ORIGINAL ARTICLES

Psychological disability in women who relinquish a baby for adoption

(for editorial comment, see page 113)

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ABSTRACT During 1986, approximately 2000 women in Australia are likely to relinquish a baby for adoption. A study is presented of 20 relinquishing mothers that demonstrates a very high incidence of pathological grief reactions which have failed to resolve although many years have elapsed since the relinquishment. This group had abnormally high scores for depression and psychosomatic symptoms on the Middlesex Hospital questionnaire. Factors that militate against the resolution of grief after relinquishment are discussed. Guidelines for the medical profession that are aimed at preventing psychological disability in relinquishing mothers are outlined.

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Since the late 1920s, over 250 000 women in Australia have relinquished a baby for adoption.[1] After a liberalization of society's attitudes towards contraception, elective termination and single motherhood, the incidence of relinquishment has steadily declined over the last decade. Nevertheless, extrapolation of the data (currently available only to 1981) suggests that approximately 2000 women will relinquish an infant during 1986 in Australia.[2]

The relevance of relinquishment to the medical profession embraces a number of areas. First, existing evidence[3-5] suggests that the experience of relinquishment renders a woman at high risk of psychological (and possibly physical[6]) disability. Moreover, very recent research indicates that actual disability or vulnerability may not diminish even decades after the event.[3] Medical and nursing staff members are frequently those best placed to influence the long-term outcome of the relinquishing mother — for better or for worse — by their actions during the critical days or weeks that surround the relinquishment crisis. Guidelines (especially with regard to the desirability or otherwise of contact between the relinquishing mother and the infant) have never been described. In spite of major technological breakthroughs in the treatment of infertility, many couples still cannot conceive. The resultant demand for babies is continuing to remain high in a situation of steadily decreasing supply. The profession must be increasingly vigilant in the face of this imbalance of supply and demand which could potentially result in the subtle pressuring of women to relinquish. Finally, the opinion of the profession is often sought regarding the complex moral and ethical issues that are involved in areas such as abortion law reform, adoption law reform and commercial mother surrogacy. Research on the consequences of relinquishment provides a background against which these issues can be considered rationally.

This study arose from my research on the development of antenatal emotional attachment to the unborn child during pregnancy[7] and my clinical experience in operating a psychiatric clinic for parents who have been bereaved by a still birth or perinatal death. The last decade has witnessed a literature explosion in the area of perinatal bereavement. However, with the exception of Winkler and van Keppel's major Australian study,[3] the outcome of women who relinquish an infant at birth has received virtually no attention in the psychological, psychiatric or obstetric literature, nor is it usually mentioned in the literature on adoption. The latter tends to focus on the outcome of the child and that of the adoptive parents. This hiatus in the literature probably reflects the misconception that, since relinquishment is "voluntary" and occurs before the woman has bonded to the child, adverse psychological sequelae would be rare.

The relinquishment experience differs from perinatal bereavement in four psychologically crucial aspects. First, although usually construed by society as "voluntary", most relinquishing mothers feel that relinquishment is their only option in the face of financial hardship; pressure from family or professional persons; the stigma associated with single motherhood or illegitimacy; and a general lack of support. Their perception of "informed consent" is that it is a charade designed to obfuscate society's guilt at "forcing" them to relinquish.[8] Secondly, their child continues to exist and develop while remaining inaccessible to them, and may "one day" be reunited with them. The situation is analogous to that of relatives of servicemen "missing, believed dead" in wartime. The reunion fantasy renders it impossible to "say goodbye" with any sense of finality. Disabling chronic grief reactions were particularly common after the war in such relatives.[9] Thirdly, lack of knowledge about the child permits the development of a variety of disturbing fantasies, such as the child being dead, ill, unhappy or hating his or her relinquishing mother. The guilt of relinquishment is thereby augmented. Fourthly, these women perceive their efforts to acquire knowledge about the child (which would give them "something to let go of") as being blocked by an uncaring bureaucracy. Shawyer describes poignantly how "confidential files are tauntingly kept just out of reach, across official desks".[8] Thus, the anger that is associated with the original event is kept alive and refocused onto those who continue to come between mother and child.

