

DIFFERENCES IN FEELINGS OF DEPRESSION, PSYCHOLOGICAL TRAUMA,  
AND PHYSICAL ILLNESS IN WOMEN WHO HAVE SURRENDERED AN INFANT  
VIA OPEN OR CLOSED ADOPTION  
A QUANTITATIVE STUDY

By

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Abstract

**Objective:** The purpose of this research was to investigate feelings of depression, psychological trauma and physical illness related to birthmothers, who have surrendered their infant to open or closed adoption.

**Methods:** An online study was done using a convenience sample of birthmothers who access online support groups and were willing to participate. Each subject completed demographic information as well as the Impact of Events - Revised (IES-R), the Beck Depression Scale (BDI), and the Medical Outcomes Study (MOS-36). Frequencies, correlations and t-Tests were evaluated to provide background and evaluation for research questions.

**Results:** Responses varied with regard to depression ( $p = 0.336$ ), trauma ( $p = 0.915$ ) and general health ( $p = 0.196$ ). Responses were not statistically significant between whether subjects had relinquished via open or closed adoption (IES-R:  $p = 0.236$ , BDI:  $p = 0.953$ , MOS36:  $p = 0.305$ ). Nor were the responses statistically significant when comparing the results of those women who are currently in contact with the adoptee versus those who are not ((IES-R:  $p = 0.915$ , BDI:  $p = 0.336$ , MOS36:  $p = 0.196$ ). Results reflect differences on the trauma and general health scales for the women whose relinquishment was placed via a closed adoption. Women with continued contact results reflect differences on the depression scale.

**Conclusion:** Symptoms of depression, trauma, and physical illness are present in women who have surrendered an infant via open or closed adoption. Further studies are recommended to determine impact and treatment options.

“Differences in feelings of depression, psychological trauma and physical illness in women who have surrendered an infant via open or closed adoption”

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## CHAPTER I

### INTRODUCTION

#### **Adoption History**

The phenomena of adoption and the impact on those involved contain many mysteries. Adoption is a social and legal process (Definition of Terms see Appendix I). Anonymity has always been a key factor in the process. This contributes to the mysteries and additionally contributes to altered grief progression and subsequent illnesses (Bellamy, 1993). Adoption confidentiality was thought to protect the birth parents, the adoptee, and the adoptive parents by removing the stigma of illegitimacy, the concern of bad heredity, and the suggestion of infertility (Ounsted, 1971). Prior to the twentieth century adoption proceedings were matters of public record. The adoption and involved parties were printed in newspapers. When privacy statutes were enacted the goal was to remove the adoption process from the public record and simultaneously seal the records to everyone except the parties and their attorneys. Still there was no anonymity between the biological and adoptive parents. In order to provide greater integration of the adoptive family, and greater separation between the adoptee and the biological family, the adoption process became a more formal, legal, and confidential procedure (Aigner, 1986).

#### **Birthmother Effects**

The adoption triad consists of the adoptive parents, the infant adoptee, and the birth parents (Pringle, 1966). Each member of the triad has its own concerns and fears related to the adoption. Birthmother concerns include the decision to relinquish and how it will impact her emotionally and physically. Fears about the health and welfare of the

infant, and whether or not there will be a placement to a good home weigh heavy on the birthmother (Wolff, 1997). For years, birthmothers continue to have concerns whether or not the child is angry or hateful towards her for having made an adoption plan. The birthmother wonders if the child is alive or dead. There may be hope for a reunion, or conversely fear of a reunion. Due to the secrecy imposed by many closed adoptions, the birthmother may resolve herself to maintaining the secret. If she has a new family, they may be unaware of her past (March, 1995).

Historically, birthmothers were typically young, unmarried white women whose middle-class families considered their out-of-wedlock pregnancies a source of terrible shame and moral failure. Many were sent to maternity homes or far away relatives, where they waited out their pregnancy in isolation and loneliness. The birthmother then surrendered her newborn to a childless couple under policies of confidentiality and sealed records (Pringle, 1966). This process eliminates the public record of the child's birth, and the birth parents are counseled by family, friends, and social agencies to go on with their lives as if the pregnancy never occurred. This socially sanctioned denial interferes with the resolution of grief (Pannor, Baran, & Sorosky, 1978).

Most modern research reveals that many birth mothers have not resolved their feelings for their relinquished child that they were told they could never see again. Many were found to have a lifelong unfulfilled need for further information about, and in some cases contact with, the relinquished child. Many report varying degrees of grief, the persistence of troubled feelings, and no belief that there was a viable alternative that would have made it possible to keep their child (Pannor, Baran & Sorosky, 1978).

Research into Post Traumatic Stress Disorder (PTSD), which is defined as the

development of symptoms following a psychologically distressing event that is outside of the usual human experience, applies to birthmothers (Briere, 1997). Serious attention is now being given to the trauma attached to the separation and loss of the mother and child through adoption, and the profound and long term effects this can have on both of them (Weinreb & Konstam, 1996). The event creates a heartbreaking trauma in an adolescent who becomes pregnant in her early sexual experience. She may go through a post traumatic stress reaction in her later relationships, associating sex with loss, shame, and loss of control (Lois Ruskai, & Kaplan Roszia, 1993). A survey conducted on 300 birthmothers suggests that the loss of their children constitutes a trauma which may be life long. Almost half of them say it had affected their physical health, and almost all say it affected their mental health. This in turn has affected their interpersonal relationships with family, partners, and the parenting of subsequent children (Briere, 1997). Symptoms of Post Traumatic Stress Disorder manifest in birthmothers. Recurrent dreams or nightmares where the trauma is relived are characteristic of some mother's experiences, especially early after the relinquishment. Many birthmothers say they split themselves off from their trauma as a coping mechanism. This avoidance as a strategy is one of the key symptoms of PTSD which may be caused by the trauma being internalized to avoid immediate pain (Weinreb & Konstam, 1996).

