep coming back to me.*

*Words like 'no one was kind to me' and ... (sobs), maybe that is because I felt that no one was kind to me either. So, the words of all of my women are in my head and I feel a bit overwhelmed. I can't work out who I feel sad for, me or them, I suppose it doesn't matter – I feel sad for us, for us as a group of women. Society did that to us, and we were all children at the time. (Tearful)*

Listening to the transcripts several months later whilst commencing the data analysis also created strong emotion. The intensity of this emotion surprised me, as I thought I had little left after the outpouring of emotion I had experienced initially following the interviews. As I started reading the transcripts and annotating initial thoughts, words and phrases jumped off the page and screamed at me – *shame, alone, scared, frightened, no voice, grief, loss, tears, shame, alone, scared, frightened, no voice, grief, loss, tears*. I had to stop the analysis; I couldn't see any other words on the page – were these themes I was identifying or were my emotions causing me to focus on those words that resonated with me? And the tears flowed again, and alongside the tears, the stark realisation that this wound for me may never be fully healed.

A final reflection for me at this point in the process was that I was envious of the participants being able to tell their story. I wanted to tell my story also – I didn't want to tell it in a therapeutic context with someone challenging me or trying to get me to make sense of it. I just wanted to tell it as it was, in the same way as those women had told me. One of the participants said to me at end, *'I wanted someone to bear witness to my story and you have done it'*. I know exactly what she meant.

### **3.15 Summary**

This chapter explores my epistemology and philosophical understanding. It outlines the methodology and methods used for my study. It includes my ethical considerations and how I evidenced rigour in my research. The reflexive statement illustrates an honest examination of my own emotions during the process and the

section on bracketing demonstrates how I mitigated the impact of these emotions impinging on my research.

The next chapter will highlight the key themes extracted from the data and include verbatim comments from the participants to support the identified themes, alongside my interpretative commentary.

## 4. Findings

### 4.1 Introduction

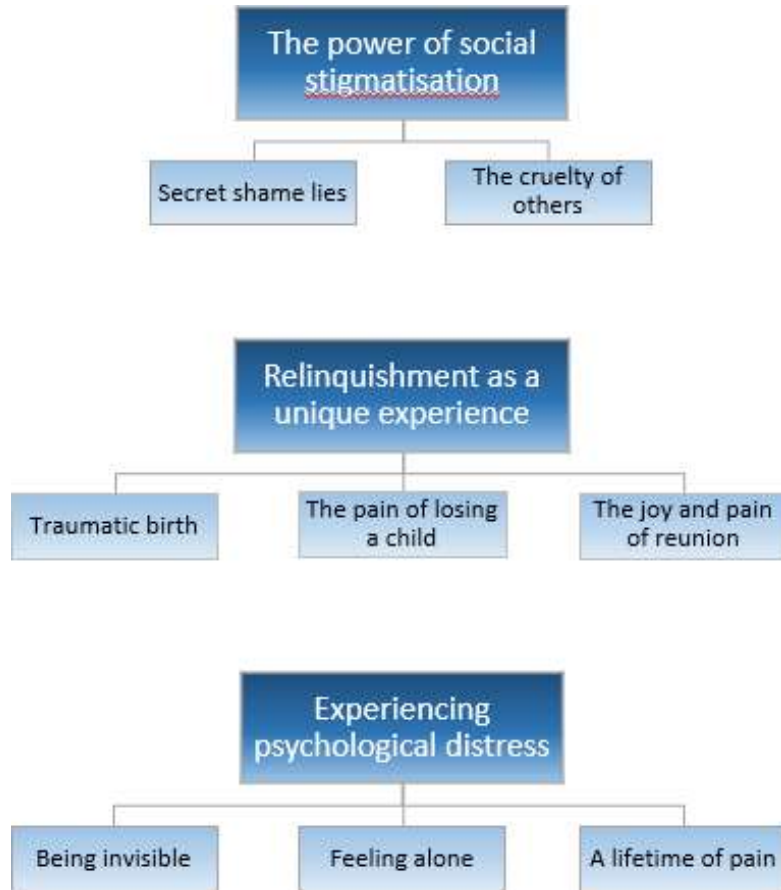
As outlined in the previous chapter, the data gathered through a series of semi-structured interviews was examined using Interpretative Phenomenology Analysis. Recurrent themes were identified in the data, which embodied most of the participants speaking about their experience in a similar way. The analysis therefore is a group analysis and is presented as a generic text. This chapter will detail and explore the themes that were identified through this process of analysis, including three master themes and eight corresponding superordinate themes. In order to capture the idiographic details within the whole research, some extracts have been selected from the interview transcripts, which represent the range of views within the group. The extracts therefore capture the lived experiences of the participants and have been coupled with my interpretative and analytical commentary, as

*Taking the insider's perspective is thus only one part of the analytic process, because the analyst also offers an interpretative account of what it mean for these participants to have these concerns in this particular context. This means that there is a balance of emic and etic positions in IPA. (Reid, Flowers and Larkin 2005:220)*

The first master theme that was identified revolved around the power and influence of social stigma and the nature of its manifestation, as experienced by the women who found themselves pregnant outside marriage. The second master theme pinpointed the uniqueness of the act of relinquishment, which, despite being considered by some as a single act, cannot be viewed in isolation. Lastly, the third master theme looked at the overall long-term psychological impact of the experience of relinquishment on the birth mother.

### Figure 6

**Table of master and superordinate themes**



Seven women took part in the interviews. Each of them had relinquished a child in the UK between 1968 and 1983 and had subsequently searched for their child. All were reunited with their child with one exception, in which the child was found but chose not to have contact with the birth mother. The ages of the participants ranged from 54 to 66 years of age, with the average age at the time of relinquishment being 19. Five of the seven participants stated that they were raised as Catholics, with one still describing herself as Catholic. Of the others who stated their religious preferences, the description 'spiritual' was used. All the women, with one exception, had lived with their parents at the time of pregnancy. Furthermore, three of the women had been in a relationship with the father of the child, one woman had been raped, and the remainder did not consider that they had been in a

relationship. Two of the women stated that whilst they made the decision themselves to give up their child, they felt that they had no other choice. The remaining five described themselves as having relinquished a child, but believe that they did not make the decision themselves.

Participants lived and were interviewed in England, Ireland, Scotland and Wales. Within these findings, each of the participants has been given a pseudonym and all identifiers have been altered to maintain their anonymity. The findings are explored through an initial summary of the master theme, followed by the detailed findings of the underpinning superordinate themes. The majority of the superordinate themes were common across all of the participants (Figure 7).

**Figure 7**  
**Presence of themes across the interviews**

<b>Superordinate Themes</b>	<b>Catherine</b>	<b>Maisie</b>	<b>Jennifer</b>	<b>Doreen</b>	<b>Elizabeth</b>	<b>Caroline</b>	<b>Tina</b>
Secrets, shame, lies							
The cruelty of others							
Traumatic childbirth							
The pain of losing a child							
The joy and pain of reunion							
Being invisible							
Feeling alone							
A lifetime of pain							

To ensure that the themes reflected the authenticity of the participants' voices, verbatim extracts were included to ground the data in the participants' experience. Willig (2007) notes that highly articulate participants can sometimes produce more abstract evasive accounts and that the richest, more powerful data often comes from participants who produce less polished accounts. This was borne in mind when choosing extracts. The interview quotations have been edited to reduce repetition and hesitation and to enhance clarity and readability.

#### **4.2 Master Theme One: The power of social stigmatisation**

This was a common theme throughout the interviews. All the participants expressed fear about telling their parents that they were pregnant, because they knew that the reaction would be negative. Initially, to avoid telling their parents, most of the women went into denial about what was happening to them, with some going to extreme lengths to conceal their pregnancy. Many described how, from the moment they discovered their pregnancy, and in some cases up until the present day, the entire experience was shrouded in secrecy and lies. Some described themselves as having been hidden out of sight, sent away from home, forced to deceive and be silent about what had happened to them. Some talked about the many layers of shame they experienced. This shame revolved around having sex outside marriage, the visibility of pregnancy, the withdrawal of parental support and the knowledge that they had done something wrong in the eyes of the church. Most significantly, and in every case, they were ashamed of their own wrongdoing in the eyes of society. In summary, they felt ostracised, alone, and disgraced. These feelings were exacerbated by the negative attitude of some of the professionals who dealt with the participants during their pregnancy, and by the wall of secrecy constructed by those involved in the process. The prevailing view of society within this era was that it was socially unacceptable to keep a baby and raise it as a single mother; better instead to give up a child to an infertile couple who could give a better life. For many of the women, this was internalised as them not being good enough to keep their child: they had broken some unwritten societal law, and the



altruistic action of giving their child up for adoption somehow compensated for their wrongdoing. For the two women who made the decision to give up their baby themselves, a feeling of intense shame was the main driving reason behind their decision.

#### **4.2.1 Superordinate theme: Secrets, shame and lies**

The initial denial of pregnancy detailed by almost all the women started a cycle of shame that permeated through their whole experience and, for some, still remains. Maisie described how she managed to disguise her pregnancy and considered herself lucky that it wasn't too obvious, enabling her to stay at work unnoticed.

*I was tiny – It's all about hiding stuff so you become an expert, and when people say your boobs are getting bigger, you tell them you are wearing a padded bra.*

Maisie

Doreen, on the other hand, described how she disguised her pregnancy by adjusting her clothes and recalls being secretive about her morning sickness for fear that she would be heard:

*I didn't have much weight gain. I had incredible morning sickness... to this day I can vomit without making any sound at all.*

Doreen

She was eight months pregnant before her mother noticed and decided to take her to see a specialist, as she thought '*I was having trouble with my back and walking oddly*'.

Caroline describes how she knew what she had to do to hide her pregnancy if she was to remain at home:

*I've got to hide this to stay at home, so I lose a lot of weight. I'm about a size X so I get down to a size X and I'm squeezing my stomach in*

*with a sweatshirt over it.*

Caroline

For some, this initial denial of the pregnancy meant that they found it hard to bond with their unborn baby:

*I could feel the baby moving but I never felt any emotion. It was an incredible feeling of denial.*

Elizabeth

*Every time the baby kicked, it was like having an alien inside me.*

Doreen

As anticipated by the women, the reactions of all their parents to the unwanted pregnancy created an atmosphere of fear and shame in the home with, in some cases, the father expressing most anger. Catherine described it in the following way:

*I told my Mum and she told my Dad and he went mad. He didn't speak to me for two weeks. He said 'you dirty little bitch, you bring shame on our house... when you come home, just as long as you realize it would be as well just hanging the red light outside the door'. 'It wasn't my fault Dad', I kept saying. I thought I was disgusting.*

Catherine

Maisie experienced a similar reaction after telling her parents:

*I remember sort of telling my Mum and I told her in the kitchen and she went around and told my Dad and the next minute, the hatch, the actual doors were almost off the hinges and he screamed quite really abusive things. He was like a raging bull, an absolutely raging bull. 'You have sullied the whole family'. Mum was crying.*

Maisie

Similarly, Doreen remembered her mother and father shouting at her, with her mother calling her all sorts of names and saying, '*I didn't think you were that kind of girl.*'

Elizabeth's experience was profound, as she said she knew immediately after seeing her mother's reaction that she would have to have the child adopted:

*I thought maybe I had a cyst, and although I had felt the baby kick at this stage, I totally ignored it. I went to the hospital ... my mother was with me. And I will never forget the moment he showed me the X-ray of my baby in my womb, and it was deeply shocking. And he called my mother in and she had a brave smile... which rapidly faded. Then I knew at the moment what I was going to do. I knew I was going to have my child adopted.*

Elizabeth

This decision was reinforced when she saw her father's disappointment and shame and heard him say, *'you will never be able to hold your head up in our village again':*

*I really believed the only way I could save me and save everybody really, the father of the child, my parents, everything. The whole thing, I thought the straightforward thing to do was to put the child up for adoption, put it up for adoption.*

Elizabeth

Caroline described how she felt that it was God's punishment that she fell pregnant and that she had a real sense that *'sex is bad stuff and you don't do it'*. She described seeing her father's shame as he kept his head down when he found out, and how she had *'sucked up his shame'*.

Catherine agreed and spoke about how she felt disgusting: *'If you have sex without marriage, you are bad; you are dirty; you are useless'*.

Only one of the participants, Tina, chose not to tell her parents, as she said they had been through this *'shameful'* experience before. She remembered feeling *'embarrassed, terrible embarrassed'*, and decided to have her baby adopted rather than bring more shame to the house:

*It is hard to put into words what a different world it was then, it was filled with shame and there was no joy in being pregnant. Tina*

It was clear from the women that the shame they felt about being pregnant was reinforced by their parents' reactions. The shame deepened as plans were made to

keep the pregnancy hidden, have the baby adopted, and the expectation of everything returning to normal afterwards.

All but two of the participants were sent to a mother and baby home as soon as they were visibly pregnant, with some of them being made to stay in hiding in the family home prior to being sent away, and all had been sworn to secrecy.

*It was this big secret and I was hushed and hushed. I had to stay and hide before they sent me away.*

Catherine

*I'm back at home – hidden upstairs.*

Caroline

*I had this huge secret I had to keep – It meant I couldn't let anyone close to me.*

Doreen

Most remembered that it was their parents or, in some cases, a priest or doctor, who made the arrangements to send them away, and they themselves were not consulted.

*I don't know how but suddenly we were on our way to a mother and baby home. I was sworn to secrecy and I believed it.*

Doreen

*It was all arranged that I would go to X home to have the baby.*

Jennifer

Catherine described how her mother, a doctor and a priest made the arrangements for her to go away.

*They decided that I wouldn't get married to him and the doctor said she wouldn't entertain an abortion 'cause we were Catholic ... and the next thing it was arranged that I would have the baby and it would be adopted. It was all done between my mother, the doctor and the priest.*

Catherine

However, Maisie stated that she was quite happy to go to a home, '*as there were other girls there in the same boat*'.

For all the participants, the very tangible manifestation of shame and the aura of secrecy demonstrated by parents and some professionals reinforced their own feelings of shame.

#### **4.2.2 Superordinate theme: The cruelty of others**

All of the women spoke about experiencing a lack of empathy or kindness from those who came into contact with them, with most remembering experiencing what they now regard as some form of cruelty. This was felt at many stages throughout the pregnancy, from the initial reaction of parents through to their subsequent treatment by nuns, medical staff and adoption agency staff. Most felt that their youth and vulnerability were used to exploit them.

Maisie describes the reaction of the parish priest when she and her boyfriend went to see him about getting married.

*And I'm all shy and the parish priest is a maniac. He is fire and brimstone, and he is like 'Who are you?' to my boyfriend and my boyfriend says 'I'm a Protestant'. And he says 'Under no circumstance can a Catholic girl marry a Protestant boy' and I remember whispering 'I am pregnant' and again it wasn't well received and my cheeks were burning.*

Maisie

Doreen spoke about the treatment of her doctor when her mother took her to see him at eight months pregnant:

*This guy was awful. And I remember walking in and he said. 'Oh, I hear you have been a naughty girl then'. And I'm sure that he said that to all his adult married female patients who came in with a pregnancy (said sarcastically). I did not say a word.* Doreen

Many spoke about how they were viewed negatively by the medical staff during and after childbirth and how the medical staff made them feel that they were not genuinely mothers:

*You get taken there in the ambulance, you don't know anybody, this is your first time and they, the hospital, treat you like shit 'cause they know where the ambulance has come from and they know you are not a bona fide mother. They don't slap you about but they are disrespectful.*

Maisie

Elizabeth described the unkindness of a nurse whom she felt was *'there to punish me'*. However, she also recognised that one *'nice'* nurse showed her some kindness.

Similarly, Caroline felt that she was treated badly by the hospital staff:

*They couldn't be human to me. They didn't make any attempt to touch or comfort me. And I thought... there must be something really bad about me.*

Caroline

Additionally, the participants also spoke about a considerable amount of unkindness that they experienced in relation to how they were treated after they had given birth to their babies.

Doreen spoke about not been looked after properly after the birth and how she was left alone without any medical attention. Her use of the word *'thankfully'* suggests that she had poor expectations about how she would be treated.

*They sewed me up, thankfully, but they didn't clean me up. They covered me with a sheet and didn't come back. And I lay there for four hours. Nobody was talking to me or treating me like a patient. I was just... I don't know... pushed aside. An act of kindness would have meant the world.*

Doreen

Catherine remembered clearly what happened to her after her baby was born and how the nurses and others treated her:

*They asked me if I wanted to see this baby. I said, 'Yes, I want to see this baby, MY baby, MY baby - I want to see it and to hold it'. And I was told not to do that and there was a social worker involved and she says 'Don't have any contact with the baby because it will be worse for you' and I said 'No, I need to see what this baby looks like'.*

Catherine

She went on to describe what happened when he was taken away to the nursery:

*I was told that I could see him, but I couldn't get close to him. And they said to me 'You won't see your baby again, you'll hear him crying but you won't be allowed to go into the nursery and you won't be able to hold him or anything like that'. So I did hear him crying and I used to go and stand in the nursery, 'cause I could see his hair. I couldn't see his face 'cause I was too far away.*

Catherine

Doreen had a similar experience and spoke about what happened immediately after having her baby:

*One of the nurses had my daughter in her arms and she said 'This baby is for adoption, isn't it? I'll take her away'. And I'm saying 'No, no, no, please bring her back'. And they kept saying, 'Don't pick her up, don't cuddle her, don't do this, don't do that', and all the... all the nuns, they were saying, 'You mustn't make a fuss of her, you mustn't do this, you mustn't do that' so by that time I was just putty. I was completely malleable. Nobody understood how damaged I felt; I labelled myself as damaged goods.*

Doreen

Catherine also talked about how bad she felt about herself when she arrived back home without her baby:

*I thought I was disgusting. I brought this shame on my family; I brought this heartbreak to my family. Nobody cared about me, you know? I'm not nice, I'm not clean, I'm unclean, 'cause that is how I felt, because that is what I was told – if you are told something enough, then you believe it, don't you?*

Catherine

Elizabeth, who had made the decision herself to give up a daughter for adoption, believes the cruellest comment of all came from her mother, many years later:

*My mother said something unforgivable years later. She said that if I had had a boy, she would have kept him. She told me that she always wanted a son and that I should have been drowned at birth.*

Elizabeth

On the whole, the experience of others being unkind to these women further reinforced their shame and led them to question their own self-worth.

### **4.3 Master Theme Two: Relinquishment as a unique experience.**

For all participants, the experience of giving birth as an unmarried mother in the knowledge that they were going to give their child away was a traumatic event. The trauma was compounded by the aura of shame, which prevailed throughout all aspects of the experience. They gave birth but without the usual celebration of a new life being brought into the world, with an absence of congratulations from family or friends. Their babies were then taken without ceremony, with no loss acknowledged and no grief recognised. One participant recalled envying her friend whose baby had died because at least she could grieve. Their experience was held within them in a dark and secret place, and many remained silent for decades, some even remaining silent about their emotions until taking part in this research. Six of the participants met their children again as adults and although this brought them some joy, it also brought them face to face with their loss.

#### **4.3.1 Superordinate theme: Traumatic childbirth**

Each of the women gave birth without any members of their family or friends present; most were terrified and did not know what was going to happen to them.



One participant stated that she has no memory at all of the birth of her son. Many spoke about the intensity of the experience, emotionally and physically, with some speaking with sadness about the fact that their parents didn't want to acknowledge their own grandchild.

Elizabeth spoke with fear about her experience of labour.

*The absolute horror of being shaved and having an enema in a freezing cold white tiled room with a completely dreadful nurse. I was treated like a piece of meat.*  
Elizabeth

Doreen similarly spoke with considerable emotion about what happened immediately after giving birth:

*She took the baby across the room. I was feeling really weak. They left me alone. I kept calling out, because every time I called out she (the baby) would quieten down and then start crying again. I was really thirsty and after a while, my voice stopped working and I tried to get off the table so I could go to her. I was so high up I was afraid I would fall off. And I couldn't get my stomach muscles to work. And I just lay there thinking, what can I do? After 4 hours, someone stuck their head around a door and said 'Oh, I didn't think anyone was in here'. And I just croaked at her 'Help me'. And she went away. And someone else came in, in a little while and said 'Oh, we are going to move you now'. And I couldn't speak.*  
Doreen

Elizabeth remembered not allowing herself to bond with her baby, as she knew she was going to be adopted. Her repetition of some words indicates the intensity of her emotions:

*Nearly two weeks I had my baby by my side in a cot and I was supposed to change her, feed her and look after this child. And I didn't want to know. I didn't want to know. I wasn't even waking for her, which was, I think, a real indicator of whatever connection I had with my child was not completely there. I just wanted to go on, you know, healing, getting better.*  
Elizabeth

Although she had made the decision herself to give up her baby, she remembered the pain she experienced when buying baby clothes for her child, as that was part of the conditions of the Church of England Adoption Society.

*I had to buy baby clothes to give to the foster parents. I remember having all the clothes in the airing cupboard...taking them out, putting them back. I remember that. And it began to break my heart. There was this tiny little... That was awful. It was pretty bloody awful, 'cause I knew I wasn't buying them... it wasn't for us. I was buying them because I had to buy them...so that brought it home.*

Elizabeth

She carried on and spoke about her parents' reaction to her daughter:

*My father looked at my baby and then he left. That was it. My mother... didn't see her. I think she went to see her once... She wasn't interested, didn't want to know. I was having a child and it was being adopted.*

Elizabeth

Caroline remembered how emotional she felt after giving birth and how, in her confusion, she didn't think it was her baby:

*But I remember crying, 'But he is not my baby' and being aware of the fact that I couldn't believe I wasn't going to be able to keep him... and I had already decided that I was staying in hospital with him for as long as it took before he was adopted. I didn't want him being handled by nurses.*

*And then I remember a grumpy doctor comes in and stitching me and he is not happy 'cause I'm on the floor. And looking back, I am thinking, why didn't you put me on a bed? Why didn't you do something rather than making me feel uncomfortable? I don't know if I was anaesthetised enough but it was horrible.*

Caroline

She spoke about the joy of looking after her son:

*I loved every moment of feeding him; I didn't care how long it took. I was patient with him; it was timeless in a way and those ten days were so precious 'cause I knew that was all I had.*

Caroline

Tina, who had made the decision to have her son adopted, spoke about how she regretted the decision after giving birth.

*Why did I agree to this (adoption)? He was a beautiful, beautiful baby and they said congratulations and they said 'What are you going to call him?' And I spent a lot of time crying and one of the staff said, 'Do you still not want him?' And I was holding him, and I just thought, 'Oh my God, how can you say that, do I want him, do I? Do I still want him?' I could have hit her. Actually, I'll never forget it because it went right through me like a bullet. That week was agony – I kept steeling myself, I must have had the impression that feelings didn't matter.*

Tina

#### **4.3.2 Superordinate theme: The pain of parting**

All of the birth mothers participating in this research described parting from their child as the most painful part of the overall experience. Additionally, all of the mothers, with the exception of Jennifer, who could not remember any details, remembered the events in considerable detail despite the fact that in some cases, they had occurred over forty years ago. They spoke about an unbearable pain that was unacknowledged by everyone, including themselves. Some spoke about searching for their child, even looking into passing prams; others talked about feelings of loss and anger.

Catherine described what happened to her just before she left the home without her baby. She remembers clearly, and with some anger, what she perceived as the patronising words of one of the nuns who explained to her why another unmarried girl could keep her baby:

*I was told at the time that I couldn't take my baby home because I was unmarried and there was no help for me. There was another girl in the home and she was taking her baby home and I said to one of the nuns, 'Why can she do this and I can't?' And the nun said. 'Ah, but she will*

*be back in here within a year because she is nothing but a dirty slut, she can't keep her legs shut.'* Catherine

She also remembered being told that she would have no financial help as a single mother, which she now knows to be untrue.

*The social worker told me that I was not entitled to anything, except a £25 maternity grant. How would I have coped? Where would we sleep?*

*And about a year and a half later, a girl on my street got pregnant and she kept her baby. She was a Protestant. And I felt then I should have been a Protestant.* Catherine

She went on to describe the rawness of the pain she felt when she was sent back home without her child:

*And I just felt like I wanted to die. I wanted to die with the pain that was inside me because there was no end; there was no end to the pain. I'd wake up thinking about him, I'd go to bed at night thinking about him and in between I'd be thinking about him - I'd be looking in prams saying, 'Is that him, Is that him?'* Catherine

Maisie remembered having to buy clothes to dress her baby in before she left and then giving them to another girl to put on her baby, as she had to leave and get out of the way before the adoptive parents came in. She was required no longer.

*And then, they gave your baby to complete strangers.* Maisie

Similarly, Catherine remembered the deep pain she experienced on returning home:

*I was just expected to revert to type and the next day I remember being in terrible pain and my mother saying 'What's up?' and I was actually... I don't know whether this was psychosomatic, but I was in terrible, terrible pain and it was like all your womb area and stuff like that.* Catherine

Maisie also has powerful memories of returning home without her daughter.

*I remember being in my bedroom really really crying and me pleading with my Dad, and his answer was 'do you think we went through all of that just to bring her back here?' So it was more important at the time for my father to be able to say he had thought the plan through, it had come to pass, the baby had gone off, you didn't know where it went, and you go home in one piece. None of the neighbours knew, nobody at work, so you know, it was a success story.*

Maisie

She spoke about feeling distraught and visiting an adoption agency in order to ask for her daughter back. She spoke about visiting the area where she believed her daughter might have been placed for adoption just to be nearer to where she might be. She later recognised that she was clinically depressed after the parting:

*I was in one emotional chaotic state and nobody could help me.*

Maisie

Doreen vividly recalled travelling back on the train with her mother and her baby just before the parting:

*I held my child all the way back and it felt right. It was the longest time I held her. My father was there. That was the first time he had seen her. And he barely looked at her, barely looked at me. And I was thinking, they won't make me go through with it... And a woman in a white coat came and said 'It's time to hand her over', or something like that... And I never felt more betrayed. .... That moment defined everything else. Then they had to sort of pick me up off the floor 'cause my legs were jellified by then. And we went home and had a nice cup of tea.*

Doreen

Even Elizabeth, who had made her own decision to relinquish her baby for adoption, stated that the experience was extremely painful.

*I knew that on a certain hour on a certain morning, someone from the adoption agency would actually come and take my daughter... She was sleeping with her hand above her head and was wearing a pink nightdress with little mice on it. She looked fabulous and it broke my*

*heart and I cried and cried. That was utterly, utterly heart-breaking. I remember that nightdress, I remember her face, I remember everything about it. A very powerful and very painful memory. It was traumatic: I had abandoned my child. I walked away from my child; whichever way I wrapped it up. I didn't have to, but I felt, I felt, I had to. But I chose to. And yeah, that's pretty bloody actually. That's pretty bloody...and when I got home, my mother poured me a very large drink. I remembered that drink. There are very few drinks I remember but that's a very significant one. I was diagnosed as an alcoholic at age 32. Elizabeth*

Caroline talked about how she hated seeing Sister X from the adoption agency because she knew that all she wanted was Caroline's signature for the adoption papers. She described taking her son to the adoption centre dressed in nice clothes that her mother had sent her, and subsequently going home, where nothing was said about what had happened.

*And I hand him over to the mother (cries) and then I can picture them walking out of the building ... and I feel as though I have a wound inside that will never heal. And I woke up in the night and it was like clutching my stomach and I just don't know how I was going to cope with all these feelings.*

*Afterwards, Sister X comes around for lunch and I am just crying at the table but we just have the food and keep the conversation going. It was complete and utterly fucking (sic) denial Caroline*

On the other hand, Tina, who had made the decision to have her child adopted, talked about considering the possibility of keeping him but being overwhelmed by the realisation that she couldn't look after him:

*How would I cope, how would I work, where would I live? I could not see a reality where I had the baby. How would I earn money? Who would mind him? I couldn't work through it in my head. Tina*

She remembered being told by the hospital as she left that her son was losing weight and remembered experiencing feelings of vulnerability and guilt:

*I remember crying the whole way home and I kept phoning to get information. Was he ok? And they told me he has lost weight. And then I knew I shouldn't have left him. I should have stayed with him.*

Tina

She was offered the chance to meet the family who were going to adopt her son but chose not to, as she didn't feel worthy:

*I didn't want them remembering me as this pathetic, tearful, roaring young one. I didn't want that to be the lasting impressions. Tina*

She coped with it by believing she was doing the right thing for her child.

*There was this couple set up to have a child – they were psychologically and spiritually ready and my son was bound to have a better life with them.*

Tina

Tina went abroad to try and recover but she said she brought her 'broken-heartedness' with her. She remembers the adoption agency being concerned that she wouldn't sign the papers, as she had gone away:

*And I got some hefty letter from them; it might even have been telegrams. 'Where are you, what is happening?' and I'm saying, 'I'm going to come when I am ready. But I felt pressure from them. And I went and signed the papers and that was that. And I was told to put it behind me. Get on with my life. If only it was that easy. So yeah, that is how it happened.*

Tina

Catherine clearly remembered the day she signed the adoption papers:

*After six weeks, I had to go and sign the adoption papers, and that was the worst day of my life. I remember climbing the stairs and this man sitting there and he was a Justice of the Peace. He explained to me that what I had to do and that I had six weeks to change my mind. There was nobody with me. If I had said 'Yes, give me that baby', I would have been standing on the street with me and my baby and nothing... Afterwards, I looked into the mirror: I was 19 and I felt 90.*

Catherine

She went on to talk about how she felt over the following years and how she used alcohol to cope and block the memory of her child:

*After five years of weeping and wailing every day and feeling empty inside, I started drinking. I drank a lot and it was to take the pain away, or try to take the pain away. And I said to myself, no more crying, I'm going to be happy now, and I couldn't even remember his birthday, couldn't remember anything 'cause I wanted it out of my head.... I couldn't function, you know?* Catherine

Maisie also has a clear memory of signing the papers and how she complied with what was required. Afterwards, she felt that she had no further purpose:

*And I remember they sent you to a Justice of the Peace, and I must have done whatever I was to sign, and I must have signed it. Then they can say to you, 'You've delivered the goods, now we don't need you'.* Maisie

She spoke about her inability to cope with her emotions afterwards.

*And I was getting more and more like OCD (Obsessive Compulsive Disorder). I'd go to the chapel, light the candles, praying for her, thinking why she is not coming to me. Maybe she is dead.* Maisie

Jennifer had little memory of the actual birth or the relinquishment but spoke about the parts she remembered. She expressed a deep shame at not remembering more:

*Yes, I can remember saying 'I wanted to keep him', that's all I can remember, and my sister saying, 'That isn't fair'. She probably thought I wouldn't be able to handle it. I can't remember saying good-bye to him, I would have to... I can't remember. I can't remember, my friend came to get me, how did I get home? You know, it's awful I can't remember.*

*And I remember my friend asking me if I wanted a picture of me holding him, and I said no. And I haven't got a picture of me holding him. I guess I couldn't bear having a photograph holding him 'cause he would be gone. So I couldn't even do that. It's like being shell-shocked.*



*Regret, regret, I wish I had kept him. So, um, I think it's a big scar and it's where my anxiety and depression is.*

*I suffered from depression for many years and I had a breakdown. I started going to the church and the priest there was wonderful and I just talked through everything.* Jennifer

Doreen describes what happened after returning home and how empty and broken she felt:

*I lost a dimension for a while. I was cardboard. And then I had to go back to school... I just went through the motions for a long while. I didn't feel anything cause there was nothing left to feel. I completely lost contact with the person I wanted to be. I wanted to sing and dance and perform and be out there, but I was so broken, or felt so broken... and I remember thinking, how did I get here, what happened, what was broken?* Doreen

Caroline remembered how she tried to carry on with her life but struggled with everyday living.