The objectives of the present study were to assess the extent and time-course of unresolved grief after a relinquishment experience and, with a control group, to assess the level of chronic emotional disability in relinquishing mothers. Some preliminary data on the effects of relinquishment upon the ability to mother subsequent children were also gathered. On the basis of these results and other studies, I have made an attempt to formulate guidelines for medical staff members who may have to deal with relinquishment in a hospital setting. In particular, the issue of contact between mother and child in the early post-partum period is discussed.

Methods

Twenty women, who were contacted through the Australian Relinquishing Mothers' Society, took part in the study. The average age of the women was 40 years (range, 25–59 years) and the mean time elapsed since relinquishment was 21 years (range, 5–35 years). Thus, most of the women had relinquished a baby in the middle 1960s when in their late teens or early twenties. The women were evenly distributed with respect to socioeconomic class; approximately one-third had received tertiary education. Eleven of the women were currently living with a spouse and children; seven lived only with children; and two lived alone. In all but two cases the relinquished baby was the result of a first pregnancy.

All the women anonymously completed a questionnaire which focused on the circumstances of their relinquishment, their emotional responses both at the time of relinquishment and currently, together with their perception of any long-term sequelae. The women were requested to rate their affective experiences on visual analogue scales. In addition, all the women completed the Middlesex Hospital questionnaire,[10] a well-validated instrument for assessing chronic psychological disability.

Results

Fourteen of the women reported that they had had no contact with (or only a fleeting glimpse of) the baby at delivery. Of the remainder, only four had held the baby more than once. All the women knew the sex of the child.

All but two of the women had made determined efforts to seek information about or locate their child. Four of the women had successfully contacted the child; a further two had obtained non-identifying information; and the remainder had obtained no information about the infant after the first six months after relinquishment.

All but two of the women reported strong feelings of affection for the infant, both during late pregnancy and in the immediate post-partum

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TABLE 1: Changes over time in intensity of affects associated with relinquishment (n = 18*)

	Depression/sadness	Anger	Guilt
Number of women reporting			
increase	6	10	7
no change	6	2	8
decrease	6	6	3
Proportion of sample (n = 18) reporting increase or no change	67%	67%	83%

* Excludes two subjects who reported only "numbness" at the time of relinquishment.

TABLE 2: Middlesex Hospital questionnaire scale ratings compared with age-matched control subjects (n = 20)

Scale	Relinquishing mothers' mean score (SD)	Control subjects' mean score	Significance*
Free-floating anxiety	10.9 (3.7)	7.2	NS
Phobic anxiety	8.1 (2.6)	5.2	NS
Obsessionalism	9.1 (3.1)	6.7	NS
Psychosomatic	9.7 (3.0)	4.3	$P < 0.05$ Significant
Depression	9.4 (2.8)	3.9	$P < 0.05$ Significant
Hysteria	6.1 (3.4)	5.4	NS

* NS = not significant.

period. None reported negative feelings towards the child. The results of the women's rating of the intensity of their sadness, anger and guilt (on visual analogue scales), both at the time of relinquishment and currently, are summarized in Table 1. Two women, who reported only emotional numbness at the time of relinquishment, are excluded. Feelings of sadness or depression at the time of relinquishment were, on average, rated as between "intense" and "the most intense ever experienced"; 67% of the sample reported either no change or intensification of these feelings over the intervening years. Anger at the time of relinquishment was rated, on average, as between "a great deal" and "intense"; only 33% reported a decrease over time and over half the sample reported that anger had increased. Guilt at the time was rated as "intense", with only 17% reporting a decrease over the intervening years.

Almost all the women reported that they received little or no support from family, friends or professionals. Over half had used alcohol or sedative medication to help them to cope after relinquishment. Almost all reported that they dealt with their distress primarily by withdrawing and "bottling up" the feelings. One-third had subsequently sought professional help.