Symptoms of depression and anxiety are commonly associated with PTSD. Many birth mothers have reported extended periods of depression, anxiety, feeling suicidal, alcohol and drug use, and poor physical health immediately following the relinquishment (Briere, 1997). In many instances the mother did not necessarily attribute these physical and emotional disturbances to the loss of her child. Existing evidence suggests that the

experience of relinquishment renders a woman to be at high risk of developing psychological (and possibly physical) disability. Recent research indicates that actual disability or vulnerability may not diminish even decades after the event (Condon, 1986).

The goal of this study is to establish the pattern of secrecy, grief and illness with specific focus on the birthmothers, women who have relinquished an infant, and differentiate between those women who experienced an open versus a closed adoption. The purpose of the study is to gain knowledge of the long-term stress reactions that may be experienced by birthmothers. The information may enable health care providers to better screen for complications associated with birthmother trauma and allow for a more holistic health care model. As with the Neuman Systems Model (Neuman & Fawcett, 2002), it is important for the health care provider to understand how a client perceives and reacts to a stressor to better identify and implement effective interventions. The Neumann systems model is a middle range theory that provides a framework for understanding the components of five interacting client variables; physiological, psychological, developmental, sociocultural and spiritual in relation to environmental influences upon the client as a system consisting of basic structure, lines of resistance and lines of defense (Neuman & Fawcett, 2002). The birthmother's perception of the impact that the relinquishment had on her physiological, psychological, developmental, sociocultural and spiritual well being are investigated.

Chapter II

Framework

Figure 1. The Neuman Systems Model

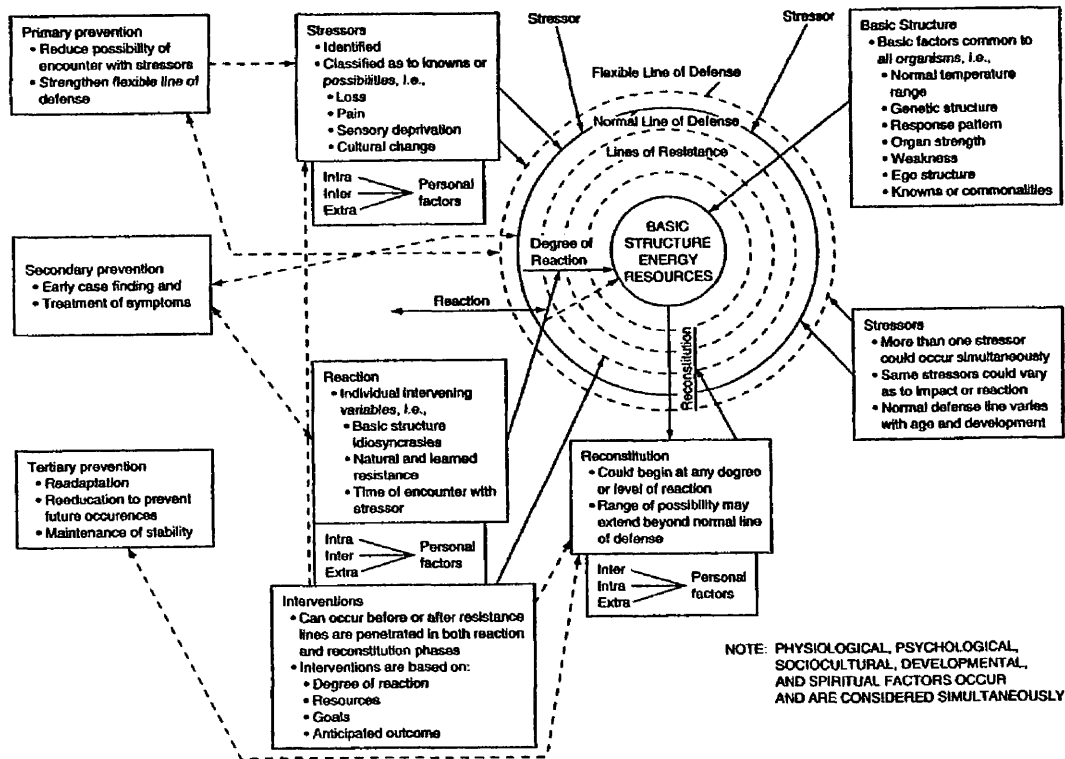


Figure 10-1. The Neuman systems model.

Neuman's model is a model, not a full theory. It is a conceptual framework, a visual representation, for thinking about humans and nurses and their interactions. The model views the person as a layered, multidimensional whole that is in constant dynamic interaction with the environment. The layers represent various levels of defense protecting the core being. The two major components in the model are stress reactions and systemic feedback loops. The person reacts to stress with lines of defense and resistance (Neuman & Fawcett, 2002). Continuous feedback loops fine-tune the lines of defense and resistance so as to achieve maximal level of stability. The client is in

continuous and dynamic interaction with the environment. The exchanges between the environment and the client are reciprocal (each one is influenced by the other). The goal is to achieve optimal stability and balance.

The person is a layered multidimensional being. Each layer consists of five person variables or subsystems:

- Physical/Physiological
- Psychological
- Socio-cultural
- Developmental
- Spiritual

The layers consist of the central core, lines of resistance, lines of normal defense, and lines of flexible defense. The basic core structure is comprised of survival mechanisms including: organ function, temperature control, genetic structure, response patterns, ego, and what Neuman terms knowns and commonalities. Lines of resistance and two lines of defense protect this core. The person, with a core of basic structures, is seen as being in constant, dynamic interaction with the environment. Around the basic core structures are lines of defense and resistance (shown diagrammatically as concentric circles), with the lines of resistance nearer to the core.

Each layer, or concentric circle, of the Neuman model is made up of the five person variables. Ideally, each of the person variables should be considered simultaneously and comprehensively.

