

- Practice-Science Integration Section of the Scientific Forum

## **Birth Parents in Adoption: Research, Practice, and Counseling Psychology**

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*This article addresses birth parents in the adoption triad by reviewing and integrating both the clinical and empirical literature from a number of professional disciplines with practice case studies. This review includes literature on the decision to relinquish one's child for adoption, the early postrelinquishment period, and the effects throughout the lifespan on birth parents. Clinical symptoms for birth parents include unresolved grief, isolation, difficulty with future relationships, and trauma. Some recent research has found that some birth mothers who relinquish tend to fare comparably to those who do not relinquish on external criteria of well-being (e.g., high school graduation rates). However, there appear to be serious long-term psychological consequences of relinquishment. Limitations of the current literature are presented, and recommendations for practice and research are offered.*

For Monica, from Her Birthmother  
We've grown together for two years.  
We've shared together your laughter and tears.  
Since your first moments in this world  
So many, many things have unfurled.  
Once a child, you're grown now,  
The time has come to pass.  
Know I'll always love you.  
That's all I'll ever ask.  
You've had the time to live and grow.  
How was I to ever, ever know  
I couldn't give the care that you would need.  
Mine wouldn't be the voice that you would heed.  
When I had to say good-bye to you  
I didn't know how much that I'd go through

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Wanting to be with you all the while.  
I pray you have someone to care  
And friends that always, always will be there  
A family to support you all the time  
Who give the love I long to give a child of mine.

—Imelda Buckley (*Roles*, 1989, p. 7)

Although the feelings expressed in Imelda Buckley's poem are widely understood, birth parents are the least studied, understood, and served members of the adoption triad (Freundlich, 2002; Reitz & Watson, 1992; Zamostny, O'Brien, Baden, & Wiley, 2003). Birth parents are often the invisible members of the adoption triad. For some, this is by choice; for others, it is an artifact of the adoption system and its historical legal requirements of full relinquishment, secrecy, and anonymity (Winkler, Brown, van Keppel, & Blanchard, 1988). In international adoptions, birth parents are often permanently invisible and silent as a result of the cultural norms and structures related to relinquishing their children (Lee, 2003; Steinberg & Hall, 2000).

Historically, research has been more limited on this hard-to-access population than on other members of the adoption triad (Freundlich, 2002; Zamostny, et al., 2003a), although theory and clinical observations related to the experience of birth parents have a longer history (A. Brodzinsky, 1990; Winkler & van Keppel, 1984). Both clinical and empirical research literature related to birth parents has been undertaken in a wide variety of professional/academic disciplines and in a number of Western countries. Disciplines contributing to this research have included psychology (A. Brodzinsky, 1990; Fravel, McRoy, & Grotevant, 2000), psychiatry (Condon, 1986; Rynearson, 1982), social work (DeSimone, 1996; Dworkin, Harding, & Schreiber, 1993), and child welfare (Blanton & Deschner, 1990; Chippindale-Bakker & Foster, 1996). Extensive data on birth parents have been collected in Australia (Condon, 1986) and Canada (Chippindale-Bakker & Foster, 1996) as well as the United States. Integration of this literature has been limited in part because of the paradigmatic differences in research and practice among disciplines. This lack of integration has slowed both the development of empirical research and the clinical treatment of birth parents. Zamostny, Wiley, O'Brien, Lee, and Baden (2003) have called on counseling psychologists to break the silence of the mental health community about issues related to adoption (as noted by Henderson, 2002), including the experiences of birth parents.

Between 1 million and 5 million Americans are adopted (Hollinger, 1998; Stolley, 1993), leading to the inference that up to 10 million people are birth parents of adoptees reared in America. These birth parents are from both the United States and numerous other countries, making this group a global pop-

ulation. Terminology related to this group has changed over the years and has included *natural parent*, *biological parent*, *genetic parent*, and *real parent*. However, the terms *birth parent*, *birth mother*, and *birth father* have become accepted nomenclature for referring to the mother and father who gave birth to a child who was placed for adoption (A. Brodzinsky, 1990).

As noted by Zamostny et al. (2003b), counseling psychology has much to offer in the understanding of adoption in general and birth parents in particular, including counseling psychology's focus on science-practice integration, developmental tasks and models, healthy coping skills, prevention approaches, adjustment to life transitions, and viewing development from a multicultural perspective (Gelso & Fretz, 2001). The purposes of this article are to provide a scientist-practitioner review of the interdisciplinary clinical and empirical literature on birth parents, to incorporate this literature with actual case studies, and to make recommendations for practice and research based on this literature.

Woven into this literature are several clinical case studies derived from the authors' combined 33 years of counseling experience and one of the author's extensive experience with international adoption practice. Clinical interventions and issues are drawn from the literature, the authors' experience, and model programs for birth parents (e.g., Barker Foundation, 2004; Center for Family Connections, 2004; Spence-Chapin, 2004).

This article first includes a review of the clinical and research literature for three periods in the life of a birth parent: (a) the prerenlinquishment period, including both voluntary and involuntary relinquishment; (b) the early postrelinquishment period; and (c) long-term postrelinquishment, including search and reunion. Each of these sections includes a case study of a birth mother in counseling, including presenting issues, background factors, assessment concerns, treatment issues, and effective treatment strategies. Reviews follow of the clinical and research literature on birth fathers, international birth parents, and openness in adoption for birth parents. The final sections discuss structuring research and practice, practice and research implications, and future directions.

### **PRERELINQUISHMENT PERIOD**

The day you were born was a very difficult but happy time. When I heard your cry at 11:30 pm, I was looking at you with much joy in my heart. While I looked at you I felt so weak; you were the most important part of me. You were so adorable when you cried. Although I am the naïve mother who bore you, I wondered who will raise you and take care of you. I love you very much. I also loved you very much as you developed in my womb. I whispered, "I love you, my dear baby" whenever I felt you in my womb. I was grateful to you whenever

you stirred so gently in my womb because it felt as if you were looking after me. My dear son, please remember that I will always love you very much. I also want you to remember that you are my son and are very important to me. I remember like it was yesterday the way that you used to fall asleep. I miss you more and more as the days go by, and my heart aches. (A Korean birth mother; Dorow, 1999, pp. 16-17)

### **Voluntary Relinquishment**

The decision about whether to voluntarily relinquish one's child for adoption is likely the most difficult decision a birth parent will ever have to make (Winkler et al., 1988). Typically, it is the birth mother who seeks professional services, but increasingly, the experience is shared by the birth father. The conflicting feelings of shame, pride, desolation, excitement, fear, terror, and denial can be overwhelming and disruptive. Birth parents consistently report that they do not talk about their feelings because somehow they believe their feelings are abnormal and out of proportion to the crisis they face. However, the authors must note that in recent years, those who assist prospective birth mothers (e.g., adoption agencies, attorneys, and medical professionals) have increasingly recognized the need for birth mothers to receive counseling and support, thereby allowing them to face their feelings and the enormous decisions they must make with more compassion and dignity (Janus, 1997; Sobol & Daly, 1992).

Different theoretical models have offered varied clinical interpretations of the issues that birth mothers face. Early psychodynamic models (Deutsch, 1945) viewed the unwed mother as using her pregnancy to regressively act out unconscious, unmet needs toward her own mother. Jung (1989) used early family systems theory to describe the unplanned pregnancy as a statement of ambivalent feelings and powerlessness in the family. Less psychodynamic, but no less influential, was the description of adoption that Silverstein and Kaplan (1988) proposed. They depicted adoption as a lifelong, intergenerational process that unites the triad of birth families, adoptees, and adoptive families forever. They proposed seven core issues in adoption that can be used to assist all triad members and professionals working in adoption to better understand each other and the residual effects of the adoption experience. These seven issues include (a) loss, (b) rejection, (c) guilt and shame, (d) grief, (e) identity, (f) intimacy, and (g) mastery/control. Shortly thereafter, D. M. Brodzinsky's (1987, 1990) stress and coping model described the cognitive adjustments and adaptations birth parents undergo in adjusting to the pregnancy and making complex decisions regarding relinquishment. Most recently, attachment theory combined with developmental neurobiology has been used to hypothesize that stress hormones and neurotransmitters of the birth mother affect the developing fetus differentially

depending on the level of attachment that the birth mother experiences with her child (Axness, 2001; Maret, 1997; Rini, Dunkel-Schetter, Wadhwa, & Sandman, 1999).

Nine empirical studies were identified that described largely adolescent birth mother samples and compared mothers who relinquished their children with control groups who chose to parent their children, making prerenaliquishment the largest category of birth parent research. These studies were all undertaken either in the United States or Canada, were most often done in maternity homes or adoption agencies, and tended to focus exclusively on predictive external variables such as age, race, educational level, socioeconomic status (SES), family situation, and attitudes. Several variables were consistently found to be related to relinquishment, including race, age, socioeconomic level, educational level, preference of birth grandmother, vocational goals, and living arrangements (Chippendale-Bakker & Foster, 1996; Cocozzelli, 1989; Dworkin et al., 1993; Herr, 1989; Low, Moely, & Willis, 1989; McLaughlin, Pearce, Manninen, & Wings, 1988; Resnick, Blum, Bose, Smith, & Toogood, 1990; Warren & Johnson, 1989; Weinman, Robinson, Simmons, Schreiber, & Stafford, 1989).