Six of the women had become pregnant again within a year of relinquishment. Over half the women reported that they were abnormally overprotective towards their subsequent children, and attributed this directly to an irrational fear of losing the child, stemming from their relinquishment experience. Two women reported a total inability to separate from the child during the first five years, or to leave the child with a relative or baby-sitter. Two-thirds of the women reported that the experience had adversely affected their subsequent relationships with men; none of the women successfully continued a long-term relationship with the father of the relinquished child.

The results of the Middlesex Hospital questionnaire are summarized in Table 2. On the six subscales of this inventory, the relinquishing mothers rated significantly higher on depression and psychosomatic symptoms than did age-matched control subjects from the same geographical area. In addition, on the total scores — a measure of general chronic psychological disability — they rated significantly higher than the control group.

Discussion

The fact that these women had all made contact with a relinquishing mother's society dictates that the results be generalized only with caution. It could be argued either that women with a better outcome have no need to join such groups, or, conversely, that those who join are healthier, more assertive and more willing to face their loss and work through it than those who remain "in the closet". It is extremely difficult to recruit a truly representative sample of relinquishing mothers. The marked similarity of the present findings to those of Winkler and van Keppel,[3] who used different and more diverse recruitment procedures, suggests that the sample may be representative. Nevertheless, the small sample size and the possible bias must be recognized and, in view of the severity of the disability that was detected, a more comprehensive and representative study would appear to be justified.

An association between relinquishment and psychological disability does not prove causation. One could argue that pre-existing psychological disability predisposed these women to both unwanted pregnancy and subsequent relinquishment. However, Winkler and van Keppel's data provide powerful evidence against this hypothesis.[3]

A most striking finding in the present study is that the majority of these women reported no diminution of their sadness, anger and guilt over the considerable number of years which had elapsed since their relinquishment. A significant minority actually reported an intensification of these feelings, especially anger (Table 1). Winkler and van Keppel[3] reported similar findings with regard to what they termed "sense of loss", this parameter increasing in 48% of their sample.[3] Taken over all, the evidence suggests that over half these women are suffering from severe and disabling grief reactions which are not resolving with the passage of time and which manifest predominantly as depression and psychosomatic illness.

A variety of factors operated to impede the grieving process in these women. The emotional significance of their loss was not acknowledged by either family or professional persons, who denied them the opportunity and support necessary for the expression of their grief. Intense anger, shame and guilt complicated their mourning, which was further inhibited by the fantasy of possible eventual reunion with the child. Many were too young to have acquired the ego strengths necessary to grieve in an unsupportive environment. Finally, few had had sufficient contact with the child at birth, or received subsequently sufficient information to enable the construction of a clear image of what they had lost. Masterson has demonstrated that mourning cannot proceed in the absence of a clear mental image of what has been lost.[12] There was a clear impression that the grief of many of these women had arrested in the early "searching phase" described by Bowlby.[13] They were desperately searching, not to regain the child *per se*, but to acquire information which would enable them to build up a picture of the lost child and thereby resolve their grief.

The notion that maternal attachment can be avoided by brisk removal of the infant at birth and the avoidance of subsequent contact between mother and child is strongly contradicted by recent research. I[7] and others[15,16] have demonstrated an intense attachment to the unborn child in most pregnant women. Moreover, evidence supporting Klaus and Kennell's theory, that a rapid and significant increase in maternal attachment occurs with physical contact in the first 24 hours,[17] has recently been strongly questioned.[18] A current consensus would be that, at best, their theory is unproven.[19,20]

The number of women in this study who had significant contact at birth (or subsequently) is insufficient for an exploration of the effect of contact on subsequent grief. Devaney and Lavery reported that none of 59 relinquishing mothers who had had contact with their babies during hospitalization regretted having done so, and the majority would have preferred more contact.[14] Comments such as: "it would have been hard giving her up without knowing what she had looked like" were recorded commonly. In a separate paper that addressed this question, van Keppel and Winkler found that "It was not whether or not the mother had contact with her child before relinquishment that affected her adjustment to loss, but rather whether or not her wishes regarding contact were respected".[21] This finding is difficult to interpret as the proportion of those who wished to see the child and were actually permitted to do so is not

reported. In addition, the authors used the number of contacts between mother and child as their only measure of the extent of interaction. Clearly, both the duration and the quality of the contact could exert a major influence.