1. Physiological - refers of the physicochemical structure and function of the body.
2. Psychological - refers to mental processes and emotions.
3. Sociocultural - refers to relationships; and social/cultural expectations and activities.
4. Spiritual - refers to the influence of spiritual beliefs.
5. Developmental - refers to those processes related to development over the lifespan.

The Neuman Systems Model looks at the impact of stressors on health and addresses stress and the reduction of stress (in the form of stressors). Stressors are capable of having either a positive or negative effect on the client system. A stressor is any environmental force which can potentially affect the stability of the system.

They are:

- Intrapersonal - occur within a person, e.g. emotions and feelings
- Interpersonal - occur between individuals, e.g. role expectations
- Extrapersonal - occur outside the individual, e.g. job or finance pressures

The person has a certain degree of reaction to any given stressor at any given time. The nature of the reaction depends in part on the strength of the lines of resistance and defense. (Neuman & Fawcett, 2002) This study gages the intrapersonal perceptions brought on by inter and extra personal stressors to measure symptoms of depression, trauma and perceptions of general health.

## Chapter III

### Review of the Literature

#### **Adoption History**

Adoption is a legal process where parental rights are transferred from birth parents to adoptive parents (Winkler, Brown, van Keppel & Blanchard, 1988). It is also a social organization. As such, it is shaped by society, culture, religion, politics, economics, and more (Winkler, Brown, van Keppel & Blanchard, 1988). An examination of its history portrays a multidimensional portrait of its social construction. Although adoption most likely pre-dates recorded history, it is the adoption practices of the last few hundred years that are most pertinent to this study. Adoption practices have taken many forms over the centuries and across cultures.

Since ancient times and in all human cultures, children have been transferred from adults who would not or could not be parents to adults who wanted them for love, labor, and property (Aigner, 1986). Adoption's close association with humanitarianism, upward mobility, and infertility, however, is a uniquely modern phenomenon (Bellamy, 1993). An especially prominent feature of modern adoption history has been matching: the idea that adoption substituted one family for another so carefully, systematically, and completely that natal kinship was rendered invisible and irrelevant (Ounsted, 1971). This notion was unusual in the history of family formation, especially because the most obvious thing about adoption has been that it is a different way to make a family. Practices that aimed to hide this difference ironically made modern adoption most distinctive.



The rise of the matching paradigm linked infertility tightly to adoption (Ounsted, 1971). Because families made socially were supposed to look like families made by blood, taking in children born to others emerged as a solution for childless heterosexuals seeking to approximate, emotionally and legally, the family they could not produce themselves. Although childless couples have probably always been interested in adoption, the practice of giving preference to infertile couples evolved only in the twentieth century and was most pronounced around 1950. By then, infertility was so closely tied to adoption that applying to raise someone else's child was considered an admission of reproductive failure. Adoption and "sterility," as infertility was typically called before the 1960s, were practically synonymous. (Bellamy, 1993; Ounsted, 1971)

There were also practical reasons for the close association between infertility and adoption. At a time when demand exceeded supply for healthy white infants, many professionals believed that limiting the pool of potential adopters to infertile couples was the fairest method of allocating children (Rothenberg, Goldey, & Sands, 1971). It was not unusual for agencies to exclude from consideration couples who had or were capable of having children of their own, even if they had experienced multiple miscarriages or were suffering from "secondary" infertility (the inability to conceive after having one child) (Bellamy, 1993).

In the era before reproductive technologies, such as in vitro fertilization, infertility usually meant one of two things: permanent childlessness or adoption. In addition to being a qualification for adoptive parenthood, infertility was treated as a sensitive barometer of marital adjustment, a predictor of parental success, and a quality in need of interpretation (Pringle, 1966). Because not being able to have children was considered

just as abnormal as giving them away, infertility was at once a logical feature of adoption and a source of potential problems in new families and psychopathology in adopted children. *Shared Fate* (Kirk, 1981), was the first to make adoption a significant issue in the sociological literatures on family and mental health. Originally written in 1964, this first major theoretical treatment of adoption, made infertility the key to understanding adoption's social significance and cultural context.

In the United States, state legislatures began passing adoption laws in the nineteenth-century. The Massachusetts Adoption of Children Act, enacted in 1851, is widely considered the first "modern" adoption law. Adoption reform in other western industrial nations lagged (Aigner, 1986). Observers have frequently attributed the acceptance of adoption in the United States to its compatibility with cherished national traditions, from immigration to democracy. According to this way of thinking, solidarities achieved on purpose are more powerful, and more quintessentially American, than solidarities ascribed to blood (Aigner, 1986). Adoption has touched only a small minority of children and adults while telling stories about identity and belonging that include everyone.

During the twentieth century the numbers of adoptions increased dramatically in the United States. In 1900, formalizing adoptive kinship in a court was still very rare. By 1970, the numerical peak of twentieth-century adoption, 175,000 adoptions were finalized annually (Aigner, 1986). "Stranger" or "non-relative" adoptions have predominated over time, and most people equate adoption with families in which parents and children lack genetic ties (Pringle, 1966). Today, however, a majority of children are

adopted by natal relatives and step-parents, a development that corresponds to the rise of divorce, remarriage, and long-term cohabitation (Bellamy, 1993).

Conservative estimates (which do not include informal adoptions) suggest that five million Americans alive today are adoptees, 2-4 percent of all families have adopted, and 2.5 percent of all children under 18 are adopted (Bellamy, 1993). Accurate historical statistics about twentieth-century adoption are, unfortunately, almost impossible to locate. A national reporting system existed for only thirty years (from 1945 to 1975) and even during this period, data were supplied by states and territories on a purely voluntary basis (Winkler, Brown, van Keppel, & Blanchard, 1988).