Chippendale-Bakker and Foster (1996) did retrospective analysis on the files of 99 women, ages 14 to 23 ( $M = 22.8$  years), from a Catholic Canadian adoption agency. Their sample comprised 78% Caucasian, 21% African Canadian, 6% Asian, 3% Native Canadian, and 4% mixed-race women. Cocozzelli (1989) analyzed file data on 279 women ( $M = 21.4$  years) from two Hawaiian adoption agencies. Thirty-seven percent were White, 13% Hawaiian, 9% Black, 8% Japanese, 7% Caucasian-Asian, 6% Filipino, 6% American Indian, and 14% Asian and Southeast Asian. Dworkin et al. (1993) studied 162 pregnant adolescents in a U.S. maternity home ( $M = 16.0$  years). They comprised 48.3% Black, 15% Hispanic, and 36% White women. Herr's (1989) sample included 125 pregnant U.S. adolescents ( $M = 16.9$  years). Fifty percent of her sample were White, 44% Black, and 6% other. Warren and Johnson (1989) studied 175 women ages 14 to 22 with unplanned pregnancies in Texas and California. Fifty percent were Black, 30% White, and 20% Mexican. Low et al. (1989) surveyed 62 unmarried adolescent women in their third trimester of pregnancy ( $M = 17.2$  years). Sixty-eight percent were White and 32% Black. McLaughlin et al. (1988) surveyed women who had recently participated in an adoption program in Minnesota and compared those who relinquished with those who parented. Racial and ethnic backgrounds were not provided. The mean age was 21.4. Resnick et al. (1990) did individual interviews with 118 young women (ages ranged from 13 to 19 years; 97% White). Finally, Weinman et al. (1989) analyzed agency records in a Texas maternity home. Their sample included 474 residents over a 2-year period. Seventy percent were listed as minority and 30% Caucasian.

The literature consistently documented that White women relinquished their infants for adoption at higher rates than women of color, including African American, Mexican American, and Filipino American women (Chippendale-Bakker & Foster, 1996; Cocozzelli, 1989; Dworkin et al., 1993; Herr, 1989; Warren & Johnson, 1989; Weinman et al., 1989). All of these studies found race to be a predictive variable of relinquishment, with White women most likely to relinquish and African American (or African Canadian) women least likely.

Moreover, the literature suggested that single mothers in African American communities are less likely to make adoption plans for their infants and more likely to use what has been termed *informal adoption* (Sandven & Resnick, 1990). An explanation offered for the lower rates of adoption for birth mothers of color is based on both cultural norms from African ancestors and survival norms from postslavery America, where family boundaries include extended family and are not limited to the nuclear family. One legacy of the forced separations of families during slavery has been a strong need reported by many African Americans to retain children of African heritage to be raised within their culture and community. Thus, various forms of informal adoption arrangements have included both shared parenting with extended family and "gifting" a child to an extended family member without legally relinquishing parental rights, practices historically unrelated to social class (Landrine & Klonoff, 1996). Other explanations for lower rates of relinquishment to adoption point to the lack of economic opportunity for birth mothers of color resulting from issues of oppression and privilege. Authors have not focused, however, on the possibility that birth mothers of color do not relinquish as often because children of color are less likely to be adopted (Lee, 2003).

The research literature also described recent trends in adoption plans (i.e., decisions to relinquish children for adoption). Adoption plans tended to be made by single mothers of higher socioeconomic and educational groups than those who chose to parent (Chippendale-Bakker & Foster, 1996; McLaughlin et al., 1988; Resnick et al., 1990). Adolescent mothers who chose to parent tended to be younger (early to mid-teens) and of a lower SES, whereas those who made an adoption plan tended to be older (late teens) and of a higher SES (Dworkin et al., 1993; Warren & Johnson, 1989). Birth mothers who made an adoption plan were also found to have higher vocational aspirations and more goal-directed life plans than those who chose to parent (Cocozzelli, 1989; Low et al., 1989).

Family attitudes and dynamics were found to predict the likelihood of a birth mother making an adoption plan versus choosing to parent. Several studies found that one of the strongest predictors of relinquishment was the

preference of the birth mother's mother (Chippendale-Bakker & Foster, 1996; Dworkin et al., 1993; Herr, 1989; Low et al., 1989). The birth mother's relationship with the birth father also was found to be predictive of relinquishment, particularly when the birth mother changes from an adoption to a parenting plan (Dworkin et al., 1993).

In summarizing the reasons given by birth mothers for making an adoption plan, Chippendale-Bakker and Foster (1996) stated that most "do so out of a belief that it will offer a better life for their child than they are able to provide" (p. 341). Resnick et al. (1990) added an additional factor in their summary and reported that both the baby's best interest and the birth mother's own school plans were primary motivators for making an adoption plan.

#### CASE STUDY 1

*Presenting issues.* Kathleen was a 17-year-old Caucasian from a middle-class family who was 6-months pregnant and was experiencing symptoms of panic, depression, and anxiety.

*Background factors.* Kathleen, a senior in high school, is the eldest of two children. Her parents have been married for 18 years. Kathleen had been dating her boyfriend, Tommy, for more than a year, but did not want to marry him and did not want to "wreck my [her] life" by becoming a mother at this stage. After she contacted a private attorney/family friend to make an adoption plan for her child, Kathleen's school counselor referred her for more comprehensive therapy.

*Assessment concerns.* Kathleen's judgment and insight appeared to be good, but she was experiencing ambivalence and fear that she was not making what she called a "popular" choice for her baby. Kathleen's parents were encouraging relinquishment and adoption, but Kathleen heard negative comments about her plan from numerous friends, teachers, and relatives. Even the nurse in her obstetrician's office said that she didn't know how Kathleen could "do such a thing." Kathleen was preparing to review histories of prospective adoptive parents for her baby, and she knew that this was what she wanted for herself and her baby but felt alone, isolated, and sad.

*Treatment issues.* Kathleen was trying to avoid internalizing the judgments of others and repeatedly stated the need to do what is right for her baby and herself, but her limited social support was a vital area to address in treatment. Kathleen's fears resulted in multiple changes to her adoption plan (i.e., wavering between keeping and relinquishing the baby) and thereby limited

her ability to feel comfortable and safe in her choice. These fears also hindered her progress through the grieving and relinquishment process.

*Effective treatment strategies.* Her therapist validated all options as potential choices, including both relinquishment and parenting, and also provided her a nonjudgmental place to talk about her ambivalent feelings. Using knowledge of the adoption system and the lifelong effect of relinquishment, Kathleen's therapist urged her to join a support group for relinquishing mothers at a local private adoption agency and to explore placement through an adoption agency with a strong birth parent support program. The therapist knew that working with such an agency would allow Kathleen to receive support for the relinquishment issues she would experience throughout her lifetime (support a private attorney could not provide). The agency Kathleen chose to work with had an ongoing birth parent support program that she could work with at any time throughout her life. This agency sent materials to Kathleen's physician and to the obstetrics unit where Kathleen would deliver her baby so that they would understand the unique needs of a mother planning to relinquish her child for adoption (Melina & Melina, 1988). Kathleen worked with her social worker at the agency, chose a mediated contact adoption for her baby (one with limited exchange of information between birth parents and adoptive parents), and participated in choosing the adoptive parents. During her 8th month of pregnancy, with her therapist, Kathleen met the adoptive parents and wrote a letter to her baby that included photographs. Kathleen wavered on her adoption plan a few times toward the end of pregnancy but followed through with her decision to allow the adopting parents to be with the baby immediately after delivery. Her widened support system of her parents, therapist, agency, and birth mother support group was invaluable to her both before and after relinquishment.

As this case illustrates, Kathleen's experience of the prerelinquishment period is a typical one in many ways. Her symptoms of depression and anxiety are common. Kathleen's background and her personal feelings are reflected in the literature's findings regarding her likelihood of making an adoption plan (i.e., her mother preferred that she make an adoption plan, she was a Caucasian teen from a middle-class family, and she did not feel ready for the responsibility of a baby). However, given the pressure and negative judgments from others regarding her choice to relinquish her baby, Kathleen clearly needed structured prerelinquishment support that could come in the form of therapy, support groups, or other supportive resources. Her therapist provided this adoption-sensitive (Janus, 1997) support for her decision making and assisted Kathleen in three crucial ways: (a) by providing a referral to a

support group of other birth mothers who were making choices about adoption plans and to an adoption agency with a strong and sensitive birth parent program, (b) by demonstrating competence regarding the issues for relinquishing birth mothers and being nonjudgmental and supportive of Kathleen's decisions, and (c) by creating an atmosphere where Kathleen could prepare for the relinquishment and could provide a link for her child following the relinquishment (by participating in choosing the adoptive parents and giving them a letter and photographs). Adoption specialists report that prerelinquishment counseling for the birth mother is best both for her and for preventing a disrupted adoption later. This case study illustrates several aspects of the specific knowledge that is crucial for effective therapy during the prerelinquishment period and reflects the points elucidated for adoption-sensitive counselors (Janus, 1997).