*And it's like I don't know how to hold myself in life and I keep feeling so low and depressed and down and there is nowhere for these emotions to go. And I went home one weekend, and I'm sitting in the front room, I'm crossed-legged and I've got stripey pyjamas on and I have a pin and a blade and I cut every piece of skin on my arms as if they are tattooed, and my legs, I completely cover myself with cuts, and actually my blood and the pain of it was fantastic because at least it was a connection – I can feel it now, something is connecting with this inner pain that I've got, it's unbearable and in some ways it was a big cry for help... I was diagnosed as a manic depressive and put on medication... And I'm just feeling like I want to die. I climb into wardrobes, I sit in wardrobes, and I just want to get away and be in the dark.* Caroline

#### **4.3.3 Superordinate theme: The joy and pain of reunion.**

Six of the participants were reunited with their now adult child, and all of them described an almost ecstatic state during the initial reunion meeting, although for many, it was bittersweet, as it reminded them of what they had lost. All spoke about the difficulties of the ensuing relationship, from establishing the nature of their roles to the fragile, delicate manoeuvring required in maintaining the relationship. For four of them, the subsequent relationships proved difficult, with long periods of separation. Most of them felt that their child dictated the terms of the relationship and that they didn't have the right to argue or assert their own preferences or views, as they had given the child away.

The intense emotion was evident in Catherine's story, when she described her feelings on meeting her son:

*Oh amazing, I've heard people saying that they want to win the lottery; I know what that feels like. I've won the lottery when I met my son that day because he was alive, because I didn't know if he was alive or if he was dead.* Catherine

She then went on to describe how they met, but became overwhelmed when speaking during the interview about the meeting:

*And I went into a pub and there were two men sitting and there was a man standing at the bar and the man at the bar turned around and I went, 'That's my son'. And then we just looked at each other and, oh God, it was ...oh (cries).* Catherine

After that first meeting, she did not see her son again for three years. She describes how she felt when he didn't contact her:

*I was so happy he was alive, but I was bewildered: 'Why hasn't he phoned?' I was getting used to the feeling of being empty – just emptiness.* Catherine

Then she remembered something he had said to her which possibly explained why he had not contacted her:

*He said he wanted to punish me: he wanted to hurt me because he felt hurt and upset.*

Catherine

She discovered that her son had been brought up two streets from where she lived and was likely to have come into contact with her daughter, his half-sister. She also discovered who his adoptive parents were and realised that the adoption agency had lied to her about their circumstances, as she was told he was going to a well-off home. She spoke with anger about this:

*I had no idea she was the woman that had my son and when I found out I had this rage inside me. My parents, how fucking (sic) dare they, how the Catholic church did what it did to me because I was brought up in a council house, my son went to people who stayed in a council house, his mother wasn't even a bloody (sic) nurse, she was a care assistant. I mean, talk about feeling cheated. I got all this inside and I don't know what to do with it. Who can I blame? My baby was taken from me. The Catholic Church has a lot to answer for.*

Catherine

She went on to describe getting to know her son, but recognised that the relationship became more distant when he got married. She also spoke about the sadness of not being allowed to be a grandmother to her grandchildren:

*And all I can say now is that he is in my life but not in my life, and I feel like, I feel like I've gone into a room and there has been a big banquet and all these people have been invited; and the tables groaning with food and drink; and everything you want is on the table; and I just sat down and I've had what I wanted to eat; and then I've gone into the room and the room is empty; all the people have gone and all the plates are empty; but there are crumbs on the floor, and I'm hungry and I'm down on the floor eating the crumbs cause that's how I feel; that is what I feel I've got in my life: crumbs off a table. Because my son acknowledges that I didn't flush him down the toilet, he acknowledges that I gave birth to him, and I'm only good enough for babysitting... I don't get to be a granny...I'm in the background, in his life but I am way in the background.*

Catherine

Maisie had similar feelings of elation when she first met her adult daughter.

*I remember trying to keep it together and I'm thinking, 'What will I wear?' You're just about to explode but you can't because you want to go and do this thing but it's like awesome, seriously awesome. I cannot believe my good luck that I have eventually found my child.*

Maisie

Again, similar to Catherine, she didn't meet her daughter again for many years and has had intermittent contact with her ever since. She has accepted the situation to some degree but feels burdened by it:

*Well, as I say, I'm in a sense doing the thing of gratitude, I'm not looking at my story now and thinking 'Woe is me'. I'm out of the black hole of Calcutta, I found my daughter, she is not dead; she has given me a lot of virtual grandchildren, so there's loads and loads of pluses. And for me, you have to offset and say well, the negative could be she is not that daft about me ...I don't know, it's much more of a story rather than a cross when it's the early days. That is what it is; it's a big cross on your back.*

Maisie

Doreen also described feelings of joy at the first meeting with her adult daughter:

*She came out and it was like looking at a younger version of myself. And I, we, just stared at each other. And she said, 'I thought you weren't coming'. And I just looked at her and you know, we sort of hugged, and spent some time together. It was very strange, we ended up comparing elbows – the kind of stuff you would do when children are children. And then her adoptive parents came back and they treated me like I was a naughty child. But to them, I was always the fallen woman, I suppose...*

Doreen

She recalled her daughter's 21st birthday, to which she and her husband were invited by the adoptive parents but she was left feeling like an outsider:

*And we walked into this room. And it's a huge family. And I have people coming up to me going 'I know who you are, glad you could come'. I had no clue who they were. I felt like the spectre at the feast. It was the weirdest feeling. It was lovely to be there but at the same time awful. There was this feeling of, em, what might have been.*

Doreen

She described her relationship with her daughter as being '*up and down*' and how difficult it was for her to relate at first, as she had '*holes*' in her memory. Her daughter, however, believed that Doreen was concealing things. Doreen now feels that they have reached '*a much better point in our relationship*'. However, her daughter still defines the roles in their relationship:

*She doesn't call me Mum, it doesn't work, because she had, she had somebody who looked after her, brought her up, did all the things that a mother would do... Our relationship is a comfortable one now, but for a while it wasn't.*

Doreen

Doreen's daughter has six children, but Doreen states that '*it's been made very clear to me that I'm not their grandmother*'. However, she believes that it is better to have contact on her daughter's terms than to not have contact at all.

The intensity of the initial contact was also highlighted by Elizabeth, who described the first contact through written correspondence in the form of a letter from her daughter:

*And I remember... it was really awesome getting that letter. I looked at the letter and the letter looked at me. And I opened it and this photograph fell out. And I did not stop crying for two hours. I howled. The shock of seeing her face was enormous. It was like looking in a mirror. It was most profound.*

Elizabeth

She went on to describe the first meeting, which included a comparison of physical features, as it had for other birth mothers in the study. This first meeting ended without any suggestion of a second meeting:

*It was ...quite surreal... did all the usual, chatted away and looked at each other and scrutinised each other, hands I mean, everything. Looked closely. Really intense examination of each other. She caught her train back and didn't give any signs at all of wanting to meet again.*

Elizabeth

They did meet again, but it didn't go particularly well and Elizabeth remembered her daughter saying to her '*I am going to hurt you*'.

They met a few times after that and then Elizabeth did not hear from her for more than three years, until Elizabeth found her on social media and made contact again. They remained in touch for a while:

*Yeah, it was beginning to develop. It was recognising that she, it wasn't going to be me, was holding back. She was...wouldn't hug me. She kind of put her arms around me, kept her distance, and give me a peck on the ... You know...it wasn't overly effusive on her part and I felt I was walking on eggshells but.... We were getting on. It was like having a family and I thought 'Wow, a family!'*

*And then, she broke contact again. Just like that. A guillotine had fallen. And I began to think, I'm being wound in, she's getting me really close and then she is hitting me as hard as she can. That is just what it felt like. And the words 'I am going to hurt you'. So I'm left, 'What have I done?', asking her, 'what have I done? Can you tell me what I have done?' You haven't done anything, I thought, I've only given birth to you. That's the biggie. That the really existential biggie, isn't it? I brought you into this world. It's everything. It's all my fault and you are going to make me pay.*

Elizabeth

They saw each other intermittently over the next few years, when Elizabeth discovered that her daughter was an alcoholic and had tried to commit suicide. Elizabeth herself had been an alcoholic but had not had a drink for over 30 years.

The relationship came to an end when her daughter asked her for money but Elizabeth refused, as she assumed that she was going to use it to buy alcohol. That was more than three years prior to our interview, and despite Elizabeth trying to renew contact with her daughter, she had not heard from her since. Elizabeth believes that she has lost her daughter '*lots of times*' and that her daughter is intent on punishing her. She doesn't believe there is much hope for a future relationship:

*I've been made... I really feel that I've been made to pay. I can't get rid of that feeling because she said she was going to hurt me and every single cut has been abrupt, almost brutal, no explanation, anything. The door is closed.*

*And I really think that when she learned she was adopted she may have thought the same thing – what have I done? What have I done to be given up for adoption by my mother.*

Elizabeth

Caroline spoke about the excitement of meeting her adult son for the first time and how she tried to hide her feelings:

*My mother had coached me so well in thinking that there is no space for how I am feeling really – it's all about him, so you have to be contained – so when I met him I was obviously excited and exuberant and I think that there is a kind of mode that I go into as a kind of 'I'm coping with this scenario', and I don't think I was able to let him know how painful it was for me 'cause I was terrified of hurting him or was terrified of doing the wrong thing... And I'm aware of a kind of awkwardness on some level but it's me wanting him to feel ok with me.*

Caroline

She met up with him on two more occasions, and although she continues to email him, she does not receive any response. She now believes that she wants a relationship with her son, or at least wants him to know that she is not a robot who gave away her child without any emotions:

*He didn't ask me any questions: I wanted him to but I didn't feel I could speak unless I was asked. I want my baby back... right now I feel like I want to dwell on this child that I haven't been able to nurture and bring up and breastfeed and treat like my children and it's almost as if I want to go through his life. ... I would like to connect with him again, I feel now that I could have a more meaningful connection with him and I would like to have it.*

Caroline

Tina described being overwhelmed with emotion the first time she was reunited with her son:

*It was something I had waited for all my life... I found that time of knowing I was going to meet him, I found that almost unbearable. I was sleepless, I was full of everything. Joy, grief, everything. And I remember saying to my partner, 'It's like someone coming back from the dead.' That is the only way I could sort of describe it.*

*And I appeared at the door and he came out with his parents behind him and he was just the most stunning beautiful boy I had ever seen, and I don't think I hugged him. I was too kind of stunned... It was like looking in the mirror and it was... and he was so like my daughter.*

Tina

She described how kind the adoptive parents were to her and how everyone acknowledged that they should be mutually grateful:

*I remember seeing a picture on the wall of his (adoptive) Mum and him, a very loving intimate picture. And she said 'What is it like for you to see that?' And I said 'it's like seeing one's husband with another woman'.*

Tina

She remains in contact with her son but recognises that theirs is a different relationship than with her daughter whom she raised. She regrets that her two children were not brought up together:

*Well, we do have an intimacy but it's like, he is from a different tribe. He looks like us, smells like us, is like us, but he is in a different tribe. I went through years of really killing myself about it. You know, being very cross with myself and very unforgiving of myself, you know? I remember once sitting in group therapy saying, 'Even animals don't give away their young'. So I was quite harsh with myself. One of my biggest pains is having separated the two of them. I feel very uncomfortable about that.*

Tina

Tina recognised that her son has two families to contend with and saw how difficult this might be for him:



*So I said to him, 'You must never ever feel obligated. I don't ever want you to do, or be, or say anything in obligation to me being who I am. Your Mum and Dad are X and X, and yes, I'm your birth mother and always will be, but you know, one family is enough to feel duty bound to'.*

Tina

Jennifer was the only woman I spoke with who had not been reunited with her child. An adoption agency had found her son and there was some written correspondence between them, but he decided not to pursue contact at this point. She has little memory of the whole experience from becoming pregnant to giving up her child for adoption. She does not know who the father of her child is and is deeply ashamed about this. She feels that the people who adopted her son were 'better' people than her:

*I really wanted to contact him, but I was afraid as well, because of the father situation. What do I say to him? How could I sit in front of him and say, 'I don't know who your father is, I don't know'? Although I would love to see his face, I don't want to mess his life up. I would like him to know that I wouldn't mess his life up in any way. I was really upset when he didn't want to see me. But I was still afraid of what I would say to him. I was very pleased to hear that his parents have nurtured and helped him a lot, but I just want to see his face. I don't want to spoil his life in any way (becomes emotional), you know what I mean? I don't want to give him a problem. I feel very sad, well, it's like having part of you cut off. Isn't it? I cope with it by thinking that those people (adoptive parents) were better than me.*

Jennifer

#### **4.4 Master Theme Three: Experiencing psychological distress**

The significant impact of relinquishment was often compounded for the birth mothers by the feeling of being ignored and silent about their experiences throughout the process and in the subsequent years. Five of the women felt that they had no voice and no say in the decision to give up their child. If they had a voice, it was ignored. People talked around them, not to them, and all felt an acute sense of being alone, with their feelings unacknowledged. All were terrified – they

didn't fully understand what was happening to them and were left alone to deal with their loss and pain with no support, professional or otherwise. One woman has no memory of any of the circumstances around the birth or relinquishment of her child and felt disconnected from her own experience. Even in reunion, the symptoms of the psychological pain from the birth and adoption re-emerged. Some turned to alcohol as a coping mechanism, with promiscuity and self-harm featuring as resultant behaviour. Two contemplated suicide and others talked about experiencing PTSD symptoms. Three of the women experienced what they described as breakdowns in their later life. All of the women believed that giving up a child for adoption had significantly impacted on their lives and that some level of pain would stay with them for the rest of their days.

#### **4.4.1 Superordinate theme: Being invisible**

Most of the women felt that they were never asked what they wanted to do with their baby, or how they felt about what was happening to them. This resulted in five of them stating that they felt ignored and unheard. This feeling was experienced throughout all the stages, with two women stating that this current research was the first time anyone had asked them what the experience was like for them. All of the interviewees felt that they were expected to carry on with their lives as if nothing had happened and although some felt strong enough to express their views to their parents, they felt that they were disregarded or unnoticed.

Catherine spoke specifically about not having a voice regarding the decision to relinquish her child. *'My mother made the decision, I had to go along with it; otherwise I was out on the street'*.

This feeling of invisibility was linked, for some participants, with a feeling of powerlessness. Maisie stated in her interview that she believed that she could have taken care of her daughter but that she was defenceless against the system that was in place to deal with unmarried pregnancy.

*I could have taken care of her. I would have been all right. I could have gone somewhere to stay... I would have been able to do it...I think it was a hierarchical decision in all honesty. A lot of it is predicated on the fact of your religion and again I had the conflict because the boy was a Protestant. If he had been a Catholic he would have got more credit, he would still get into trouble because the GP was a Catholic...*

*You know there is an element that you need to blame your parents, but actually they were just as conditioned to go into that ready-made system. If that ready-made system wasn't there, there would have needed to be some other resolution and again you think there is no point blaming anyone really: it's just like a set of time and circumstances and that was what happened.* Maisie

Doreen remembered feeling invisible from the very moment she told her parents and they took her to the doctor:

*I remember, he didn't speak to me, nobody spoke to me. And he spoke to my parents separately... And afterward, I just sat there frozen, with them yelling at me.* Doreen

She remembered another occasion when her mother said to her that she wished she had known earlier, as she could have arranged an abortion:

*But she never actually asked me if that was what I wanted. So that is the whole thing, you know, I wasn't in the equation. The equation was all about the inconvenience I had created and what had to be dealt with. And I was expected to just go along with all of that, which of course I did.* Doreen

She recollected that when her waters broke and she started labour, she looked for help, but was not believed:

*I'm sure they (the nuns), weren't medically qualified, but one of them insisted on examining me to make sure I was in labour. And that, I thought was... if felt it was such, it was such an indignity. I felt really horrified by it to be honest. She was sort of arguing with me about whether or not I was in labour. And then I had a contraction, and she went 'Oh, well maybe you are'. Everyone fussed around me but nobody spoke to me. And I can remember being so frightened.*

*Nobody looked at me and said, 'Oh my God, she is only 16' and held my hand and said 'It's going to be all right.*

Doreen

She later described that when her mother came to see her daughter, she had no voice to express her thoughts.

*She bent over the cot and said 'She is going to make someone really happy'. And I wanted to say 'Well, why not me?' I couldn't get the words out. I couldn't speak when she was in the room.... And I felt like I may as well not exist 'cause there is no acknowledgment of me in any way.*

Doreen

This was a common view expressed among the participants, with Caroline similarly stating that she was unable to express her views as to what she wanted:

*I didn't have a voice then. There I am at 19, doing as I am told. In a way I wish I was left to my own devices 'cause then I would have had my baby. To be honest, my mother likes to say that it was my decision.*

Caroline

She described how she tried to make sense of it afterward and said she '*wasn't allowed to cry*'. In fact, Caroline stated that she feels as if she has been silenced throughout her life until now:

*I've never told my story to anyone; nobody in my family ever really listened to my story, so actually to be able to tell it is very validating because I haven't been able to tell my son. I feel as if it's been forbidden and this event was as if it didn't happen. But yes it did.*

Caroline

Doreen also noted this feeling of invisibility when her mother took her for a postnatal check-up: an invisibility which spread beyond the process of relinquishment and into decisions about her body and even her sexuality.

*And she and the nurse had a conversation about me, whether or not I should be fitted with a coil, because 'You know, once they've said yes, they will say yes again'. I remember thinking, 'Well, hello, I'm here'. But apparently I wasn't because the conversation carried on around*

*me. And my mother said 'No, I don't think that is appropriate', so still, she was sort of taking away my body autonomy and leaving me bereft of not only my child, but my rights, and my choices, and myself'.*

Doreen

#### **4.4.2 Superordinate theme: Feeling alone**

There was a strong feeling amongst all of the women that they had received little support or kindness during their experience, and this made them feel very alone, and in some cases isolated.

Catherine remembered being frightened and having no one to turn to.

*I was scared, just scared, wondering what was going to happen. I didn't even know what adoption was, I didn't know what it was, I knew I was pregnant and that was it...I had no support whatsoever.*

Catherine

She recalled getting ready to go home without her baby, and a nun telling her that she was lucky to be going home to all this love and support.

*But it didn't work out like that. I went home and I wasn't supposed to talk about it and I had all these hormones raging, and I was going off my bloody head and all I wanted was babies around me and teddy bears and cuddly toys and little bouncy lambs.*

Catherine

Doreen remembered feeling like a prisoner in the Mother and Baby home, as she had 'no money, was sworn to secrecy and had nobody to turn to'. She described her isolation during that period:

*I felt like I was completely out of control – my body wasn't my own and my life wasn't my own. It was really frightening. At the back of the house was a fire escape and they used to leave the door open because it was warm, and several times I would go out there and watch the sunset, and I would look down. There was a courtyard at*

*the bottom, because we were at the top of the house. Um, quite a way down. And I used to consider just climbing over and dropping off. Nothing could stop me... I could see myself bursting like a ripe melon, and I thought, 'well, if I do that and then I live, things might be far worse'... And if I did that, what would happen to this baby...? But yeah, I can remember being really really afraid and isolated and confused. It was a horrible way to treat a kid really.*

Doreen

She described a social worker who told her that they would select the right parents for her daughter, but who wasn't there when Doreen needed her:

*I'm not sure how she came to be my social worker. This woman knew a lot about what I was thinking; 'I know you'll do the best thing; I know you'll do the right thing; I know you won't change your mind; I know you'll go through with this and won't make life difficult for us'. That kind of thing. So she seemed to know a lot about what was going on in my head – a very knowing person. But she wasn't there when I needed help support and counselling, comfort, help with grief. She wasn't there. She was only there at the beginning, because that is all that mattered.*

Doreen

Caroline remembered a similar feeling of being alone and wanting to die following her father's rejection of her when he when he found out she was pregnant.

*Oh, God, what have I done, and I was really scared and I thought I need to kill myself, I need to let a bus come over me and then came the realisation, 'Ok, I am on my own now'.*

Caroline

She recalled trying to find the doctor's surgery in order to register and '*feeling so lost and alone but yet I know I've got to do this, so I do, and I'm very good at making the best of things*'.

She also remembered feeling anxious and alone, just before giving birth, and as she didn't know what was going to happen:

*I was feeling very anxious because I didn't know what was going to happen, but I knew I had to cope with it ... I was very much on my own with all of this.*

Caroline

Elizabeth also recalled feeling very alone when signing the adoption papers, despite having made the decision to relinquish her baby:

*I did actually weep when I lost her and signing the papers wasn't easy and I did that on my own. I did so much of this on my own. And I didn't see it at the time that I was on my own. But now I see.* Elizabeth

Additionally, Jennifer, who can remember only a few details of the experience, believes that if she had had support, *'the outcomes would have been different'*.

#### **4.4.3 Superordinate theme: A lifetime of pain**

Throughout the interviews, it was evident that the psychological impact of giving up a child for adoption was long-lasting, with many still intensely feeling the impact years later. The topic of long-lasting pain was expressed through different avenues during the interviews, including the impact it had on subsequent relationships with partners and children born later, the remaining anger and need for accountability, and the mental health problems experienced by some. Three of the participants stated that these interviews were the first time that they had talked about their experience from an emotional perspective. Catherine also acknowledged this and stated that this research interview was the first time she had even spoken about her emotions.

*I drank a lot and it was to take the pain away, or try to take the pain away. It caused problems in my marriage, it did cause problems 'cause I never dealt with it, in my head I never dealt with it, and sex caused huge problems.*

*I've been through so much emotional pain. When my daughter was young, she started cutting herself and we had to take her to a child psychologist.... I thought they were going to take her away, I couldn't let her out of my sight because I kept thinking someone was going to take her away, because they took my baby away. And I believed I've got to be this perfect mother. They put me on Prozac and I was on*

*that for years and it kind of quietened me down... I'm a recovering alcoholic so I know what group therapy stuff is all about but you are the first person I have ever spoken to about all of this. Catherine*

She also stated that she feels that she deserves some reward for all she has been through.

*I deserve a massive amount of gold because I gave away the most precious thing in my life to strangers, to absolute strangers. No, no, no, no, that's wrong, and if there is anything out there then I know if I don't get rewards in this life, I'll get my rewards in another life.*

Catherine

However, like many of the participants, she also expressed considerable anger towards the Catholic Church and others for how she was treated.

*It was cruel what was done to me and women like me, and the Catholic church has got a crime to answer for, because they put in place the homes where unmarried mothers went, and all this guilt and the shame and it was a big big machine because priests were involved, nuns were involved, social workers were involved, the butcher and the baker would come and deliver stuff to the home, they knew who we were and they talked about it... It was cruel to be told there were no choices when there were choices and there was support out there and I was denied that support... If you were a lawyer sitting here in front of me, I'd say 'give me compensation. I want compensation. I want you to take the fucking (sic) Catholic Church to court'. You see on television about all of the paedophiles. What about me? My pain doesn't go away, my pain will never go away until the day I die, when I take my last breath on this life. I'm still happy that I have met him, I'm extremely happy at that because it gave me a sense of peace inside that he was still alive and a sense of peace that I knew who he was.*

Catherine

Elizabeth spoke about not wanting more children and, similar to Catherine, spoke about how alcohol dominated her life until she was diagnosed as an alcoholic at age 32, at which point she stopped drinking:

*But for a time, I hadn't thought about wanting children. I joined an airline, which is great for a budding alcoholic, and had a wonderful career until I became impossible with alcohol and I lost my career as*



*well. So, then it went, I went, thoroughly downhill, so really, there was no way I was going to have another child really. Elizabeth*

In terms of the impact of the whole experience, Elizabeth believes that for her, *'it has left a vacuum'*:

*Mother's day for me is extraordinarily difficult. I hate it, I absolutely hate it. A very difficult day for me. Elizabeth*

Maisie remembered experiencing intense loss and longing after parting with her child, and recognised how depressed she felt afterwards.

*I am not at peace, why am I not at peace? Because I am demented: 'Where is she? How is she?' I have lost my child; she is out there somewhere. Maisie*

She also now considers that the experience remains a *'big cross on her back'*.

Jennifer, who never met her son, was unable to have more children.

*I wanted children and that didn't turn out. I thought it was a twist, a cruel, cruel twist. And how could I adopt after giving up? I made one huge mistake by not keeping my baby. I'm afraid to make any other decisions. Jennifer*

She suffered from anxiety and depression for years afterwards and eventually had a breakdown. She still recognises that she doesn't feel quite right and doesn't fully understand what happened to her:

*I always had it in my head that I wasn't where I should be, and, how can I say this, I feel as if I am not a full person...Did that really happen...? It has been for me a very heavy burden, very heavy burden. I don't think it is ever going to go away, and it's always going to be... you know... I would really love to meet him... but it's not going to go away. Jennifer*

Doreen also commented on how the experience had impacted on her ability to relate to people, describing how difficult she found it to have any relationships after her experience:

*I couldn't relate to people: I was a serial monogamist. I couldn't get involved with people. Because I couldn't trust myself and I couldn't trust them. So I felt this complete disconnect. So it affected any physical and emotional relationship.*

Doreen

She then described how she had become involved in an abusive relationship, because she wanted someone to look after her:

*He was a big person and I presumed I was looking for someone to protect me. He blacked both my eyes, broke my nose, threw me across the room. Because I was emotionally vulnerable, very vulnerable emotionally, I took all that. And then one day I woke up and thought, 'No'. And I said to him, 'If you lay one more hand on me, I'll kill you'. And at that point I knew I had some power.*

Doreen

Doreen had no more children and remembers vividly what she felt after the birth of her daughter.

*In some circles, they talk about people expressing themselves and how their words have a physical manifestation, so if you say 'someone is a pain in the neck', you might reflect this by showing or pointing to the neck. So for me, I found myself saying over and over again, 'I couldn't bear to go through that again', so I bore no more children.*

Doreen

However, Doreen went on to describe how she began to regain control of herself.

*I had an eating disorder, which was a huge problem, so I have to exercise manically. And I thought, 'you can't carry on like that, it's not good for me, it's not life affirming'. So I had a series of realisations but it took a very long time.*

Doreen

She spoke emotionally about how these intense emotions could be triggered and described the reaction she had, thirty-five years after her child was adopted, when her mother apologised to her for the part she had played in the adoption process:

*And it was as if something moved in my mind. I can remember making a really odd noise; I think it was a sort of howling... I felt very odd; I went through a whole cycle of loss and grief... And all my repressed memories came back. I had all the post-traumatic stress stuff going on, I had flashbacks, I had nightmares. I had (sighs) really negative feelings and I actually reached a point where I thought about suicide because I couldn't cope with how I felt. And then I just turned a corner and something changed. It was like everything had come back that could come back. And I feel like I own myself again. And it's taken all this time.*

Doreen

When talking about the lifelong impact, Doreen added:

*I think the feelings are not as raw.... It's like a wound that never heals but it finally stops bleeding. Um, I think I am still very sad. I think there is still grief and loss. But I am at the point where I'm not overwhelmed by the feelings in the same way. And I am able to articulate them more effectively than those times when I was younger and couldn't speak. I couldn't say the words about, I couldn't put my feelings into words 'cause they were so painful... I don't think they ever go... you just get to the point where you don't fall to bits when they come up.* Doreen

Similarly to Catherine, she also expressed strong views about accountability and injustice and states that somebody should be held responsible.

*Those who treated young women and girls so callously, everyone from the medical profession to those in the Roman Catholic Church, to those in social services and the justice system, parents, guardians, people who make decisions for others who really ought to have been given their own voice. I think there ought to be a level of accountability, even now after so many years. And until something is expressed in those ways, until people who've perpetrated all of this are held to account, I think that injustice won't be recognised.* Doreen

Following the relinquishment of her son, Caroline was diagnosed as a manic-depressive and put on medication:

*I have this wound inside me that will never heal and I can live with that, but over the years, it's as if my family have completely and utterly denied that this has happened and I have felt subjugated as a person... I had this huge sense of shame, and I realised how much shame I was carrying, how buried I was, I didn't feel good enough, nothing was good enough about me.*

Caroline

She talked about how she struggled with relationships and with sex, even in marriage.

*I think sex has made me feel guilty for a lot of years, even after being married. I've had lots of different relationship where I've been in relationship with people like my father who have needed healing.*

Caroline

She is now trying to move on with her life and is ready to make a change. She sees her participation in this interview as helpful in making that change:

*I've had 30 years of just living in a cave in the underground; it feels as if I haven't been alive and it has put me in prison, it has made me feel very ashamed at a very deep level.... I've been good at keeping going, all the while underneath there has been something rotten, and turgid and black just rotting inside me and I'm not keeping the lid on that anymore...I feel as if my life has been on hold and now I'm going to start living again and I'm not frightened to have a voice. I'm very good at just behaving as if nothing has happened – I'm not doing it anymore, but yeah, it feels on one level exhausting but on another releasing, so I feel very freed actually sharing this information.*

Caroline

Additionally, Tina talked about the impact of the experience on her relationship with the child she has raised, and that her role as a mother was affected by the grief she held for her adopted child:

*One of the things my daughter tells me is that she was lonely as a child. That I wasn't always available. And I think, I finally realised I was still grieving.*

Tina

She summarised the overall experience as living with sadness and pain, on some level, throughout her entire life:

*I felt on some crazy level that I deserved this wound. I think it has impacted everything, in some way or another. I think I have a huge sadness about it. I think it was a terrible thing to do. I think it's a terrible thing to encourage women to do. Crazy to think it would be ok to take your child from you and never see them again. I've spent most of my life with people who are unavailable. Part of me is broken- hearted all the time. I wouldn't recommend it to anyone. It's the most deeply painful, deeply, deeply painful thing you could ever do to yourself. Tina*

#### **4.5 Reflexive statement**

The identification of the themes from the transcripts presented huge challenges for me. When choosing extracts to quote within my findings, I found myself drawn to, and fixated with, sections of the transcripts that resonated with me, even though I was conscious of the pain that this was causing me. It was as if I wanted to see my own experience in black and white as evidence that I had shared the same experience as my participants, as if I needed an explanation for my years of unprocessed pain. Despite this emotional turmoil, I was able to identify what was happening to me as an emotional bias and was aware that it could skew the data. Subsequently, I knew I needed to detach myself as best I could from the data to prevent this happening. I reverted to a well-established behaviour that I had developed and used as a coping mechanism in the past: I disassociated from the emotional element of my own experience. Initially, this appeared to work, as I could read the transcripts more objectively and choose extracts from a logical perspective. However, it felt somewhat surreal - almost as if I had no relationship with the research. As a result, the flow of my work stopped; I became stunted in my thinking and couldn't progress with my writing. During this period, as part of the DPsych programme, I attended a professional knowledge seminar at Metanoia Institute entitled '*Using Therapeutically Informed Imagery to Enhance Researcher Reflexivity*' which was run by Dr. Val Thomas. The idea of using imagery in my therapeutic

practice was not something I was familiar or comfortable with, as my therapeutic orientation is CBT and my dominant way of thinking and working is from a cognitive perspective. Therefore, I approached this seminar with a degree of scepticism and apprehension. During the seminar, we discussed where we were with our research projects and were asked to draw an image that reflected our current position in the research. I struggled with this task, as I didn't know how to, or indeed have any desire, to describe in words or pictures the nature of what I was feeling, but an image eventually emerged, I think from my unconscious. It was a simple image of an outline of a heart with solid edges and an empty centre that was suspended on its own, and isolated. I was required to write a reflective journal following the seminar, and below is an extract from my journal as to how I interpreted the image.