It is known that adoptive kinship is not typical. Families touched by adoption are significantly more racially diverse, better educated, and more affluent than families in general. We know this because in 2000, “adopted son/daughter” was included as a census category for the first time in U.S. history. Since World War II, adoption has clearly globalized. From Germany in the 1940s, and Korea in the 1950s, to China and Guatemala today, countries that export children for adoption have been devastated by poverty, war, and genocide. Because growing numbers of adoptions are transracial and/or international, many of today’s adoptive families have literally made adoption more visible than it was in the past, although the total numbers of adoptions have actually declined since 1970. In recent years, approximately 125,000 children have been adopted annually by strangers and relatives in the United States (Bellamy, 1993).

Modern adoption history has been marked by vigorous reforms dedicated to surrounding child placement with legal and scientific safeguards enforced by trained professionals working under the auspices of certified agencies. In 1917, for instance,

Minnesota passed the first state law that required children and adults to be investigated and adoption records to be shielded from public view. By mid-century, virtually all states in the country had revised their laws to incorporate such minimum standards as pre-placement inquiry, post-placement probation, and confidentiality and sealed records. (Aigner, 1986)

Since 1950, a number of major shifts have occurred. The “adoptability” factor expanded beyond “normal” children to include older, disabled, non-white, and other children with special needs (Aigner, 1986). Since 1970, earlier reforms guaranteeing confidentiality and sealed records have been forcefully criticized and movements to encourage search, reunion, and “open adoption” have mobilized sympathy and support (Bellamy, 1993). The adoption “closet” has been replaced by an astonishing variety of adoption communities and communications. Adoption is visible in popular culture, grassroots organizations, politics, daily media, and on the internet.

Historical statistics on domestic adoptions during the twentieth century are interesting, but they are scarce and can also be misleading. Field studies did not even begin to estimate numbers of adoptions, or document who was being adopted by whom, until almost 1920. When researchers began to tally adoptions, they did so in only a handful of Northeastern and Midwestern states and based conclusions about statewide patterns on records from a few counties, usually in urban areas (Winkler, Brown, van Keppel & Blanchard, 1988). The Adoption and Safe Families Act of 1997 requires states to collect information about the adoptions of children in public foster care, but these are the only adoption-related statistics regularly reported by governments. Today, most

statistics available about adoption are being gathered by private organizations, such as universities and foundations.

One thing is known with certainty on the basis of historical statistics, adoptions were rare, even in the 1970s, at the height of their popularity. What is paradoxical is that adoptions have become rarer during the past several decades; just as they have become more visible. A total of approximately 125,000 children have been adopted annually in the United States in recent years, a sharp drop since the century-long high point of 175,000 adoptions in 1970 (Bellamy, 1993). A growing numbers of recent adoptions have been transracial and international, thus producing families in which parents and children look nothing alike. The attention attracted by these adoptive families has led many Americans to believe that adoption was increasing (Aigner, 1986). The adoption rate has actually been declining since 1970, along with the total number of adoptions.

Adoption history illustrates that public and private issues are inseparable. Ideas about blood and belonging, nature and nurture, and needs and rights are not the exclusive products of individual choices and personal freedoms. They have been decisively shaped by law and public policy and cultural change, which in turn have altered Americans' ordinary lives and the families in which they live and love (Rothenberg, et al., 1971).

### **Sealed Records**

The earliest statutes did not contain privacy provisions and until the early twentieth century adoption proceedings, including party names, were printed in newspapers. The first statutes providing any measure of privacy for the parties were passed in the early twentieth century and were aimed at removing the adoption process from the public record. The records were sealed to everyone except the parties and their

attorneys. There was no anonymity between the biological and adoptive parents, and indeed, many states required the birth parents to give their consent to the adoption in front of the adopting parents (Aigner, 1986). Anonymity was not an issue in adoptions until the 1920s. Prior to that, most judicially approved adoptions were frequently the result of informal or unsupervised placements in which few if any details were known or recorded about the child.

During the 1920s, professional social workers' organizations pushed for the sealing of adoption records. These organizations were advocating adoptions handled by agencies rather than private individuals. The purposes for this proposed shift in adoption trends were to provide greater integration of the adoptive family and greater separation between the adoptee and the biological family (Winkler, Brown, van Keppel, & Blanchard, 1988). Throughout the twenties many states allowed judges to exercise discretion whether or not to seal the records. Once the records were sealed, however, good cause was needed to gain access to the records. In 1917, the Minnesota adoption law was revised to mandate confidential records, and between the world wars, most states in the country followed suit. Confidential records placed information off limits to nosy members of the public but kept it accessible to the children and adults directly involved in adoption, who were called the "parties in interest" (Aigner, 1986). It was not until the late 1930s that New York sealed all adoption records and required the issuance of revised birth certificates. Eventually sealed records became the norm and support for the laws came from lawyers, psychologists, child welfare organizations and social workers (Ounsted, 1971).

The fact that adoption information has been both highly regulated and extremely controversial is one of the hallmarks of modern adoption. At first, sketchy and incomplete, data contained in the adoption records of early twentieth-century courts and agencies were available to anyone curious enough to search it out. The same was true of uniform birth records, which were products of state efforts to standardize birth registration during the first third of the twentieth century (Rothenberg et al., 1971).

Confidentiality was advocated by professionals and policy-makers determined to establish minimum standards in adoption, decrease the stigma associated with illegitimacy, and make child welfare the governing rule in placement decisions. In practice, confidentiality placed a premium on adoptions arranged anonymously, without any identifying contact between natural and adoptive parents. Confidentiality also meant that when courts issued adoption decrees, states produced new birth certificates, listing adopters' names, and sealed away the originals, which contained the names of birth parents, or at least birth mothers (Bellamy, 1993). To the adoptive parents the birth parent information might be confidential or anonymous. To the child the parent-child information about birth parents is anonymous.

Many adopters, especially those whose infertility made them long for exclusive parent-child ties, surely preferred anonymity as well. Confidentiality made it possible for some of these parents to avoid telling their children that they were adopted at all. The relatives of many unmarried birth mothers also favored confidentiality. This was especially true during the postwar baby boom, when more out-of-wedlock births occurred in middle-class families than had been the case earlier in the century. Mortified parents argued that their daughters should have a second chance to lead normal, married lives.