### **Relinquishment Continuum and Coerced Relinquishment**

It is important to note that the distinction between voluntary and involuntary relinquishments is actually a continuum rather than a dichotomy. Whereas some birth parents who sign voluntary relinquishment papers actually feel coerced by loved ones, spouses, parents, or even their culture (i.e., cultural norms against childbearing out of wedlock) to relinquish their children (DeSimone, 1996), other birth parents who formally have their rights terminated by the court system can be in agreement with that plan. This continuum and the issue of coercion have not been addressed in the birth parent literature and have been addressed only as an ethical issue in the more recent adoption literature (Post, 1996). Although no literature currently exists that documents this phenomenon, the personal stories and communications of many birth parents, particularly birth mothers, strongly support the concept of a continuum. The distinction between the legal category of relinquishment (voluntary vs. involuntary) and the emotional experience of the birth parent(s) (totally voluntary vs. coerced) is important to make in both practice and research.

### **Involuntary Relinquishment**

When birth parents do not choose to relinquish their children voluntarily, the experiences of birth parents during the prerelinquishment period differ greatly. Involuntary relinquishment is accompanied by legal processes and court decisions that culminate in a process known as the termination of parental rights (Edelstein, Burge, & Waterman, 2002; Wattenberg, Kelley, & Kim, 2001). Likened to the "death penalty" for parents because of its finality

and gravity (Hewett, 1983), the termination of parental rights is a path that leads to distress and a unique and different set of birth parent issues.

Before the termination of their parental rights, birth parents whose children are removed because of findings of neglect or maltreatment are given visitation rights, and the children enter foster care. But who are these parents who no longer have the legal right to parent their children? These parents have been briefly and superficially described in the literature. The literature describes their characteristics and tends to report reasons for the termination of rights (e.g., mental illness, abusive domestic relationships, substance abuse, limited intellectual functioning, legal problems or incarceration, or inability to maintain stable housing; Wattenberg et al., 2001) and birth mother background histories (e.g., little formal education, unemployment, abuse, out-of-home placement as children, birth of first child at a young age, children by multiple fathers, chaotic home environments; Wattenberg et al., 2001), but national statistics on these individuals, developmental histories, and outcomes are difficult to determine (Freundlich, 2002). Statistics on the numbers of children whose parents have had their rights terminated can be readily accessed (e.g., in 2001, parents of 65,000 children in the United States have had their parental rights terminated; U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2003); however, statistics on the actual numbers of birth parents whose rights have been terminated are not available. Despite this lack of reported statistics, recent trends in family preservation support the rehabilitation of parents who have been deemed neglectful or maltreating, and attempts at family reunification are built into the system (Wattenberg et al., 2001). However, increasing concerns about the length of time children spend in foster care without permanency planning has spurred a movement toward legislation to speed the process of termination of parental rights for parents who fail to make substantial progress in their rehabilitation efforts (Festinger & Pratt, 2002).

We do not have a clear understanding of the experiences of birth parents whose rights have been terminated. Research on the effect of parental rights terminations reflects little attention to the effect of the involuntary relinquishment on birth parents and focuses on the adoption or placement outcomes for the children.

Also missing from the statistics on birth parents whose parental rights have been terminated are data on their racial and ethnic backgrounds. Extrapolating from the data available from 2001 (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2003) and assuming a similar distribution among children in foster care and parents whose parental

rights have been terminated suggests that the racial and ethnic backgrounds of those birth parents may generally fit the following categories: (a) 2% American Indian non-Hispanic, (b) 1% Asian non-Hispanic, (c) 38% Black non-Hispanic, (d) 17% Hispanic, (e) 37% White, (f) 3% unknown, and (g) 2% two or more races non-Hispanic. However, the racial-ethnic distribution of people in America indicates very different proportions of racial-ethnic minorities in the United States as follows: (a) 75.1% White, (b) 12.3% African American, (c) 13% Hispanic or Latino, (d) 0.9% American Indian non-Hispanic, (e) 3.7% Asian Pacific Islander non-Hispanic, (f) 5.5% other race (Grieco & Cassidy, 2001). Thus, the disparity in the figures between the proportion of racial and ethnic minorities in the population and the proportion of racial and ethnic minorities whose parental rights are terminated suggests some degree of inequity in several systems that affect involuntary relinquishment. This bias can be attributed to institutions such as the judicial system and children's welfare agencies and can be a reflection of the system of disadvantage (e.g., racism) and oppression all too commonly found in these institutions. Moreover, although these disparate figures may also reflect bias and oppression related to social class, the degree to which social class affects the likelihood of involuntary termination of parental rights is not fully explained in the literature.

The only research to address outcomes for birth parents whose rights have been involuntarily terminated has repeatedly found long-term psychological distress (Freundlich, 2002). Some outcomes commonly found among these birth parents are (a) an ongoing sense of anger and guilt, (b) significant psychological problems, (c) health problems usually associated with bereavement (e.g., sleep and appetite disruption, dreams about loss and search), and (d) relationship problems (Charlton, Crank, Kansara, & Oliver, 1998; Hughes & Logan, 1993; Mason & Selman, 1997). We found neither research nor documented counseling programs that addressed birth parents following the involuntary termination of their parental rights. Although a single study was found that discussed group therapy issues for birth parents whose children were in foster care (Charbonneau & Kaplan, 1989), no literature addressed treatment following involuntary relinquishment. Given all the challenges facing birth parents who involuntarily relinquish their children and the complete failure to cover this issue in the literature, the case study below will illustrate several issues likely to be presented by these birth parents.

#### CASE STUDY 2

*Presenting issues.* Joanne, a 27-year-old Caucasian woman, was referred to a MICA (mental illness and chemically addicted) treatment center follow-

ing a recent hospitalization for a suicide attempt. Joanne had been diagnosed with major depression 6 years ago and had a 9-year history of alcohol dependency. During the intake session, Joanne, who has two sons ages 3 and 8, revealed that her parental rights were terminated prior to her suicide attempt but that she had attempted suicide because she had been depressed and drinking. Joanne expressed anger, sadness, guilt, and the inability to cope with those emotions.

*Background factors.* Joanne is the middle child of a family with three children. Her mother lives in Joanne's hometown but has only irregular contact with Joanne. Joanne's father left her family when she was 2 years old, and she has not had contact with him since. At age 4, Joanne entered foster care along with her siblings when their mother was unable to care for them, but they returned home when Joanne was 9. After high school, Joanne met Joe; they moved in together and had two sons. She and Joe ended their relationship a little over 3 years ago, and she hasn't heard from him since. After Joe left, Joanne became very depressed and was drinking heavily. She reported that her sons had been removed from her home and put into foster care shortly after the birth of her youngest child because of a lack of stable housing and her occasional heavy drinking during pregnancy. Although Joanne's son was healthy at birth, all attempts at reunification had failed because of her continued alcoholism. Her sons were eventually transferred to a preadoptive home in anticipation of the termination of her parental rights.

*Assessment concerns.* Joanne's long history of addiction and depression coupled with her recent losses raise many areas of concern. Joanne has no social supports and has few social, economic, and personal resources at this time. Joanne is readily able to discuss her alcoholism and her depression, but she is more reticent and less open about the loss of her children. Detoxification and depression treatment may need to be established before an accurate assessment of her grief over the termination of her parental rights can be conducted.

*Treatment issues.* Joanne was at high risk for relapsing, given her numerous challenges and her lack of social supports. She differed in her ability to cope and in her ways of dealing with her grief. She reflected on her losses very differently than birth parents who relinquished voluntarily. Anger at the child welfare system and at the preadoptive parents was explained as the result of Joanne's feeling that her rights were terminated because she is poor. Self-esteem problems were also prominent given Joanne's feeling that she had been publicly called a "bad parent."

*Effective treatment strategies.* The therapist admitted Joanne into the MICA inpatient treatment center and began detox and a thorough program to treat her substance abuse and depression. Twice-weekly individual sessions and daily group sessions were conducted during which she worked to cope with her addiction and explored her depression. Through this exploration, Joanne expressed fear for her children, and the therapist helped Joanne relate this fear to her own experiences in foster care as a child. The therapist addressed Joanne's fears through a detailed exploration of Joanne's personal history in foster care and a realistic appraisal of her sons' current placement.

Joanne was transferred to the outpatient MICA program after her severe depression stabilized. At this point, Joanne began a 12-step program and worked with a sponsor while her therapist used cognitive-behavioral strategies and mindfulness training to help her cope with feelings that she had denied. Joanne was evaluated for medication and eventually began taking antidepressants. Vocational counseling was initiated. Thus, the combination of mental health professionals and a self-help program allowed Joanne to begin putting her life back together for the first time in many years while honestly facing the grief over the loss of her sons. The therapist recognized and acknowledged Joanne's need to know that her sons were safe and would not be experiencing what Joanne had as a child, so the therapist supported Joanne's decision to contact her sons' caseworker to get information about them. The therapist's understanding and acceptance of Joanne's anger and the recognition of the oppression that Joanne experienced as a mother coping with the struggles of poverty allowed Joanne to feel understood and validated rather than guilty and defensive.