*The heart represented how my heart felt – I was alone with the emotional pain that had been triggered by the research. I was in denial about its intensity. My feelings were securely protected with no means of escape, hence the solid outline. My pain was tightly contained, and I didn't want to acknowledge it. More significantly, I didn't want anyone to see, I didn't want my vulnerability on show. It was as if my pain didn't exist - hence the empty heart. (Extract from my own journal. Written 9th December 2016)*

Following this experience, I recognised that I could not continue with my analysis until I had fully acknowledged the pain and allowed myself to be soothed. As I carried on with my work over the following weeks, many tears were shed, but out of the tears came a clarity, which enabled the work to flow. I was comforted by Etherington's (2004) belief that by using reflexivity in research '*we close the illusory gap between researcher and researched and between the knower and what is known*' (2004:32). This reminded me that reflexivity is concerned with who I am in the research, and therefore, by denying the emotional impact of my own experience, I was not being authentic. This awareness facilitated me in working through the data in a methodical manner, with as much objectivity as possible and with full acknowledgement of my own experience.

## **4.6 Summary**

This chapter presented the data from the research in the form of three master themes: (1) The power of Social Stigma; (2) The unique experience of relinquishment; (3) The psychological impact of relinquishment. It also identified eight superordinate themes, which were presented using verbatim extracts from the transcripts to support the identified themes. The next chapter will discuss the findings in the light of the research question and existing literature to address the aims of the research.

## **5. Discussion**

### **5.1 Introduction**

This chapter will revisit the aims of the research and highlight the areas from the findings that support existing research. The findings will be discussed under the three master themes: the power of social stigmatisation, relinquishment as a unique experience and experiencing psychological distress. These themes will be explored in relation to the existing research and the research aims of this study, which set out to understand the depth and breadth of the experience of relinquishment on the birth mother and to establish whether the impact was long term. The objective of the research was to use the findings to develop therapeutic guidance for practitioners working with this group of women. Additionally, I hoped that the research findings would be useful for practitioners working with current birth mothers whose children have been taken from them into the care system and subsequently adopted.

This study asserts that the current findings are congruent with previous empirical investigations into the experience of relinquishment but have been extended to include some incremental knowledge, which will be covered later in the chapter. The inclusion of additional literature is due to the nature of an IPA study, which can take you to new and unanticipated territory which is acceptable to introduce for the first time in the discussion of the data (Smith, Flowers and Larkin 2009). The chapter will conclude with a reflection on the limitations of the research and suggestions of areas for future research.

### **5.2 Theme One. The power of social stigma**



This study reaffirms many themes prevalent within the literature, including the stigmatisation of unmarried women between 1960 and 1990, the influence of the Church and State in finding solutions to the 'problem' of unplanned pregnancies and the social and moral condemnation of those who did not conform to the norms of a conventional family structure (Wegar, 1997; Keating, 2008; Sandhu, 2012). It was clear from the research findings that this stigma arose from wide-ranging sources, which included religious organisations, medical staff, adoption professionals, and family members. All the participants were influenced by their parents' views and attitudes, and therefore the shame they felt was partly vicarious: their parents were generally from a generation that grew up in the 1930s-1950s and had acquired a set of values that emphasised the traditional family as the only acceptable familial structure. The findings clearly show that the parents of unmarried pregnant girls believed that having an illegitimate child and raising the child as a single mother was morally wrong and socially unacceptable. In these circumstances, the concept of family honour and respectability was deemed to be paramount, and adoption provided a solution that allowed the family to preserve it:

*My Dad shouted at me initially and then he stopped speaking to me. He just wouldn't talk to me. Neither of them acknowledged that it was their grandchild. It was just something horrible to be got rid of.*

Doreen

*My Dad turned my son's photograph to the wall.* Catherine

The legal position regarding adoption added to the stigma. Secrecy was enshrined in the process through various adoption acts, which ensured that adopters' identities remained undisclosed, and the culture of secrecy surrounding adoption only exacerbated the closed nature of the process. The experience of women in the study, all of whom parted with a child for adoption, is well encapsulated within the literature: in Sawbridge's words, *'that there was not even a hairline crack in the wall of silence, let alone a suggestion of openness'* (Sawbridge, 1991:116). Social policies at the time were also factors in reinforcing the stigma of single parenthood, with society being geared economically and socially to two-parent families. The housing plight of the single parent was not considered until the introduction of the Housing

Act (1977), which extended housing provision to non-traditional families such as single parents (Crowson, 2012). Prior to this act, unmarried girls who wished to keep their baby would probably have had nowhere to live except with their parents or relatives. Additionally, there was limited state income support for women who could not work and very little pre-school provision. Child benefit was introduced in 1977 and phased in from 1977 to 1979 (Revenue Benefits, 2016). However, the first piece of family legislation in the UK which did not describe children born to unmarried mothers as 'illegitimate' was not introduced until the reform of the Family Act in 1987. Instead of using the term 'illegitimate', it described such children as having parents who were not married at the time of birth. Illegitimacy has not been used as a legal term since (Robinson, 2015).

Alongside the legal position, social stigma in relation to adoption was exacerbated by the psychoanalytic literature of the time. The literature review found that such studies tended to begin by assuming that something must be wrong with the unmarried woman who found herself pregnant. The putative failing was illustrated as being '*a fault found in the personality of the mother in supposed unconscious drives, or in the prior socialisation patterns of the woman*' (Hartley, 1975:75). Indeed, it was only in 1959 that the Mental Health Act of 1913 was repealed, thus taking away the right of authorities to commit women regarded as promiscuous or morally defective to a mental institution.

Similarly, Bowlby's work on attachment (1951: 1958), which was prevalent after the Second World War, also contributed to the stigma of single motherhood. Within this work, Bowlby suggested that mothers who could not care adequately for their children were likely to raise children with emotional difficulties, and he viewed full-time motherhood as essential to the emotional stability of a child.

*Thus, if a single mother chose to keep her baby and support herself financially, they would have been condemned for providing an inadequate level of care for the child. (Sandhu, 2012: 105)*

Furthermore, Mother and Baby homes, although set up to provide a place of safety for pregnant single women, became a hiding place by isolating them from the support of family and friends and thus increasing the growing feelings of stigmatisation. Robinson describes this as '*segregating the sinful from the righteous*' (2015:106). Whilst these homes might have been a welcome refuge for some, and provided camaraderie with other women in the same position, it was clear from the research that the women who went there were viewed by the people who ran them as having breached some unwritten societal law. All such homes were affiliated to religious organisations, with moral welfare officers assisting the women in the adoption process. Jones (2015) points out that it is important to be aware of the moral welfare workers' ethos, which included a spiritual as well as a pragmatic vocation:

*Moral welfare work explicitly combined a concern for the material welfare of people in sexual difficulty with concern for their spiritual welfare. This metaphysical concern was grounded in the fundamentally democratic doctrine that all humans are fallen sinners.... Whilst it was not the moral welfare workers' task to force Christian standards of morality on these women, differences in moral and spiritual status would have been more than visible in this context. (2015:153)*

Similarly, Sandhu (2012) suggests that adoption agencies were acting as guardians of public morality. Her interviews with agency professionals and documentary sources show how the social condemnation of unmarried mothers was '*reinforced by agency policy and practice, which enshrined secrecy in adoption thus adding to the stigma*' (2012:254). This was touched upon in the interviews, in which some of the women believed that that they were not told by the agencies what support might be available to them.

*To be told there were no choices, when there were choices. I was lied to on a daily basis.*

Catherine

In reality, the choices were daunting. A woman could keep her baby if she could overcome widespread social disapproval, poor housing and an absence of financial

support, and somehow maintain enough self-esteem to see her through what lay ahead (Shawyer, 2003).

The responses of the women in the study as to how they experienced stigma were consistent with a social cognitive perspective of public stigma: the public perspective comprised '*stereotypical attitudes, prejudice and discrimination*' (Knight, Wykes and Hayward 2003:214). The attitudes the women experienced were predominantly negative and many internalised these negative attitudes and blamed themselves for their predicament. They were painfully aware that they had not complied with the societal rules of the era and came to believe that their stigma was deserved and brought on by themselves. All of the participants were subjected to hostile words and actions from numerous sources and all felt negatively judged. Little empathy was shown and some even felt that they deserved to be treated that way, because of the depth of shame they felt. However, a few acknowledged some occasional acts of kindness. All of the women felt caught in a web of lies and deceit, with little room for any emotion except fear and shame. The women's feelings and distress were ignored by others; it was as if the nature of the stigma was so overpowering that it rendered all involved incapable of acting in a compassionate manner.

*And my father barely looked at me, barely looked at my  
daughter* Doreen

*Why didn't you do something to make me comfortable?*  
Caroline

Although the dominance of social stigma within societal narratives and popular culture was changing throughout the period covered by this study, my findings challenge the notion that the liberal enlightened period commenced from the late 1970s onwards as stated in the literature (Sandhu, 2012). I believe that this perception over-emphasises the nature and speed of change. Although some change was occurring, as was evidenced by the decline in the number of women giving up their children for adoption from the 1970s onwards (Figure 2), I believe that the social stigmatisation relating to adoption remained very much alive until at least the

middle of the 1980s. The research supports this view in that one of the participants, who relinquished a child in 1983, encountered similar experiences to those who had relinquished their children in the previous two decades.

In summary, the present study supports the common view held within the existing literature that the perceived stigma was a significant factor affecting all of the participants' decisions to relinquish their babies. The findings demonstrate that stigma was as potent in the 1980s as it was in the 1960s and that the process of social change in relation to stigmatisation of unmarried mothers was not evident in the period of the study.

### **5.3 Theme Two. Relinquishment as a unique experience**

Regarding the process of relinquishment as a unique experience, the findings of the study were consistent with the existing literature, which recognises that although the process of relinquishment culminates in a single act, it is a multi-layered and complex process in terms of its impact on the birth mother (Higgins, 2010; Winkler and Van Keppel, 1984). My findings, as reflected in the participants' descriptions of their experience, also suggest that in order to understand the full impact of the act of relinquishment, it must be viewed in the context of the secrecy and shame that surrounded the pregnancy; the trauma of childbirth, exacerbated by the prevailing attitude; the lack of support from loved ones, and the nature of the loss experienced in the post-relinquishment period. The findings demonstrate that the immense impact of the experience, in all cases, is still being felt by all the mothers, even though it had happened between 34 and 49 years ago.

*Because I really believe that the mother relinquishing a child is the smallest and least significant part of the equation, because in those times, so many women got nothing in terms of help and support. The fact that I was sent back to school without counselling, without any kind of anyone to talk to, and I had to keep it secret. So I had to lie to everybody. It ruined my relationship with my grandparents.... I had*

*this huge secret to keep. It meant I couldn't let any anyone close to me.*

Doreen

Creedy, Shochet and Horsfall (2000) assert that trauma experienced at or around the time of childbirth may result in a type of post-traumatic stress disorder. They describe post-traumatic stress as *'a complex set of symptoms, mainly anxiety-related, that result from, and persist after, exposure to extreme stress'* (2000:104). In their study, carried out in 1997, 592 women were questioned by telephone about their experience of childbirth. The results identified that *'women who perceived that they were not supported were more likely to be dissatisfied with childbirth and report acute trauma symptoms'* (2000:110). Women who rated their care as poor perceived that they were not consulted or respected. It is reasonable, therefore, to draw the conclusion that the women in this current study, who experienced poor care from professionals and who felt that they had no voice and no one to support them, also experienced some form of trauma as a result. DeLong (2012) recognises the importance of support in relation to trauma and states that social support predicted greater symptom improvement in trauma than any other variable.

Additionally, the unique circumstances of relinquishment meant that many of the birth mothers felt a sense of powerlessness. The term 'relinquishment' itself means to *'voluntarily cease to keep or claim'* (Oxford English Dictionary online, 2017) and implies a willingness to carry out the act. Only two of the women in the research stated that they had made their own decision to relinquish their child; however, both felt that they had no other choice.

*I didn't have to give my child away, but I felt I had to.*

Elizabeth

*Adoption was, it was almost... like pushed on you. It was almost like it was put to you as if you were going to do it, you were doing something altruistic, you know? You were doing something for these poor childless couples, if you like. That was the way that they put it to you.*

Tina

Each of the remaining five women felt that that the decision to give up their child was not made by them. In reality, the choice was pre-determined by those they turned to for help: parents, medics, religious figures and various professionals, supported in turn by the policies and practices of adoption agencies. Some of the women felt that they were invisible and disempowered, which made it difficult for them to protest. Professionals may have perceived this as a willingness to give up the child. Perhaps this provides some explanation as to why the emotion of guilt was not cited by the women when discussing their experience. They did not experience guilt, quite simply because they did not make the decision themselves to relinquish their baby. This contradicts some of the existing literature, such as Pannor, Baran and Sorosky (1978), who state that almost all mothers who cannot keep their infants carry a considerable load of guilt. Guilt also formed part of Silverstein and Kaplan's (1982) model of the seven core issues in adoption. However, whilst not expressing guilt, some of the women expressed regret about not keeping their child and their inability to influence the decision in any way, and shame for letting it happen:

*I was powerless. I couldn't say a word* Doreen

*Regret, regret, I wish I had kept him* Jennifer

The literature also refers to relinquishment as a unique sorrow and describes it as a disenfranchised grief (Doka, 1989). The research shows that this was a common experience for all the women and there was a sense that their grief and loss was not considered legitimate by others or themselves. There was no closure, no healing, no ceremony, no place to express grief, no photographs, no memories of good times, no solace, and no empathy – just secrecy, silence and heartbreak. Unlike other permanent losses, for which society has constructed supportive rituals, there is no recognisable support following the loss of a child to adoption. This unexpressed grief caused significant emotional difficulties for all of the women and continues to do so to this very day:

*It's never going to go away, it's always going to be.... (cries)*  
Jennifer

*And I am also realising as I am speaking that there is this broken-heartedness, which never goes away. Tina*

All of the women spoke about the strength of desire to know about their child, leading all to search for them, some obstructed by uncooperative bureaucracies:

*And I phoned the agency and said 'I just want to know that she is okay'. And the man on the phone said 'Oh, the family have moved away, we have no contact with them'. It felt like a body blow. If I hadn't been so emotional, I would have realised that he was lying through his teeth because he didn't pause, didn't even go away and check. Doreen*

All succeeded in being reunited with their child, with one exception. However, the process of reunion rekindled their loss and brought its own unique pain – the pain of knowing what might have been. The experience of reunion mirrors the existing literature (Howe and Feast, 2001; Triselitois, Feast and Kyle, 2005), with joy and pain featuring as alternating emotions. The uniqueness of the relationship between a mother who relinquished a child and the relinquished child as an adult is demonstrated by the difficulty the women faced in trying to come to terms with, and understand, the role they played in this complex relationship. Generally, a mother and child's love complement each other, with each needing and receiving the other's love. This is complicated, for all parties, by the intervention of adoption. The child the mother gave birth to had another mother who reared them, cared for them and nourished them: therefore, the birth mother does not have a place or role. The women in the study felt that they had no right to ask for anything from the relationship, even though they wished for an emotional connection. March (2014) recognises this phenomenon and states how birth mothers, in their attempt to ensure that contact continued, accepted the role they played with the relinquished child '*as that of a friend*' (2014:17). In every case, the birth mother regarded the new relationship as fragile, and in three cases out of the six that had been reunited, there had been a rupture in the relationship, which was still in existence at the time of the research. Howe and Feast (2001) suggest that such breakdowns in contact could be for a number of reasons, such as '*personality clash, lack of a shared history*



or gross mismatches in social and cultural backgrounds' (2001:364). However, even Catherine, who had a difficult relationship with her son, stated that she was still happy to know him:

*I am delighted he is in my life. The pain I feel is nowhere near  
the pain I had before I traced him.* Catherine

March (2014) asserts that all birth mothers convey a latent sense of sorrow from their powerlessness to mother the adopted child and a continuing anxiety because they could be rejected at any time.

In summary, the findings under this theme confirmed the findings within existing literature. However, they extended the findings by highlighting the absence of guilt as a significant emotion felt by the women in the study. Instead, the emotions expressed were centred on grief, loss and shame.

#### **5.4 Theme Three Experiencing psychological distress**

The research shows how the stigma associated with unmarried pregnancy gave rise to many emotions, with a key one being shame. Price Tangney, Stuewig and Mashek describe shame as a:

*moral emotion, which is viewed as a public emotion arising from  
public exposure and disapproval of some shortcoming or  
transgression. (2007:348).*

They believe that people's moral standards are dictated in part by universal moral laws and in part by culturally specific proscriptions. In the case of the women in this study, it is clear that they felt that they had breached culturally specific moral codes. Clough (2014) adds to the debate by asserting that shame is a universal affect and an emotion that is little talked about, often lurking as the unacknowledged elephant in the room. Put simply, she believes that shame relates to our sense of who we are;

we feel that in some ways we have fallen short both in our own eyes and in the eyes of others. Both the clinical literature and empirical research agree that people who frequently experience feelings of shame are correspondingly more vulnerable to a range of psychological problems (Price Tangney, Stuewig and Mashek, 2007). Many of the women in this study felt that they were bad, with some even suggesting that they deserved what happened to them. The shame existed at every stage of their experience, from having had sex and becoming pregnant to giving birth and giving away a child. As their pregnancy became conspicuous, their shame increased and was reinforced by the negative judgements of family and others.

The research also demonstrated that all of the women experienced varying levels of psychological distress from the beginning of their pregnancy, and that it continues up to the present day, with some even developing significant mental health problems after the experience of relinquishment. This may not be solely because of the relinquishment, but it is obvious that the trauma and stress of relinquishment would have heavily exacerbated any pre-existing condition. Doreen suffered with addictive behaviours, PTSD symptoms and an eating disorder. Both Jennifer and Caroline had breakdowns and spent periods in a psychiatric unit. Maisie described herself as being clinically depressed after the relinquishment. Catherine and Elizabeth were recovering alcoholics and both Catherine and Jennifer were taking psychotropic medication at the time of the study. Furthermore, Caroline and Doreen contemplated suicide at some point during or after the experience. While all of the women acknowledged that the pain has become less intense with time, in some cases, the emotion of shame and loss has been replaced with anger. Clough (2014) states that when shame is felt, it quickly moves into a place of blame, rage and hostility:

*In many individuals (particularly women), rage may turn inwards, leading to depression, addiction, eating disorders, self-harm or suicide. In more narcissistically orientated individuals that rage will turn outwards in blame, projection, hostility and aggression as the individual seeks to avoid the painful feelings of shame by deflecting them onto another. (2014:10)*

This was evidenced in the research, with many of the women expressing deep anger about the way they had been treated and seeking accountability from the people and organisations that were responsible.

*Those who treated young girls so callously, from the medical profession to the church, to the social services and the justice system, parents and guardians, people who made decisions for others when really they ought to have their own voice.*

Doreen

The following factors are of interest, especially in terms of the impact the experience had on subsequent events in the women's lives. Three of the women in the study (43%) did not have any more children, although it is not clear from the research why this occurred. This is higher than the findings of a study by Andrews (2010), who states that between 13% and 20% of the twelve participants she interviewed did not go on to have other children. In her study, twelve women were asked to rate on a scale from 1 to 10 the impact of relinquishing a child on their subsequent decision or inability to have another child. Eight of the twelve women chose scores of 9 or 10, i.e. a great deal of impact, with the remaining four scoring little or low impact. From this research, Andrews (2010) acknowledges that *'the role of stress and the subconscious in infertility is a subject with considerable discussion but no resolution'* (2010:87).

In relation to personal relationships, four of the women in the study were divorced, with a fifth having just made the decision to divorce her husband. That represents a divorce figure of 71%, which is significantly higher than the 2012 divorce rate of 42% in England and Wales (ONS, 2013). This supports the claims in the literature that the experience of relinquishment affects marital interactions, resulting in problems such as allegiance, commitment and jealousy (Deykin, Campbell and Patti, 1984). Furthermore, five of the women described themselves as Catholics at the time of relinquishment, with only one now retaining that belief and others describing themselves as more spiritual than religious. This suggests disillusionment with the

Church, which they recognised as having been instrumental in the harsh treatment they experienced:

*It was a big machine because priests were involved; nuns and social workers were involved.* Catherine

The feeling of psychological distress experienced by the women was not soothed or relieved in any way. No one around them acknowledged what was happening. The women felt disempowered, alone, invisible and in pain. They could not talk about their emotions; no one enquired, no one wanted to hear. The pain therefore became internalised, and in the case of Jennifer, the events became totally erased from her memory.

*Isn't it strange that it is all a blank...did that really happen? 'Cause when I am looking at it now, I can't believe where was my head (sic). You know it's awful.... I can't remember....I feel as if I am not a full person.* Jennifer

In summary, the study echoes the prevalent view within the literature that the experience of relinquishment had a significant psychological impact on the birth mother and that the lack of support hindered recovery. The findings also show that the socially sanctioned denial of the experience interfered with the resolution of grief, and added to the view held by the mother that she had done something very wrong – so wrong it could never be mentioned. No form of counselling or support was offered to any of the women. They all tried as best they could to get on with their lives, thereby fulfilling the social requirements of the time. In their effort to do so, all experienced significant levels of psychological distress, which for some, still remain, albeit less intense.

## **5.5 Summary of the discussion**

The aim of this research was to understand the depth and breadth of the experience of relinquishment on the birth mother and to establish whether or not this impact was long-lasting. The research clearly demonstrates that the unique experience of relinquishment psychologically impacts on the birth mother and continues to do so over time, albeit to a lesser extent. The uniformity of the responses within this study strengthens the findings and could possibly be attributed to some sort of universal experience of loss and pain. However, it could also indicate that the research questions and the order in which they were presented shaped responses towards similarity. There were two themes identified which were not present for all of the women: Firstly, *The joy and pain of reunion*, which was not experienced by Jennifer, as she had not been reunited with her son, and secondly, the feeling of *Being invisible*, which was not expressed by Tina and Elizabeth during their interviews. A probable explanation for this is that they were the only two participants who stated that they had made the decision themselves to give up their child. They did not feel so powerless, and this gave them some sense of being visible to others. The findings, without a doubt, illustrate that all the women experienced an emotional trauma, which began with their awareness of the social stigma surrounding unmarried motherhood and was reinforced by the behaviours and actions of those around them – both during and after the relinquishment. The Diagnostic and Statistical Manual of Mental Disorders states that trauma is limited to threatened death or serious injury, or other threats to one's physical integrity (American Psychiatric Association, 2000). However, Briere and Scott (2013) believe that threats to psychological integrity are a valid form of trauma:

*An event is traumatic if it is extremely upsetting, at least temporarily overwhelms the individuals' internal resources, and produces lasting psychological symptoms. (2013:8)*

They have included this broader definition of trauma in their work on symptoms, evaluation and treatment of trauma. Stolorow (2011) also recognises emotional trauma and describes it as:

*constituted in an intersubjective context in which severe emotional pain cannot find a relational home in which it can be held. In such a context, painful affect states become unendurable - that is, traumatic (2011:143)*

Stolorow (2011) believes that if there is not adequate attunement by others to the painful emotions being experienced, it renders the emotions unendurable and thus a source of unresolved trauma. It is evident from the findings that very little support, empathy or understanding was offered to, or experienced by, any of the women, thus suggesting inadequate professional understanding or recognition of the effects of relinquishment on the birth mother. Gusich (2012) adds to the debate by stating that an essential feature of emotional trauma is the disbelief that pervades traumatic experience. This is a belief that the events did not happen in order to shield one's self from the painful emotional response. The women in this study were told and expected to get on with their lives as if the event had not happened, resulting in Jennifer having no recollection of the event. The remainder of the women suppressed their emotions in order to comply with what was being asked of them. However, it was very evident during the interviews that they had clear memory of the major events, despite the passage of time. This was particularly so in the case of their recollection of the birth itself and the subsequent surrender of their child. Their level of detail was precise and sharp, and delivered without hesitation: The events were embedded in their memory forever. Sotgiu and Galati (2007) state that there is evidence that memory from directly experienced traumatic events is detailed, accurate and persistent over time. This phenomenon reminded me of my time spent working as a therapist with adult survivors of sexual abuse, who, in many cases, could recall precise and exact knowledge of the details surrounding the event, such as smells, words, and clothes, despite having buried it for a significant number of years.

As a result of my findings, a question arose for me as to whether any person who held Christian beliefs and who treated these women unkindly was conscious of the impact of their attitudes and actions on the women who found themselves in this position. Were their actions deliberately hurtful or were they driven by some

misplaced Christian value? Perhaps it is similar to historical events, for example slavery, where a system of property laws applied to people, allowing individuals to own, buy and sell other individuals in the same way as one would buy or sell a piece of property. This was once an accepted practice and went unchallenged by many with Christian beliefs. American Christians who owned slaves had a simple but powerful defence in the run-up to the Civil War in that they considered the Bible as infallible, and as both the Old and New Testaments sanctioned slavery, it was considered part of God's order (Blake, 2012). Perhaps this demonstrates how religions can embrace accepted practice, regardless of its impact, if there are no dissenting voices within the community. Morality, of course, is not just tied to religion, and some of the people who behaved unkindly might not have been Christian. One wonders what moral code allowed these individuals to behave unkindly to someone who was so much more vulnerable than them. I do not seek to answer these questions but merely to highlight that even though most of us believe we are morally good, many of us are capable of acting unkindly or immorally in certain instances, for example when striving to adhere to accepted practices in society. It is also worth remembering that even the terrorist has a moral code: he or she believes that they are doing the right thing.

Robinson (2015) believes that it is eminently possible that in another fifty years, the concept of illegitimacy will be remembered with nothing more than 'a *shrug of the shoulder*' (2015:122). Indeed, the very concept of adoption as it is understood today may cease to exist. In May 2017, an Australian organisation called ARMS (Association for Relinquishing Mothers) made a submission to the State of Victoria's Law Reform. They recommended that adoption be abolished.

*The rights of the child as outlined under the UN convention are paramount and are not served by the continuation of adoption. Adoption serves adopters, not adoptees, by giving them legal ownership of children. No one has the right to another person's child. The notion of entitlement to a baby has to stop. Even if protection of a child is paramount and that child needs an alternative family, guardianship or stewardship are preferable to adoption. We should look for people who can commit*

*emotionally to caring for a child for the rest of their life whilst accepting that the child had a family. (ARMS, 2017)*

Through my work with an adoption panel, I know that at present, it is very unusual for a child in the UK to be voluntarily surrendered for adoption. In 2008, only 1% of unmarried mothers relinquished their child to adoption, compared to 20% in 1975 (Sandhu, 2012: 32). The remainder who were placed for adoption were children who had been taken into the care system, regardless of the mother's wishes. I am only aware of one such case coming before the adoption panel where I work in the last ten years. People on the panel were surprised to find that an unmarried mother today would consider adoption as a solution to the problem of an unwanted pregnancy. In a timespan of thirty years, we have moved from a society that shunned unmarried mothers to one that embraces women who have the socio- economic means to raise a child themselves. Raising a child as a single parent has become normalised within society and condoned and even facilitated by the state. A single parent is financially supported and culturally accepted. Therefore, it is possible that some in our society may take the view that the act of relinquishment today is unacceptable and unnecessary and may make a negative judgement on any mother who makes such a decision, thus stigmatising the act of relinquishment yet again. It is also possible, of course, that some people considered the act of relinquishment unacceptable even during the period of the study.

Finally, it is worth noting the absence of the birth father in the participants' accounts. Three of the women in the study who considered themselves to be in a relationship with the child's father did not mention whether they had considered or explored the views of the father in relation to the fate of the child. The remainder also made no reference to the views of the birth father in relation to the decision to have the child adopted. This could be for many reasons. Legally, the mother had, and still has, sole rights over the child and is not obliged to include the father's name on the birth certificate. Additionally, Witney (2005) purports that it was not only stigma and stereotypical attitudes that prevented men from being included in the



discussions about their babies' fate during the mid-20th century, but *'the centrality of the belief in the mother/child dyad in western culture'* that perpetuated the belief that babies are *'women's business'* (2005:84). Witney also suggests that adoption agencies were often overworked and their primary concern was for the women who found themselves unmarried and pregnant: they therefore had little time or inclination to consider the child's father. It is reasonable to conclude that many birth fathers would have been impacted by their lack of involvement in the decision about the fate of their child, and this is recognised by Pannor *et al.* (1971), who state that *'to assume that the unmarried mother should arrive at decisions about the baby without consideration of the father is, in effect, denying his very existence'* (1971:85). For many birth fathers, this must have been a very painful experience.

I am aware through my work with social services, that contact with both parents for the sake of the child who is being adopted is now common practice, and that every effort is made to involve the birth father in decisions relating to his child. Some choose not to engage, and on these occasions, as much detail as possible is captured about the birth father to ensure that the adopted child has a sense of identity in relation to his or her biological heritage.

## **5.6 Contribution to knowledge**

In addition to validating the findings of the extant literature, this study, I believe, has made an incremental contribution to knowledge in three distinct areas. The first is in relation to the length of time for which the impact of relinquishment is felt by the birth mother. The study was carried out with women who had experienced relinquishment between 34 years and 49 years ago. I have been unable to identify a qualitative study that has included interviews with birth mothers who had given up a child for adoption with an equivalent time lapse. It was evident from the narratives that all the women in this study continue to feel a significant emotional impact, despite a considerable passage of time. Many of them felt that the impact would remain with them for the rest of their days.

A second point, which differs from the literature, is the absence of guilt. As explained earlier, this emotion is likely to be absent due to the fact that the women felt that they had no part in the decision-making. All the participants had wanted to keep their child, but did not know how that was possible. The two women who stated that they had made the decision themselves still felt that they had no other choice. There did however, express regret about not speaking up or not fighting for what they wanted, but in reality, they felt powerless. They were unable to fight an established system underpinned by fixed moral and religious attitudes. Quite simply, the decision was made for them – the accepted societal solution to illegitimacy was adoption. Perhaps this demonstrates how compliance with cultural and social norms is paramount to how we feel judged and how the pressure to comply with such norms can stifle our very existence.

Finally, whilst all of literature has recognised the significant impact of relinquishment on the birth mother, it is ambivalent as to what factor or factors contributed most to the enduring psychological stress experienced by the women. The literature (Winkler and Van Keppel, 1984; Bouchier *et al.*, 1991; Silverstein and Kaplan, 1982) identifies several emotions such as grief, loss, shame, and sadness as impacting on the birth mother's emotional state and also recognises the lack of support as being a contributory factor in preventing the birth mother from healing emotionally following the loss of her child. This study supports these findings; however, I consider the main cause of the psychological damage, initially and up to the present, to be the lack of acknowledgement of the emotions experienced at the time of relinquishment and afterwards. This lack of acknowledgment was evidenced by the reactions of society as a whole, but also, and very significantly, by the women themselves. They tried to get on with their lives, and in doing so, suppressed their emotions, thereby blocking any opportunity to heal. This lack of acknowledgment caused, and continues to cause, the most psychological damage. No one wanted to know how the birth mother felt, and so the women internalised the events and buried the pain. The pain had nowhere to go and so resided in the women's psyche, and there it remains, unprocessed. Because the women had not adhered to the

societal morals of their time, they came to believe that their own devaluation was deserved (Weinreb and Konstam, 1995).