No previous study has reported the effects of relinquishment on the ability to mother subsequent children. The present results suggest that half the women had become excessively overprotective. There is a strong impression from the data that this overprotectiveness is part of the phenomenon of unresolved grief and serves both to assuage guilt and to compensate for the severe blow dealt by relinquishment to the self-esteem in the area of being a "good mother". The relatively high incidence of pregnancy during the year after relinquishment invites speculation that this represents a maladaptive coping strategy that involves a "replacement baby".

Conclusions and guidelines

The conclusions of the present study may be stated in the form of guidelines for medical staff with a relinquishing mother as a patient, as follows.

All women who express the intention during pregnancy of relinquishing a baby should be offered consultation with a psychiatrist or other professional person who is experienced in this area. An intention to relinquish is obviously not an indication of some psychiatric illness; however, such a referral can be an important preventive measure, since any such woman falls into a high-risk group for subsequent depressive or psychosomatic illness. In this setting, the woman can undertake a full exploration of the options available, achieve an increased understanding of her motivation for relinquishment and, if appropriate, begin anticipatory grief work. Such counselling should be non-directive and no pressure should be exerted to alter the woman's decision to relinquish or to keep the baby. Wherever possible, joint sessions with the woman and the father of the baby, and with the woman's own family, should be included.

After delivery, relinquishing mothers should be gently encouraged, rather than discouraged, to see, hold and, if they wish, breast-feed the infant. However, no pressure to do so should be exerted, and the woman's wishes in this regard should be respected. If the opportunity is declined, it should be re-offered before discharge. All such infants should be photographed, and this photograph offered to the woman or, if she declines it, filed in her case notes. The woman should be offered follow-up counselling for a minimum period of six months. The psychological risks that are inherent in becoming pregnant within a year of the relinquishment should be openly discussed.

The medical profession cannot be considered entirely blameless for the trauma which many of these women experienced in less enlightened times, and should endeavour at least to understand, if not to empathize with, the sense of alienation which many of them experience towards doctors in general. Many of these women benefit from contact with supportive groups such as the Australian Relinquishing Mothers' Society (which has branches in all States) or from a therapeutic relationship with a psychiatrist or other professional person who is skilled in grief work. The practitioner who encounters a patient whose depression or psychosomatic illness may be related to relinquishment should not hesitate to offer such referral.

Insofar as the profession is influential in law reform, it should support unequivocally the right of these women to obtain non-identifying information about the well being and progress of their children. The available evidence suggests that this, in many cases, is sufficient to enable women to resolve their grief. The question of information regarding the identity and whereabouts of the child is complex, and clearly involves parties other than the woman herself. To my knowledge, no research has been conducted on the effects of reuniting these women with their children, and hence each case must be dealt with on its merits. Within Australia, Victoria's new adoption laws, which have been implemented in stages during 1985, reflect a more enlightened appreciation of the difficulties and needs of the relinquishing mother, and it is to be hoped that this precedent will be followed by other States.

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Effects of intervention on medication compliance in children with asthma

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ABSTRACT We have assessed the effects of intervention on medication compliance in asthmatic children. The intervention comprised both written information about the medications and behavioural strategies effected by the physician. Children were assigned at random to either control (received no intervention) or test (received the intervention) groups. Compliance was assessed by questionnaire. The mean compliance for the test (78.0%; $n = 93$) and for the control (54.5%; $n = 103$) groups differed significantly ($P < 0.001$; Mann–Whitney U-test). The test group had a better knowledge of asthma and of the medications, and was more satisfied with the physician and with the regimen than was the control group. These variables were also related to good compliance. This study demonstrates that a programme of intervention can significantly improve medication