Joanne's case reflects the multiple layers of presenting problems experienced by birth parents who involuntarily relinquish. Joanne's clinical concerns (e.g., alcoholism and depression) coupled with the involuntary relinquishment of her children are complicated counseling issues that require a careful treatment plan. Given the treatment primacy of Joanne's suicide attempt and the interaction of depression and alcoholism, Joanne's involuntary relinquishment of her children was an issue to be covered after stabilization had been achieved. Joanne's case also reflects several of the common experiences of birth parents who involuntarily relinquish their children—psychological distress, guilt, and anger. The adoption-sensitive therapist (Janus, 1997) in the case study recognized the grief caused by the involuntary nature of the relinquishment and Joanne's need for assurance; this post-relinquishment plan gave Joanne reassurance and the ability to start a future with support rather than just guilt, anger, and blame.

### EARLY POSTRELINQUISHMENT PERIOD

Words will not give expression to the aching within,  
the anguish of birthing but not nurturing  
of creating but not guiding,  
of the giving of life but not the care-giving of life.

*Guttman, 1999, p. 32*

During the early postrelinquishment period (defined broadly as the first 2 years following relinquishment), the reported effect of relinquishment on birth parents, but especially birth mothers, varies greatly depending on their coping skills, support system, and degree of involvement in planning the adoption—that is, to what degree the birth mother is involved in choosing the adoptive parents and meeting them.

Clinically, birth mothers tend to report that relinquishment involves a powerful sense of loss and isolation (A. Brodzinsky, 1990) and that these feelings accompany both closed adoptions (i.e., traditional adoptions where no contact or information occurs between birth and adoptive families either before or after placement) and open adoptions (i.e., the degree to which the birth mother is involved in choosing the adoptive parents and meeting them) (Zamostny et al., 2003a). Birth mothers in more open arrangements may become childlike in their dependence on the adopting parents, only to feel discarded and betrayed by them once the baby is born. Birth mothers in more traditional, closed arrangements report more traumatic dreams, sleep disruption, and a sense that experience is surreal. Physical, hormonal, and relationship changes bring disruption to the birth mother's life, and they consistently report that their hope to be able to "get on with their life" doesn't reach fruition (A. Brodzinsky, 1990; Sorosky, Baran, & Pannor, 1976).

Three empirical studies were identified that studied birth mothers during the initial period following relinquishment. Cushman, Kalmuss, and Namerow (1993) interviewed 215 adolescent birth mothers from 30 maternity homes in 13 states in their third trimester of pregnancy and then again 6 to 8 months after delivery. Ninety three percent of the subjects were White, and the mean age at first interview was 17.9 years. Donnelly and Voydanoff (1996) interviewed 113 pregnant adolescents from one city in Ohio at birth and again at 6-, 12-, 18-, and 24-months postpartum. Racial composition of the sample was not reported. Comparisons were made between those who placed their children for adoption and those who chose to parent. McLaughlin et al. (1988) surveyed 146 birth mothers who relinquished or placed their children with adoptive parents and compared them with 123 adolescent birth mothers who did not relinquish their children and chose to par-

ent them from an adoption counseling agency in the Pacific Northwest that practices open adoption. Racial composition of the sample was not reported.

In those studies, data collection occurred from 6 months to 7 years after placement, although focus of the data was on outcomes from 6 months to 2 years after placement. Two of the three studies were longitudinal (Cushman et al., 1993; Donnelly & Voydanoff, 1996), and one was cross-sectional (McLaughlin et al., 1988). Two studies used control groups of program participants who chose to parent (McLaughlin et al., 1988; Donnelly & Voydanoff, 1996), and one had no control group (Cushman et al., 1993). Variables studied included self-reported satisfaction (McLaughlin et al., 1988), grief (Cushman et al., 1993), perceived pressure to relinquish (Cushman et al., 1993), and depression and self-efficacy, which were measured on a five-item scale (Donnelly & Voydanoff, 1996). Only Donnelly and Voydanoff (1996) studied both internal (grief, self-efficacy, satisfaction with decision) and external (education, religion, SES) variables, although interaction effects were not analyzed.

The findings indicate a complex combination of differences and similarities in outcome between mothers who placed their children for adoption and those who chose to parent. There were no differences between the groups in school enrollment at 6 months, high school graduation rate, and perceived quality of life (McLaughlin et al., 1988) nor was there a difference in SES, religion, self-reported depression, and self-reported self-efficacy. Both groups reported satisfaction with their decisions 2 years later (Donnelly & Voydanoff, 1996). However, Cushman et al. (1993), in the only multistate sample with interview data, found higher reported levels of grief at 6 months than postpartum and highest levels of grief in birth mothers whose babies went to foster placement prior to adoptive placement. They also reported that 55% of birth mothers found signing adoption papers to be one of the most difficult parts of the adoption process, and 9% reported that they felt pressure from their agency to sign the papers. At 6 months after they gave birth, 38% of the placer sample reported feeling a lot of grief, and 27% reported feeling "some" grief. Kalmuss, Namerow, and Bauer (1992), using the same longitudinal data set, found that relinquishers fared somewhat better than those who parented on a set of sociodemographic outcomes assessed at 6 months post-birth. However, they also found that even when controlling for preplacement variables, relinquishers were less comfortable with the pregnancy resolution decision than those who parented.

#### CASE STUDY 1 (Continued)

*Course of treatment.* Kathleen found herself alternating between numbness and grief both in the hospital and after returning home. She spent time

with her baby girl in the hospital, and her mother took a few photographs of the baby with Kathleen and with the adoptive parents before they left the hospital with their new daughter. Others wanted her to “get on with her life,” but she sensed that a change had occurred in her that wouldn’t go away. She tried to remember details of her baby’s birth and the hours after she was born, but she found herself unable to, as is common for birth mothers. Kathleen found that both the physical and emotional changes were overwhelming and that her feelings would erupt at unpredictable times.

*Effective treatment strategies.* She worked with both her therapist and her birth mother support group to express her feelings. She also worked at accepting and owning her decision, getting past blaming others for her circumstances, and becoming able to share her story and defend her decision. Kathleen realized that it was normal to think about her child and discussed her fantasies with her therapist. She learned through continued reading that birth parents identified living with the unknown as the most difficult part to cope with throughout life, and she worked to become more comfortable with this unknown. Kathleen’s counselor became more didactic during this period of treatment, teaching her about the stages of grief, and she found comfort in hearing her feelings echoed in the stories of other birth mothers, both in her group and from her therapist’s experience.

This case study demonstrates how Kathleen’s counselor allowed her to face her grief and also avoid the factors suggested by Roles (1989), which block, delay, or prolong mourning. Based on clinical experience, these factors are (a) lack of acknowledgement of the loss by society, family, friends, and professionals; (b) lack of expression of intense feelings; (c) not having a mental image of the baby as a result of lack of information or not having seen the baby; (d) preoccupation with the fantasy of reunion in such a way as to avoid dealing with the loss; (e) preoccupation with searching for something to fill the gap, to avoid facing painful feelings; (f) belief that having a choice takes away the right to grieve; (g) self-depreciation and self-blame; (h) pressure from others to decide on adoption, which makes it difficult to take responsibility for making a decision; (i) lack of support; (j) numbing through abuse of alcohol or drugs; and (k) maintaining secrecy and not acknowledging the loss to oneself or others. The adoption-sensitive counselor’s knowledge about these factors, the counselor’s educating Kathleen on the grief reactions common for birth parents, and the counselor’s assistance in normalizing Kathleen’s anger, loss, and sadness were crucial in effectively treating her during the postrelinquishment period (Janus, 1997).

Because relinquishment of the parental role is lifelong, it is vital for counselors to recognize that many postrelinquishment reactions can revisit birth

parents at any point during their lives. Counselors should also be prepared to address these issues during important transitions in the birth parents' and the adoptee's lives, such as birthdays, holidays, Mother's Day, and other events that mark the relationship.

### LONG-TERM POSTRELINQUISHMENT

I'll be folding laundry, . . . and suddenly I'm sixteen again, packing my clothes for the maternity home. Minutes later, I'll pull myself into the present and stop crying. Or, just recently, I was at my son's school as room mother. They were fixing macaroni and cheese in the cafeteria. I was no longer in his school, but back at the [maternity] home where, every Friday, we got macaroni and cheese. It even smelled the same. These flashbacks happen all the time. I'll hear an old song from when I was a teenager, and suddenly, I'll feel the baby kicking me so hard that I have to massage my ribs, even though I'm not pregnant! Or something will set me off, like seeing a newborn baby or driving by a hospital, and the next thing I know, I'm reliving the moment that I left the hospital and came home. I mean, reliving it. It's like replaying a tape. The scenes happen again and again. This happens to me unpredictably, only sometimes—not all the time. But one flashback occurs pretty often. I'm writing checks—paying the bills, but instead of signing the checks, I'm suddenly signing relinquishing papers! It's embarrassing—I've voided more checks that way, by messing up my name in the middle and ruining the signature before I come back to the present, control myself, and see what I'm really doing. (Jones, 2000, pp. 178-179)

Long-term effects of relinquishment on birth mothers fill the clinical literature, with long-term outcome being defined broadly as more than 2 years postrelinquishment. The clinical literature (A. Brodzinsky, 1990; Gediman & Brown, 1991; Guttman, 1999; Jones, 2000; Robinson, 2000; Schaefer, 1991) includes many different personal accounts of birth mothers who experience lifelong symptoms of depression, anxiety, and posttrauma. In this literature, birth mothers detail ongoing symptoms of grief, isolation, and difficulty setting aside the experience of relinquishment. They describe what Fravel et al. (2000) have termed the birth mother's experience of the "psychological presence" of the relinquished child. At the same time, some research has found reports of satisfaction with the relinquishment decision and favorable outcomes on some sociodemographic and social psychological outcomes 4 years after giving birth, in addition to continuing grief and loss (Namerow, Kalmuss, & Cushman, 1997).