Maternity homes proliferated to shield non-marital pregnancies from public view and helped to make adoption a topic of embarrassment and shame (Bellamy, 1993).

Anonymity and new birth certificates were both consistent with matching, which set out to make new families that appeared to have been made naturally. Confidentiality was converted into secrecy only after World War II. Secrecy meant that even adult adoptees, to their great surprise and frustration, could not obtain information about their births and backgrounds. The intentions behind confidentiality were benevolent, but sealed records created an oppressive adoption closet (Rothenberg, et al., 1971).

Even though sealed records were recent inventions, rather than enduring features of adoption history, they were largely responsible for the adoption reform movement that gathered steam in the 1970s. New York housewife Florence Fisher set out to find her birth mother and inspired adoptees around the country when she founded the Adoptees' Liberty Movement Association, a pioneering reform organization that called sealed records "an affront to human dignity" (Bellamy, 1993, p. 43). Records activism attracted great sympathy but achieved relatively few practical victories and sealed records continue to provoke heated controversy today. Many states have established mutual consent registries, which aim for compromise between the rights of adult adoptees to obtain birth information and the assurance that many birth mothers were given that their identities would remain confidential to the authorities and anonymous to the child. Sealed records are also the target of militant activism by such groups as Bastard Nation, which succeeded in passing Ballot Measure 58, an open records law, in the state of Oregon (Sorosky, 1987).



Until 1945, however, most members of adoptive families in the United States had perfectly legal access to birth certificates and adoption-related court documents, and most agencies acted as passive registries through which separated relatives might locate one another. Disclosure, not secrecy, has been the historical norm in adoption.

### **Open vs. Closed Adoption**

Open Adoption is typically an adoption where birth parents and adoptive parents meet, names and addresses may be exchanged, and communication may continue indefinitely. Closed Adoption is an adoption in which confidentiality of both adoptive parents and birth parents are protected under the law and the courts seal all records. The information cannot be obtained by the child, which means that the information about names of birth parents is anonymous to the child.

Open, or fully disclosed, adoptions allow adoptive parents, and often the adopted child, to interact directly with birth parents. Open adoption falls at one end of an openness communication continuum that allows family members to interact in ways that feel most comfortable to them. In semi-open or mediated adoptions, information is relayed through a mediator (e.g., an agency caseworker or attorney) rather than through direct contact between the birth and adoptive families. In confidential adoptions, no identifying information is exchanged (Sorosky, 1987).

A client survey project by Open Adoption & Family Services (2003), called “Emotional Intelligence in Children of Open Adoption” found that 95% of birthmothers gave positive overall evaluations of their open adoptions and that 92% reported high levels of feeling respected and honored in their open adoption relationships.

Michigan's adoption law requires that adoption agencies, Family Independence Agency, and the probate courts maintain and release information from adoption records in their possession. In general, information from closed adoption records can be released to the adult adopted person, adoptive parents of a minor child, biological/former parent, and adult biological/former sibling. The type of information that can be released to the above referenced individuals varies. All individuals are entitled to receive nonidentifying information. It is the adult adopted person who may obtain identifying information, which would be dependent on certain circumstances. The type of information that can be released depends on the inquiring party and when the parental rights were terminated (Family Independence Agency, 2005). The birth parents, adult birth sibling, and the adoptive parents of a minor child would be able to receive non-identifying information only. Non-identifying information would include date, time and place of birth, health, psychological and genetic history of the child, including prenatal care. Additional non-identifying information would include race, ethnic and religious background and a general description of birth parents including age (Family Independence Agency). This information is already known to the birth mother, thus no new information is provided to her. Thus, many adoptees and birth families have turned to voluntary registries to receive additional information and potentially meet.

### **Adoption triad**

During much of the twentieth century, matching was the philosophy that governed non-relative adoption. Its goal was to make families socially that would “match” families made naturally. Matching required that adoptive parents be married heterosexual couples who looked, felt, and behaved as if they had, by themselves, conceived other people’s

children. What this meant in practice was that physical resemblance, intellectual similarity, and racial and religious continuity between parents and children were preferred goals in adoptive families. Matching was the technique that could inject naturalness and realness into a family form stigmatized as artificial and less real than the “real thing.” Matching stood for safety and security. Difference spelled trouble (Bellamy, 1993).

Under the matching paradigm, one family was substituted for another so carefully, systematically, and completely that the old family was replaced, rendered invisible and unnecessary (Pringle, 1966). This was not usually the case before the twentieth century. Children who were placed did not lose contact with their natal kin, even in the case of very young children placed permanently for adoption. The only matching required by early adoption laws was matching by religion. In the nineteenth century, many adoptions involved sharing children rather than giving them away (Rothenberg et al., 1971).

The naturalness of matching still has ardent defenders today, especially with regard to race. Since 1970, however, its dominance has been criticized by movements opposing confidentiality and sealed records. Transracial adoptions and international adoptions also challenge matching by celebrating families deliberately and visibly formed across lines of race, ethnicity, and nation. Open adoption arrangements undercut matching too. They acknowledge an obvious truth that matching concealed: it is possible to have more than one mother, one father, one family (Giddens, 1983).

Statistical studies have recently shown that a majority of birth parents before 1940 were married. This suggests that poverty, desertion, illness, and other family crises may

have been as significant as illegitimacy in leading to surrender and placement. But many adopters preferred illegitimate babies and toddlers and went out of their way to obtain them. They believed that the dishonorable origins of illegitimate children made it less likely that natural relatives would ever come back to claim them or interfere in their lives. Such views led to the charge early in the century that adoption encouraged illegitimacy (Aigner, 1986).