This finding helped me to understand why I had so many responses within the first hour following my recruitment advertisement. Women wrote to me – a complete stranger – giving me intimate details of their stories in their introductory emails. It explains to me why one of the women, when I contacted her to tell her that I could not interview her, as I had sufficient participants, contacted me again, expressing her disappointment and beseeching me to hear her story. It explains why two of the women explicitly said to me at the end of their interviews that they had needed someone to bear witness to their stories. It also explains why some women were angry and demanding a public apology – they wanted acknowledgment of what happened to them. Finally, it explains to me why I chose this as a research topic – it acknowledged my own story and gave others the opportunity to do the same; it was an opportunity for all of us who participated in the research to ease our psychological pain and to be heard.

### **5.7 The relevance of the research**

This study concerned a discrete group of older women who had relinquished a child between 1960 and 1990. None of the women in this study were offered any emotional support at the time of relinquishment or after. When asked what support they might now need, most struggled to answer the question, and it was almost as if all of the women were resigned to living with their pain. It has almost become a part of them. When pressed on this point, some stated that talking about their experience would be important: they would like to be heard and acknowledged. There are many thousands of women from this era who are still seeking to be reunited with their children and may seek counselling during this process. Most of the work involving adoption search and reunion is carried out by Adoption Support Agencies (ASA) that offer therapeutic post-adoption support to any child or adult who has been adopted, or to their birth relatives. These agencies are registered with

the Office for Standards in Education, Children's Services and Skills (OFSTED) and require appropriately trained staff to provide counselling and support services (Dept of Education, 2014).

Many of the staff working with birth mothers may not even have been born during the period of the study: consequently, they may find it difficult to appreciate the context in which mothers relinquished their children. Sandhu (2012) suggests that there is a gap in the training provision for this group, and that many new social workers tasked with the responsibilities of delivering birth records counselling have not received any specialist training. ASAs or Local Authorities could therefore use these findings as an informative part of their training to enhance the delivery of adoption-sensitive therapy. Of course, some birth mothers may seek out therapy for a variety of other reasons, and may never disclose the relinquishment of their child to the therapist. This could be because they do not see it as relevant to their current difficulties or, quite simply, because they still feel the shame connected to the event. When I attended therapy as part of my mandatory training whilst becoming a therapist, I choose not to talk about what was emotionally the most distressing experience of my life, as I did not then see it as significant. My naivety now astounds me.

There is another important area where these findings may be relevant. In 2016 in England, 70,440 children were in the care of Local Authorities, with 4,690 of these children adopted from care (Coram Baaf, 2016). Each of these children has a mother who has experienced the loss of her child. An IPA study by Memarnia (2014), which included interviews with seven birth mothers whose children had been taken into the care system or adopted in the UK in the recent past, identified themes very similar to the themes of this study, including: *'No one in my corner'*, *'Disconnecting from emotion'* and *'The children are gone, but still here'* (2014:34). Memarnia acknowledges that many of the women who lose a child to the care system often have pre-existing mental health difficulties and therefore cannot be directly compared to birth mothers who have relinquished their child, who may not have had such difficulties. However, Memarnia's findings show that these birth mothers:

*face psychological tasks such as processing complex and disenfranchised grief, coping with difficult feelings such as guilt and shame, and renegotiating identity in the context of stigma (2014:84).*

Additionally, a clear finding from this study was the lack of professional support received by the mothers after their children were taken from them. Mermania (2014) states that despite the fact that policies like the Adoption and Children Act 2002 specify the need for post-adoption services, in practice the provision of such services is minimal. Therefore, the finding of this research, albeit from a different perspective, is very relevant and could be applied to birth mothers whose children are taken from them into the care system and subsequently adopted.

Finally, Sandhu's (2012) study on birth mothers' motivation to relinquish their babies during this era stated that the limitations of her thesis stems from the lack of evidence from birth mothers themselves. She acknowledges that her findings relating to birth mothers' motivations and experience of adoption are examined and presented through the prism of the adoption agency and suggests that future research with birth mothers themselves would be important in order to verify her findings. This research has gone some way towards breaching that gap.

### **5.8 Limitations of the study and future research**

It should be noted that there are limitations to this study. The current sample is restricted in numbers and includes a discrete group of women within a specific age range who self-selected to tell their story. A criticism might be that the study attracted people who strongly wanted to tell their story and excluded people who viewed it as 'water under the bridge' or women who found it too painful to talk about. The limited number of participants also means that the study cannot describe the experiences of all birth mothers who relinquished a child during that era. Additionally, as it is an IPA study and is thus idiographic in nature, its findings are not generalisable. Furthermore, I have had personal experience of the phenomena

being researched, which means that I have influenced the study in a particular way. I recognise that despite my attempts to bracket my own experience, I could not ignore it, and this may be viewed as a limitation, but also as a strength. To minimise any bias, I stated my position throughout and used a series of bracketing interviews to understand my own biased assumptions and preconceptions and how they might impact the research. My experience could also be viewed as an enabler in that it facilitated closeness with my participants, which allowed me to build trust and establish rapport during the interviews, thereby extracting rich data. I used an inductive method and let the data create theories rather than bring any predesigned theories to the research. Despite these limitations, the study produced valid themes that, although described separately, are best views as connected to each other.

As a result of the findings, I believe a useful area of research for the future would be with current birth mothers who, in many cases, do not access support and counselling despite it being offered to them. During a conversation with a social worker from the Adoption Support team of a Local Authority, conducted on 15th November 2017, it was confirmed to me that in 2016, only 12% of birth mothers who had their children removed from them accepted the offer of support. It would be useful to understand the reasons for their reluctance to access support with a view to increasing the take-up and effectiveness of support services.

The next chapter will examine the implications of the research findings for practitioners supporting birth mothers and explore how the findings of the study can be disseminated to relevant agencies.

## **6. Guidance for practitioners who provide therapeutic support to birth mothers who have relinquished a child to adoption**

### **6.1 Introduction**

This chapter highlights the key issues that practitioners need to take into consideration when providing therapeutic support to birth mothers. Based on the findings of this study, the following section will explain the importance of these issues and provide evidence-based recommendations concerning the range of skills that would benefit practitioners who provide therapeutic support to birth mothers.

### **6.2 Support for birth parents**

An American study by Brodzinsky (2013) identifies that all members of the adoption triad often encounter significant barriers in their efforts to obtain the support they require. One of the most frequent complaints from this group concerns their inability to find mental health care and ancillary service professionals who understand the unique issues relating to adoption and how adoption can colour their self-perception, their identities and their relationships:

*For a variety of reasons mental health professionals do not receive the training required to fill adoption related counselling needs, and too often, either do not fully understand why such training is necessary or mistakenly believe that the knowledge they have is sufficient.*  
(Brodzinsky, 2013:3)

Brodzinsky believes that this is because adoption counselling in America has not yet been identified as a professional speciality in the field of health care and thus has no clear guidelines for training and practice. In the UK, the nature of how support is provided to birth parents varies across agencies. Adoption Support Agencies or Local Authorities have a statutory obligation to carry out a needs assessment if a

birth parent needs help in tracing a relinquished child. This may involve help with tracing, support, guidance or counselling. Contact may be face-to-face, or initially via a telephone advice line. Sometimes the support is provided by social workers with knowledge of adoption issues and possibly some training in counselling skills, but this is not a guaranteed prerequisite. Qualified therapists with a variety of theoretical approaches provide therapeutic support, with many having a background in social work. I have been unable to establish the nature of the training delivered to adoption support workers due to the wide-ranging manner in which it is provided; my guidance, therefore, is primarily intended to augment the skills of therapists who are already trained in adoption support. However, it will also be relevant to other practitioners who are involved in providing support to birth parents.

### **6.3 Key therapeutic issues from findings**

This study has confirmed the major themes consistent with the existing literature on adoption (Figure 7). However, whilst the literature recognised the suppression of emotions by birth mothers and the importance of their story being heard, this study has identified an additional significant therapeutic issue. This research suggests that birth mothers can only begin to resolve specific emotions such as shame, loss, and anger when their story is heard and acknowledged in its entirety. It is not until there is a recognition that the events actually happened that the processing of other related emotions can take place: the participants of this research were unable to process their emotions because the events surrounding the relinquishment had still not been validated. Validation is needed to enable the flow of emotions, which in turn can ease the pain. This, I believe, is a major contributory factor to the enduring nature of their distress, resulting in a lifetime of pain. Consequently, the focus of the guidance is to enhance the therapeutic interventions that support validation of the birth mother's story.

The current literature recognises that attempts have been made to conceptualise adoption in a theoretical context in the recent past, although the focus of most of



the theoretical models relates to all parties of the adoption triad. Zamostny *et al.* (2003) summarise some of the main theories that have relevance to birth parents:

***Psychodynamic perspectives:*** *Psychodynamic theories have thrived in the clinical literature on adoption and have centred on the unconscious conflicts of adoption triad members that can have detrimental effects on the development of family relations. Some scholars have criticised the psychodynamic approach as leading to an over-reliance on pathogenic models.*

***Social Role theory.*** *Social Role theory was the first systematic articulation of difference between adoptive and biological family systems. It detailed the role of loss in adoptive family relationships and the stress created by society's stigmatised view of adoption. This theory was one of only a few to emphasise the role of stigma in adoption adjustment*

***Family Systems perspective.*** *The Family Systems perspective was rooted in the view that adoption unites the adopted child, the birth family and the adoptive family in a lifelong kinship network. It recognised that adoptive families experience different stressors than biological families and therefore have unique developmental concerns.*  
(2003:667-668)

Whilst differing therapeutic approaches may be helpful in dealing with the emotions relating to relinquishment, this study suggests that a relationship-oriented approach underpinned by empathy would best facilitate the validation of the birth mother's story. My own experience as a birth mother, who entered therapy but failed to tell my story because of a poor therapeutic relationship, supports this view. The focus on the therapeutic relationship is sometimes dismissed by proponents of shorter-term therapy, who may consider the relational effects of therapy to be nonspecific or

placebo phenomena (Briere and Scott, 2013). In contrast, however, Briere and Scott suggest that the:

*Therapeutic relationship activates important psychological and physiological processes that – far from being placebo effects – serve to evoke, countercondition, and otherwise process traumatic (especially relational) memories. (Briere and Scott, 2013: 285)*

Rogers' (1951) person-centred approach, which places an emphasis on the client-therapist relationship, is a useful approach, as it encompasses the core conditions of congruence, empathy and unconditional positive regard. This facilitates healing through a process of genuine dialogue with the client. Other theoretical orientations that may facilitate the birth mother's expression of distress include the humanistic-existentialist approach (Yalom, 1980; Frankl, 1963), which has parallels with person-centred therapy in that it places the client-therapist relationship at the centre of the therapy (Corey, 2013). That is not to say that other approaches would not also be beneficial: for example, Cognitive Behavioural Therapy (Beck, 1976; Padesky and Greenberger, 1995) would be useful for dealing with anger and shame, as would Compassion Focused Therapy (Gilbert, 2009). Narrative therapy (White and Epston, 1990) could be useful in allowing the woman's story to be told, and indeed Feminist Therapy (Enns, 2003) could be particularly helpful in empowering some women, since women's perspectives are central in understanding their distress, and clients' problems are placed in the context of their sociocultural environment.

#### **6.4 Implication for practitioners.**

Brodzinsky (2013) asserts that adoption clinical competence can be viewed as a continuum of knowledge, values, skills and experiences related to the assessment and treatment of members of the adoption triad:

*...at one end there are the professionals with little to no knowledge or experience of how adoption impacts people and at the other end,*

*there are the professionals who have a broad-based adoption-related knowledge and a deep understanding of its lifelong influence on individuals (2013:24).*

Regardless, Brodzinsky asserts that at each stage of the process, the therapist must be attuned to the complex array of historical and contemporary factors that impact the lives of each member of the triad. For that to happen, there are some key factors that need to be considered when counselling birth mothers, whichever theoretical orientation is used. Knowledge of these issues would be beneficial to all practitioners who provide support to birth mothers. The courage required from a birth mother to pick up the phone or walk into an adoption agency and enquire about her relinquished child, after perhaps forty years of psychological pain, cannot be overestimated. To be confronted with a non-empathic response may result in a continuation of the cycle of pain. O'Leary Wiley and Baden (2005) recognise that clinical work with birth parents is different than with other members of the adoption triad; subsequently, this requires practitioners not to minimise the painful and sometimes traumatic experience of relinquishment.

#### **6.4.1 Therapists' own bias**

As individuals and as therapists, we come to every situation with our own worldview. As therapists, we talk about being non-judgmental whilst admitting that we cannot help but be shaped by our own life experiences. It is possible that pre-existing judgements, conscious or unconscious, may already exist for some professionals working with birth mothers. Some may have had personal experience of some aspect of adoption, or may even be adopted themselves; some may be infertile and long for a child; others may have had an abortion; some may hold strong religious beliefs and therefore have a narrow view as to what constitutes a proper family structure; some quite simply may not understand how any mother could give away her child, regardless of factors such as coercion or stigma. Additionally, the age and culture of a therapist may be relevant in that it will have shaped their perspective of

the world. Furthermore, adoption as we know it does not exist in some cultures and this may make it difficult for a therapist from another culture to empathise with the birth mother. Some therapists, like myself, may even be birth mothers. It is also possible that male therapists might struggle with the birth mother's story and consciously or unconsciously identify with the birth father. A male therapist may have had personal experience of being shut out of a situation by his female partner, such as a decision to have an abortion, and therefore may have felt powerless as a result. Consequently, it is important for therapists to avoid being captives of their own world-view (Corey, 2013). This requires them to have an appreciation of their own core values, coupled with a respect for the rights of a client to have a disparate value system.

#### **6.4.2 Differentiating between guilt and shame**

Another important requirement for any clinician dealing with birth mothers is an understanding of the nature of the emotions that are being expressed by the client. Some clinicians may make the assumption that birth mothers feel guilty for surrendering their child; however, the findings of my research do not support this view. The participants in this study did not express feelings of guilt because they felt they had no choice regarding the relinquishment decision. Instead, the prevailing emotion was shame. Price Tangney *et al.* (2007) caution against confusing shame and guilt and state that many clinicians incorrectly use the terms synonymously. They recognise that both are negative emotions that can cause intrapsychic pain. The distinction between shame and guilt focuses on the public versus private nature of transgression:

*From this perspective, shame is the more public emotion arising from public exposure and disapproval of some shortcoming or transgression. Guilt on the other hand is conceived as a more private experience arising from self-generated pangs of consciousness. Nonetheless shame is the more painful emotion because one's core self, not simply one's behaviours, is at stake. (Price Tangney et al., 2007:349)*

Clough (2014:14) also makes an important distinction between guilt and shame and states that *'Guilt is about doing; shame is about being. Guilt is "I've done something bad"; shame is, "I am bad".'* Clough believes that guilt is adaptive in that there is the capacity to put things right or make amends, whereas shame is maladaptive. People often feel relief at confessing their guilt, whereas many feel ashamed of their shame (Clough, 2014). The shame the women expressed in the interviews related to the sense of who they were; they felt that they had fallen short, both in their own eyes and in the eyes of others. Shame felt personal to them and such feelings of shame are difficult to resolve. Clark (2012) suggests that heightened shame sensitivity is often a contributory predisposing factor in disorders that are characterised by low self-esteem, such as depression.

For many, talking about their experience in a therapeutic setting may increase the shame and they may not have words to describe their feelings. Cordess, Davidson and Morris believe that *'for some, this can lead them to feel at the mercy of the clinician, who, armed with knowledge of their intimate feelings, may be seen as someone who will exact further humiliation'* (2005:271). These women experienced a lack of empathy and support from some professionals at a time when they needed them most and consequently may find it very difficult to trust anyone in the caring professions.

#### **6.4.3 A visceral grief**

As stated earlier, the literature identifies the uniqueness of the grief and loss experienced by relinquishment as being a disenfranchised grief and the findings of this research support this conclusion. Doka (2002) states that the emotions associated with grief are intensified and complicated when grief is disenfranchised. In addition, Deykin, Campbell and Patti (1984) acknowledge that psychodynamic theory has proposed, and clinical experience confirmed, that losses inadequately grieved may produce feelings of unworthiness, diminished self-esteem, and depression. O'Leary Wiley and Baden (2005) contribute to the debate and remind us

that the loss experience by a birth parent who has relinquished a child is an actual, rather than a socially constructed, loss. A therapist working with a birth mother may not recognise that the grief of a birth mother is different in kind than, for example, the grief of a mother whose child has died. A grieving mother would usually have had no effective role in the inevitable outcome; however, whilst their child is gone forever, the life can be celebrated and the memories kept alive. This mother would not face her grief alone and is likely to receive empathic support from a network of family and friends. In adoption, however, the child is not gone forever: instead, it has gone to a new life with a different identity. For a mother who has surrendered her child, the hope that they might meet again never completely goes away. These factors contribute to the unsuitability of traditional grief models for this client group. March (2014) states that the social importance placed on motherhood in Western culture and the primacy placed on the blood bond accentuate the loss of a child to adoption. Additionally, Aloï (2009) recognises that there is a need for professionals to recognise the differences in grieving and respond by providing compassionate care to this group of women.

#### **6.4.4 Individuality of stories.**

Clinicians regularly supporting birth mothers may feel that they know and understand what the experience was like for such clients. They might assume that the psychological distress experienced by the women is centred on the grief and loss of their child and their interventions may focus on this. However, as this study has shown, that is only one aspect of the emotional trauma. Although there were common themes within the narratives of all seven of the women interviewed (Figure 8), each story was unique, as was each woman's ability to deal with the subsequent emotions. Although not evidenced in this study, some birth mothers who seek counselling might not have felt a connection to their child or might have felt disappointment when they met, and therefore their sense of shame might be heightened. They might even have felt relief when their child was taken from them. There is an expectation in our society that mothers love their children, so it may not

be possible for a mother to broach this subject with a therapist. This illustrates the need for the therapist not to make assumptions about what their client is experiencing. Some therapists may seek to achieve specific goals, or look for closure or acceptance of what happened as a way to help the client heal. However, in many cases, the women may not want this: they may only want to be heard – to be acknowledged. Without such acknowledgment, there can be no proper healing. Professionals need to be aware of the differing complexities of each story and must respect the individuality of each birth mother.

*Those of us who philosophise about adoption had best be listening, and listening well, to what the adoption participants themselves are saying. They are searching for internal validity and being denied access. (Baumann 1997:333)*

#### **6.4.5 The relationship with no name**

The media often portray a reunion between a mother and a relinquished child in dramatic ways – almost like a modern fairy tale that ends with a happily ever after. In reality, it is a complex emotional event with conflicting motivations from the different parties of the reunion. The birth mother often needs to know that her child is well and has had a good life (March, 2014). The child is often looking for answers relating to origins, background and the reasons for being relinquished (Howe and Feast, 2001). The findings from this research show that the birth mother in every case wished to establish a continuing relationship with the child. The research indicated that the responses from the adopted children were inconsistent with regard to maintaining contact. On some occasions, they withdrew from the relationship altogether. The therapist needs to be aware of such tensions and recognise that there is no relationship model for anyone to emulate. The uniqueness of each reunion situation requires sensitive handling by clinicians working with birth mothers, whose natural instinct is to want to mother a child to whom they gave birth and whom they loved, then lost, but never forgot, culminating in a reunion many years later. March (2014) believes that birth mothers need to explore their

perception of motherhood, their sense of what makes a good or bad mother, and their meaning of such images in relation to how they view themselves. The therapist needs to understand the complexities involved and recognise that it might be inappropriate to normalise such complex emotions. Finally, Zamostny *et al.* believe that practitioners need to maintain a balanced perspective that allows them:

*To acknowledge therapeutically the positive and negative impact of adoption, and to use assessment and treatment models that attend to the array of person and contextual factors that promote or impede adoption adjustment. (2003:671)*

They state that is not possible to fully understand adoption historically and the impact it has on our society and on the members of the adoption triad without considering the powerful effects of social context.

#### **6.4.6 The role of empathy**

The research revealed that at some stage, all of the birth mothers experienced what many described as cruel treatment by professionals and others whom they turned to for help; this included social workers, medical practitioners, parents and religious figures. The universal absence of compassion, much less empathy, may seem inconceivable in today's world. However, in a study carried out by Gair (2009) in Australia, thirty-eight social work students were given four narratives of different situations, with a view to understanding the level of empathy each narrative aroused. The scenarios were as follows:

- The story of a birth mother who was forced by her mother to relinquish her child for adoption and was experiencing internal grief;
- An aboriginal leader talking about past atrocities;
- A police whistle-blower who feared for his life;
- A suicide story from an adoptive mother, including her perceived role in her son's suicide.



The author speculated that the birth mother narrative would be the one which most, if not all, of the students would find it easy to empathise with, given the significant shift in social sentiment about women who placed their children for adoption in the past. In the order of least to most empathy felt by students (Do you feel empathy: Yes or No?) the birth mother scenario prompted the second highest 'No' response. Typical comments from the studies included:

*I feel confused because I can't visualise the situation that allowed it to happen.*

*Because I feel she made a bad decision at the time.*

*I can empathise to an extent... but stronger for the child who had no choice.*

(Gair 2010:47)

A common repeated response in the study was that they could not feel empathy because they had never experienced the situation. However, Rogers (1980) does not believe that experience is necessary for empathy: instead, what is necessary is to understand how the world looks and feels from the other's point of view and to convey that feeling to the other. Gair's (2010) study concluded that there is a need for a deeper and continuing cultivation of empathy in the training needs of social workers, particularly when students will be dealing with circumstances that they have not experienced themselves or when there is an association with social stigma or discrimination, as in the case of adoption. It is worth noting, however, that this is a study situated in Australia and may not be generalisable. Nonetheless, it highlights that many practitioners today may be dealing with birth mothers who have relinquished a child, whilst having little or no comprehension of the prevailing historical and social attitudes which helped to create stigma surrounding illegitimacy and adoption. Therefore, their ability to empathise with the birth mother may be hindered. Another instance where it might be difficult for practitioners to empathise is when a feminist may assume or convey the idea that the mother should not bear the sole responsibility for relinquishment in a patriarchal society, and this might subsequently hinder their ability to relate to the birth mother's experience. They

may be sympathetic, of course, but that is not necessarily helpful for the client, who needs to feel at a deep level that this person wants to hear their story. Empathy, when experienced, denotes a stronger, more personal sense of shared emotion that the client needs to experience before she can reveal her inner self:

*Empathic practitioners appreciate all of this. They proceed slowly and with care. They back off when they sense that emotional closeness is being experienced as intrusive and frightening. They express emotion and give voice to feeling when they lie hidden or confused in the minds of other. They contain arousal. They regulate distress. (Howe, 2013:139)*

The empathic practitioner would also recognise the enduring nature of the distress. It was not a period of sadness, not a 'bad patch', but instead a lifetime of sadness.

## **6.5 Skills required from practitioners**

Besides having an awareness of the issues highlighted in the previous section, it is important that practitioners be equipped with specific skills to enable them to deal with the uniqueness of the emotions arising out of the experience of relinquishment. One might argue that many of the skills outlined below are necessary for any therapeutic encounter, but the research findings suggest that women who have denied and suppressed the emotions regarding relinquishment for most of their life need a specific response to their story. Brodzinsky recognises this and states that practitioners must understand:

*The challenges facing all members of the adoption kinship system including the bases for those challenges, and have the knowledge and skills to support psychological growth and resilience in adopted persons, adoptive parent and birth parents. (2013:25)*

Birth mothers' experience of insensitive and even harsh treatment by professionals at the time of their relinquishment may remain in their consciousness, and may make it difficult to trust and reveal the emotions connected to their story to yet

another professional. Additionally, Coleman and Garratt (2016) remind us that in academic and professional circles, words that feel offensive to birth mothers are still frequently used, and descriptions used by professionals to describe the loss experienced by the birth mother do not adequately explain the depth of emotion related to the loss.

The table below highlights a variety of skills that support an empathic therapeutic approach and may be useful for any practitioner dealing with this client group in their training on adoption-related issues. Although none of the participants explicitly stated what skills they felt would be necessary for them to feel acknowledged, my own experience of relinquishment plus my clinical reflexivity suggest that the specific skills outlined are necessary for successful interventions. Whatever support is provided, it must be flexible and relevant to the client’s specific needs and concerns and be responsive to her specific relational context (Briere and Scott, 2013). Furthermore, an assessment of the birth mother’s needs at the beginning of therapy would support empathic interventions.

**Figure 8**  
**Skills for Practitioners supporting birth parents.**

<b>SKILL</b>	
<b>Ability to demonstrate empathy</b>	Empathy is not tangible; it cannot be seen, it can only be experienced. It is not enough for a therapist to understand empathy from a theoretical perspective; they must demonstrate their ability to use it effectively. The empathic individual’s focus remains on the experiences and needs of the other person, not on his or her own empathic response (Price <i>et al.</i> , 2007).
<b>Ability to demonstrate an understanding of the cultural and social issues surrounding the relinquishment</b>	A cultural-specific understanding of the social attitudes at the time of relinquishment would be useful in enhancing the therapeutic relationship. Without this understanding, it might prove difficult to appreciate the power and nature of the stigma attached to illegitimacy.
<b>Attuned listening/regulates own responses</b>	Timely and considered interventions are necessary. Sometimes, there is no need to intervene – just a need for attuned listening. Levitt <i>et al.</i> (2006) found that during vulnerable explorations, therapists’ compassion and listening kept clients from pulling away because of the fear of pain and aided them in sustaining reflexivity.
<b>Non-judgemental</b>	Being judged has created shame for this client group. The shame is

	likely to still be present and could be triggered inadvertently by the words or actions of the therapist. <i>'We need to enable the victims of shaming to tell their story and we need to witness these stories with respect, credulity, compassion and acceptance'</i> (Clough, 2014:15).
<b>Use of models of grief</b>	The empathic therapist must be aware of a type of grief that arises for a birth mother of 'not knowing' about their child, which requires different interventions than a traditional grief model. Without a natural opportunity to express grief, the emotions become internalised and therefore may need to be explored in a different manner. March (2014) states that it would be useful for birth mothers to be able to recognise their grief emotions and to possess a vocabulary by which they might explain the source of these emotions to themselves and others.
<b>Sensitivity to use of language</b>	Much of the language used during the era in the study relating to illegitimacy and relinquishment is value-laden and outdated. Therapists need to be sensitive to this and recognise that even using the word 'mother' or 'relinquished' in this context may cause distress.
<b>Ability to stay with the client whilst recognising their autonomy</b>	The story the birth mother tells may have no ending and no solutions. She may not require goals to be set, behaviours to be changed, or suggestions as to how she might 'move on'. It is important to stay with the client and not be guided by a rigid theoretical structure.
<b>Understands the significance of the validation of their story</b>	This may be the client's only requirement. She may have been denied this validation for most of her life and need her story to be acknowledged. She was told to get on with their life as if nothing happened. But something life changing did happen. That acknowledgment needs to be experienced by the client. In a study by Levitt <i>et al.</i> (2006), clients described the expression of their personal narratives in therapy as cathartic and as helpful in providing the basis for further exploration.
<b>Self awareness</b>	Awareness of one's own prejudices and biases is important. That may seem obvious to any therapist but it is clear from the findings of this research that in the not too distant past, most of the professionals dealing with unmarried mothers operated from societal moral codes laden with prejudice and disapproval. Supervision may be helpful in this instance
<b>Making assumptions about how the client feels.</b>	As the study showed, guilt was not a theme identified in the research. However, this has contradicted much of the literature, so therapists need to be aware of their own assumptions and check for validation from the client.
<b>Ability to distinguish between similar emotions</b>	Besides wanting to have their stories heard, some birth mothers may still be struggling with specific emotions such as anger, resentment, shame, or a myriad of other emotions. They may find it difficult to distinguish between the emotions or indeed may not have a vocabulary to articulate their pain. The therapist needs to be skilful in identifying and separating the emotions to allow the client to choose which ones would be most beneficial to work with. The clients also may need to be helped with tolerating their own emotions.
<b>The ability to deal with the reality of the situation.</b>	The client may need to deconstruct the events of the past and consider how she might want to reconstruct her life from a more objective viewpoint (Howe <i>et al.</i> , 1992). She needs to be helped to realise that she made the decisions at a particular time and place, perhaps as a vulnerable teenager without adult skills or resources. The ability to be a compassionate witness may allow exploration of these issues.

## **6.6 Support groups**

There is evidence in the literature that supports therapeutic practice for birth mothers within a group setting as a safe place for women to talk about their experiences. In a group study of birth mothers by Harris and Whyte (1999), the women reported that by sharing their experiences and offering support to one another, they felt less isolated in their pain. However, they also reported that the group had been too unstructured and they would have liked more direction from the facilitators. From a therapeutic viewpoint, a support group facilitated by a practitioner with the necessary skills and competencies together with an insight of the relevant issues could contribute to a positive therapeutic experience and would be sufficient for some to achieve validation.

## **6.7 Birth parents today who have their children taken into the care system**

One of the aims of my research was to produce findings that may also be useful in supporting parents today whose children are taken into care in the current climate. It has already been emphasised that many of these parents have complex needs, and that many are from dysfunctional backgrounds with a history of drug, alcohol or sexual abuse. However, each will have a unique story and will require a non-judgemental empathic listener. Memarnia (2014) points out that these mothers felt that their needs and emotions were ignored, much like the experience of the mothers in this research. She also speculates that it is possible that professionals struggle to empathise with these mothers because of social discourses around motherhood and around the kinds of mothers whose children have been taken into care. Consequently, one can infer that some of the key issues highlighted in this study, and the skills identified as necessary for empathic interventions, are as relevant to present-day birth parents as they are to birth mothers from the era of the study.

## **6.8 Dissemination of the findings**

The findings of my research were presented to an adoption agency called 'After Adoption' on the 6th December 2017 in their Regional Office in Birmingham. 'After Adoption' is one of the largest ASAs in the UK and offers support to historical and current birth mothers. The audience for my presentation included current birth mothers, practitioners who support birth mothers and the head of adoption services. The findings were well received and the birth mothers who were present confirmed that they experienced similar emotions to those highlighted in this research. Furthermore, the agency has expressed an interest in understanding how my findings might assist their current training and support programmes for birth mothers. Additionally, I presented these findings to the adoption panel members of a Local Authority on 12th December 2017. The audience on this occasions included social work members of the adoption support team, plus a clinical psychologist who works with adoption-related issues. They have requested that I present my findings as training to larger numbers of practitioners within the adoption support team. Going forward, the findings will be developed into a workshop (Appendix K), which can be delivered by ASAs to practitioners who support birth mothers as part of their initial and ongoing training.

## **6.9 Summary**

The unique experience of relinquishment presents therapists with a range of complex and challenging issues, which must be addressed if their interventions are to be effective. It is conceivable that it may be too difficult for anyone, including the therapist, to accept that it was right for a mother to give away her own child, regardless of the circumstances. I am not sure that I have this acceptance myself, or ever will. What is important is for the therapist to understand and acknowledge that there is a valid reason why the mothers in this study did not express feelings of guilt. It is because, from their point of view, they did not give away their children, but

were coerced into relinquishment by a judgemental society, and that this occurred when they were vulnerable and most in need of succour and support. They do however, feel residual shame. Price Tangney *et al.* (2007) make the following distinction between guilt and shame, which is worth reiterating: shame is more public emotion arising from public disapproval whereas guilt is a more private experience arising from self generated pangs of consciousness. Shame is more painful because one's core self is at stake.