Clinicians report that the birth mothers they see in therapy alternate between denial of the relinquishment of their child and feelings of continuing shame, depression, and negative self-image. They feel they carry a serious secret and that they are unacceptable and unlovable. They report difficulty

attaching to romantic partners and, sometimes, their subsequent children. If the birth mother has had an open support system, one that she can honestly communicate within, then these intense emotional sequelae seem to be reduced. Those in closed adoptions worry if their birth child is alive and safe. They report recurring dreams about their children and a tendency to wonder more intensely about their children near birthdays and holidays. If they have maintained secrecy, they may fear that others will reject them if the adoption placement is disclosed. Many report losing their sense of faith and spirituality during this stage.

When considering both the clinical and research literature on long-term outcomes, it is essential to remember that research tends to be heavily focused on the birth mothers who continue to struggle with the loss of their child for years following the relinquishment. This is likely the result of a sample bias because research participants tend to come for treatment and have obviously been involved enough in exploring relinquishment to have volunteered for these research studies. No data were found in either the clinical or empirical literature on birth parents that suggest that birth parents cope well with their decision to relinquish, although Namerow et al. (1997) found some positive outcomes on both sociodemographic and social psychological variables.

Eight empirical studies were identified. In five of these studies, either clinical samples or self-selected samples from adoption support groups or organizations were used, and therefore, these studies have biased samples. However, clinical descriptions and empirical studies nonetheless provide valuable information about a hard-to-access population, although their generalizability should be viewed with caution.

The length of time from relinquishment for individual subjects in the eight studies varied from less than 5 years (Deykin, Campbell, & Patti, 1984) to more than 60 years (Carr, 2000). Four of the studies used survey data and three involved personal interviews with a longitudinal sample of 187 maternity-home adolescents (Namerow et al., 1997), 20 psychiatric outpatients (Rynearson, 1982), and a national sample of 163 birth mothers (Fravel et al., 2000). Only two of the six studies used standard instruments exclusively as part of the data collection (DeSimone, 1996; Winkler & van Keppel, 1984). Most included both internal and external variables in their design, although they did not incorporate the interaction of these variables in the analysis (e.g., grief was not analyzed by age at relinquishment nor by level of social support). None of the studies analyzed the data by relinquishment cohort (i.e., relinquishments from the 1930s were combined with those from the 1990s), so comparisons of outcome with adoption practices over the course of time cannot be assessed. In general, this research found that the emotional effect of relinquishment can be long lasting and includes confusion, anger, guilt,

and sadness about relinquishing a child for adoption (Winkler & van Keppel, 1984).

All seven studies implied that at least for a percentage of birth mothers, the experience of relinquishment had been a trauma in their lives. Unresolved grief was reported in all studies (Carr, 2000; DeSimone, 1996; Deykin et al., 1984; Namerow et al., 1997; Rynearson, 1982; Winkler & van Keppel, 1984). Findings indicated a negative effect on future relationships, and three studies found an increased incidence of secondary infertility (Carr, 2000; DeSimone, 1996; Deykin et al., 1984).

Condon (1986) studied 20 birth mothers on disability in Australia (mean years since relinquishment = 21; other demographic data not reported) and compared them to an age-matched control group. He found that the majority reported no decrease in feelings of sadness, anger, and guilt since their relinquishment up to 30 years after relinquishing their child. Condon also reported that the birth mothers reported dysfunctional relationships with subsequent children and with men. Rynearson (1982) gathered retrospective reports of relinquishing experiences through two interviews with 20 female psychiatric outpatients who had relinquished their first child when they were 15 to 29 years old (although their treatment was for symptoms not identified with the relinquishment). All birth mothers were White and middle class, their current age range was 30 to 46 years, and their age at relinquishment was 15 to 19 years old. All participants felt that the relinquishment had been externally enforced by parental, social, and altruistic demands. All of the women had dreaded delivery and remembered labor as a time of loneliness and painful panic. Each reported that signing the adoption papers was traumatic and that she left the hospital with lingering questions about what happened to the baby. Each reported recurring traumatic dreams about relinquishment and episodes of seeing strangers with babies and wondering if it was her child. They reported that the relinquishment had affected their future relationships and parenting. He proposed that relinquishment had put them at higher risk for future mental health difficulties.

DeSimone (1996) assessed 264 Australian birth mothers who self-selected from newspaper ads, birth parent organizations, and adoption-related publications. Mean current age was 45, and mean age at relinquishment was 20 years. Ninety-six percent were Caucasian, 2% Black, and 1% Hispanic. Participants' religions were listed as 31% Catholic, 21% Protestant, 12% Jewish, 20% none, and 14% other. Forty-six percent reported that relinquishment was "not at all what I wanted." Thirty-four percent did not have other children. Higher grief levels were related to (a) feelings of guilt/shame about the decision to relinquish, (b) the perception of coercion by others into relinquishment, (c) the lack of opportunity to express feelings about the relinquishment, and (d) involvement in searching for their relinquished child. No

significant correlation was found between grief levels and lack of social support. Lower grief levels were related to high satisfaction with current marriage, more personal achievements, and having gained information about their child since placement. Carr (2000) found that 37% of the 87 birth mothers surveyed at national adoption conventions had secondary infertility, which was higher in this population than the national average. The current age of the birth parents ranged from 40 to 76 years old, and their average age at relinquishment was 20.2 years; the racial composition of the sample was not reported. Emotional pain, including grief, was reported as one consistent outcome in each of these long-term studies of birth mothers.

Namerow et al. (1997) reported that, in spite of this grief, after 4 years postbirth, their longitudinal sample of adolescent placers from maternity homes fared better on external outcomes than parenters. In this sample, 93% of the birth parents were White, and 7% were African American; their mean age at placement was 17.4 years. Specifically, 71% of the parenters had graduated from high school compared with 91% of the placers, although few women from either group had continued for a postsecondary degree. At 4 years, 47% of the parenters were employed outside the home versus 70% of the placers. Focusing on regret regarding their pregnancy resolution decision, at 4 years, more than 90% of the parenters versus 66% of the placers reported no regret, and 3% of the parenters versus 10% of the placers reported a lot of regret. Thus, a more complicated picture emerges as the sample becomes less clinical.

Using a somewhat different outcome measure of "psychological presence of the relinquished child," Fravel et al. (2000) presented findings from interviews with a national sample of 163 birth mothers (93% Caucasian, 4% Latina, 2% other; mean current age 27 years; mean age at relinquishment was 19.3 years) and found that the adopted child remained psychologically present for them both on special occasions and as they went about their daily lives. They discussed these findings 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. The adopted child, in their study, was psychologically present to some degree in every case.

### CASE STUDY 3

*Presenting issues.* Donna is a 62-year-old African American woman who came to therapy for depression and anxiety.

*Background factors.* Donna was raised in an orphanage from the age of 9 along with her brother because her mother was alcoholic and her father was out of the country in the military. Evidently, this was common practice at that

time and in that locale because Donna knew that others at the orphanage weren't "orphans" either but had been brought there by their parents for various family circumstances. Older boys at the orphanage sexually molested Donna when she was 11 years old and continued to do so until she ran away at age 16. Donna married a 25-year-old when she was 18 and had four children in 5 years. Her husband drank heavily and soon left her abruptly and moved to another state. Unable to support herself or her children, Donna became despondent and developed pneumonia. She had no car, no income, and no social services or other social support. A cousin gave her food, which she gave to her children, denying herself. She finally sought medical care for herself (she believed she was going to die) and went along with her physician's suggestion to relinquish her children (ages 3, 2, 1, and newborn) for adoption because she feared they too would end up in the orphanage (and she refused to allow that for her children). She backed out of relinquishing her youngest child and only daughter because she was afraid her daughter would be victimized as she had been. Donna knew the adoptive families of her three sons and had kept track of two of the three silently throughout their lives. The third had left the area with his adoptive family when he was a toddler, and Donna had always feared they had moved to get far away from her. Donna married again, adopted another daughter herself through social services, and went on to live a healthy and productive life. However, the sexual abuse and the trauma of relinquishing her sons tormented her most of her life, and her psychologist diagnosed her with posttraumatic stress disorder (PTSD).

*Assessment concerns.* Donna's insight and judgment appear to be strong despite her experience of multiple traumas. The accumulation of many years since the sexual abuse and the relinquishment have allowed her to feel buffered from their effects, but the PTSD symptoms suggest a 40- to 50-year history of trauma. Furthermore, Donna's tracking of her sons' movements suggests some fixation on the trauma without any apparent resolution to this point.

*Treatment issues.* Donna had several major losses that complicated her PTSD issues—abandonment by her parents, sexual abuse as a child, abandonment by her husband, poverty and feeling powerless, illness, relinquishment of her three children, and her secrecy. Treatment included attention to Donna's PTSD symptoms and issues but also recognized how closely connected were the losses and the trauma. Donna's actions suggested an interest in search and reunion, and this required careful planning and support.