Birth parents who place children for adoption are expected to live a lie the rest of their lives. The adoption eliminates the public record of the child's birth, and the birth parents are counseled by family, friends and social agencies to go on with their lives as if the pregnancy never occurred. This socially sanctioned denial not only interferes with the resolution of grief, but intensifies the parents' poor self-image by reinforcing the idea that what they have done is so heinous that it must be concealed forever (van Keppel & Winkler, 1982).

### **Birthmother**

The term "birth parent" was embraced by adoption reformers in the 1970s. This terminology did not simply erase adoptive parents, or underline their secondary status, as older adoption terminology, such as "natural" or "real" parent, would have done (Bellamy, 1993). In practice, "birth parent" almost always meant "birth mother". In the public imagination, birth mothers were presumed to be unmarried women whose unrestrained sexuality violated an important cultural rule.

The research financed by the Institute of Family Studies has found that many mothers never get over the trauma of giving up their babies. The research also found that in at least 50% of the women studied, a deep sense of loss had never left them since the

time of relinquishment of their babies. In many of these mothers their sense of loss only got worse with time and in some cases lasted forty years (Winkler & van Keppel, 1984). Another study indicates that most women found it difficult to cope and some needed psychological help to come to terms with their sense of loss. Birth mothers in open and ongoing mediated adoptions do not have more problems with grief resolution; indeed, they show better grief resolution than those in closed adoptions. (Sorosky, 1987). Researchers did find that birth mothers in time-limited mediated adoptions (where contact stopped) had more difficulty resolving grief at the first interview of the study, when the children were between 4 and 12 years old (Kelly, 1999).

A variety of factors operated to impede the grieving process in these women. Their loss was not acknowledged by family and professionals, who denied them the support necessary for the expression of their grief. Intense anger, shame and guilt complicated their mourning, which was further inhibited by the fantasy of eventual reunion with their child. And lastly, many were too young to have acquired the ego strength necessary to grieve in an unsupported environment (Condon, 1986).

### **Unresolved grief, depression, psychological trauma, and general health**

Many birth mothers have reported extended periods of depression, anxiety, feeling suicidal, as well as alcohol and drug use, and poor physical health immediately following the relinquishment. In many instances the mother did not necessarily attribute these physical and emotional disturbances to the loss of her child, primarily because they had been led to believe they would not suffer and if they did, it would be short lived (Wolff, 1997).

A study of birthmothers demonstrates a very high incidence of pathological grief reactions which have failed to resolve although many years have elapsed since the relinquishment. This group had abnormally high scores for depression and psychosomatic symptoms on the Middlesex Hospital questionnaire (Condon, 1986). Recent studies continue to reflect that the relinquishment experience was a traumatic life event for the birthmother; birthmothers reported being misled or misinformed of the effects of relinquishment; and they did not receive adequate counseling at the time of the relinquishment (Kelly, 1999). The profound effects of the imposition of secrecy were a prominent theme in a post-survey discussion group. Additionally, the fact that a significant population of the survey participants had specific reproductive health concerns is a finding that merits further investigation (Kelly, 1999).

Trauma Theory states: "Unlike other forms of psychological disorders, the core issue in trauma is reality: 'It is indeed the truth of the traumatic experience that forms the center of its psychopathology; it is not a pathology of falsehood or displacement of meaning, but of history itself'" (Caruth, 1995, p. 122). However, the critical element that makes an event traumatic is the subjective assessment by victims of how threatened and helpless they feel. So, although the reality of extraordinary events is at the core of post traumatic stress disorder (PTSD), the meaning that victims attach to these events is as fundamental as the trauma itself. People's interpretations of the meaning of the trauma continue to evolve well after the trauma itself has ceased (van der Kolk, McFarlane, & van der Hart, 1996).

Serious attention is now being given to the trauma attached to the separation and loss of the mother and child through adoption, and the profound and long term effects this

can have on both of them. A survey conducted on 300 birthmothers suggested that the loss of their children constitutes a trauma which may be life long. Almost half of them say it had affected their physical health, and almost all say it affected their mental health. This in turn has affected their interpersonal relationships with family, partners and the parenting of subsequent children. In addition to the impact on their feelings about themselves and their lost children, birthmothers report still other kinds of consequences resulting from long ago adoptions. Some reveal that the psychic strain of living with such a secret over the years has taken a profound toll; consuming energies which might have otherwise have been put to more constructive educational, career oriented or other pursuits (Verrier, 1996).

Symptoms of Post Traumatic Stress Disorder manifest in birthmothers. Many birthmothers say they split themselves off from their trauma as a coping mechanism. This avoidance as a strategy is one of the key symptoms of PTSD, which may itself be caused by the trauma being internalized to avoid immediate pain. Many say they escaped into drugs and alcohol or precocious sexual activity, especially in the year or so after relinquishment. Most say they felt numb, shocked, empty, and sad and many said they felt the same way many years later (Wolff, 1997).

The adoption experience for most birthmothers leaves a large emotional scar. Most birthmothers express feelings of loss, pain, and mourning that remained undimmed with time (Sorosky, 1978). The pain of the experience was hard to bear. As time went by the pain did not diminish, it increased. It is reported that ninety percent of birthmothers surveyed felt deeply harmed by the adoption and the pain increased with time (Winkler & van Keppel, 1984). Research has found that birthmothers articulated deep suffering over

adoption (van Keppel & Winkler, 1982). Additional studies testify that ninety-five percent of the women studied found their loss shattering and worse than they imagined (Silverman, 1981). The effect of the pain felt by birthmothers manifests itself in many ways. Yet most birthmothers do not enter psychotherapy because they surrendered a child; they suppress that experience to the subconscious (Pannor, Baran & Sorosky, 1978). However, it often surfaces as the key to their inability to cope. Further studies of birthmothers who surrendered babies report depression as the most common emotional disorder. Sixty percent of those studied, reported medical, sexual, and psychiatric problems (Deykin, Campbell, Lee, & Patti, 1984). In another study 20 of 22 birthmothers sought psychotherapy for problems including depression alienation, physical complaints with no biological basis, sexual difficulties and difficulty making commitments (Simon & Senturia, 1966). An interview of fifty birthmothers found many were not aware until years later that they were grieving. They all described a sense of dissatisfaction. Additionally, the birthmothers list that they had become tearful, agitated, nervous and forgetful. (Silverman, 1981).