The women in my study spoke about not being heard, not having a voice, not being acknowledged, and not being treated kindly. There was an imposed avoidance of what happened, resulting in the obstruction of normal emotional processing. Therapeutic support can address this to some extent and help ease the pain through the process of the client telling their story and having an empathic compassionate witness who can validate their experience. One of the participants wrote to me following our research interview:

*I would like to say that I deeply appreciate the opportunity to tell my story – to have it witnessed by one such as you. It means a very great deal – the time spent with you is, and always will be, of infinite value.*

Elizabeth

Howe *et al.* (1992:152) believe that it is only by understanding more fully who she was and what has happened that '*the mother can change the meaning which she gives to her experience.*' What happens in therapy is a formal processing of events with emotions. Talking to an appropriately skilled counsellor enables these clients to talk to others. The more one talks, the less severe the emotions become. Therapists need to be able to maintain empathy. They should not intervene prematurely, but should let the story unfold in full. Their approach must include sensitivity to the stigma experienced, acknowledgment of the nature of the loss, and an appreciation of the birth mothers' attempt to move forward in a way that is right for them.

*If I could give advice to mental health professionals, it would be to tolerate and understand the enormity of the experience....*

*surrendering a baby is a real event with real and profound feelings and is not a derivative of other issues. There needs to be literature and workshops that help therapists recognise that this is an event worth focusing on. (Anon. Cited in Weinreb and Konstam, 1995)*

This chapter has highlighted the key issues that practitioners need to be aware of when supporting birth mothers and identified some key skills which could effectively underpin any therapeutic approach. The next chapter provides a reflexive summary of how the development and writing of this thesis impacted on me personally and professionally.



## 7. Personal reflections on the process

### 7.1 Reflections

Banister *et al.* (1994) argue that reflexivity in its many forms could be considered a defining feature of qualitative research. However, Pillow (2003) cautions against assuming that just because we are reflective, our research is more valuable or authentic. For me, whilst I struggled initially with any element of my own visibility in the research for fear of opening up the experience of discomfort and '*seeing my own biases and mistakes*' (Probst and Berenson, 2014:817), my own experience of the research subject demanded a reflexive stance.

Through the process of writing this thesis, I have exposed emotions that were buried so deep within me that they were almost unreachable. This has been painful, cathartic, and on many occasions, overwhelming. I will now reflect on the overall process from a practice, professional and personal perspective.

In relation to my practice as a therapist, I have enhanced my therapeutic understanding in many ways: I understand at a deeper level the importance of attuned empathic listening with clients. During my research interviews, I experienced a visceral connection with my participants: this desire to understand the essence of their experience by truly listening in order to understand what was being said, rather than listening in order to reply, allowed me access to an authentic dialogue with the participants. This reinforced my belief about the importance of listening as part of an empathic therapeutic relationship and how authentically people tell their stories when they feel they are being truly heard.

Additionally, through this research, I have gained an insight into the use of imagery as a means of unblocking thought processes – an area to which I paid little attention in the past. At times, my immersion in the participants' transcripts felt heart-

breaking, and at some points, this rendered me incapable of progressing in my work. To move forward, I understood that I needed to acknowledge and confront what was happening to me. This I achieved through the use of imagery, as described in the reflexive statement in Chapter 4, as a means of reflection and meaning-making. I have subsequently used this technique with clients who were experiencing blockages in their processing of emotions.

Furthermore, as a consequence of my research, I understand in greater depth the vulnerabilities that accompany shame and how readily it can distort one's view of one's self. My views on shame resonate strongly with Adam's (2014) statement that shame is the biggest hindrance to self-exploration. This heightened awareness has allowed me to gently explore this emotion with clients if I feel that it is relevant to their story.

This research has also taught me about the difficulties of endings in therapy, and reminded me how, on occasions, they can be stressful for the client. It was immensely difficult for me to finish the last paragraph in my concluding chapter, and I was not sure if I would be able to do it. The last few words and sentences felt harder to write than all of the other 65,000 words combined, as I felt as if I had nothing left to give. I now realise the significance of this: I was not ready for the ending, as I still had vulnerabilities in relation to my own experience of relinquishment. By finishing the thesis, my experience was going from the private to the public. It was no longer just between my supervisors, my participants and me: no longer contained in a safe space. It made me think about how many clients must feel the same when they finish therapy. Such clients would have spoken about their difficulties in a safe, nurturing environment and then must go out to face the world, whilst still retaining some of their vulnerabilities. For many, that must seem daunting. This awareness has prompted me to give more consideration in managing endings with my clients.

Finally, this research has highlighted to me the importance of the quality of kindness, both in how we use it in our lives with others and how we use it as part of the

therapeutic relationship. Quite simply, if the participants had experienced kindness during their experience of relinquishment, it is likely that their enduring pain would be far less intense. In an increasingly complex world of therapy where new theoretical models are continually being developed, and where we are in danger of '*being suffocated*' (Feltham, 1989:91) by our own theories, it may seem unfashionable to focus on something as simple as kindness. But to clients who have experienced unkindness in their lives at a time of vulnerability and have not had their feelings acknowledged, the power of finally experiencing it within an empathic therapeutic relationship cannot be underestimated.

From a different perspective, the knowledge gained from this study has increased my confidence in relation to my position as a member of an adoption panel. At panel meetings, when discussions are taking place about a child being matched with perspective parents and how their needs will be met, birth parents are the least considered members of the debate. I now feel confident in raising their profile with a view to ensuring that their emotional needs are considered, as I now recognise that I have some expertise in this area.

I set out to establish whether the impact of the experience of relinquishment on birth mothers is long term and the study confirmed that it is. What I discovered in the process is that the impact for me is also long term. My actions 46 years ago had enormous consequences and those consequences will remain with me for ever: the loss of a daughter that I never had the opportunity to raise and love in the natural order of events, the pain of a daughter knowing that her mother gave her away, the loss of a sibling relationship to a brother and a sister, and the loss to us all as a family unit. I don't feel angry, but I feel a huge sense of loss at what might have been. Unlike the other emotions, the loss is not diminishing over time but instead feels more acute as I get older. As I write these words, I feel myself becoming emotional, with a familiar pain revisiting me. Before writing this thesis, I would have ignored this pain, discarded it and soldiered on. Now, at least I understand the nature of the pain and can process what is happening to me in a reflexive manner, resulting in an easing of the pain. In my introduction chapter, I talked about always trying to prove

how competent and good I was because I felt that I had done something bad by relinquishing my daughter. Now I recognise that feeling as being one of my primary reasons for carrying out this research: I wanted to do something good – I wanted to make amends.

It is difficult for me to assess whether the reader of this study would consider the research more or less valuable from having a sense of me as the researcher, but I can state with conviction that my reflexive stance has added to the authenticity of the research. Additionally, reflexivity in the context of this research has been a form of self-discovery – in finding out about others, I have found out about myself.

*Adoption was like a crack that happened in my soul. A crack I thought and was encouraged to believe would be temporary, or always below the surface. Over time, the rest of life worked its way in, like water in cement, and caused the very foundation of myself to crumble. (A Girl like her, 2014)*

## **8. Concluding Statement**

### **8.1 Introduction**

This chapter will reiterate the research aims and describe how each of them was met. It will summarise the major findings in the form of themes extracted from the data. Finally, it will encapsulate the therapeutic guidance for practitioners which was developed as a result of the study.

### **8.2 Research aims and objectives**

This study is an exploration of the experiences of birth mothers who relinquished a child for adoption between 1960 and 1990, and who subsequently engaged in the searching process.

The research aims were as follows:

- To understand the depth and breadth of the experience of relinquishment on the birth mother;
- To establish whether the impact of the experience on the birth mother is long-lasting.

The objective of the research was to develop therapeutic guidance for practitioners working with this client group. This entailed:

- Undertaking a critical review of the relevant literature to determine the current state of knowledge and establish what gaps may exist;

- Conducting face-to-face interviews with birth mothers who have had this experience and developing rich descriptive accounts of the experience;
- Analysing the findings and categorising them into a variety of themes to identify the key issues;
- Critically examining the resultant issues and themes, and developing appropriate guidance and support for practitioners working in this field.

The process was underpinned by a reflexive element throughout.

### **8.3 Literature Review**

The literature review confirmed that the impact of relinquishment on all birth mothers was significant. It was consistent in acknowledging that the social mores present in society within the time period of the study were the major contributory factor in inducing the stigma experienced by these mothers. The recurring emotions of shame, loss, grief and guilt were present in all studies. However, guilt was not an emotion identified in this study. Additionally, a few researchers intimated that coercion was a factor in the mother's decision to relinquish, whilst other explicitly stated that it was commonplace. Furthermore, the literature consistently acknowledged an absence of support for birth mothers who relinquished a child.

There was universal recognition in the literature that the issue of reunion is a multifaceted and complex emotional event that requires therapeutic support. However, a notable gap in the literature was the lack of commentary suggesting the type of therapeutic support that would be appropriate for birth mothers experiencing long-term psychological distress as a result of their experience. The literature reviewed on this subject was mainly relevant to birth parents who had experienced open adoption, meaning that they had some contact with their child, or birth parents whose children had been removed from them into the care system.

In the 1990s, the main focus of the literature shifted to the issues faced by adoptive parents and the adopted child. This is due to a decrease in relinquishment since the 1990s, which also resulted in the focus of researchers' attention switching to the issues faced by birth mothers whose children had been taken into care and subsequently fostered or adopted. This trend in the literature has continued into the 21st century, with the plight of birth mothers who relinquished children in the era of this study receiving less and less attention with the passage of time. There have been some recent exceptions (Keating, 2012; Rossini, 2014, Robinson, 2015), all of which provide a historical view of events surrounding illegitimacy between 1960 and 1990, but are not academic studies.

#### **8.4 Methodology**

Qualitative research was the approach adopted, since this methodology facilitates an in-depth understanding of real life experience. Face-to-face interviews were conducted with seven women, six across the UK and one in Ireland. The participants were made aware in advance that I too had relinquished my child for adoption. This, I believe, was instrumental in allowing the interviews to flow freely, as the women felt that they were understood and not being judged. Consequently, the participants told their story with a compelling honesty, which resulted in the production of rich, authentic data. This data was explored using IPA, which, because of its idiographic approach, facilitated an in-depth analysis, which captured the essence of the experience.

#### **8.5 Findings**

The first research aim was met through the process of analysis, which enabled the identification of themes, and this resulted in an understanding of the depth and breadth of the nature of the experience of relinquishment.

The findings were classified under three major themes:

- **The power of social stigmatisation**, which captured the nature of social attitudes and moral judgments, which were significant factors influencing the decision of relinquishment;
- **The unique experience of relinquishment**, which illustrated that it was not a single act but a complicated series of events, each part invoking varying emotions.
- **Experiencing psychological distress**, which speaks of the lifetime of pain that is experienced by the mothers, which is mostly caused by their inability to talk about their emotions in relation to the event.

Additionally, seven superordinate themes were identified (Figure 7). What was unusual in this study was the uniformity of themes across all the women, with only three exceptions (Figure 8), which reinforced the strength and authenticity of the identified themes.

The second research aim, i.e. determining whether the impact of relinquishment was long-term, was also firmly ascertained. All the participants were unequivocal about the enduring negative emotions related to the experience of relinquishment, despite the passage of time. Similarly, all of the participants felt that the impact would be with them forever, though some acknowledged that it had become less intense over time.

## **8.6 Contribution to knowledge**

In addition to the above findings, the study produced incremental knowledge in two distinct areas. The first, which directly challenges the existing literature, was the absence of guilt expressed by the women as a result of relinquishing a child. They



felt that the decision was made for them; therefore, they attributed the guilt to the decision-makers.

The second area concerns my own belief, based on the findings, that the lifetime of pain was not caused by the relinquishment *per se*, but by the denial of the events by a prejudiced, value-laden society, resulting in the suppression of the ensuing emotions by the birth mothers. Consequently, they became unable to process the emotions, which in turn prevented them from emotionally healing. These two findings are substantiated by the richness of the interview data and by my own experience of relinquishment.

### **8.7 Guidance for practitioners**

The objective of the research was to use the findings to develop therapeutic guidance for practitioners working with this client group. It is suggested that initially, practitioners should take whatever time is necessary to let the birth mother tell her story in full whilst acknowledging and validating the complex emotions surrounding the event. Consequently, the guidance is focused on educating therapists to recognise the unique experience of relinquishment and stressing the importance of a relational empathic approach in therapeutic interventions. The guidance identifies the key issues that therapists should consider when dealing with such clients and also provides an outline of the key skills required to underpin appropriate interventions.

Additionally, it was anticipated that the guidance produced would also be relevant to current birth mothers whose children have been taken from them into care and subsequently adopted. The literature confirms that these birth mothers also experienced emotions such as shame, isolation and negative judgement and that they also reported a lack of support. This guidance, where appropriate, can be adapted to help practitioners provide appropriate therapeutic interventions for this group of women

The research findings have been delivered to two Adoption Support Agencies, with positive feedback being received on both occasions. It is planned that these findings will be developed into a workshop, which can be presented to relevant organisations, and subsequently delivered to practitioners as part of their ongoing training.

## **8.8 Conclusion**

This thesis set out to examine the consequences of the adoption policies and practices of the time for birth mothers who relinquished children between 1960 and 1990. It did not set out to evaluate the morality or the appropriateness of the policies and practices in question, but rather to examine the resultant detrimental effects and emotional damage. In doing so, it established that the impact was significant and long-lasting. The most important product of this study is the guidance developed, which will help practitioners to provide therapeutic support when dealing with this client group. Adoption Agencies and Local Authorities have a statutory duty to provide support to birth mothers and to ensure that the practitioners who provide this support are properly trained in the provision of adoption-sensitive support. The guidelines developed as a result of this study will help such organisations to address these responsibilities.

This study is concerned with events relating to adoption, which occurred between 34 and 49 years ago. It is important to note that we are viewing past actions and judging them by today's standards. However, that does not alter the impact of these practices on those affected by then. Since then, lessons have been learnt and society now treats birth mothers with empathy. However, there is ample evidence in the current literature to suggest that birth mothers whose children are taken into care at present, and in the recent past, experience psychological distress comparable to the distress of the birth mothers who were the subjects of this study. It is essential that as future policies relating to adoption are developed, attention be paid to the impact of those policies on all parties involved. This means ensuring that appropriate

support is made available to those who are rendered vulnerable as a result of changes in policy. Parents who lose a child through adoption will almost inevitably find it a devastating experience. Smeeton and Boxall (2011) state that although there may be little done to ameliorate their overwhelming feels of loss, *'the way that practitioners and agencies manage this process should, at the very least, not further compound the parents' grief'* (2011:451).

Word count 62,710

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## **Appendix A**

### **Interview schedule**

**1). Can you tell me what your circumstances were at the time you discovered you were pregnant?**

(Prompt: Home life, siblings, job, school, friends, finance.)

**2). Can you remember what factors led to adoption being the choice for your baby?**

(Prompt: Family, church, neighbours, child's father, status, reputation, class.)

**3) Tell me how you felt at the time of birth and up to the parting from your child? What did it all mean to you?**

(Prompt: Range of emotions, support, coping strategies)

**4). Tell me about the months afterwards.....the years afterwards?**

(Prompt: Secrecy, re-integration, role of child's father, support, relationships)

**5). Tell me about the circumstances around how and when you tried to make contact with your child?**

(Prompt: Use of agencies, levels of support, secrecy,)

**6). What was the outcome and what emotions were connected to this experience?**

**7). If reunited, describe how the relationship with your child has developed?**

(Prompt: Nature and frequency of contact, role in relationship)

**8). Can you tell me how this has impacted on you?**

**9). If not reunited, how has this impacted on you?**

**11). Today, what do you think the impact of the whole experience has had on you in terms of how it has shaped your life?**

(Prompt: secrets, stigma, family, society, job, emotional stability, self esteem, religion)

**12). What would have helped to minimise any negative impact of your experience?**

(Prompt: Tolerance, understanding, supportive family, professional help)

**12). How do you think society today's views your experience - Do you think people fully understand what it was like for you?**

(Prompt: Social media, 'Long lost families,' 'Philomena,')

**13). Have you ever sought any professional help to deal with your emotions in relation to this experience. If so, what was your experience?**

**14). With the passage of time, how have your emotions changed in relation to your experience?**

**15). What help do you think professionals (social workers, therapists) who work in this area could provide to birth mothers either seeking their child or looking to come to terms with the experience of relinquishment.**

(Prompt: Group support, one to one counselling, being heard)

# Birth Mothers

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## *Tell your story*

*If you gave up your child for adoption during the 1960s – 1980s, and have subsequently tried to make contact with your child, I would like to hear your story.*



*I am carrying out research on this subject so that I can help professionals better understand the impact of the experience of relinquishment on the birthmother. I also wish to help them gain a greater understanding of the social and cultural issues that existed during that era. I gave up my own daughter for adoption in 1971 so I am aware of how that experience has impacted on me but I now wish to know what it was like from the perspective of others. If you would like to share your story and let your voice be heard by contributing to this research, I would be delighted to talk with you.*



## Appendix B : Continued

# Birth Mothers

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### **Introduction**

*My name is Bernadette Hatton and I am a Doctoral candidate at the Metanoia Institute in London. I am conducting Doctoral research into exploring the experiences of birth mothers who relinquished a child for adoption and who subsequently engaged in the searching process. The project has ethical approval from the Metanoia Institute, through the auspices of Middlesex University.*

### **Study title**

*An exploration into the experiences of birth mothers who relinquished a child for adoption in the 1960s-1980s and who subsequently engaged in the searching process: The clinical implication for therapists.*

### **Invitation to you**

*You are invited to take part in a research study. Before you do, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that you don't understand, please ask. Take time to decide whether or not you wish to take part.*

### **What is the purpose of the study?**

*I would like to understand the range and depth of emotions connected to the experience of relinquishing a child. I have had this experience myself and I would like to hear how others experienced it. Based on the findings, I intend to produce guidance for therapists and social workers to help them understand the issues that were relevant to birth mothers during that era thus helping to ensure the provision of adoption sensitive therapy to these women.*

### **How you can help**

*You have had this experience and that is the reason I would like to talk to you. I will be interviewing 6 people in total, all of whom have had this experience.*

### **Do you have to take part?**

*It is up to you to decide whether to take part. If you do take part, you will be given an information sheet and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason.*

### **What will happen if you do take part?**

*You will be involved in a one to one semi-structured interview with myself lasting approximately 1.5 hours. The interview will be audio taped and transcribed at a later point.*

**What risks are involved?**

*This is a very sensitive subject and it may be painful for you to talk about your feelings and experiences. You may experience some re-occurrence of the trauma you experienced at the time of the relinquishment. You may have kept this a secret all your life and this may be the first time you speak openly about it. That may evoke many emotions, one of which might be relief. I will support you in whatever way I can and because I have shared some of your experience, I hopefully will understand some of the emotions you are experiencing. Although I work as a therapist, I cannot provide therapy to you in relation to this, but I will provide you with information in relation to agencies that provide such support. My questioning will be sensitive and we can stop at any point if you feel uncomfortable. At the end of the interview, we can spend some talking about how you feel.*

**What about confidentiality?**

*All information that is collected will be kept strictly confidential. Any information about you that is used will have your name and address removed.*


*All data will be stored securely in compliance with the Data Protection Act.*

**What will happen to the results of the study?**

*This will be published as part of a Doctoral Thesis. The outcome will be in the form of clinical guidance for therapists/social workers working with birth mothers and will not contain any personal information.*

# Appendix B : Continued *Birth Mothers*

[Home](#) [about the project](#) [contact me](#)



You can contact me at -  
[berhatton@aol.com](mailto:berhatton@aol.com)

*I will be supervised throughout the project by a member of staff from the Metonoia Institute and her contact details are as follows:*

**Dr. Marie Adams**  
[Mariead@aol.com](mailto:Mariead@aol.com)

## Appendix C Doreens's Transcript

- Interviewer: Okay. Don't know about folder but let's just go for the record. Record, red light on. Looking good. And finally, failsafe. My phone. If I didn't have this, the last lady came to my house because she lived in Cardiff, and I did a test on there, and after the test I switched it off and forgot to switch it back on.
- Respondent: Do you want to check that these are recording before [inaudible 0:00:38.4]
- I: Um, I know by the red light because that's what the mistake I made the last time, that I, I tested it and then I turned it, forgot to, but the two red lights and the two signs are on in both, so I'm going to trust that. Um, could just get the voice memo on here and record. I never knew iPhone was so good at this. This is really...
- R: Yeah, I haven't got an iPhone, but I've got voice memo on mine.
- I: Have you?
- R: Just be for odd things, I'll be driving and something, oh I've to, and my phone's on its little stand and I kind of, get in there and just say something.
- I: Brilliant. Now recording, so we know that that's going. Okay. So, um, I'm going to start with a sort of a general question, and then you can really take it where you want to go, but, can you tell me what your circumstances were when you discovered you were pregnant? So for example, how old you were, where were you living? How you told your parents, what you felt, around that period?
- R: Okay, I was 16. Um, I'm not sure when I realised I was pregnant. Simply because I went into denial pretty quickly. Um, I didn't tell my daughter's father. And I tried on several occasions to tell my parents. I was living with them, I was in school. Um, and due to the nature of our relationship, I just felt unable to say the words. Um, the nature of the relationship with my parents, that is. Um, it wasn't a particularly good relationship. It wasn't, the lines of communication weren't there. Um, so, I just pretended it wasn't happening. When it got to about four and a half, five months, I was still seeing, um, the guy I was involved with and he, kind of worked it out and said, I think it was about five months, and I was starting to have a little pot belly, and I was quite slim, and we sat in his car, and he reached over and he put his hand on my stomach and he went, oh that's it then, it's over. And I never saw him again. That was the full extent of his reaction to discovering that he was the father of a child. So that was a bit devastating.
- I: And was that your point of acknowledgement? Do you think?



- R: No. No. I actually went into even more denial and I, and I kept saying to him, no I'm not, I'm not, it's not happening, it's not happening, and he just didn't engage in the conversation, and of course I didn't see him again. And I just went into denial. I just couldn't deal with what was going on. So I basically pretended it wasn't happening. I was quite physical, so I was doing all sorts of different things, including ice skating. Um, and I was getting bigger, but I was, and still am, a bit of a seamstress so I'd adjust my clothes.
- I: Oh gosh.
- R: Um, it got to about eight months, and my mother said, you don't look right. And I said, and I had had incredibly bad morning sickness. I had had um, um, diabetes insipidus, so you know, I'd had all kinds of reactions to things. Um, I hadn't had much else, and I didn't have much weight gain, but I really, I, to this day I can vomit without making any sound at all. Um, yeah, lovely (laughs). So, um...
- I: And got carried on at school and that? Okay?
- R: Sat my O levels when I was six months pregnant.
- I: Oh gosh.
- R: I did quite well actually.
- I: Did you? (laughs)

R: Yeah. Um, I think a couple of the teachers were kind of looking at me and thinking she's very round. Considering she was very skinny. Um, but nobody said anything. Um, got to eight months and my mother started sort of saying well, what's wrong with you? And I was getting a lot of back pain. Somewhere in the back of my teenage brain, I had decided that I was just going to go through it alone and present them with a fait accompli. I now know that because um, I had a lot of repressed memories which only have come back in the last few years, and I'll tell you about that, as and when. Um, but I kind of decided I was going to go it alone, because I didn't know what to do, and I was so scared, I just kind of buried the whole thing. And then my mother announced she was taking me to see a specialist because I was obviously having trouble with my back, because I was walking oddly. Who knew? Eight months pregnant, walking oddly. That's how close we were, because she was really caring. Um. So she took me to this doctor and he kind of examined me and put his hand on my stomach and went how long have you been like this? And I said, I don't know. And I can remember he didn't speak to me. Nobody spoke to me. He just kind of went, okay then, and I hadn't really got undressed, but I'd taken my shoes off, and he said, you know, pop your things back on, and I, I'll be out in a minute. And he spoke to my parents separately. He wouldn't speak to me. And, then we went home and my parents sat me down, at a table where we used to sit and eat our meals, and they said, the, I can't remember his name, lots of names have just gone and I'm really good with names. Um, he had had a long chat with them and in his professional opinion I was pregnant. What did I have to say about that? And I said, well, he might be right then. And, it, I, I have a kind of a blank at that point, because I do remember there were three of us in the room, my mother was shouting at me and my father was shouting at me. And I remember sitting there thinking, that I wanted to be anywhere but there. Um, and my mother called me all kinds of names. She started with I didn't think you were that kind of girl, and it all went downhill and she was [inaudible 0:06:52.5] through the dictionary options from there really. Um, it, she wasn't kind. Nobody was kind. Never occurred to her that I might be afraid. Um, the fact that I had no medical help at all to that point didn't seem to enter their heads. Um, and I'm saying all this with the benefit of hindsight, because I just know that I sat there, frozen, with them yelling at me, and, she said things like, oh, I suppose we've got to get a pram then, as if a pram was some sort of um, the dirtiest most filthy object in the world that anyone would possibly want to, you know, it was just, unthinkable. Um, and I can remember as a teenager, I was 16, I sat there, and she was sort of asking me questions about what I wanted and I can remember the way she used to say, well, what do you want then? Um, whenever we had that conversation, it would very much be, I would tell her what I want, she would tell me what was going to happen. So from, from that point I just felt completely helpless. And I can remember sitting there and she was saying, well what do you want to do? And I just sat there and shrugged. And then I don't really remember all of the conversation after that, because you know there's that point where you just shut down and you just think, I don't know what to do. And, (pause), from there she took me to the doctor and she'd obviously had a conversation with him beforehand, and our old family doctor had retired, and he was a lovely man. He really was. This guy was awful. And I remember walking in, and he said, oh I hear you've been a, a naughty girl then. And I'm sure he said that to all his adult, married, female patients who came in with a pregnancy. Um, and I can remember I didn't say a word. I did not say a word. And they had some conversation about me. He didn't speak to me after that, he just sort of went through all this stuff, um, he didn't examine me. Um, and it sort of snowballed

into my mother taking me to places, making arrangements, and I don't really remember how, but we were suddenly at [REDACTED] on our way to [REDACTED] with me carrying a bag, going to a mother and baby home. And um, at some point, I can remember talking to various people who were saying, it's the best thing for the baby, and, you know, you're not old enough. You're not a suitable mother, blah, blah, blah. But I can't remember who those people are. Were. Who they were. Um, and my mother made these arrangements. She didn't really talk to me about it. She never once showed me any kindness or compassion. She was just ashamed and that was the hardest bit. So, that's what I remember of the, the early bit.

I: And your dad?

R: He shouted at me initially and then he stopped speaking to me. He just wouldn't talk to me. So neither of them acknowledged that this was their grandchild. It was just something horrible to be got rid of. And I know my mother at one point said, I wish you'd told me sooner, we could have arranged an abortion. But she never actually asked me if that was what I wanted. So there's that whole thing of, you know, I wasn't in the equation. The equation was all about the inconvenience I'd created and what had to be dealt with. And, I was expected to just go along with all of that. Which of course I did. Because I didn't know what else to do. And my mother was so afraid of her grandmother, of her mother, finding out because her mother was a very difficult woman, so there was this fear driving her presumably. Um, so yeah, I mean.

I: So you were packed off to [REDACTED]?

R: Yeah, to a mother and baby home.

I: And did you know at that point that adoption was going to be the outcome or how does that?

R: Um, I think it was sort of thrown around the room during that initial confrontation. And I remember saying that I hadn't planned the pregnancy. (sighs) Which I think she took to mean that I didn't want the baby. I may even have said, I don't want this, because I have a vague recollection of saying that. But what I meant was, I didn't want to be in that situation. That I didn't want to be shouted out. I didn't want to be, um, I didn't want to deal with it, really. I was too young to deal with it, so I was doing what teenagers do. Which is go for an avoidance. So um, I did kind of know, um, but I didn't believe they would go through with it. And that's one of the things I actually have clarity on now, which I didn't have until recently. I didn't believe that they would do that to me. And they sent me to this place. One of those Nazareth House places in [REDACTED].

I: Oh, was it Catholic nuns?

R: So yeah. Catholic school, Catholic mother and baby home.

I: Oh gosh.

R: Lovely.

I: Yeah.

- R: We had all the usual things where you do the chores and whatever, but because I was still in school and school were sending me stuff to do for my A levels, because I was expected to carry on studying when I got back, um, I didn't get to do as many chores, and that caused a certain amount of friction, because there were only two of us who were studying, Um, but yeah, we were given things to do. We had to do, we had to do, um, laundry and cleaning and, all of that stuff. And some of the girls there were so big, they were so heavily pregnant, and they were expected to scrub floors and things, and you think, there's something really wrong with that. When at the time we all just [inaudible 0:13:35.1] on with it, you know. What do you do? You're a prisoner. Um, I had no money, I had nobody I could turn to. Um, I was sworn to secrecy and I believed it, that I believed them when they told me it was the right thing to do. You know, not to tell anyone. Um. So I just didn't. Um, I was there from the 13<sup>th</sup> of September that year, ■. I remember it was a warm, it was a warm summer. And when I could I'd go out for a walk, because I'd been very active, and they expected us to sit around and watch TV and play games and, not so much television, we wouldn't watch much television. They kind of cut us off from the world in that way. Um, but they expected us to sit around and play Scrabble. Problem is, I have a huge vocabulary, and, it was still, it was pretty good then. And I keep adding to it. And I would produce words and they'd go, oh no, that's not a real word. And they'd argue with me and I'd just sit there thinking, oh I'm clearly in the wrong place here. Anyway, I used to go out for walks and I'd walk and walk and walk until I knew I had to go back. And that was kind of my only escape. I couldn't go anywhere, I had no money. I had nothing. So, um, I'd do that, and they put me in a room, it was, the house was like a big double fronted thing with dark wood panels everywhere, so dark in there. And we were allocated rooms and I remember they put me in a room that was up at the top of the house. At the back. And the person that, we were two or three to a room at the most, but I was with one other girl, and she was from Bolivia, and her pregnancy wasn't kind to her. She'd put on lots of weight, she wasn't very well. It affected her breathing, all sorts of stuff. Don't know if she had any medical care either. And again, it was only years later I realised the two brown girls were in a room together. And I thought, you know it's that, those moments where you have that clarity and you go, oh! Of course! And we were, we were treated as slightly separate. I mean I'm not that dark. Neither was she. But we were both, um, she could hardly speak English and I taught her some words because she struggled and we kind of, because we all had to go to bed early, we'd just lie there and sort of chat. And then she would ask about stuff she couldn't understand, and I'd try and explain and it, she was actually a really, lovely girl. She was about 20 I think. Nineteen, 20. I know, I don't know what happened to her. I don't know if she went back to Bolivia with her baby or without, but, she was, she was a nice person.
- I: Can you remember [name], the, the baby was obviously was moving, your daughter was moving, can you remember how much you were connecting with what was going on inside?
- R: I was terrified.
- I: Okay.
- R: Every time the baby moved or kicked it was like having an alien inside me. Um, I was not relating to it as a child.