*Effective treatment strategies.* Treatment consisted of appropriate protocols for PTSD and special attention to the loss she experienced as a relin-

quishing birth mother. Donna was extremely harsh on herself for this relinquishment, yet her repetitive reviews of her prerelinquishment situation always resulted in her reaching the conclusion that relinquishment had been best for her sons. She wished, however, that she could have placed them together. Nevertheless, she found it very hard to forgive herself. Her therapist used journaling, photo reviews, bibliotherapy, and psychoeducation as strategies for facing this loss. They also used grief strategies such as writing letters to each of her sons on numerous occasions. Her therapist used her own knowledge of adoptee development to reassure Donna that the vast majority of adoptees do quite well (Zamostny et al., 2003a) and gave her reading material on the birth parent experience (e.g., Jones, 2000) to decrease her feelings of isolation. Donna eventually decided to contact each birth son and established caring relationships with two of them; the third preferred no contact, but she made it clear that she was open to contact should he ever desire it. Her birth sons met her daughter and other family members and continually reassured Donna that they had had good lives and did not harbor resentment toward her. On the suggestion of Donna's therapist, Donna's two birth sons and her daughters entered family therapy for three sessions where family dynamics were addressed via family sculpting and other experiential techniques. Donna's PTSD symptoms diminished (but did not disappear), but even with good treatment and appropriate medication, she continued to find it hard to forgive herself for relinquishing her children. She has, however, improved in her ability to speak about her traumas and has developed a group of supportive friends for the first time in her life.

Donna's case illustrates the lifelong effects that relinquishment can have on a birth mother. However, in Donna's case, her own traumatic history combined with the closed adoptions of her sons to create additional stress reactions, grief, loss, and intense guilt and remorse. Donna's psychological treatment was designed to address the multiple layers of trauma she experienced and to begin the grieving and self-forgiveness processes that she needed (Janus, 1997). The treatment provided by Donna's psychologist reflects the importance when diagnosing and treating birth parents of understanding the powerful effects of relinquishment. Had the treating psychologist minimized the relinquishment of her three sons, Donna's history of trauma prior to the relinquishment could have been the focus of treatment, with poor overall results. The effective use with birth parents of techniques such as journaling, bibliotherapy, and letter writing requires sensitivity to the grief, loss, guilt, anger, and trauma that often continue for many years following relinquishment. The use of family therapy following the search and reunion helped Donna to better understand the role that relinquishment had in her family (Reitz & Watson, 1992).

### Search and Reunion

Feast, Marwood, Seabrook, and Webb (1994) note that in recent years, there has been an increase in birth relatives' initiating searches for the child relinquished for adoption, although the research is limited to adoptee-initiated searches. Feast et al. (1994) report that "some birth mothers [search because they] need to feel reassured that they did the right thing and want to make certain that their child knows they were very much loved and why they were adopted" (p. 9).

Research addressing search and reunions has described or categorized the ensuing relationships that do or do not develop between birth parents and their relinquished children. Howe and Feast (2001) surveyed adoptees who had been in reunion with their birth parent(s) an average of 10.6 years (63% women, 37% men; 93% in matched White same-race placements, 7% of mixed race and adopted transracially). They found that reunions were characterized by (a) continued contact and positive evaluation (30%), (b) ceased contact and positive evaluation (30%), (c) continued contact and mixed or negative evaluation (30%), and (d) ceased contact and mixed or negative evaluation (10%). Gladstone and Westhues (1998) surveyed 67 Canadian adoptees in reunion (mean age 42.5 years, 81% female, 19% male) and identified seven categories of postreunion relationships that can occur: close (35%), close but not too close (10%), distant (22%), tense (6%), ambivalent (14%), searching (8%), and no contact (6%). Factors found to affect the types of relationships developed included structural factors (geographic distance and time), interactive factors (boundaries of the relationships, adoptive family's support, and birth family's perceived level of responsiveness), motivating factors (sense of involvement or pleasure from contact), and the outlook of birth relatives (close matching on lifestyle, values, and desire regarding intensity of relationship). Feast et al. (1994) noted, "For the most part, though, birth parents are very pleased to see their children again" (p. 104).

### BIRTH FATHERS

Birth fathers are underrepresented in both the clinical and the research literature. Perhaps this is because they tend to be less involved in the pregnancy and less involved in the decision to relinquish than the birth mother. Perhaps it is because many birth fathers do not see the child prior to relinquishment. There is very little in the clinical literature about birth fathers, although it is routine to decry their absence in the literature (Freundlich, 2002; Grotevant, 2003; Zamosny et al., 2003a). Perhaps as the literature expands to include birth fathers in general and birth fathers who have had contact with their chil-

dren in particular, our understanding of their experiences will increase. In any case, based on current literature, although birth fathers may seem to be less affected than birth mothers by the relinquishment and adoption of their children, an accurate assessment of the effect of relinquishment on birth fathers is difficult given the paucity of empirical investigation with this population.

Two articles reported research on birth fathers. Deykin, Patti, and Ryan (1988) surveyed American birth fathers through the international birth parents' support and advocacy organization known as Concerned United Birthparents (Concerned United Birthparents [CUB], 2004) and personal networks, resulting in a sample of 125 (92% White, 2% Black, 5% other; 30% Catholic, 40% Protestant, 3% Jewish, 13% no religion, 9% unknown; average age of relinquishment 21 years). They found that the birth fathers' relationships with the birth mothers had often continued beyond the relinquishment. Forty-four percent of these birth fathers reported marrying the child's birth mother at some point during their lives, and 25% reported that they were currently married to the birth mother. They reported that the relinquishment had an effect on their relationship with the birth mother: 22% negative, 34% positive, and 44% mixed or none. Most did not see or hold the child prior to relinquishment, and half were not involved in the adoption process. Birth fathers who were older and who identified external pressure as a primary reason behind the adoption were almost five times as likely to be presently opposed to adoption compared with those who cited their unpreparedness for fatherhood or the best interest of the child as reasons for relinquishment.

Similarly, Cicchini (1993) did a study of 30 Australian birth fathers who volunteered in response to articles and public appeals and found that the majority (66%) had no or minimal say in the adoption. Most remember it as "a most distressing experience," and only 17% of the men reported feeling positive about the experience. A majority of the birth fathers in this sample had taken active steps to locate their child; however, most had not yet had reunions. The most often-cited reason for searching was to make sure that their child was doing well. The authors concluded that the fathers retained an emotional and psychological feeling of responsibility for the child and challenged prevailing assumptions that birth fathers are irresponsible, uncaring, and uninvolved.

### **INTERNATIONAL BIRTH PARENTS**

My son, I don't know how to begin. You might be grown up when you read this letter. Yet I would prefer that you didn't read this letter because I worry about your pain and shock when you learn the truth about your birth and your

birthmother. I love you. Even though I repeat these words over and over, I know they are not enough. More than saying I love you, I should say I am sorry. My son! Can you forgive me? When I first saw you after your birth, it was as if I had loved you for a long time. When I looked at you, there were so many things I wanted to say to you. But the only thing I could do was cry without stopping. After that, I felt so much guilt because I couldn't do anything for you and I had to let you go. I wonder if you can understand that I had to let you go because I loved you and wanted you to be raised in a better environment. How can I ask for your understanding and forgiveness? The fact that I gave birth to you and then placed you with others will leave deep scars on my heart forever. I hope that you won't suffer any great hurt because of me, and that this letter won't upset you. I want your life to be trouble-free. I will always pray for you. I will think about you when I look up to the sky because you also look up to the sky. I feel so sorry that I had to say good-bye to you when you weren't conscious of anything, could barely move your hands and feet, and could not yet express your thoughts. That I was the one to send you away like that leaves me feeling heartbroken. I hope you will grow up full of life like a pine tree. Always be happy. Your birthmother. (A Korean birth mother, Dorow, 1999, pp. 80-81)

Research on international birth parents is exceptionally limited despite the increased visibility of international adoption in America. Media portrayals of transracial families where international adoption has taken place (e.g., celebrity international adoptions, print and television commercials, newspaper and magazine articles, web-based adoption sites), an older population of "waiting parents," increased acceptance of single-parent adoptions, and greater availability of healthy infants internationally have all led to a growing population of adoptive families who have power, influence, financial resources, and a thirst for information about the nations from which their children were adopted. Despite this growing population of internationally adopting families, very little is actually known about the birth parents from these countries. The perception of greater permanency in relinquishing internationally and the implications of relinquishing children to an entirely different culture are just a few of the issues that arise when considering treating birth parents who have relinquished internationally.

Johnson, Banghan, and Liyao (1998), in their descriptive work on infant abandonment in China, found that almost all of the birth parents ( $n = 237$ ) were married and that the abandonments were related to government birth regulations. Relinquishment decisions were most often made by the birth father (50%), although 40% were made by both birth parents. Eighty-eight percent of relinquishing families came from rural areas, with their primary occupation being agriculture. Reasons given for relinquishment were the children's gender (90% female), health (86% healthy), birth order (82% of females not firstborn; no data on males), and gender composition of siblings (88% of females had no brothers, 93% of females had older sister(s); no data

on males). Relinquished male children comprised those having disabilities and those born to widowed or unwed mothers.