Birthmothers were not prepared for the aftermath of the surrender. They were told by the adoption professionals involved that it would be over soon; they would forget the experience; go on with their life and have more children. In time birthmothers do go on with the day-to-day tasks, but it proved impossible for most to pick-up where they left off before becoming pregnant. In *Lost and Found: The Adoption Experience*, Betty Jean Lifton (1996) describes what birthmothers were told. Birthmothers were told by social workers that they would soon forget the initial pain. Yet in reality they were forever altered by the experience and were not able to return to their previous lives as if nothing



had changed. Some birthmothers did marry and have other children. However, according to research, many did not have another child, 20% to 30% by choice, and others suffered a secondary infertility rate 170% higher than the general population. Ninety-six percent of birthmothers want a reunion (Deykin, et al., 1984).

### **Impact of Reunion**

Reunions are a way for healing through reconciliation. Still though, they can be very difficult. What rights and responsibilities does one have in a reunion? What does one do with intimate strangers? There are no relationships with which to compare a reunion (Geddiman & Brown, 1991; Verrier, 1996). Nevertheless, reunions are healing. The personal well-being, in both birth mothers and adoptees, is almost universally reported to be enhanced through a reunion (McColm, 1993). It can take years after a reunion for all the repressed emotions to surface. The reunitees must come to the acknowledgment that they can never regain what was lost. It takes years to undo all of the conditioning for what each one's expected role in adoption was (McColm, 1993). Before reunion, Birthmothers who were not able to attain information regarding the relinquished child demonstrated greater negative affects and poorer psychological health than the women who had minimal non-identifying information.(Field, 1992).

Women who give a child up for adoption are subject to a unique life stressor that has impact on their health. Research has demonstrated that in the long term relinquishing mothers are more susceptible to a variety of physical and emotional difficulties due to their experience of an on-going sense of loss. The literature portrays and supports relinquishment as having an effect on health related risks to birth mothers. Neuman Theory addresses the components of health, which include physiological, psychological,

sociocultural, developmental, and spiritual (Neuman & Fawcett. 2002). By increasing awareness, providing support services, and increasing availability of information, health care practitioners may provide better care for birthmothers.

### **Research Questions**

This study focuses on the long term impact of relinquishment on birthmothers; how the trauma of relinquishment manifests itself in birthmothers, and seeks to evaluate the differences of perception in an open versus closed adoption.

The following research questions are addressed:

1. Are there symptoms of depression, psychological trauma, and physical illness in women who have surrendered an infant via open or closed adoption?
2. Are there differences in symptoms of depression, psychological trauma, and physical illness between women who relinquished their child in an open adoption versus a closed adoption contact?
3. Are there differences in symptoms of depression, psychological trauma and physical illness between women who have current contact with their relinquished child and women who do not have current contact?

## Chapter IV

### Methodology

The research project is an exploration of perceived birthmother stigma from the perspective of women who have given a child up for adoption. A comparison of results between those women whose experience was with an open versus a closed adoption was investigated.

#### **SAMPLING/SETTING:**

The study participants were obtained from a convenience sample accessed through adoption agencies and organizations which facilitate adoptions or support groups. Inclusion criteria included the ability to read and write English in order to complete the survey instrument. An additional inclusion criterion to qualify was that the adopted child was surrendered at birth.

#### **DESIGN/PROCEDURE:**

Before beginning the data collection the principle investigator applied for and received project approval from Human Subjects Committee at the University of Michigan – Flint (Appendix A). The procedure for this research endeavor began with an initial contact via e-mail to the online adoption site to obtain permission to access the birthmother support group and approach potential research participants (Appendix B). Once permission was granted, an online solicitation stating the purpose and goals of the study (Appendix C), participant's rights and follow-up information was provided to the support group (Appendix D). Subjects were directed to a website where they were requested to fill out the research instruments. Participants were advised of their right to privacy and their right to decline or withdraw from participation at any time.

The research instruments included a demographic questionnaire (Appendix E), the Impact of Events Scale – Revised (IES-R) (Weiss & Marmar, 1997) (Appendix F), the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) (Appendix G), and the Medical Outcome Health Form Short Survey 36 (MOS-36) (Devilley, 2004) (Appendix H). The completed instruments were anonymously forwarded to a designated e-mail address. They were printed and coded 101 through 173.

## **INSTRUMENTS**

The original Impact of Events (IES) tool was written prior to the adoption of Posttraumatic Stress Disorder (PTSD) as a diagnosis in the DSM-III published in 1980 (Scott & Dua, 1999). It is a self-report measure designed to assess current subjective distress for any specific life event. The IES – Revised (IES-R) includes the subscales: intrusion, avoidance and hyperarousal symptoms as criteria for this diagnosis (Weiss & Marmar, 1997). The Beck Depression Inventory (BDI) is multiple choice format which measures presence and degree of depression. The Medical Outcomes Study (MOS) is a self reporting measurement of general health perceptions (Hays et al., 1995).

### **Reliability:**

In their IES-R study of 4 different population samples, Weiss and Marmar (1997) reported that the internal consistency of the 3 subscales was found to be very high, with intrusion alphas ranging from .87 to .92, avoidance alphas ranging from .84 to .86, and hyperarousal alphas ranging from .79 to .90 (Briere, 1997).

Internal consistency for the BDI ranges from .73 to .92 with a mean of .86. The BDI demonstrates high internal consistency, with alpha coefficients of .86 and .81 for psychiatric and non-psychiatric populations, respectively (Beck et al., 1961).