- I: Okay, okay.
- R: Um, because I just felt like I was completely out of control of my body. Um, and nobody reassured me in any way. Yes, I had a rudimentary understanding of the biology involved but I was terrified of giving birth. I was terrified that I might die. Um, I was terrified that the baby would be damaged in some way because I'd been so active. Um, and it was just, I just felt like I was completely out of control. And my body wasn't my own, and my life wasn't my own. Um, and it was, it was really frightening, (pause). (sighs). And I felt very isolated. And at the back of the house was a fire escape and they used to leave the door open because it was warm and the house would cool down a bit, and several times I'd go out there and I'd watch the sunset and I'd look down and there was a courtyard at the bottom, because we were at the top of the house. Um, quite a way down. And I used to consider just climbing over and dropping off. Nothing could stop me. Always a vivid imagination I guess, that I could see myself bursting like a ripe melon, and, I thought well if I do that and then I live, things would be far worse. So that weird rationale kicked in of, you know, also I had this other life, that if I did that, what would happen to this, this baby? What would happen? So I used to stand there and think about it, but I never actually did anything about it. Um, but yeah, I can remember being really, really afraid and isolated and confused. It was a horrible way to treat a kid really. But.
- I: So was there talk, as the birth was getting nearer, was there, did the nuns talk to you about what was going to happen, or, how?
- R: No, not really. Er, I think what they said was, if you think it's happening, it is happening, then you must let someone know. But most of the time babies arrive when they arrive, and they would arrive in the early hours of the morning and we'd find somebody was missing at the breakfast table, and they'd go, oh yes, her waters broke at four o'clock this morning. And then someone else would pipe up, yeah and I had to clean them up. Um, because obviously you know, the nuns didn't do anything. Far beneath them. Um, I think there were some conversations about it, but again I have no conscious recollection of them.
- I: Okay, sure, sure.
- R: Um. I don't think they were terribly concerned about what happened to us.
- I: Sure.
- R: And I honestly get the impression that if we lived or died, they didn't care, as long as the baby was okay, because I think there was possibly a financial incentive.
- I: Yeah, I suspect so.
- R: So, and that makes me angry, but, that's probably a separate discussion.
- I: So were you, before your daughter was born, you knew for sure that adoption, that that was the solution? Were you still considering keeping your daughter or not?
- R: I didn't actually deal with any of it.
- I: Okay, okay.

- R: Um, because I was so frightened and I was just thinking that I just kind of want to, I want to know if I'm going to live.
- I: Okay.
- R: I actually thought I was going to die in childbirth. Um, the adoption thing was sort of there, but as I said, I, until the very last minute, I didn't think my parents would actually go with that. I thought they'd relent. I actually thought they'd go, well, you know, this is our grandchild, we, we can't put you through this. And I was really, really wrong. And I never forgave them for that. Ever. Because I just feel that any parent who cares about their child would appreciate that that child will then go on to have a child, possibly, um, and that is part of your lineage. That is part of you. Doesn't it matter to you? I used to think to myself, doesn't it matter to you at all? How can you just kind of palm, palm me off to strangers and hope for the best? I don't know, it's still a mystery to me really. Um, I knew that that was the plan, but I didn't believe that they'd put me through it.
- I: Okay.
- R: I didn't believe it was going to happen. I thought they'd see the baby and it would all be okay. Um. When I eventually did go into labour, I was out on one of my long walks, and I could feel these sort of twinges and I just ignored them. Because that was my whole modus operandi about this. Let's pretend nothing's happening. Um, and it got more and more intense, and then eventually, when I finally went into labour properly and the waters broke, I was awfully tidy about it. I managed to get to the loo, and the waters broke into the bowl. Um. And I can remember one of the nuns not believing me, 'cos there was no evidence anywhere. And I was saying to her well, yeah, it did, I just didn't make a mess. Partly because people were complaining about having to clean up, so I was so conscious of that, I kind of.
- I: You were a good girl.
- R: Oh I was a very good, girl, yes. Except I was a very bad girl.
- I: Yes, well, yeah.

R: But you know, I was so sort of worried about making a mess, so it seemed important, so I kind of, I don't know how I did it actually. I kind of dragged myself into this area. Um, and I can remember the way the nuns treated me. I felt like I was just this animal. They told me what to do, and I'm sure they weren't medically qualified, but one of them insisted on examining me to make sure I was in labour. And that, I thought, was, I felt it was such an, it was such an indignity. I felt really, um, horrified by it, to be honest. Um, and she was sort of arguing with me about whether or not I was in labour. And then I had a, a contraction, and she went oh, well maybe you are. Um, and they called an ambulance and got to hospital and, everybody fussed around me, but nobody spoke to me. And I can remember being so frightened, I was so scared the whole time. Nobody looked at me and said, oh my god, she's only 16 and held my hand and said it's going to be alright. Nobody did that. So I just felt I was completely alone. And yes, in many respects I was. So, yeah, so, the birth was unremarkable I guess. I was terrified. But you know, in the respect that, you know, it was fairly routine for them. I can remember they wouldn't give me my baby, and I was lying, and, the table I was on felt really high up. I don't know if it was, but it felt like I was a long way off the floor. And I can remember I felt really weak and one of the nurses had my daughter in her arms and she said, this baby's for adoption isn't it? I'll take her away. And I'm saying no, no, please, please, bring her back. And she sort of came and stood near me, and then she took the baby across the room and the room was maybe one and a half times this size? So I'm over here, and my baby is over there, on some kind of cot thing, crying, and they just left me. They didn't. They sewed me up, thankfully. Um, but, you know there'd been some cutting, but they didn't clean me up. They covered me with a, just a sheet. And they didn't come back. And I lay there for four hours, because I remember going in and out of being awake, and I was so tired, that I, I kept calling out, because every time I called out, she'd quieten down, and she'd start crying again. Um (pause). I was really thirsty, and after a while my voice stopped working and I tried to get off the table so I could go to her. I was so high up I was afraid that I'd fall off. And I couldn't get my stomach muscles to work. And I just lay there, thinking, what can I do? And then someone stuck their head in, it was four o'clock, four fifteen when she was born, just after eight, because there was a clock like that on the wall. After eight o'clock, someone stuck their head round the door and said, oh I didn't think anyone was in here. And I just croaked at her, help me. And she went away. And someone else came in, a little while later, and said oh we're going to move you now. I couldn't speak. And I just [inaudible 0:27:38.9] this was a hospital, this wasn't like some backwater somewhere, they just left me there. And then they moved me. I can't remember being moved but they moved me to a room. But I was so weak. They put her next to me but I couldn't even prop myself up I was just so exhausted. Um, they didn't actually clean all the blood and everything off me until the afternoon I guess. So I was not feeling very cared for, shall we say. Um, for me, the whole process was horrifying. And terrifying. And, do you know the [inaudible 0:28:31.4] language? In some circles they talk about the way people expressing themselves having an impact on physically, so if you say someone's a pain in the neck, you know, you might reflect to that by showing a pain in the neck. So for me, ah, I found myself saying over and over again, I couldn't bear to go through that again, so I never bore any more children. And I only realised that recently, but I just found myself saying I couldn't bear it. Um, nobody was talking to me or helping me or treating me as, as a patient. I was just. I don't know. Pushed aside. And it was okay when I was in a room on my own, but once they put me in the ward, it was, it was a nightmare, it was a nightmare. They had all these happy mums and their babies and coming in with hearts and flowers and, hello. I was there on my own. I did have a visit, a couple of visits from the girls, but they

just came out of curiosity. We just wondered what you had. There was no kind of warmth in it, because I think, we were all really broken and detached and whatever.

I: And was your daughter brought to the ward with you or was she taken away?

R: She was actually, yeah, she was. I was expected to feed her and take care of her, but I wasn't expected to breast feed her because they gave me a drug to stop the milk. And I had breast pain ever since, but I didn't know why, because I'd blocked everything. It was only much, much later I realised that I'd had this constant pain. Um, which apparently can happen. I did a lot of research after I made the connection, but I had all sorts of problems. Um, 'cos it's not a natural thing to do, is it? So. Um. Yeah, my mother came and saw me while I stayed in that little single room for about three days I think. Probably because I was so weak. Um, and my mother came and looked at the baby. And I think that was when I realised that I was actually in an impossible situation because she bent right over the cot and she said, she's going to make somebody really happy. And I wanted to say, well, why not me? I couldn't get the words out. I couldn't speak when she was in the room. I felt powerless when she was around. And honestly, I think she was actually quite evil at times. Um, because she really was cruel. She did not think about how I was feeling or how this would impact me in my life. Or if she did, she gave no indication of that. I was completely caught in this web of her construction. And, unable to break free. She had in no way included my feelings in the situation. My experience. My emotional state. Never occurred to her I think that any of that mattered. So. So presumably it didn't matter.

I: Did your dad see your daughter?

R: Not until later.

I: Okay.

R: Um. I can't remember how long I was in the hospital. It may have been less than a week.

I: Okay.

R: It may have been more. [inaudible 0:32:55.2] about a week. (sighs) and I went back. So I had her on the eighth and I went back to that place, just before my birthday. My birthday was on the [redacted]. Still is, funnily enough. Um, so eight of October I had her and then I got back there on, I think, probably the 16<sup>th</sup>, ish. And I remember on the [redacted], I felt like I may as well not exist, 'cos there is no acknowledgement of me in any way, and there was a doctor and nurse that used to come and check up on things. They'd weigh the baby and ask questions about the baby and, I think they checked my blood pressure. Then the doctor went, oh, just looking at the form, it's your birthday today. I remember thinking, you're the only one that's noticed. Um.



- I: That's funny because I spent my birthday in, my 18<sup>th</sup> birthday in hospital two days after, so it's just strange when you say that because I can remember feeling a bit like you just said there. Nobody noticed, it didn't matter. Yeah.
- R: Yeah, yeah, so you feel sort of irrelevant to the whole thing.
- I: Yeah. Yeah.
- R: It's like oh well, you know, I don't matter any more. Um. Yeah so it was only a year really, because I mean I was 17, it was my 17<sup>th</sup> birthday.
- I: Mmm. It was my 18<sup>th</sup>, yeah.
- R: Yeah. It's so young, it's so young to be put through that. Um. Very cruel experience.
- I: And, and you were still feeding your daughter and caring for her? Did you feel yourself bonding or were you still conscious of a distance or, what was it like?
- R: Er, I didn't know how to deal with how I felt.
- I: Yeah, yeah, I get that.
- R: I think for me there was a, there was a sort of a, disconnect. It was like I was doing all of this, but there was this little person, and I was really frightened, because again, I didn't know what to do. And they kept saying, don't pick her up, don't cuddle her, don't do this, don't do that, and, all the, all the nuns there were saying, you mustn't make a fuss of her, you mustn't do this, you mustn't do that, so, by that point I was just putty. I was completely malleable. And um, I felt so, I think I must have been in shock after the whole birth experience, because I was comp, I was just numb. I didn't feel very much at all. Um, other than there was this baby, and I would get up and I would feed her and I'd do all this stuff. I don't know what I felt. At that point. But I looked after her as best I could. And the irony of being expected to buy formula after they'd stopped my milk wasn't lost on me. Um. And I had wanted to breast feed her. Understandably. But, you know, I wasn't. They also tried to ply me with Valium. I remember that.
- I: Oh.

R: Ah, because I was numb but not particularly stupid, they'd give me these pills and I'd wanted to know what they were, they said oh, it's just for your blood pressure, they said. So I'd shove them under my tongue, swallow. And they'd go, right, fine, wander off, and I'd spit them out, look at them, and they were Valium. So knowing er, as I did, what Valium could do. Because when I was in school, when I was 11, a friend of mine, her mother had become hooked on Valium and I knew what her mother was like, 'cos I met her a couple of times, and she was just a zombie. And I thought well, okay, you know, she was addicted to them because her husband was a GP, my friend's father. So my awareness was there from that experience. So I remember thinking well, okay, this is to keep me calm, quiet, this is to calm me down. And I knew enough to not want to play that game. The drug they gave me to stop the milk was an injection, and I wasn't completely au fait with what it would do. Um, other than they said oh, this is something to help you. And they told me afterwards what it did. Um, but the Valium I could deal with, I could do something about it. So I took a little bit control back and spat them out, threw them down the sink. So I probably wasn't as calm and docile as they wanted me to be, but I wasn't, I mean, I'm quite a fiery person, and if crossed and put in a difficult situation now, I will fight back, but at the time, I think I had all the stuffing kicked out of me, emotionally. But that was one thing I could do to have a little bit of control.

I: Yeah, yeah.

R: So while I was in the hospital and they were giving me Valium it didn't get any further than under my tongue. Um. My mother came to pick me up on the 23<sup>rd</sup> of October and, you're right, the story just, just kind of pour out, doesn't it? She came to pick me up on the 23<sup>rd</sup> of October, and I said my goodbyes to various people, including the Bolivian girl, whose name I wish I could remember. And she had a really cute little baby. Um. And we went back on the train and I held my child all the way back, and it felt right, it felt like the right thing, me holding her. And it was the longest time I held her. (pause). And we got to Waterloo, and that was in the days when you could sort of park nearby and my father was there. That was the first time her saw her. And he barely looked at her. Barely looked at me. (pause). And then we drove to [REDACTED] and went into this place, and all the time I was thinking, they'll, they'll take me home, they won't make me go through it. And they didn't speak to me. They just didn't talk to me at all. And we went into this place, and various conversations took place and I'm standing there holding my baby. And then a woman in a white coat came out and said it's, it's time to, it's time to hand her over. Or something like that. I can't remember exactly what she said. But I can remember crying. Then my mother looked at me and said, oh for goodness sake, took my child from my arms, and handed her to this stranger. Who then turned around and faced me and went, say bye-bye, waved her hand, took her away. And I've never felt more betrayed. [inaudible 0:40:37.6] that moment. (sighs). (pause) And that was kind of the end of any meaningful relationship with my parents. For me, anyway. I would still speak to them, and deal with them, but, um, over the years, that moment defined everything else. Really. Um, after, after all of that, and they had to sort of pick me up off the floor, 'cos my legs were jellified by then. We went home and we had a nice cup of tea. And I sat there, staring at my stomach and wondering what the hell had happened to me, and my mother said, oh for god's sake, pull yourself together. I suppose you're feeling broody. Because she is a warm, caring woman. Um, and I just kind of, I don't know. I lost a dimension for a while. I was cardboard. And

then I had to go back to school. And that was weird. That was like learning on another planet. Where everybody looked familiar but there was nothing in common [inaudible 0:42:24.6] other than a bit of history from you know, sharing classrooms. And I survived six months. Um, but the first week I was back there was a girl from the year above who I found out had also had a baby, she was there visiting the headmistress who had been complicit in all my mother's plans, and she was there with her baby. And I can remember feeling like this, something hot and painful had plunged itself into my mid section, I just couldn't believe that, this was happening and I hadn't been allowed to, to do what she was doing. And after that I just went through the motions for a long time. I didn't feel anything, because there was nothing left to feel really. I think I was really depressed. Um, I didn't have any help, though the social worker who buzzed around me in the early stages of the arrangements, vanished into the mist. Um. I can remember my mother taking me for the six week check-up, the post-natal thing. And she and the nurse had a conversation about me, about whether or not I should be fitted with a coil because, you know, once they've said yes, they'll say yes again. I remember thinking, well, hello! I'm here! But apparently I wasn't because the conversation carried on around me, and my mother said, no, no I don't think that's appropriate. Um, so, still, she was sort of taking away my body autonomy and leaving me bereft of not only my child, but my, my rights, and my choices and my self. Um. And I never saw, I never saw my daughter's father again. I did try and find him but he made himself very scarce. So.

I: Did you know where your daughter was going when they took her away? Did you have any information about where her parents or?

R: (sighs). Well, um, the social worker, I'm not sure how she came to be my social worker, I'm not sure who made the arrangement. Whether she was part of the, er, [redacted] or what she was, I don't know. But she, er, she said that they would help select the right parents. And they, she said, they'd found Anglo-Indian parents and they were both teachers and she gave me this whole thing about this couple she was going to. And I kind of comforted myself with the idea that she had a similar background. Um, I think it was all a crock. But in the, in the final event she did actually go to an Anglo-Indian family, so she does share that commonality which is, in some ways, um, very nice because some things will, some things are shared that perhaps wouldn't have been otherwise. Um. (sighs). But I was told that this couple would be, I was told they were teachers. And all the while I was thinking, this isn't really going to happen. My parents won't, you know. So I, I hadn't really dealt with the, the realities of the situation. And this woman knew a lot about what I was thinking. I know you'll do the best thing. I know you'll do the right thing. I know you won't change your mind. I know you'll go through with this and you won't make life difficult for us. That kind of thing? Um, so she seemed to know an awful lot about what, what was going to go ahead, a very knowing person. But she wasn't there when I needed help, support, counselling, comfort, er, help with grief. She wasn't there. She was only there at the beginning, you know, because that's all that mattered. Because I really, really believe that, in those situations, the mother relinquishing a child, is the smallest and least significant part of any equation, because, in those, in that time, so many women got nothing in terms of help and support. The fact that I was sent back to school without counselling, without any kind of, anyone to talk to, and I had to keep it secret. So I had to lie to everybody. I, it ruined my relationship with my grandparents. It ruined what was in fact a not very healthy relationship with my sibling anyway, because we never get on that well. I had this huge secret I had to keep. It meant I couldn't let anyone close to me.

I: Yeah. Yeah.

R: So I was separate. I was this, I was this sort of secret pariah. And I had this terrible thing I had to keep to myself.

I: Yeah.

R: I don't really know what the repercussions would have been had I told everybody. I don't really know. There was one person who knew, and that was somebody I got involved with who was a, an older guy, who was working at the [REDACTED] I went to. And we weren't that close, initially, but we sort of got closer, and I told him, after we'd sort of um, reached a certain point in the relationship. I told him that this had happened. Er, then he said to me, he already knew. And that was very confusing. Because I knew him from all the while I was going to the ice rink. So I started going when I was about 15. And he'd always been there, we always chatted. Um. And he must have realised. He was in his 30s I think. He must have realised that I was pregnant, because he obviously could see it.

I: Okay. Him being older he was probably more, more aware [inaudible 0:49:48.7]

R: He had a wife and child.

I: Okay.

R: And he and I sort of spent some time together, but it wasn't, you know, significant in any way, but clearly he was aware. And then he told me that he'd actually come to visit me in [REDACTED] but he hadn't had the courage to come in.

I: Oh gosh.

R: And I remember thinking, you could have saved me.

I: Oh gosh.

R: But of course he couldn't have saved me. He had his own problems.

I: No. But an act of kindness might have [inaudible 0:50:22.9]

R: Meant the world.

I: Yeah.

R: Um, that was really, that was quite a shock when he told me he knew.

I: Yeah.

R: Because I had this whole fabricated story of where I was and, what I was doing. I was supposed to be on some study course. It was my mother's idea.



I: And did your grandparents know? No, they didn't. Gosh.

R: No. Well, if they did they didn't give any indication, I'm fairly certain they didn't know.

I: Yeah. And your, sister or brother?

R: Brother.

I: Did he know?

R: He didn't know until I was reunited with [REDACTED] [inaudible 0:51:01.6]

I: Okay. Okay.

R: And er, his reaction was not great. Because he felt that I had, I'd been dishonest with him. The major trauma that had gone on in my life was not the point I'd been dishonest with him. I hadn't shared with him this, this thing that had happened, so he'd been shut out.

I: Is he older or younger?

R: He's younger, and a little strange. But, nobody really knew until later on, but it, it informed every interaction, every relationship. People would say, have you got any children? And I'd have to say no.

I: And after a while I get, for me, that used to become automatic. So you don't even think, you don't even think you're denying, you're just saying it. Yeah.

R: You're just saying it, it's a habitual denial that, that becomes ingrained in your inner psyche.

I: Yeah. So did you, you went back to school? Did you finish your 'A' levels?

R: No.

I: You didn't?

- R: I lasted six months and I went to see the headmistress, and said I can't do this anymore. And she said, oh well that's a shame because, you know, you could have done quite well. With brisk, jolly hockey sticks sort of approach to life. And I looked at her and she didn't mention what had happened. And I thought, you know why I'm going. You know why I can't do this. Why can't you say something? But I thought I'm not going to bring it up if you're not. Er, and she just said oh well, that's a shame, and that was it. But I made a point of not telling my parents I've not gone, I wasn't going to school, so I just kept going out and instead I went to the ice rink and skated. Because there was no point in telling them anything ever again really. But the aftermath is, considerable significant [inaudible 0:53:11.4] And the problem there is that nobody really gets it. Nobody, unless they've been through the same thing, or they are very close to someone who has, nobody understands what's happened. They don't understand why, why a person has changed. Um. And they don't understand how, certainly for me, no-one understood how damaged I felt. Um, not only did I labelled myself, I no longer do, but I labelled myself as damaged goods. Um, I think the emotional impact was so enormous, I had no way of appreciating just how much damage had been done. Um, not for years. Years and years. When I used to go down the street and then see children, I'd sort of look at their faces and think you know, are you the one? And I'm sure, you appreciate, you look into prams and you look into pushchairs and you look at toddlers and you look, as time passes, and then you realise you've lost so much.
- I: Did you have a photograph of your daughter?
- R: No. No. It didn't even occur to me. No I had no photographs. No mementos, nothing.
- I: Nothing. As if she hadn't happened?
- R: Mmm. And my father, when he did mention it, he would say, well, you know, it was just, he actually wrote me a letter. And he said we will regard this is a youthful indiscretion that you will put behind you and get on with your life. And now when I think about it, that's probably one of the coldest and most heartless things he could have written. But it was easier for him to write me a letter than to speak to me. But I have my views on my father, which, again are another conversation.
- I: So, um, tell me then about your life over the next few years in terms of you adjusting back in, if you did, and how you felt, had, were you successful? Did you feel good about yourself? When did that come back, or, tell me a bit about that.
- R: Um, okay, so, after all of that, and I, I ran away to an ice show, and did a season at [REDACTED]. Er, as you do. Um. I actually ran away from everything. I left with my possessions in carrier bags and went to live with somebody who, I, it was a very ill-advised relationship, and it didn't last but I needed somebody who was at least going to treat me better than my parents had. He didn't, but that's neither here nor there.
- I: You thought you were going to be treated better than?

R: I wanted that. I wanted, initially I thought that he would be, anyone would be better than them. Um, but I ended up going back home because I couldn't go anywhere else. Um. And they, at some point, well you've got to have a few skills. You've got to be able to earn yourself a living. So they sent me to learn to type and be a secretary and, you know, all of that sort of, you know, really high fallutin' stuff. So I learned to type and I can answer a switchboard in numerous different technologies. It was way back when you had doll's eyes switchboards and all that. Um, [inaudible 0:57:27.7] could go and get myself a job. Which for them meant I was sort of, edging back into respectability. I hated office work. But I did it, because that was what was expected, and I had no concept of myself. I had completely lost contact with the person I wanted to be. I wanted to sing and dance and perform and be out there, but I was so broken, or felt so broken, that I ended up sitting in an office typing somebody's letters after they'd dictated them into a tape. And I remember thinking, how did I get here? What happened? What was broken? And I had a conversation at one point with my mother, when she said, oh you, we wanted to send you to drama school but you didn't want to go. I know that's a lie. Because I'd have bitten her arm off to go. I don't know why she said things like that, but she said them often. Um. So I did various office jobs and worked my way up, if you can call it that, to being a legal secretary. As a backdrop I had, a, I was sort of a serial monogamist really. Some of them only lasted one night. Um, I couldn't relate to people. I couldn't get involved with people. Because I couldn't trust myself and I couldn't trust them. So I felt this complete disconnect. So it affected any physical relationship and emotional relationship, any kind of interaction that I was cut off from people. Um, I ended up, living with somebody who I met in a, a friend I worked with, she, she met somebody. She said, oh, he's got a friend, let's go. And this guy was doing, he run his own company, a backstage security thing going on with the music business. And we got on reasonably well, and, he seemed like, he was a very big person. Physically big. Um, and I presumed I was looking for someone to protect me. So I got involved with him, and we were together for five years, during which time he blacked both my eyes, broke my nose, threw me across the room and slapped me numerous times. And there was, he was very much that sort of abusive level. Because I was very emotional, vulnerably, very vulnerable emotionally, I took all of that. And then one day, I just woke up and thought, no. And I said to him, if you lay one more hand on me I'll kill you. I remember him laughing in my face. I said, well, you've got to sleep some time. I know where your heart is. Small as it might be, I can find it with a knife. And I can remember having that conversation as clear as anything. I can remember this look on his face. And he was six foot five, 18 stone and I was um, five one and a half, and considerably less and he was scared of me, and that was really, really a big deal.

I: Yeah.

R: And he carried on with the psychological abuse, but not the physical, he never laid a hand on me again. And at that point, I knew I had some power.

I: Okay.

- R: And this weird, distorted, perverted, route that I took to regain my own power started at that point, where I realised that I could either let him use me as a punch bag or I could take back my power. So eventually that relationship ended. I ended it. Which is something I still jump up and down about in my quiet moments. It was um, it, he'd actually said to me, if you, if I can't have you, no-one else will. The classic line. Um, I figured he'd either kill me or disfigure me or both. And probably a particular order, but you know what I mean. Um, but actually what he did was burst into tears, when I said, well it's over. Because I knew he was seeing someone else. And again I had that moment of like a click in my head of, of, wow. I was the strong one. I didn't know. And I, I started on a really painful journey of selfdiscovery. I had a, I had an eating disorder which was a huge problem. Um, I, I just was a compulsive eater, so I'd have to exercise manically.
- I: Okay.
- R: And in the background I'd got involved with competitive bodybuilding which I'm not, I haven't been involved [inaudible 1:02:43.6] so I was doing lots and lots of training, and I was doing all of this stuff. So I was getting stronger, um, physically. But as I was building the kind of outward strength, I felt wasn't, still wasn't my inner strength, so I started reading everything from er, Fat is a Feminist Issue, to the Louise Hay stuff. [inaudible 1:03:07.1] to books on psychology. I read Half a Million Women.
- I: Yeah, yeah.
- R: Um, the adoption triangle, and a couple of others, yeah. So I just read and I read and I read and I kind of had these aha moments and, I realised how dysfunctional my life had been.
- I: Okay.
- R: So I made choices. I made choices about what I was going to do. I looked at the, the level of my personal promiscuity, you know, historically, and I thought, you can't carry on like that. That, it's not good for me, it's not healthy, it's risky behaviour. It's not life-affirming. So I had these, these kind of, a series of realisations but it took a very long time. Um, and it really wasn't until um, I was, I actually was in a, a sort of, a slightly better relationship, and I began to reevaluate more. I married somebody who, I later discovered was an alcoholic, so, I realised that I was doing, in a repeating pattern, of choosing inappropriate men. And I made some choices then. So then I met the chap who's now my husband, and we had a really turbulent few years, because I must have been hell to live with. He had some issues too. No-one's perfect. But I've no idea why he stuck with me. Um. (pause). When my daughter was 15, I tried to found out about her. And I phoned the [redacted]. I said, you don't have to give me any information. (coughs). Sorry.
- I: It's okay.

R: I just want to know if she's okay. And the man on the phone said to me, I mean, if I hadn't been so emotional I would have realised he was lying through his teeth, because he didn't pause, didn't even go and check, he just said to me, oh the family have moved away, we've no contact with them. I can't tell you anything. And the, it felt like a body blow. Er, and I kind of want to take them to task over that. Now. But my response to that was to write a long letter to my daughter saying, I don't know if it was the right thing. I was so young, blah, blah, blah. I don't actually know what I said, but, it was very much, the door's always open. You can write to me, you can phone me, you can turn up on the doorstep. I don't care. But I'm here if you want to meet me. When she was 15 (coughs), excuse me a moment. She went to the [REDACTED] offices, with a friend. And she wanted to see her file. She wanted information about me. Can we stop for a minute?

I: Of course.

(paused until 1:07:03.10)

R: Are we good?

I: Yeah, good to go.

R: So I mentioned the, I had written a long letter.

I: Yeah.

R: And my daughter, when she was 15, had been trying to find me.

I: Yeah.

R: The legal situation was such that she was too young. But she got to the [REDACTED] [REDACTED] with a friend of hers, um, someone that I've met, they're still friends now. Lovely chap. And she said the worst moment in her life, in terms of trying to find me, was being in this office, and the social worker or whoever it was, came back with the file, put it on the desk and, oh I'm sorry, you're only 15. I thought you were older, so I can't give you any information. You'll have to come back. And I can't imagine how crushed she must have felt.

I: Because she's looking at the file?

R: Yeah.

I: With her mum in there, and she's?

R: Yeah.

I: Okay.

R: The irony there was, that her adoptive mother had all my details.

I: Gosh.

R: But hadn't given them to her.

I: Gosh.



- R: She knew my name. She knew where, certainly where my parents lived. Um, my daughter told me recently that her adoptive, her adoptive mother had actually sent a letter and photographs for the first few years. I didn't receive anything. I don't know where they were sent. [inaudible 1:08:25.9] made a huge difference to me, but I didn't get any of that. But anyway, when she got to 18, um, she obviously went back to them and read my letter and wrote to me. Oh no, no. They contacted me and said she'd been in touch. Was it okay? Even though I'd said to them, and I'd said to her, I still had to kind of go, yes, it's okay. Honestly, it's fine. And when eventually um, I spoke to her on the phone. We exchanged letters and I spoke to her on the phone, it was weird. There was little voice at the other end, and I thought I should know you, but I don't.
- I: And was [REDACTED] the name you had called her?
- R: No I called her [REDACTED]. I actually wanted to call her [REDACTED], but my mother said that was not a good name. So even then I had no control. It's the whole thing, and I think about, I mean the name [REDACTED] came into my head as she arrived in the world. She called her second daughter [REDACTED]. I never, ever mentioned the name to her. I've never told a soul.
- I: Woah!
- R: Apart from my mother, who said, no you can't call her that. Um, and then when she called her [REDACTED] I went, oh my god! And I had to explain. And that was a real weird moment between us. But anyway, she, she, um, she contacted me, we spoke, we arranged to meet. And [REDACTED], my partner, my husband, he said look, I'll drive you, because I think you might be in a bit of a state.
- I: How long ago was this [name]?
- R: [REDACTED].
- I: Okay.
- R: 14<sup>th</sup> of November, [REDACTED]. It's just there. So I went to meet at this house where her adoptive family had lived since before they had actually had her. So they hadn't moved away, they hadn't lost contact with anyone. You know. This person at the [REDACTED] had lied through his teeth. And when she came out, um, we were slightly late because we got lost. Pre satnav you know. Um, she came out and it was like looking at a younger version of myself. And I, just, we just stared at each other. And, she said, I thought you weren't coming. (laughs). And I just looked at her and you know, we sort of, hugged and spent some time together. It was very strange. I mean, we ended up comparing elbows and, because I've got quite hypermobile elbows and so does she. The kind of stuff you would do when children are children. Women like us end up doing, if we are lucky enough to be reunited with our children, we end up doing that as adults. It's bizarre. But it happens. So it's sort of re-establishing those points of familiarity. Um, then her adoptive parents came back, and my husband was there, well he wasn't my husband then, and they were really not very approving of the fact that someone else was with me. And they treated me really like I was a naughty child. And I remember thinking, I'm an adult, why are you doing this to me? But to them, I was always the fallen woman I suppose. So, I mean, that was [REDACTED]. Since then, I've

worked to reclaim myself really. And I thought I'd done a reasonably good job. My relationship with my daughter has been up and down. Because relationships are. She's settled down with someone. She's got [REDACTED] children of her own.