In Korea, 85% of unwed mothers in a maternity home relinquished their children (Dorow, 1999). Freundlich (2001) described the typical Korean birth mother as being very poor, coming from a large family in which she is the youngest, and lacking family and social support.

These data, although very limited, are at least a beginning of research in two countries that adopt children to the United States. Birth parents in many of the other countries, including Latin America and Eastern Europe, are not represented in the research literature at all. Clearly, research that leads to an increased understanding of international birth parents in many countries needs to be done.

Other areas not fully elucidated in the research include the need for understanding the cultural, political, and social reasons that countries outside the United States relinquish children and the psychological effect of those reasons on birth parents. For example, on a visit to South Korea, one of the authors visited Ae Ran Won, a home in Seoul for unwed birth mothers who were relinquishing their children for adoption both internationally and domestically. The birth mothers expressed deep regret, sorrow, and shame for their decision but felt they had few options for survival. Given the social stigma, poverty, social structure of Korean society, and lack of social support, the women felt they had no choice but to relinquish their children. Without the father of the child to affirm paternity and thereby allow the child to be legally registered, the child would have no status in Korean society and could not legally attend Korean schools or have a future free from poverty. Furthermore, unwed, Korean single mothers would face severe moral stigma and social disenfranchisement from their status (Kim & Davis, 2003).

Political, social, and economic reasons affecting the relinquishment/abandonment of infants in China should also be further understood. Johnson et al. (1998) detailed the misunderstandings in China's infamous "one-child policy" and explained the gender bias toward female abandonment.

Sons are necessary to continue the patrilineal family line and all it stands for in the family-centered culture and religious life of rural China. Most important, sons are permanent members of their father's family and are still the major source of support for elderly parents in old age because rural China, outside of a few wealthy suburban areas, lacks a social security system. Daughters "marry away" and join their husband's family, where they are obligated to support his parents. The main problem with daughters is that they "belong to other people." (p. 20)

Johnson et al. (1998) also described the double bind that birth parents face if they have a child that forces them over their quota of one in urban areas and

two in rural areas (if the first is a girl). Voluntary relinquishment of a child is illegal and does not exist. If the parents are caught, abandonment of children carries stiff financial penalties that are similar to fines imposed by the Chinese government for “over-quota” children (approximately a year’s income). Thus, families already struggling to survive must choose between more severe poverty to keep the child and the risk of being caught by abandoning it. All of these factors, in addition to issues of urban migration, civil unrest, and other issues, clearly have influenced birth parents’ relinquishment decisions, but the psychological effect of the relinquishment/abandonment on these birth parents has yet to be determined. Because of the stigma and the social and legal ramifications in countries such as China and South Korea and the cultural and economic issues in countries such as Russia, Vietnam, Ukraine, and Guatemala (Freundlich, 2002), international birth parents may fear making their presence known to therapists and agencies that assist in placement. However, when the international birth parents do seek treatment, it is often for reasons other than relinquishment. Therapists should be aware of the potential relinquishment issues that may be present among birth parents from countries where children are relinquished to the United States. Furthermore, ongoing immigration of individuals from these countries as well as the need to develop culturally sensitive counseling treatment for diverse individuals requires that counseling psychologists better and more thoroughly investigate the counseling and psychological needs of international birth parents.

Seoul, South Korea

Dear adoptive parents,

How do you do? I am the birth mother of your baby. I don’t know how I can adequately express my thanks to you for raising the child to whom I gave birth. I guess I can only say thank you. I believe you will be good parents. I hope this baby will grow up to be an upright and normal person like others.

The birthfather has the same last name as mine. He was twenty-four, one year older than me. He was a cheerful and sociable man. I thought we truly loved each other but he just up and left me. Although I was happy about my baby when he was first born, I cried every day because I felt sad and guilty at not being able to give happiness to my child. I could hardly bear the thought of having been betrayed by my lover and having to let my first baby go.

I would really like to meet my baby someday, but I am afraid that he won’t want to meet me because of his resentment and hatred toward me. Moreover, if meeting him should be a cause of trouble to others, I won’t try to meet him.

Please lead my baby to be a righteous and happy person. I want him to know God. Please love my baby. Thank you very much. (Dorow, 1999, pp. 81-82)

That letter reflects the cultural climate in Korea and other countries where single parenthood and birth to an unwed mother is socially unacceptable.

Although therapists in the United States may have limited opportunities to counsel these individuals, therapists abroad and those who work with other individuals from the adoption triad would benefit from greater knowledge of international birth parents. The letter also reflects birth parents' desire for reunion with their relinquished children and demonstrates that such reunions may be possible despite popular belief that birth parents in these countries will not seek them.

### OPENNESS IN ADOPTION FOR BIRTH PARENTS

Over the past 10 years, birth mothers making adoption plans for their children have increasingly chosen alternatives that include some degree of openness between themselves and the adopting family. Three studies were identified as assessing openness and its effect on birth parents (Christian, McRoy, Grotevant, & Bryant, 1997; Cushman, Kalmuss, & Namerow, 1997; Lauderdale & Boyle, 1994). In their interviews with 12 birth mothers planning open adoption versus those planning closed adoption, Lauderdale and Boyle (1994) reported that those who planned open adoptions showed more attachment to their unborn babies and were more likely to seek support and prenatal care, although they experienced more grief in the immediate postadoption period than mothers with closed adoption plans or bereaved parents. Birth mothers who planned closed adoption reported nonattachment to their unborn babies, hid their pregnancies, were less likely to receive prenatal care, and reported more difficulty accepting the loss of the child after relinquishment.

Christian et al. (1997) studied a national sample of U.S. birth parents from 15 states ( $N = 75$ ; mean age at relinquishment was 19.5 years; mean current age is 27.5 years; 97% Caucasian, 3% Mexican American) who placed their children for adoption between 4 and 12 years ago. Retrospectively, they found a wide range of grief resolution experiences in each level of openness. Grief was coded by trained coders who analyzed tapes of the interviews using qualitative methods. However, they also found that 4 to 12 years after placing a child, birth mothers who had ongoing contact with the adoptive family through either ongoing mediated or fully disclosed adoptions showed better resolution of grief than birth mothers whose contact had ceased. Furthermore, they found that those with fully disclosed adoptions also showed better grief resolution than those who never had contact (confidential adoptions).

Cushman et al. (1997) interviewed those in their longitudinal sample (Kalmuss et al., 1992) who reflected the shift toward more openness in adoption ( $N = 171$ ; 94% White, 6% African American). The sample was limited to adolescent birth mothers who were maternity home residents at relinquish-

ment and who were reinterviewed 4 years after relinquishment to study the relationship between openness in adoption and social psychological outcomes for birth mothers. They found that 69% helped choose the couple who ultimately adopted their baby and that 28% had met the adoptive couple; 62% had received letters or pictures since the adoption, and 12% had visited or talked on the phone with the adoptive parents since placement. The most notable pattern was the association between helping to choose the adoptive couple prior to relinquishment and positive social psychological outcomes for birth mothers 4 years later. Those who received letters or pictures reported significantly lower levels of worry and slightly higher levels of relief. Visiting the adoptive family or talking with them on the phone postrelinquishment was strongly associated with lower levels of grief, regret, and worry and greater feelings of relief and peace regarding the adoption.

Continuing research is needed to assess the specific variants of openness in adoption and their effects on outcome for birth parents. Early research suggests that open adoption may be a process that decreases the emergence of negative symptoms for birth parents. Given how serious and long-term the psychological effects of relinquishment can be, a model that ameliorates these effects is greatly needed.

### **STRUCTURING RESEARCH AND PRACTICE WITH BIRTH PARENTS**

Many authors have stressed that counseling can be of value to birth parents, both before and after relinquishment (Baden & Steward, 2000; A. Brodzinsky, 1990; Friedlander, 2003; Friedlander et al., 2000; Janus, 1997; Sobol & Daly, 1992; Zamostny et al., 2003b). They suggest that both clinicians and researchers need to be informed about adoption so that they can confront myths within themselves, their clients, and the general public. It has also been emphasized that clinical themes in adoption overlap with traditional themes of counseling psychology, such as relationship and attachment processes, stress and coping skill enhancement, coping with loss and transitions, and cross-cultural issues. Zamostny et al. (2003a) and O'Brien and Zamostny (2003) take this further, however, and stress that clinicians and researchers must not overrely on models that reflect the cultural biases toward the centrality of blood relations, thereby overpsychopathologizing members of the adoption triad.

Research and clinical work with birth parents is different than with other members of the adoption triad. As this review of the literature shows, although the current body of literature on birth parents could be viewed as pathology focused, more than 20 years of research has demonstrated that at

least those birth parents who come for treatment or participate in research experience significant disruption in their lives. It is important that as clinicians and researchers, we do not attempt to minimize their painful and sometimes traumatic experiences. The loss experienced by birth parents who relinquish their child is an actual rather than a socially constructed loss.