I: Woah!

R: I know.

I: Wow.

R: Yeah. Um, but after my father died, um, in [REDACTED]. Um, things changed, my mother sold the house. We agreed that my mother would move in with myself and my husband because we never had children. And my brother has four. Make of that what you will. Um. And when I was living under the same roof as the woman who had been the architect of what could almost have been my downfall, I kind of had to cope with her. I didn't realise how I'd feel. She's older, frailer, got some health problems, but at the time she was still fairly mobile, and she had memory issues, but she was sort of okay. And I didn't know, because I don't read the newspapers, but the Daily Mail ran a series of articles on adoption in 2013. She's Daily Mail reader. So she gets the paper delivered every day, she's reading this stuff. I didn't even look at them, she's got her own part of the house. One day she came out and she said, I keep wanting to say sorry.

I: Oh gosh.

R: And I kind of looked at her and, what for?

I: And she said, for [REDACTED]

R: And it was as if something moved in my mind.

I: Oh gosh.

R: I don't know how to explain that. Um, it, I can remember I was making a really odd noise, I think I was sort of howling.

I: Ooohh.

R: And she said, oh, I didn't want to upset you. And my husband was home and he came in and said, what the hell's going on? Took me away. And, it took me a long time to really calm down. I felt very odd. And I went through a whole cycle of loss and grief and stuff. I went through that in a very short timeframe. And all my repressed memories came back.

I: Oh.

R: So I had all the post-traumatic stress stuff going on. I had flashbacks, I had nightmares.

I: Oh gosh.

R: I had, (sighs) really, really negative feelings and I actually reached a point where I thought about suicide because I couldn't cope with how I felt. I couldn't cope with being with her. And then I just turned a corner and thought, I don't know, something changed. It was like everything had come back that could come back.

And I feel like I own myself again. And it's taken all this time.

I: Okay.

R: And I had a conversation with my daughter about it and said, look, I don't really know how to explain this, but if there were times when we talked about what happened when you were little, and I told you I couldn't remember, I really genuinely couldn't remember. I can now. She said, what do you mean? So I explained. She was horrified. She said, something along the lines of, how could you, how could you cope with that? And I said, well to be honest, I very nearly didn't. And she actually said to me, my god, were you suicidal? And I said, yeah. But I'm kind of out the other side of it now. And, (pause) even though it's difficult sometimes to talk about it, I have it all back. So the bits I'd repressed, the bits that horrified me, the bits that I've talked about now, like, the stuff that happened in the hospital, a lot of that was really vague, but I had it back in full technicolour for a while. As if I was, you know, clear and present right there. And then it sort of settled into where it needed to be. But there were moments when I honestly thought I was going crazy. So I also read about post-traumatic stress, and I did lots of EFT on myself. And er, in subsequent years I've trained in NLP. I'm still learning hypnotherapy. I train EFT to level two. I did reiki. I've done energy healing, I've kind of got myself into that whole thing. I'm very out there, fringey, sort of energy balancing chakras, kind of level. Um, but er, I just think that there is absolutely no point in me having walked this path, if I can't at least do something with someone else. So my stage in life now, very late, having reclaimed a lot of memories that I thought were buried under, concrete, I suppose, they're just all back. Um. I believe that I have the tools to help other people like me. I haven't quite got there yet, but that's where I'm at now. Because it's been awful. And it shouldn't be awful. There should be help. [inaudible 1:18:29.9].

I: The fact your mum said sorry. The way she did. And I know that subsequently triggered a lot of stuff for you, but did it mean something to you?

R: No.

I: It didn't?

R: No. It's too late.

I: Okay.

R: It's too late. She didn't mean it, the only reason she said it was she read a load of articles about it, it made her think about it. This is the same woman who, about ten years after it had all happened, she said to me, do you think about the baby?

I: Oh okay, okay.



R: And when I said, every day, she looked genuinely shocked.

I: Yeah, okay. Okay.

R: So no, she [inaudible 1:19:15.6]

I: And, can I ask you a bit about your relationship with [REDACTED]? Is it, is it c's she has her own parents obviously...

R: Yeah/

I: ...and did she have a good upbringing and does she talk to you about how it felt for her and? What, do you tell her about yourself?

R: I'll tell her anything she wants to know.

I: Yeah, yeah.

R: I will be as open and honest as I can. After all the recent kind of rush of stuff that happened to me, um, I was able to have a very open conversation with her and say, look, she's a very smart cookie, so she understood, she understood what I was talking about. And I said to her, I didn't know I'd repressed memories. I now have them back, it hasn't been fun, but, and I explained how [inaudible 1:20:02.5] had come about. I said anything you want to know, anything you want to ask. I'll answer to the best of my ability. I can't guarantee that everything is there, I have some holes in my memory, but, because so much of it came flooding back the way it did, there's a lot that I now know. Sadly some of it I still can't tell her because I really don't know, but she and I have reached a much better point in our relationship as a result of that.

I: Okay.

R: And she now realises that when we first got together and she asked me questions and I'd say I can't remember, I really couldn't remember.

I: Okay, okay.

R: But at the time she thought I just didn't want to talk about it.

I: And she might have felt quite hurt and, and...

R: I think she probably did.

I: Yeah. Yeah.

R: Um, but I don't think, I think now, as a mother, as an older woman, she's now appreciating that I was younger than her eldest child when it all happened. And, she is now understanding the full impact that it would have had on me. And it's enabled her to open a dialogue with her children. She has four girls, two boys, and with the girls she said, I would rather you weren't pregnant when you were young, but if that happens to you, what happened to [name] will not happen to you. I will take care of you. And for me that is a major victory. Because it'll never happen in my line again.

I: Yeah, and does she call you [name]?

R: Mmm.

I: Does she ever call you mum or would you like her to call your mum, or?

R: It's not, it, it doesn't work, because she has a, she has somebody who looked after her, brought her up, did all the things that a mother would do. Er, I think our relationship is a comfortable one now. For a while it wasn't.

I: Yeah, I had the same. Yeah, do, this sounds, this might be a stupid question, but does she feel like your daughter?

R: I think she might do.

I: Yeah.

R: She's never actually said but she's, (sighs) we're comfortable with each other in a way now that I think we weren't when she thought I was hiding things.

I: Yeah.

R: And I think that, that's actually been, it's been, even though it's been really er, turbulent ride, recently, I think it was worth it just to, have that new depth of understanding between us. My mother has no clue. She doesn't know. Um, and that's fine. I don't really care what she feels, in this respect. I mean, what's left of her is just a little old lady who's terrified of everything, so, you know I just make her quality of life is as good as it can be, but I stopped loving her when I was 18, 17. So, it could be duty, it could be that I wish she had been different. It could be any one of a number of things, and I'm not a cruel person, so I can't treat her the way she treated me. It might even be a point of principle that I make sure she's okay. But as far as she feels about anything to do with my daughter I, I don't really care.

I: So, if people meet you know and say have you any children, what do you say?

R: Yes, I have a daughter and ■■■ grandchildren.

I: Yeah, yeah.

R: But even though I've been told, I've been, it's been made very clear to me I'm not their grandmother.

I: Yeah, yeah.

R: Even though, they look at me and they look at her and they can see we're like peas in a pod.

I: Yeah, yeah, I think um, that's common with all the women that I spoke to, and myself. That's just the way it is isn't it? But I think I can accept that because, it's better to be there than not be there.

R: I would rather have contact.

I: Yeah.

R: On their terms...

I: Yeah, yeah.

R: Rather than not have contact.

I: One woman I spoke to summed it like this, she said, the pain, she has a fractured relationship I think with her son but she said the pain I feel having him in my life is less than the pain without him. So, she's saying, yeah, it's difficult but do you know, it's still better than not. Because it fills some of that void that...

R: Yeah, reunion doesn't resolve it.

I: No it doesn't, and I, I don't know about you when you see things like Long Lost Families and the implication is they walk off into the sunset. I actually feel underneath quite, er, I feel it's immoral almost to do that.

R: It is. It's dishonest, because nobody sees the, the, um, the process that follows. Because it's a bumpy ride. With most people. I suppose when it's siblings being reunited it's probably not quite so difficult.

I: No, it's not. It's, because I know a family where that's happened. That's easier.

R: Mmm.

I: Yeah.

R: It would still be weird, but, er, I can't imagine it being as difficult as this, and of course you have all the adoptive family to deal with.

I: Yeah.

R: When my daughter was 21, her adoptive family invited me to her birthday party.

I: Right, okay. Right.

R: They also invited my brother, his wife, and my parents.

I: Right.

R: So er, and obviously [REDACTED]. And so we all turned up. And we walked into this room, and it's a huge family. Massive. Loads of people. Cousins, aunts, uncles, it's a big sort of Anglo-Indian sort of melee. And I walked into the room, and I had people coming up to me going, I know who you are, glad you could come. I had no clue who they were, and I felt like the spectre at the feast. It was the weirdest feeling. It was lovely to be there but at the same time it was awful. Do you know what I mean? There was this feeling of um, what might have been. And that was really hard. Particularly that my parents were there, because I remember thinking, I don't really want them there. And they were invited, so.

I: Sure.

R: They were there.

I: And did your daughter have a good, were they good parents to her? Are they good parents rather to her?

R: I think they've taken very good care of her.

I: Okay.

R: She's had a lot of love, lavished on her. They've taken good care of her in many respects. There's been some issues, but then in any family there will be issues. I think that if it, if, er, if I'd have been able to choose with more awareness of who they were as people, um, they were probably one of the better choices.

I: Okay, okay.

R: Um, we don't particularly get on, and I think that my presence poses a threat even now to her adoptive mother, because she didn't have any children. And I know why. Um, but that's a sort of private thing between them. Um, and I think that she expected [REDACTED] would just take off and live with me. And when she, because [REDACTED] told me, she said um, she'd had this conversation, and I went, why would she think that? And she said, I don't know. It's weird isn't it? I mean she was, she was 18 and her mother suddenly said you know, if you want to go and live with her that's okay. And I think that that's actually quite harsh, because this is the person who brought her up. She's the person who was her mother.

I: She might have been saying it though out of...

R: Magnanimity.

I: Yeah, or, an insecurity that, don't let her know I'm insecure, so I'll say it's okay to go. All sorts of things, there could be all sorts of things.

R: It's very complicated.

I: Very complicated, yeah.

R: And I don't really know what this woman does or doesn't feel. I know she's insecure and I know she was threatened by me, and I know that she found it enormously difficult dealing with the reality of the fact that this was my child, but she had her instead. Because there is that whole psychology of, well actually, you know, I've taken another woman's baby. And I think that was very, um, very prominent in her thinking, and it's definitely affected the way she related to me. And it culminated at one point, where we had a disagreement, with me writing her a long letter, saying, look, I can never usurp your position. I wasn't there when she needed a mother to wipe away her tears or to take her to school or to do any of the many, many things you've done for her. I can't express the depth of my gratitude to you for doing all of that, and I can't take your place, so don't ever think I'm going to try. And it was a much longer letter.

I: Sure, yeah.

R: But I wanted her to know that I wasn't a threat, but I think I will always be a threat.

I: Yeah, but that's her stuff isn't it?

R: Very much.

I: You know, you know, whereas you, yeah, because you've been through all of this, you, you see it differently. She probably is, is not in a place to see that.

R: No, but they still invite us occasionally to things. Usually they're church related which is interesting, you know, sort of communions and confessions and all that.

I: Is that Catholic as well?

R: Yeah.

I: Okay.

R: Yeah, you can't get away from it, no matter how hard you try. Um, yeah.

I: I'm just going to check my questions, I think you've actually. Oh yeah, just a, you've sort of covered it, but I'll just ask you again. Um, so, with the passage of time, how do you think your emotions have changed in relation to your experience? You've sort of answered it as you went along, but if you were? Let me put that another way, when you think about your feelings now in relation to the whole experience, what are you left with?

R: I think the feelings are not as raw. Um, somebody else I was talking to recently asked me a similar question and I said it's like a wound that never heals, but it's finally stopped bleeding. Um. I think I'm still very sad. I think there's still grief and loss. But I think I'm at the point where I'm not overwhelmed by the feelings in the same way. And I'm able to articulate them more effectively so that I can actually express my current experience as being less intense than those times when I was younger, and I couldn't speak. I couldn't say the words about, I couldn't put my feelings into words because they were so painful. Um, I think those people who liken adoption to amputation have probably got it right. You get phantom limb pain but it doesn't go on for ever, it calms down to the point where you can manage it. Does that make it phantom child pain? That's an interesting point, I don't know. I think those feelings are manageable now. Um, but they're still there. I don't think they ever go. They just get to the point where you don't fall to bits when they come up. It's a little bit like the tide. The waves overwhelm you occasionally, and then they go out again, and you think...

I: That tsunami sometimes.

R: Sometimes, yeah.

I: So just the last question then before I switch the tape off. Is there anything else that you want to say that you haven't said? Or hasn't come up in the natural conversation?

R: Er, I think that, er, the only, the only real issue is accountability. Um, which is not something I'd thought about much until comparatively recently. Those who treated fairly young women and girls, so callously, everyone from the medical profession, to the, those in the Roman Catholic church, to those in social services and the justice system, parents, guardians, people who make decisions for others, who really ought to have been given their own voice. I think that there ought to be a level of accountability, even now after so many years. And until something is expressed in those ways, until people who've perpetrated all of this are held to account, I think that the injustice won't be recognised.

I: That's a great way to end. Thank you.

[End of transcript]



Appendix D: Excerpt from Doreen's transcript with stage 1 and 2 annotations

R: <sup>Morning sickness</sup> 1 Um, it got to about eight months, and my mother said, you don't look right. And  
 2 I said, and I had had incredibly bad morning sickness. I had had um, um, diabetes  
 3 insipidus, so you know, I'd had all kinds of reactions to things. Um, I hadn't had  
 4 much else, and I didn't have much weight gain, but I really, to this day I can  
 5 vomit without making any sound at all. Um, yeah, lovely (laughs). So, um...

I: 6 And got carried on at school and that? Okay?

R: <sup>School primate</sup> 7 Sat my O levels when I was six months pregnant.

I: 8 Oh gosh.

R: 9 I did quite well actually.

I: 10 Did you? (laughs)

R: <sup>I was being looked at by mother causing beginning to notice & was going to do it on my own</sup> 11 Yeah. Um, I think a couple of the teachers were kind of looking at me and  
 12 thinking she's very round. Considering she was very skinny. Um, but nobody said  
 13 anything. Um, got to eight months and my mother started sort of saying well,  
 14 what's wrong with you? And I was getting a lot of back pain. Somewhere in the  
 15 back of my teenage brain, I had decided that I was just going to go through it  
 16 alone and present them with a fait accompli. I now know that because um, I had  
 17 a lot of repressed memories which only have come back in the last few years,  
 18 and I'll tell you about that, as and when. Um, but I kind of decided I was going  
 19 to go it alone, because I didn't know what to do, and I was so scared, I just kind  
 20 of buried the whole thing. And then my mother announced she was taking me to  
 21 see a specialist because I was obviously having trouble with my back, because I  
 22 was walking oddly. Who knew? Eight months pregnant, walking oddly. That's how  
 23 close we were, because she was really caring. Um. So she took me to this doctor  
 24 and he kind of examined me and put his hand on my stomach and went how long  
 25 have you been like this? And I said, I don't know. And I can remember he didn't  
 26 speak to me. Nobody spoke to me. He just kind of went, okay then, and I hadn't  
 27 really got undressed, but I'd taken my shoes off, and he said, you know, pop  
 28 your things back on, and I, I'll be out in a minute. And he spoke to my parents  
 29 separately. He wouldn't speak to me. And, then we went home and my parents  
 30 sat me down, at a table where we used to sit and eat our meals, and they said,  
 31 the, I can't remember his name, lots of names have just gone and I'm really  
 32 good with names. Um, he had had a long chat with them and in his professional  
 33 opinion I was pregnant. What did I have to say about that? And I said, well, he  
 34 might be right then. And, it, I, I have a kind of a blank at that point, because I  
 35 do remember there were three of us in the room, my mother was shouting at me  
 36 and my father was shouting at me. And I remember sitting there thinking, that I  
 37 wanted to be anywhere but there. Um, and my mother called me all kinds of  
 38 names. She started with I didn't think you were that kind of girl, and it all went  
 39 downhill and she was [inaudible 0:06:52.5] through the dictionary options from  
 40 there really. Um, it, she wasn't kind. Nobody was kind. Never occurred to her  
 41 that I might be afraid. Um, the fact that I had no medical help at all to that  
 42 point didn't seem to enter their heads. Um, and I'm saying all this with the  
 43 benefit of hindsight, because I just know that I sat there, frozen, with them  
 44 yelling at me, and she said things like, oh, I suppose we've got to get a pram  
 45 then, as if a pram was some sort of um, the dirtiest most filthy object in the  
 46 world that anyone would possibly want to, you know, it was just, unthinkable.  
 47 Um, and I can remember as a teenager, I was 16, I sat there, and she was sort of  
 48 asking me questions about what I wanted and I can remember the way she used  
 49 to say, well, what do you want then? Um, whenever we had that conversation, it  
 50 would very much be, I would tell her what I want, she would tell me what was  
 51 going to happen. So from, from that point I just felt completely helpless. And I

I can still vomit

Light  
Bel  
hows

Mother causing beginning to notice & was going to do it on my own

Didn't know what to do - I'd buried

Mother took me to the doc at 8 months

Nobody spoke to me

He spoke to my parents, without me

What did I have to say about being pregnant

I can remember everything thinking

She calls me names

What kind of fear

No medical help

I was frozen

Significance of the pram

I wished tell her what I want & she would tell me what was going to happen

Judged?

forgot  
a J  
didn't  
know  
what  
to  
do

No body  
spoke  
NO one  
realised

Shame

Called  
name  
Shame

No feeling  
or empathy

Helpless

Shame  
PRAM

NO  
one  
realised

# Appendix D. CONTINUED.

I shut claim what was the part  
 you've been a naughty girl then  
 I never spoke He never spoke to me  
 decisions were made  
 Ruggan knew best  
 Name calling my mother was ashamed

1 can remember sitting there and she was saying, well what do you want to do?  
 2 And I just sat there and shrugged. And then I don't really remember all of the  
 3 conversation after that, because you know there's that point where you just shut  
 4 down and you just think, I don't know what to do. And, (pause), from there she  
 5 took me to the doctor and she'd obviously had a conversation with him  
 6 beforehand, and our old family doctor had retired, and he was a lovely man. He  
 7 really was. This guy was awful. And I remember walking in, and he said, oh I  
 8 hear you've been a, a naughty girl then. And I'm sure he said that to all his  
 9 adult, married, female patients who came in with a pregnancy. Um, and I can  
 10 remember I didn't say a word. I did not say a word. And they had some  
 11 conversation about me. He didn't speak to me after that, he just sort of went  
 12 through all this stuff, um, he didn't examine me. Um, and it sort of snowballed  
 13 into my mother taking me to places, making arrangements, and I don't really  
 14 remember how, but we were suddenly at [redacted] on our way to [redacted]  
 15 with me carrying a bag, going to a mother and baby home. And um, at some  
 16 point, I can remember talking to various people who were saying, it's the best  
 17 thing for the baby, and, you know, you're not old enough. You're not a suitable  
 18 mother, blah, blah, blah. But I can't remember who those people are. Were.  
 19 Who they were. Um, and my mother made these arrangements. She didn't really  
 20 talk to me about it. She never once showed me any kindness or compassion. She  
 21 was just ashamed and that was the hardest bit. So, that's what I remember of  
 22 the, the early bit.

with her  
 Shame  
 Judge me  
 Being  
 Unhappy  
 No comfort  
 Being  
 judgement  
 Shame

I: 23 And your dad?

Dad didn't speak to me - ashamed?  
 These grandchild was unacceptable  
 the support children but I wasn't accepted  
 I had created my own mother  
 Repeat behavior

24 He shouted at me initially and then he stopped speaking to me. He just wouldn't  
 25 talk to me. So neither of them acknowledged that this was their grandchild. It  
 26 was just something horrible to be got rid of. And I know my mother at one point  
 27 said, I wish you'd told me sooner, we could have arranged an abortion. But she  
 28 never actually asked me if that was what I wanted. So there's that whole thing  
 29 of, you know, I wasn't in the equation. The equation was all about the  
 30 inconvenience I'd created and what had to be dealt with. And, I was expected to  
 31 just go along with all of that. Which of course I did. Because I didn't know what  
 32 else to do. And my mother was so afraid of her grandmother, of her mother,  
 33 finding out because her mother was a very difficult woman, so there was this  
 34 fear driving her presumably. Um, so yeah, I mean.

Shame  
 unacceptable  
 was a bit  
 scared  
 My  
 fear

I: 35 So you were packed off to [redacted]?

R: 36 Yeah, to a mother and baby home.

I: 37 And did you know at that point that adoption was going to be the outcome or  
 38 how does that?

I didn't want to be in this position. I didn't want to be shouted at  
 I was too young so I avoided  
 I didn't think they would do it to me

39 Um, I think it was sort of thrown around the room during that initial  
 40 confrontation. And I remember saying that I hadn't planned the pregnancy.  
 41 (sighs) Which I think she took to mean that I didn't want the baby. I may even  
 42 have said, I don't want this, because I have a vague recollection of saying that.  
 43 But what I meant was, I didn't want to be in that situation. That I didn't want to  
 44 be shouted out. I didn't want to be, um, I didn't want to deal with it, really. I  
 45 was too young to deal with it, so I was doing what teenagers do. Which is go for  
 46 an avoidance. So um, I did kind of know, um, but I didn't believe they would go  
 47 through with it. And that's one of the things I actually have clarity on now,  
 48 which I didn't have until recently. I didn't believe that they would do that to  
 49 me. And they sent me to this place. One of those Nazareth House places in  
 50 [redacted]

Shouted out  
 Too young  
 I didn't believe it  
 was a  
 hope



1 Oh, was it Catholic nuns?

R: 2 So yeah. Catholic school, Catholic mother and baby home.

I: 3 Oh gosh.

R: 4 Lovely.

I: 5 Yeah.

R: 6 We had all the usual things where you do the chores and whatever, but because I  
 7 was still in school and school were sending me stuff to do for my A levels,  
 8 because I was expected to carry on studying when I got back, um, I didn't get to  
 9 do as many chores, and that caused a certain amount of friction, because there  
 10 were only two of us who were studying. Um, but yeah, we were given things to  
 11 do. We had to do, we had to do, um, laundry and cleaning and, all of that stuff.  
 12 And some of the girls there were so big, they were so heavily pregnant, and they  
 13 were expected to scrub floors and things, and you think, there's something  
 14 really wrong with that. When at the time we all just [inaudible 0:13:35.1] on  
 15 with it, you know. What do you do? You're a prisoner. Um, I had no money, I had  
 16 nobody I could turn to. Um, I was sworn to secrecy and I believed it, that I  
 17 believed them when they told me it was the right thing to do. You know, not to  
 18 tell anyone. Um. So I just didn't. Um, I was there from the 13<sup>th</sup> of September  
 19 that year, 74. I remember it was a warm, it was a warm summer. And when I  
 20 could I'd go out for a walk, because I'd been very active, and they expected us  
 21 to sit around and watch TV and play games and, not so much television, we  
 22 wouldn't watch much television. They kind of cut us off from the world in that  
 23 way. Um, but they expected us to sit around and play Scrabble. Problem is, I  
 24 have a huge vocabulary, and, it was still, it was pretty good then. And I keep  
 25 adding to it. And I would produce words and they'd go, oh no, that's not a real  
 26 word. And they'd argue with me and I'd just sit there thinking, oh I'm clearly in  
 27 the wrong place here. Anyway, I used to go out for walks and I'd walk and walk  
 28 and walk until I knew I had to go back. And that was kind of my only escape. I  
 29 couldn't go anywhere, I had no money. I had nothing. So, um, I'd do that, and  
 30 they put me in a room, it was, the house was like a big double fronted thing with  
 31 dark wood panels everywhere, so dark in there. And we were allocated rooms  
 32 and I remember they put me in a room that was up at the top of the house. At  
 33 the back. And the person that, we were two or three to a room at the most, but  
 34 I was with one other girl, and she was from Bolivia, and her pregnancy wasn't  
 35 kind to her. She'd put on lots of weight, she wasn't very well. It affected her  
 36 breathing, all sorts of stuff. Don't know if she had any medical care either. And  
 37 again, it was only years later I realised the two brown girls were in a room  
 38 together. And I thought, you know it's that, those moments where you have that  
 39 clarity and you go, oh! Of course! And we were, we were treated as slightly  
 40 separate. I mean I'm not that dark. Neither was she. But we were both, um, she  
 41 could hardly speak English and I taught her some words because she struggled  
 42 and we kind of, because we all had to go to bed early, we'd just lie there and  
 43 sort of chat. And then she would ask about stuff she couldn't understand, and I'd  
 44 try and explain and it, she was actually a really, lovely girl. She was about 20 I  
 45 think. Nineteen, 20. I know, I don't know what happened to her. I don't know if  
 46 she went back to Bolivia with her baby or without, but, she was, she was a nice  
 47 person.

I: 48 Can you remember Diana, the, the baby was obviously was moving, your  
 49 daughter was moving, can you remember how much you were connecting with  
 50 what was going on inside?

Expected to  
keep studying

We had to  
clean  
our heavily  
pregnant girls  
had to scrub  
floors,  
had like a prisoner  
sworn to secrecy

Cut off from the  
world.

trapped?

Natalie's

Had I  
PAY

Secrets

Isolated  
Threat

APPENDIX D CONTINUED

R: <sup>wasn't</sup> I was terrified. JEAN

I: 2 Okay.

R: <sup>SATS WAS ON AIDER WITH POPE & LOR</sup> 3 Every time the baby moved or kicked it was like having an alien inside me. Um, I was not relating to it as a child. BABY WAS ON ALIEN

I: 4 Okay, okay. out of control

R: <sup>No control over her body</sup> 5 Um, because I just felt like I was completely out of control of my body. Um, and nobody reassured me in any way. Yes, I had a rudimentary understanding of the biology involved but I was terrified of giving birth. I was terrified that I might die. Um, I was terrified that the baby would be damaged in some way because I'd been so active. Um, and it was just, I just felt like I was completely out of control. And my body wasn't my own, and my life wasn't my own. Um, and it was, it was really frightening, (pause). (sighs). And I felt very isolated. And at the back of the house was a fire escape and they used to leave the door open because it was warm and the house would cool down a bit, and several times I'd go out there and I'd watch the sunset and I'd look down and there was a courtyard at the bottom, because we were at the top of the house. Um, quite a way down. And I used to consider just climbing over and dropping off. Nothing could stop me. Always a vivid imagination I guess, that I could see myself bursting like a ripe melon, and, I thought well if I do that and then I live, things would be far worse. So that weird rationale kicked in of, you know, also I had this other life, that if I did that, what would happen to this, this baby? What would happen? So I used to stand there and think about it, but I never actually did anything about it. Um, but yeah, I can remember being really, really afraid and isolated and confused. It was a horrible way to treat a kid really. But. I thought I felt my body wasn't my own

I: 24 So was there talk, as the birth was getting nearer, was there, did the nuns talk to you about what was going to happen, or, how? Sweetie

R: <sup>considered suicide</sup> 26 No, not really. Er, I think what they said was, if you think it's happening, it is happening, then you must let someone know. But most of the time babies arrive when they arrive, and they would arrive in the early hours of the morning and we'd find somebody was missing at the breakfast table, and they'd go, oh yes, her waters broke at four o'clock this morning. And then someone else would pipe up, yeah and I had to clean them up. Um, because obviously you know, the nuns didn't do anything. Far beneath them. Um, I think there were some conversations about it, but again I have no conscious recollection of them. confused & isolated

I: 34 Okay, sure, sure. Did I know about child birth

R: <sup>Did R not know about child birth</sup> 35 Um, I don't think they were terribly concerned about what happened to us. Not ARR

I: 36 Sure.

R: <sup>financial incentive</sup> 37 And I honestly get the impression that if we lived or died, they didn't care, as long as the baby was okay, because I think there was possibly a financial incentive. Not ARR

I: 40 Yeah, I suspect so.

R: <sup>She made me cry</sup> 41 So, and that makes me angry, but, that's probably a separate discussion.

# APPENDIX D CONTINUED

I: 1 So were you, before your daughter was born, you knew for sure that adoption,  
 2 that that was the solution? Were you still considering keeping your daughter or  
 3 not?

R: 4 I didn't actually deal with any of it

I: 5 Okay, okay.

R: 6 Um, because I was so frightened and I was just thinking that I just kind of want  
 7 to, I want to know if I'm going to live.

I: 8 Okay.

R: 9 I actually thought I was going to die in childbirth. Um, the adoption thing was  
 10 sort of there, but as I said, I, until the very last minute, I didn't think my parents  
 11 would actually go with that. I thought they'd relent. I actually thought they'd  
 12 go, well, you know, this is our grandchild, we, we can't put you through this.  
 13 And I was really, really wrong. And I never forgave them for that. Ever. Because I  
 14 just feel that any parent who cares about their child would appreciate that that  
 15 child will then go on to have a child, possibly, um, and that is part of your  
 16 lineage. That is part of you. Doesn't it matter to you? I used to think to myself,  
 17 doesn't it matter to you at all? How can you just kind of palm, palm me off to  
 18 strangers and hope for the best? I don't know, it's still a mystery to me really.  
 19 Um, I knew that that was the plan, but I didn't believe that they'd put me  
 20 through it.

I: 21 Okay.

R: 22 I didn't believe it was going to happen. I thought they'd see the baby and it  
 23 would all be okay. Um. When I eventually did go into labour, I was out on one of  
 24 my long walks, and I could feel these sort of twinges and I just ignored them.  
 25 Because that was my whole modus operandi about this. Let's pretend nothing's  
 26 happening. Um, and it got more and more intense, and then eventually, when I  
 27 finally went into labour properly and the waters broke, I was awfully tidy about  
 28 it. I managed to get to the loo, and the waters broke into the bowl. Um. And I  
 29 can remember one of the nuns not believing me, 'cos there was no evidence  
 30 anywhere. And I was saying to her well, yeah, it did, I just didn't make a mess.  
 31 Partly because people were complaining about having to clean up, so I was so  
 32 conscious of that, I kind of.

I: 33 You were a good girl.

R: 34 Oh I was a very good girl, yes. Except I was a very bad girl.

I: 35 Yes, well, yeah.

R: 36 But you know, I was so sort of worried about making a mess, so it seemed  
 37 important, so I kind of, I don't know how I did it actually. I kind of dragged  
 38 myself into this area. Um, and I can remember the way the nuns treated me. I  
 39 felt like I was just this animal. They told me what to do, and I'm sure they  
 40 weren't medically qualified, but one of them insisted on examining me to make  
 41 sure I was in labour. And that, I thought, was, I felt it was such an, it was such  
 42 an indignity. I felt really, um, horrified by it, to be honest, Um, and she was sort  
 43 of arguing with me about whether or not I was in labour. And then I had a, a  
 44 contraction, and she went oh, well maybe you are. Um, and they called an  
 45 ambulance and got to hospital and, everybody fussed around me, but nobody  
 46 spoke to me. And I can remember being so frightened, I was so scared the whole

*Just concerned  
 as I remembered to  
 I: I was  
 R: She was  
 saying  
 but  
 Believe her  
 parent would  
 change mind  
 She wondered  
 how could they  
 do that - give  
 away part of soul  
 I: I was*

*R: I think  
 they  
 would  
 change their  
 mind  
 secret  
 not believed  
 by nuns who  
 water broke*

*I was treated  
 like a animal  
 they weren't  
 medically qualified  
 everyone fussed  
 but no body  
 spoke to me. I felt so scared*

*Just  
 on I  
 saying  
 but  
 going to  
 die  
 How  
 could  
 they  
 do  
 it?  
 I had  
 heard  
 they  
 do  
 it  
 secret  
 Home  
 No  
 answer  
 she  
 in  
 chair  
 but  
 checked  
 diet  
 experience  
 in  
 answer  
 they  
 her  
 some*

APPENDIX D CONTINUED

No comfort  
 assurance  
 compassion  
 persistent.  
 Transport of chestnut  
 long way off the  
 floor  
 She baby is for  
 adoption - well  
 that's how they  
 here baby was too  
 for away for her  
 to reach  
 They didn't  
 clean her up  
 She was  
 hysterical  
 she couldn't  
 speak  
 she was weak  
 all left alone  
 I wasn't  
 cared for  
 I expected  
 I couldn't  
 bear to go  
 through with  
 it again  
 She wasn't  
 been helped  
 She was  
 emotional  
 @! for our  
 we were well  
 braced &  
 details

1 time. Nobody looked at me and said, oh my god, she's only 16 and held my hand  
 2 and said it's going to be alright. Nobody did that. So I just felt I was completely  
 3 alone. And yes, in many respects I was. So, yeah, so, the birth was unremarkable  
 4 I guess. I was terrified. But you know, in the respect that, you know, it was fairly  
 5 routine for them. I can remember they wouldn't give me my baby, and I was  
 6 lying, and the table I was on felt really high up. I don't know if it was, but it  
 7 felt like I was a long way off the floor. And I can remember I felt really weak and  
 8 one of the nurses had my daughter in her arms and she said, this baby's for  
 9 adoption isn't it? I'll take her away. And I'm saying no, no, please, please, bring  
 10 her back. And she sort of came and stood near me, and then she took the baby  
 11 across the room and the room was maybe one and a half times this size? So I'm  
 12 over here, and my baby is over there, on some kind of cot thing, crying, and  
 13 they just left me. They didn't. They sewed me up, thankfully. Um, but, you  
 14 know there'd been some cutting, but they didn't clean me up. They covered me  
 15 with a, just a sheet. And they didn't come back. And I lay there for four hours,  
 16 because I remember going in and out of being awake, and I was so tired, that I, I  
 17 kept calling out, because every time I called out, she'd quieten down, and she'd  
 18 start crying again. Um (pause). I was really thirsty, and after a while my voice  
 19 stopped working and I tried to get off the table so I could go to her. I was so high  
 20 up I was afraid that I'd fall off. And I couldn't get my stomach muscles to work.  
 21 And I just lay there, thinking, what can I do? And then someone stuck their head  
 22 in, it was four o'clock, four fifteen when she was born, just after eight, because  
 23 there was a clock like that on the wall. After eight o'clock, someone stuck their  
 24 head round the door and said, oh I didn't think anyone was in here. And I just  
 25 croaked at her, help me. And she went away. And someone else came in, a little  
 26 while later, and said oh we're going to move you now. I couldn't speak. And I  
 27 just [inaudible 0:27:38.9] this was a hospital, this wasn't like some backwater  
 28 somewhere, they just left me there. And then they moved me. I can't remember  
 29 being moved but they moved me to a room. But I was so weak. They put her  
 30 next to me but I couldn't even prop myself up. I was just so exhausted. Um, they  
 31 didn't actually clean all the blood and everything off me until the afternoon I  
 32 guess. So I was not feeling very cared for, shall we say. Um, for me, the whole  
 33 process was horrifying. And terrifying. And, do you know the [inaudible  
 34 0:28:31.4] language? In some circles they talk about the way people expressing  
 35 themselves having an impact on physically, so if you say someone's a pain in the  
 36 neck, you know, you might reflect to that by showing a pain in the neck. So for  
 37 me, ah, I found myself saying over and over again, I couldn't bear to go through  
 38 that again, so I never bore any more children, And I only realised that recently,  
 39 but I just found myself saying I couldn't bear it. Um, nobody was talking to me  
 40 or helping me or treating me as, as a patient. I was just. I don't know. Pushed  
 41 aside. And it was okay when I was in a room on my own, but once they put me in  
 42 the ward, it was, it was a nightmare, it was a nightmare. They had all these  
 43 happy mums and their babies and coming in with hearts and flowers and, hello. I  
 44 was there on my own. I did have a visit, a couple of visits from the girls, but  
 45 they just came out of curiosity. We just wondered what you had. There was no  
 46 kind of warmth in it, because I think, we were all really broken and detached  
 47 and whatever.

No  
 know  
 know  
 dare  
 baby  
 away  
 could  
 reach  
 baby  
 too old  
 know  
 Not  
 great  
 for  
 I could  
 Careful  
 dare to  
 go there  
 it  
 again  
 know  
 Careful  
 No  
 know

1: 48 And was your daughter brought to the ward with you or was she taken away?

Head top was  
 for the baby  
 Breast pain

49 She was actually, yeah, she was. I was expected to feed her and take care of  
 50 her, but I wasn't expected to breast feed her because they gave me a drug to  
 51 stop the milk. And I had breast pain ever since, but I didn't know why, because  
 52 I'd blocked everything. It was only much, much later I realised that I'd had this  
 53 constant pain. Um, which apparently can happen. I did a lot of research after I  
 54 made the connection, but I had all sorts of problems. Um, 'cos it's not a natural  
 55 thing to do, is it? So. Um. Yeah, my mother came and saw me while I stayed in

Breast  
 pain

## Appendix E

### Doreen's emerging themes

Initial phrases of interest following annotation on transcript (Chronological)	Transcript excerpt and line number	Emerging themes
Denial	1.2	Denial of being pregnant
Tried to talk	1.2	
Unable to talk	1.3	Not being able to tell anyway
Pretended it wasn't happening	1.7	
It was devastating	1.13	
More denial	1.14	Increasing denial
Its not happening	1.15	
Couldn't deal with it	1.17	
Pretended it wasn't happening	1.18	Increasing denial.
Bad morning sickness – had to hide it	2.2	Secrecy of pregnancy
Can now vomit without making a sound!	2.5	
Teenage brain	2.15	
Mother beginning to notice	2.14	Being judged
Go through with it alone	2.16	Being alone
Repressed memories	2.17	
I didn't know what to do	2.19	Feeling helpless, frightened
I was scared	2.20	Fear of the situation
Buried everything	2.20	More denial
No one spoke to me		How others behaved
He wouldn't speak to me	2.29	My feelings not being acknowledged
Mother shouting – father shouting	2.36	
Called me names	2.38	Shame of being pregnant – having sex
"That kind of girl"	2.38	Shame of having sex
Nobody was kind	2.40	Lack of compassion
Nobody thought I might be afraid	2.41	How others behaved
No medical help	2.41	
I sat frozen with them yelling at me	2.44	Helpless
I would tell her what I want and she would tell me what was going to happen		No one listened
Significance of the pram	2.44	Shame and taboo
I felt helpless	2.51	Helpless
You shut down	3.4	Not being able to speak about it
'You've been a naughty girl'	3.8	Shame – having sex
Didn't say a word	3.10	Couldn't talk
Spoke about me – never spoke to me	3.11	Ignored by others
Everyone knew best	3.16	What others did
Best thing for the baby	3.16	
You are not old enough	3.17	

You are not a suitable mother	3.18	Shame - judgment
She didn't talk to me	3.20	Unacknowledged
She never once showed me kindness or compassion	3.21	No kindness
She was ashamed	3.21	Shame
Dad stopped speaking to me	3.24	Shame
No acknowledgement of grandchild	3.25	Shame
I wasn't in the equation	3.29	Ignored
Was expected to go along with it	3.31	Compliant
I had created inconvenience	3.30	My fault. Guilt
I didn't want to be shouted at – I was too young to deal with it		
I didn't believe they would do it to me	3.48	Denial of what parents were doing
They sent me to this place	3.49	Helpless
Sworn to secrecy	4.16	Secrecy
Cut off from the world - prisoner	4.22	Alone Isolated
I had nothing	4.29	Helpless
Terrified	5.1	Fear of being pregnant
Baby kicking felt like an alien	5.3	Fear of being pregnant
Out of control	5.5	Fear

Going to die in childbirth	5.8	Fear of childbirth
Isolated, frightened	5.11	Fear of being alone
Climbing out and jumping out	5.16	Suicidal thoughts
Afraid, isolated, confused	5.22	Alone
Clean up the 'waters' of others	5.31	
Nuns not concerned about us	5.35	Lack of compassion
Financial incentive	5.37	The behaviors of others
Angry	5.41	Anger
Didn't deal with any of it	6.4	Denial
I thought I would die in childbirth	6.9	Fear of childbirth
I never forgave my parents	6.13	Anger
Palmed me off to strangers	6.18	The unkindness of others
Lets pretend nothing happened	6.25	Sworn to Secrecy
Waters broke into the bowl – I was tidy.	6.30	
Believed she was a bad girl	6.34	View of self
Treated like an animal – not medically qualified	6.38	No compassion
Everyone fussed but no one spoke to me	6.45	Unacknowledged
No one said ' Oh my God, she is only 16', held my hand or told me it was going to be ok. Frightened and scared	7.2	Fear of being alone
I felt completely alone. Terrified		Being alone
They wouldn't give me my baby	7.5	The unkindness of others
Took my baby away	7.8	The unkindness of others
Didn't clean me up after birth	7.15	Ignored
Not cared for - terrified	7.33	Fear of what was happening to my body
Weak and left alone – couldn't reach her baby	7.17	Trauma of childbirth
Couldn't bear to go through it	7.38	Psychosomatic

again (bore no more children) Use of language		(Unable to have more children)
Pushed aside	7.41	Ignored
Put on wards with Mums - nightmare	7.43	Trauma following childbirth
We were all really broken, detached	7.46	Damaged
Drugs for breast milk – breast pains ever since	7.49	Psychosomatic?
My mother said ‘ This baby is going to make someone happy’	8.4	‘But what about me’
I couldn’t speak - powerless	8.6	Powerless
Cruelty of mum -caught in the web of her construction’	8.10	The actions of others
Unable to break free	8.11	Powerless
No acknowledgement of me. Did not exist	8.22	No presence
Didn’t know how to deal with my feelings	8.40	Confused
Disconnected – doing everything but frightened	9.3	Disassociation
I was putty - malleable	9.6	Compliant
I don’t know what I felt	9.10	
They tried to give me valium	9.13	No say
They tried to deceive me	9.17	Betrayed/lies
All the stuffing knocked out of me	9.34	Damaged
Held my child on the train – it felt right	9.42	Holding my baby
Father barely looked at her or me	9,47	Shame
Various conversations around me – about me	9.50	Being ignored in decisions
Time to hand her over	9.52	The moment of parting
I was crying. Mother saying ‘ oh, for goodness sake	10.2	Not allowed to grieve
Betrayed	10.5	Trust
That moment defined everything else (her baby been taken away)	10.8	How It impacted me
Nice cup of tea!	10.9	Normalising (as if it didn’t happen)
I lost a dimension – I was cardboard	10.13	Impact on me
Went back to school – headmistress complicit		Normalising
I didn’t feel anything – nothing left to feel	10.25	Numb - disassociation
No support	10.27	Being alone
Conversations about me. ‘Hello – I’m here’	10.29	Ignored
If she said yes once, she will say it again (fitted with a coil)		The actions of others Being judged
No say	10.34	Powerless
Social workers knew a lot about what I was thinking	10.52	Power of others
She wasn’t there when I needed	11.3	No support

help		
Kept secrets. Couldn't let anyone get close	11.11	Secrets
I was separate – a sort of secret pariah	11.14	Secrets
An act of kindness would have meant the world	11.39	No kindness
Had to lie about having children	12.20	Secrets
Becomes ingrained in your psyche (lying)	12.24	Lies
No acknowledgement from school/grandparents	12.35	Ignored
No one understood how damaged I felt Labeled myself as damaged goods	13.4	Damaged by the experience
I had no way of appreciating how damaged I felt – I would look for my child	13.6	Trauma
Letter from Dad – get on with your life.	13.7	Shame
Ran away from everything	13.26	Inability to cope
Lost contact with the person I wanted to be	13.42	Loss of self
I was broken	13.43	Damaged
Serial monogamist	14.2	Inappropriate relationship
Couldn't relate to people	14.4	Loss of self
Affected physical and emotional relationship	14.6	Subsequent relationship
I was emotionally vulnerable	14.5	Damage
He never laid a hand on my again. I knew I had some power	14.25	
Eating disorder – maniac exercising	14.36	Need for control
Dysfunctional life	15.3	No control
Choose inappropriate relationships	15.11	Unable to make decision
I tried to make contact - they lied. It was like a body blow	15.22	Trust/betrayed
The adoptive parents didn't pass on information	16.6	Betrayed
Wasn't allowed choose her name	16.20	No control
Adoption agency lied	17.4	Trust
Meeting my daughter	17.7-12, 21	Stranger but familiar
Adoptive parents treated me like a naughty child - 'Always the fallen women'	17.16	Shame
Mum apologies (years later.) Triggered enormous emotions. I howled	17.35/40	Impact of mothers apology - repressed memories
Went through a cycle of loss and grief	18.4/5	Loss and grief
Had to explain to daughter	18.13-15	
PTSD - suicidal	18.6/9	Repressed memories
Had my memories back in	18.23/24	Repressed memories



Technicolor		
Never forgave Mum	18.42	Lack of forgiveness
My daughter though I didn't want to talk but I just couldn't remember	19.23	Relationship with daughter
Daughter understood impact	19.27	
Not called Mum	20.9	What role do I play
Nature of relationship with daughter	20.16	
I am not their grandmother	20.33	My role
We are like peas in a pod	20.36	
Rather have contact than not	21.8	Reality of situation
Reunion doesn't resolve it	21.9	
I went to a family party – I was the spectre at the feast	21.21	Where do I fit?
I pose a threat (to her adoptive mother) She thinks she had taken my baby	22.10,25-30	
You cant get away from it (church)	23.8	Blame
Now not so raw – the wound has stopped bleeding. Still grief and loss but not so overwhelmed (phantom child pain)	23.15 23.15	Lifelong impact
Less intense then when I couldn't speak	23.21	Lifelong impact. Pain
Accountability – Church and state, social workers, medical profession Until people who perpetrated all of this are held to account, I don't think justice will be recognised	23.36-42	Blame/accountability

## Appendix F

### Doreen's superordinate themes

Theme name	Components	Link to text
<b>Shame, secrets and lies</b>	Denial of situation Physical manifestation of pregnancy Being judged by others Sex outside marriage Having to hide A pact of secrecy and lies	<i>Went into denial quickly</i> 1:21 <i>I was getting bigger so I would adjust my clothes</i> 1:40 <i>Every time the baby kicked, it was like having an alien inside me</i> 5:3 <i>Some teachers were looking at me thinking I was very round</i> 2:11 <i>My mother and father were shouting at me – didn't think you were that kind of girl</i> 2:38 <i>I don't know how but suddenly we on our way to a mother and baby home</i> 3:15 <i>I was sworn to secrecy and I believed it</i> 4:16 <i>I had this huge secret I had to keep, I had to lie to everyone</i> 11:9 <i>I had this whole fabricated story of where I had been</i> 12:3
<b>The cruelty of others</b>	Collusion Insensitivity Judgement	<i>She was cruel – she did not think about how I was feeling</i> 8:7 <i>They sewed me up but didn't clean me up. They left me alone for 4 hours</i> 7:14 <i>Very cruel experience</i> 8:36 <i>I had all the stuffing kicked out of me emotionally</i> 9:34 <i>An act of kindness would have meant the world</i> 11:40 <i>I went to the headmistress – she didn't mention it. I thought 'why don't you mention it?'</i> 29:12 <i>I didn't even have control over what I called my daughter</i> 16:20 <i>They (Crusade of Rescue) had lied through their teeth</i> 17:4 <i>Its been awful – it shouldn't be awful there should be help</i> 18:36 <i>This baby is for adoption- I will take her away. No please don't</i> 7:9
<b>Traumatic childbirth</b>	Pain of giving birth Not understanding what was happening Being left alone whilst unwell Unable to process emotion Holding the baby Breast pain Being medicated Vulnerable	<i>I was terrified I might die or the baby might be damaged</i> 5:7 <i>Not believed when I started labour</i> 6:27 <i>I worried about making a mess</i> 6:36 <i>I felt like I was just this animal</i> 6:38 <i>No one held my hand and said it was going to be all right</i> 7:1 <i>They wouldn't give me my baby</i> 7:5 <i>No one was talking to me, helping me, or treating me like a patient</i> <i>I was given a drug to stop the milk – pain in my breast ever since</i> 7:50 <i>It was a night mare – it was a nightmare</i> 7:42 <i>I was this little person and I was really frightened</i> 9:2 <i>They tried to ply me with valium</i> 13:9
<b>The pain of parting</b>	The moment of parting The damage to self The continued denial Betrayal Suicidal Identity Loss and grief No control	<i>It's time to hand her over....I was crying, my mother said "oh, for goodness sake, and took her from me</i> 10:2 <i>I never felt more betrayed in my life...that moment defined everything else</i> 10:8 <i>I lost a dimension – I was cardboard</i> 10:14 <i>I didn't feel anything – there was nothing to feel</i> 10:24 <i>People asked if I had any children and I would say 'no'. After a while its automatic</i> 12:20 <i>I looked at babies faces and wondered 'are you the one?'</i> 13:8 <i>Put this behind you and get on with your life</i> 13:17 <i>I ran away from everything</i> 13:27 <i>I lost myself – I was broken.</i> 13:42 <i>I was a serial monogamist</i> 14:2 <i>I was emotional, vulnerable</i> 14:15 <i>I was a compulsive eater and a maniac exerciser</i> 14:37 <i>I went through a whole cycle of loss and grief</i> 18:4 <i>I thought about suicide cause I couldn't cope</i> 18:9 <i>There were times when I thought I was going mad – and I thought about PTSD</i> 18:26
<b>The joy and pain of</b>	Strangers or family? Blame Explanation	<i>The adoptive mother had my details but didn't give them to her</i> 16:6 <i>The adoptive mother sent letter and photographs but I didn't receive them</i> 16:10 <i>We just stared at each other</i> 7:17

<b>reunion</b>	Role of individuals Loss Being judged	<i>I couldn't explain as I had holes in my memory 19:17 And they treated me like I was a naughty girl. I was always the fallen woman I suppose 17:16 She doesn't call me Mum – it doesn't work 20:9 We are comfortable with each other 20:16 Its made clear to me I am not their grandmother 20:33 Reunion doesn't resolve the pain 21:9 I felt like the spectre at the feast 21:21 My presence poses a threat to the adoptive mother 22:10 I cant express the depth of gratitude to you (adoptive mother) for doing all of this 22:34</i>
<b>Being invisible</b>	Not being able to talk Feelings not being acknowledge by others Not being asked Having no choice Being ignored Not existing Feeling small	<i>I tried to tell my parents 1:22 I was unable to say the words 1:24 He (Doctor), wouldn't speak to me 2:29 I didn't say a word 3:10 Never asked me what I wanted 3:28 I didn't believe my parents would do that to me 3:48 I wasn't in the equation. I had to go along with all of it 3:29. I felt powerless 8:6 I felt like I may as well not exist 'cas there was no acknowledgement of me in any way 8:22 Various conversations took place around me; they didn't speak to me 9:48 I remember thinking, 'hello, I'm here', but apparently I wasn't because the conversation carried on without me 10:30</i>
<b>Being alone</b>	Terror – would I die? Fear of the unknown Feeling suicidal Helpless – no-one there Isolation No support No kindness, empathy or compassion No medical help Powerless Vulnerable	<i>I had no one I could turn to 4:16 I felt very isolated 5:11 Nobody was kind. Never occurred to my mother that I might be afraid 2:40 I felt completely helpless 2:51 No one reassured me in any way 5:6 If I lived or died, they didn't care I was pushed aside 7:41 There was no warmth – we were all broken and detached 7:45 She wasn't there when I need help, support, counselling or comfort 11:3</i>
<b>A lifetime of pain</b>	No more children Damaged person Relationships PTSD symptoms Repressed memories	<i>It's like a wound that never heals. I'm still very sad and still feel grief and loss but I am not now overwhelmed 23:17 Couldn't bear to go through it again.7: 38 Nobody understood how damaged I felt – I labelled myself as damaged goods 13:3 Those who treated young girls so callously, from the medical profession, to the church, to the social services and the justice system, parents and guardian. People who made decisions for others when really they ought to have their own voice 23:37 It affected any psychological and emotion experience, I was cut off from people 14:5 My repressed memories came back 18:5</i>

## Appendix G

### Identified risks and benefits from an ethical perspective

Risk to whom?	Nature of risk	Strategies to help	Benefits
Myself	My emotional well-being.  The risk of bias	Reflexive journal Supervision Support of friends and family Therapy (if needed)  Bracketing interview Reflexive journal	Could help me process some unresolved emotions.  Can bring authenticity to the study.
My daughter who was relinquished	Her emotional well-being. It is partly her story - have I the right to tell it?  Damage to our relationship	Consent Confidentiality Honest dialogue Permission My emotional support or involvement (if required)	Could bring us closer together.
My son (my relinquished daughter's half brother)	His emotional wellbeing. This study is concerning his two closest family members. He may not be aware of the depth of emotion experienced by either party.	My emotional support Honest dialogue	Could strengthen the relationship between all three of us.
My participants	Their emotional wellbeing. They may never have spoken about their experience in this manner before. They may feel exposed. What might the reactive effect of honesty be? What obligation do I have to them?	Confidentiality and anonymity Full informed consent Clear explanations Right to withdraw Signpost to psychological support if needed Debriefing Empathic approach No coercion	They may finally feel that their story had been validated.
Relinquished children and family members of participants	This could be a shock for many family members who may never have considered what the impact of adoption might be. It may evoke feelings of sadness, regret, and compassion for many involved.	Clarity of purpose Stated aims Transparency Sensitivity to all parties involved	Could bring families closer together and increase awareness of the nature of stigmatisation in relation to adoption during the era of the study.
Practitioners working in adoption services	They may find value in my study but it may challenge some of their	Transparent study with clear rationale and robust quality	Could enhance their understanding of the emotions expressed

	thinking as it comes from a different perspective than the current research	checks. Rigour demonstrated throughout.	my mothers who relinquished a child.
Psychotherapists	Some may not be aware of the complexities of adoption and may not understand the need for specific adoption-sensitive therapy.	As above	As above.
Agencies involved with adoption	The study may suggest that an increase in psychological support for this client group may be beneficial. This may pose problems operationally as there may not be resources available.	A robust study will allow an opportunity for agencies to seek funding.	The findings may be useful for birth mothers today whose children are taken into care and who require psychological support

## APPENDIX H

### Information Sheet

#### Introduction

My name is Bernadette Hatton and I am a Doctoral candidate at the Metanoia Institute in London. I am conducting Doctoral research into exploring the experiences of birth mothers who relinquished a child for adoption and have sought or been sought out, by the adopted child. The project has ethical approval from Metanoia, through the auspices of Middlesex University.

#### Study title

An exploration into the experiences of birth mothers who relinquished a child for adoption in the 1960s-1980s and who subsequently engaged in the searching process: The clinical implication for therapists.

#### Invitation paragraph

You are invited to take part in a research study. Before you do, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that you don't understand, please ask. Take time to decide whether or not you wish to take part.

#### What is the purpose of the study?

I would like to understand the range and depth of emotions connected to the experience of relinquishing a child. I have had this experience myself and I would like to hear what it meant for others. Based on the findings, I intend to produce guidance for therapists/counsellors/social workers, working with these birth mothers to help ensure that they receive adoption- sensitive therapy.

#### Why have I been chosen?

You have had this experience and that is the reason I would like to talk to you. I will be interviewing 12 people in total, all of whom have had this experience.

#### Do I have to take part?

It is up to you to decide whether to take part. If you do take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, are still free to withdraw at any time without giving a reason.

#### What will happen if I take part?

You will be involved in a one to one semi- structured interview with myself lasting approximately 1.5 hours. The interview will be audio taped and transcribed by me at a later point.

#### What risks are involved?

This is a very sensitive subject and it may be painful for you to talk about your feelings and experiences. You may experience some re -occurrence of the trauma you experienced at the time of the relinquishment. You may have kept this a secret all your life and this may be

the first time you speak openly about. That may evoke many emotions, one of which might be relief. I will support you in whatever way I can and because I have shared some of your experience, I hopefully will understand some of the emotions you are experiencing. Although I work as a therapist, I cannot enter into therapy with you in relation to this, but I will provide you with contact details of agencies that provide therapeutic support for birth mothers. If you still feel that you need additional support as a result of being involved in this research, I am willing to pay for 3 therapy sessions to help deal with the issues raised. My questioning will be sensitive and we can stop at any point if you feel uncomfortable. At the end of the interview, we can spend some talking about how you feel.

**What about confidentiality?**

All information that is collected will be kept strictly confidential. Any information about you, which is used, will have your name and address removed. For the purposes of the study, we can use a name for you of your choosing to protect identification.

All data will be stored securely in compliance with the Data Protection Act.

**What will happen to the results of the study?**

This will be published as part of a Doctoral Thesis. The outcome will be in the form of clinical guidelines for therapist working with birth mother and will not contain any personal information. It is possible at some future point that the outcomes of the study will be used as chapters in a book in which case all identifying information will be removed.

**Contact details**

berhatton@icloud.com

Mobile 07841 260854

A member of staff from the Metanoia Institute whose contact details are as follows will supervise me throughout the project:

Marie Adams

[Marieadams@aol.com](mailto:Marieadams@aol.com)

07949 200747

**Organisations providing support for people affected by adoption**

British Association of Adoption and Fostering (BAAF)

0207 4212600

Post Adoption Centre (PAC)

0207 2840555

After Adoption UK

0161 8394932

## Appendix I

### Informed consent Form

**Title**

An exploration into the experiences of birth mothers who relinquished a child for adoption during the 1960s-1980s and who subsequently engaged in the searching process: The clinical implication for therapists.

**Researcher's name**

Bernadette Hatton

- 1 I confirm that I have read and understand the information sheet dated ..... for the above study and have had the opportunity to ask questions.
- 2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any information I have given
- 3 I understand that my interviews will be taped and subsequently transcribed
- 4 I agree to take part in the above study
- 5 I agree that this form that bears my name and signature and may be seen by a designated auditor

Name of participant ..... Date..... Signature .....

Name of researcher..... Date..... Signature.....



## Appendix J

### Inside researcher

Strategies for helping to decide on the best approach to use with participants.

Options	How do I do this? What benefits?	Difficulties it may pose
Minimise my experience	<ul style="list-style-type: none"> <li>• Make little or no effort to represent my story in the research.</li> <li>• Effective strategy for maintaining privacy.</li> </ul>	<ul style="list-style-type: none"> <li>• Comes at the cost of silencing my voice and masking my powers</li> </ul>
Utilise my experience	<ul style="list-style-type: none"> <li>• Can help gain access to hard to research group</li> <li>• Can engender trust</li> <li>• Can enhance empathy</li> <li>• Can make it easier to get high quality data</li> </ul>	<ul style="list-style-type: none"> <li>• Issues of power and voice may not be addressed</li> <li>• Can lead to false assumptions of commonality</li> </ul>
Maximise my experience	<ul style="list-style-type: none"> <li>• Study my own experience (Autoethnographic)</li> <li>• Open up my intimate details</li> </ul>	<ul style="list-style-type: none"> <li>• Too exposing</li> <li>• May empower me but may have the opposite effect on participants</li> <li>• Might prevent me from recognising the plurality of experience that exists within group</li> </ul>
Incorporate my experience	<ul style="list-style-type: none"> <li>• Be a participant with the same status as other</li> <li>• Protects my privacy but allows a voice</li> <li>• Reduces the power differentials between researcher and research</li> </ul>	<ul style="list-style-type: none"> <li>• In reality, the voices are not equal or equivalent</li> <li>• Can lead to according more weight to my own voice</li> <li>• Double contribution to the research, researcher and researched. Perhaps an overrepresentation and over-privilege of my experience</li> </ul>

Wilkinson & Kitzinger (2013)

## Appendix K

### Draft outline of 2-day workshop for practitioners supporting birth parents who relinquished a child for adoption

(Although primarily designed for therapists, any practitioner who provides support to birth mothers may find this useful)

<b>Session One</b>	<b>Considerations</b>
Contract  Issues of confidentiality/anonymity	<ul style="list-style-type: none"> <li>• Who knows about the relinquishment?</li> <li>• What are the views of other family members?</li> <li>• Is secrecy still a requirement?</li> </ul>
<b>Session Two</b>	<b>Considerations</b>
Assessment (Consider use of an assessment questionnaire)  Goals of therapy	<ul style="list-style-type: none"> <li>• Background to story</li> <li>• Other contributory factors</li> <li>• Areas of concern</li> <li>• General well being</li> <li>• What does the birth mother wish to happen now</li> </ul>
<b>Session Three</b>	<b>Considerations</b>
Historical context of the era when relinquishment happened	<ul style="list-style-type: none"> <li>• Stigmatisation</li> <li>• Role of church and state</li> <li>• Choice</li> <li>• Coercion</li> </ul>
<b>Session Four</b>	<b>Considerations</b>
Core issues in adoption literature (Silverman and Kaplan 1984)  However, not uniform (Guilt?)	<ul style="list-style-type: none"> <li>• Shame</li> <li>• Loss</li> <li>• Grief</li> <li>• Anger</li> <li>• Identity</li> <li>• Self-esteem</li> </ul>
<b>Session Five</b>	<b>Considerations</b>
Implications for practitioners	<ul style="list-style-type: none"> <li>• Disenfranchised grief – models of grief</li> <li>• Differentiating between guilt and shame</li> <li>• Own bias</li> <li>• Sensitivity of language</li> <li>• Individuality of stories</li> <li>• Cultural context</li> <li>• Relationship with no model to emulate</li> </ul>
<b>Session Six</b>	<b>Considerations</b>
Skills required from practitioner	<ul style="list-style-type: none"> <li>• Attuned listening</li> <li>• Empathic interventions</li> <li>• Understands the role of validation in this context.</li> </ul>

	<ul style="list-style-type: none"> <li>• Non judgmental (being judged contributed significantly to the distress)</li> <li>• Ability to distinguish between different emotions and not make assumptions.</li> <li>• The ability to understand that there may not be a solution. Validation may be sufficient.</li> </ul>
<b>Session Seven</b>	
Relevance to contemporary birth parents whose children are adopted through the care system	<ul style="list-style-type: none"> <li>• Identification of emotions - commonalities with historical birth mothers.</li> <li>• Previous and current mental health conditions</li> <li>• Current support</li> <li>• Motivation to change</li> <li>• Consideration of group work/therapy</li> <li>• Obstacles to making change</li> <li>• Facilitating contact</li> </ul>