At the same time, however, birth parents are probably the most stigmatized and marginalized members of the adoption triad, sometimes by other members of the triad themselves. Whether they are upper-middle-class young women with career aspirations and family support, birth mothers in the Marshall Islands (South Pacific) whose culture and language do not permit an understanding of permanent voluntary termination of parental rights (Roby, 2002), or parents with multiple problems that lead to the involuntary termination of parental rights, birth parents experience a loss that is nearly unparalleled in society. When this loss is shrouded in secrecy, the feelings of shame, stigmatization, and marginalization are increased. The movement toward the spirit of openness in adoption as well as the actual level of openness between adoptees, adoptive families, and birth families holds promise for birth parents' experience of relinquishment and adoption. The movement toward openness is further supported by early research with birth parents, which suggests that open adoption may actually decrease the emergence of negative symptoms for birth parents. Both the clinical work and the research undertaken by counseling psychologists must incorporate sensitivity to this stigmatization, acknowledgement of the actual loss, and careful attention to birth parents' attempts to move forward with their lives in a healthy and resilient manner. Attention also should be given to the need for a model of adoption with some level of openness that can ameliorate some of the long-term and serious psychological effects of relinquishment.

### **PRACTICE IMPLICATIONS FOR COUNSELING BIRTH PARENTS**

The case studies, empirical findings regarding the lifelong trauma associated with relinquishment, and sizable numbers of birth parents both in the United States and abroad suggest that helping professionals should be well prepared to counsel birth parents. However, despite the recognition of the effect of relinquishment on birth parents and some identification of who relinquishes, for what reasons, and how that may affect these clients, clinicians have virtually no empirically validated guidelines for practice with birth parents.

Clinical practice with birth parents, therefore, has relied on best practices generated from case studies, theoretical guidelines, and a few treatment pro-

grams developed with sensitivity to adoption-related and relinquishment issues. The literature reviewed and the cases analyzed here suggest several techniques and sensitivities to the unique and complex issues that birth parents face when relinquishing either voluntarily or involuntarily.

Janus (1997) proposed the term *adoption-sensitive counseling* and proposed that counselors are in an excellent position to become adoption-counseling specialists. A review of the clinical and research literature on birth parents, drawn from many professional disciplines and countries, leads to the following suggestions for counseling psychologists working with birth parents.

- Adoption-sensitive counselors and psychologists are attuned to their own attitudes and biases about birth parents. These biases include their own feelings about giving birth, raising children, and relinquishing children; their attitudes toward the openness continuum in adoption; and the concept of an adoption kinship network. They are keenly sensitive to issues of ethics—both professional and adoption-related ethical practices (such as coerced relinquishments) (Post, 1996).
- Adoption-sensitive counselors and psychologists are always conscious of the social and cultural factors involved in the lives of birth parents and all members of the adoption triad (Lee, 2003). These factors include race, culture (including religious and spiritual beliefs), family dynamics, and socioeconomic status for birth parents and can be expanded in the case of international birth parents to include civil unrest, cultural norms, and legal regulation of family size. Adoption-sensitive counselors and psychologists practice using the APA multicultural guidelines (APA 2003) and are aware of all adoptions as multicultural, in the broadest sense of the word.
- Adoption-sensitive counselors and psychologists are aware of the political and economic aspects of adoption and their effects on birth parents. Zamostny et al. (2003a) point to the increasing role of commercialization in the adoption process, and these economic forces have a significant effect on birth parents prior to relinquishment and beyond. Grotevant (2003) describes advocacy groups that are calling for reform within the birth parent community such as CUB (2004) and the American Adoption Congress (2004). Counselors must be aware of the wide range of political awareness and activism among birth parents.
- Adoption-sensitive counselors and psychologists are familiar with community and national resources for birth parents, including support groups, agencies that have birth parent support programs, online resources (e.g., <http://www.kinnect.org>, <http://forums.adoption.com>), reading material, and search assistance. Some birth parent specialists believe that adoption agency services present an inherent conflict of interest because they are also placing children for adoption. It is incumbent on the counselor to be familiar with agencies in their communities and refer birth parents carefully to services and organizations that will advocate for them.

- Adoption-sensitive counselors and psychologists allow birth parents to experience their loss without minimizing it. They are aware of the seven core issues of adoption (Silverstein & Kaplan, 1988) and how they affect birth parents, as we have described .
- Adoption-sensitive counselors and psychologists allow birth parents to experience their own resiliency and strength, increase their self-esteem, and plan for their own future. They are aware that not all birth parents share the same experience and that satisfaction with their relinquishment experience may be positive, having led to positive outcomes in their own lives.
- Finally, adoption-sensitive counselors and psychologists are aware of the complexity of each birth parent's story. Grotevant (2003) points out that adoption refers to a surprisingly diverse set of family circumstances, and that is certainly true for birth parents. To avoid overgeneralizing to this heterogeneous population (Zamostny et al., 2003a), counselors and psychologists working with birth parents must respect the individuality of birth parents, regardless of their life circumstances.

### **CLINICALLY DRIVEN RESEARCH: FUTURE DIRECTIONS**

Research on birth parents has been more limited than on other members of the adoption triad (Freundlich, 2002; Zamostny et al., 2003b). Counseling psychologists as scientist-practitioners with a lifespan developmental framework are in an excellent position to expand the research and clinical literature on birth parents in a way that has important implications for this population. The current empirical research on birth parents would benefit from attention to several areas to make it both methodologically sound and clinically informed.

First, the use of broad, nonclinical samples; standardized instruments; process-outcome studies; and individual surveys or interview data with less reliance on retrospective reports and/or self-reports would increase the generalizability of birth parent research. Because of methodological and sampling problems, much of the existing literature has limitations in its applicability to current relinquishing populations, and validity and reliability have suffered. Both short-term and long-term outcome studies would be improved by controlling for age at relinquishment and the prerelinquishment adjustment level of birth parents because the developmental stage and psychological history at relinquishment could be hypothesized to affect outcomes.

Birth parent research would also benefit from greater attention to the complexity of the birth parent experience. Rather than focus solely on self-reported indices of adjustment, birth parent outcomes would be more informative if they included both internal (e.g., measures of grief, depression,

self-esteem, coping skills, satisfaction, etc.) and external (e.g., SES, educational level, income, vocational level, etc.) variables. More detailed and richer depictions of birth parents also can be obtained from the use of advanced statistical analysis to determine the interaction effects of these variables. With greater knowledge of the complex experience of birth parents, more effective treatment interventions, counseling skills, therapeutic techniques, counseling process concerns, and treatment models can be proposed, empirically validated, and implemented in counseling and psychology preparation programs. This research could be built on further by enabling a study, for example, of the effectiveness of treatment using adoption-sensitive therapy through training versus therapy without adoption training versus some other support or intervention. Using case studies as foundations for additional research, clinical practice would inform ongoing research and allow the identification of more effective and appropriate treatment methods and means.

Another major area for future research includes the background, clinical, and outcome issues for birth parents of color. A greater understanding of the factors leading to relinquishment for birth parents of color, of the inequities found in the racial-ethnic distribution of involuntary relinquishment, of effective treatment strategies for assisting those coping with relinquishment (voluntary or involuntary), and of their postrelinquishment experiences would provide very useful treatment and research information. Furthermore, more research is needed on the experiences of birth parents whose parental rights have been terminated through the legal system.

The reasons that international birth parents relinquish their children also need to be assessed, including poverty, civil unrest, financial incentives, and urban migration. To better serve the needs of international birth parents, the profoundly intricate and often difficult circumstances, factors, treatment issues (e.g., stigma of therapy), and outcomes for international birth parents must be understood. The lifelong effects and outcomes for international birth parents need to be assessed with no less consideration than for domestic birth parents.

An area yet to be explored in the birth parent literature involves attention to relinquishment coercion as an important variable. Specifically, in both voluntary and involuntary relinquishments, the phenomenological experience of birth parents on the relinquishment continuum (voluntary to coerced) should be considered in the design of future research. Empirical designs that account for this continuum may assist in elucidating possible differential outcomes based on the degree to which the birth parents felt empowered to make their own adoption plan.

More research needs to be conducted assessing both the short- and long-term effects of relinquishment and any subsequent treatment on nonclinical

samples of birth parents. Longitudinal cohort studies of both birth mothers and birth fathers, including studies of openness and search, would be powerful additions to the outcome literature. Longitudinal studies of birth parents would also allow clinicians and researchers to make substantial progress in their knowledge of the developmental effects of relinquishing. Developmental issues also could be identified by additional research incorporating health psychology models about stress and pregnancy outcomes (e.g., Rini et al., 1999) that would elucidate the effect of the prenatal experience on both birth mothers and their children. This research would substantially aid our ability to choose or design effective and appropriate treatment models that account for the effects of these various dimensions of development.

Multicultural models must be used in the design and implementation of research with this global population. Models used for understanding oppression, privilege, identity, and awareness of difference experienced by many birth parents can help when considering the unique life circumstances that lead to relinquishment for birth parents.

## CONCLUSION

Both the research and clinical literature reviewed on birth parents has shown that relinquishing a child for adoption is a traumatic experience for many birth parents, in spite of some positive outcomes shown in more recent research. The development of research and practice that explicitly uses trauma as a framework for the study of the birth parent experience also could add to our understanding. Moving beyond a trauma paradigm, however, to incorporate an epidemiological stress and coping model for the study of the birth parent experience and incorporating a multicultural perspective in all research and practice with birth parents would allow counseling psychologists to set a powerful agenda for research and practice in the field of adoption in the 21st century.

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