**Test-Retest Reliability:**

This is the assessment of the stability of an instrument by correlating the scores obtained on repeated administrations (Polit & Beck, 2004). Test-retest data were available for 2 of the samples in the IES-R Weiss and Marmar (1997) study. Data from sample 1 (n = 429) yielded the following test-retest correlation coefficients for the subscales: intrusion = .57, avoidance = .51, hyperarousal = .59. From sample 2 (n = 197) the correlation coefficients were considerably higher: intrusion = .94, avoidance = .89, hyperarousal = .92. It is believed that the shorter interval between assessments and the greater recency of the traumatic event for Sample 2 contributed to the higher coefficients of stability. Beck et al., (1961) did not recommend conventional test-retest reliability for his original measures for the BDI (1961).

**Criterion / Predictive Validity:**

Weiss and Marmar noted that the hyperarousal subscale has good predictive validity with regard to trauma (Briere, 1997). The intrusion and avoidance subscales, which are original IES components, have been shown to detect change in respondents' clinical status over time and detect relevant differences in the response to traumatic events of varying severity (Weiss & Marmar, 1997; Horowitz, Wilner & Alvarez, 1979). Predictive validity is the tool's ability to create specific data in the future. (Polit & Beck, 2004)

**Construct Validity:**

Weiss and Marmar (1997) utilized the item-to-subscale correlation with that item removed from the subscale generated by the standard alpha coefficient analyses. These

were then compared to the cross-subscale correlations. The results showed that only 1 item ("I had trouble falling asleep") showed a stronger relationship between it and a different subscale. The corrected correlation of this item with its assigned hyperarousal subscale was .71, and its correlation with the intrusion subscale was .79. Nineteen items showed a correlation with their assigned subscale that was higher than with the other subscales; and 2 items ("I had trouble staying asleep" and "I avoided letting myself get upset when I thought about it or was reminded of it") showed a correlation that was equal (Briere, 1997).

The explanations given by Weiss and Marmar (1997) for these results are that the 2 sleep items are very highly correlated, driving a relationship between them in terms of intrusion and hyperarousal; and as to the equal relationship of the avoidance item with the avoidance and intrusion subscales, this may have occurred because the presentation of the thought or the reminder invokes intrusion, and the not dealing with it invokes avoidance.

#### **DATA ANALYSIS:**

Data were entered and evaluated via SPSS. Data input and SPSS analysis was provided and overseen by the University of Michigan – Flint Statistical Consultant. Frequencies and t-tests were evaluated to provide background and support to research questions. The demographic data were calculated to provide means and frequencies. Further statistical analysis of the means utilized the t-test to determine differences of symptoms between women who relinquished via open or closed adoption and between women who have reunited and are still in contact with the adoptee and those who are not, with regard to the tools for depression (BDI), trauma (IES-R), and general health (MOS36).

## Chapter V

## Results

**DEMOGRAPHICS:**

There were 72 respondents who completed the survey. Participants had the option to not answer questions; some results reflect a less than 100% response rate as a result. All 72 survey respondents participating in this study had relinquished their infants to adoption during the years 1954 and 2004 (Table 1). Their mean age at the time of giving birth was 18; ages ranged from 14 to 35 (Table 1). The mean age of the birthmothers at the time of the interview was 45; ages ranged from 17 to 70 years of age (Table 1). Current relationship responses reflect 22.2% (n = 16) of the respondents were single, 51.4% (n = 37) were married, 18.1% (n = 13) divorced, 4.2% (n = 3) living with someone, 1.4% (n = 1) separated, and 1.4% (n = 1) widowed (Table 1). Of the 72 respondents, 25% (n = 18) did not have other children (Table 1).

Of the 71 responses, 84.7% (n = 61) had a closed adoption (Table 1) and 61.1% (n = 44) of those women have searched for their relinquished child (Table 1). Of the 68 responses 61.1% (n = 44) had been reunited with their child (Table 1). Of these women (69 responses) 62.5% (n = 45) were still in contact with the child (Table 1).

When asked about use of support services, 38.9% (n = 28) of the birthmothers had received psychotherapy because of the relinquishment (Table 1); 75% (n = 21) of whom responded that psychotherapy had helped (Table 1). Additionally, 43.1% (n = 31) of the birthmothers had participated in birthmother support groups (Table 1), of which 93% (n = 29) reported that it was helpful (Table 1). Table 1 reflects percentages based on total population (N = 72).

In addition, the survey provided a place where the participants could provide additional comments. There were 29 participants who provided additional comments. Topics addressed within that discussion space centered on their health, medications, and depression. Some stated that they felt their current health status was related to the relinquishment, while others felt that the illness was not associated with the adoption. The following is an excerpt from comments received: “As a result of my adoption experience I was diagnosed with major depressive disorder severe recurrent with psychotic symptoms. This was not done until 30 years after the experience. I was never given the opportunity after the birth to deal with my feelings. I was told never to mention the experience again from the day I came home from the unwed mothers’ home. This whole experience had definitely had an impact on my life. I am not friendly and do not have any friends. I currently see a psychiatrist about every month and take Wellbutrin XL and Seroquel. I have to take these medications for the rest of my life.”

**Demographic Results:**

Table 1: Demographic Results

N = 72	Mean	Standard Deviation	Range
In what year did you give birth?			1954-2004
How old were you when you gave birth?	18.72	3.15	14-35
What is your current age?	45.63	10.97	17-70
How many other children do you have?	1.54	1.20	0-5



n = 71	Frequency	Percent
What is your current relationship status?		
Single	16	22.2
Married	37	51.4
Divorced	13	18.1
Living with someone	3	4.2
Separated	1	1.4
Widowed	1	1.4

	Frequency	Percent
Have you raised any other children you have had?		
YES	54	75.0
NO	16	22.2
Was the adoption a closed adoption?		
YES	61	84.7
NO	9	12.5
Have you searched for your relinquished child?		
YES	44	61.1
NO	26	36.1
Have you been reunited with your relinquished child?		
YES	44	61.1
NO	24	33.3

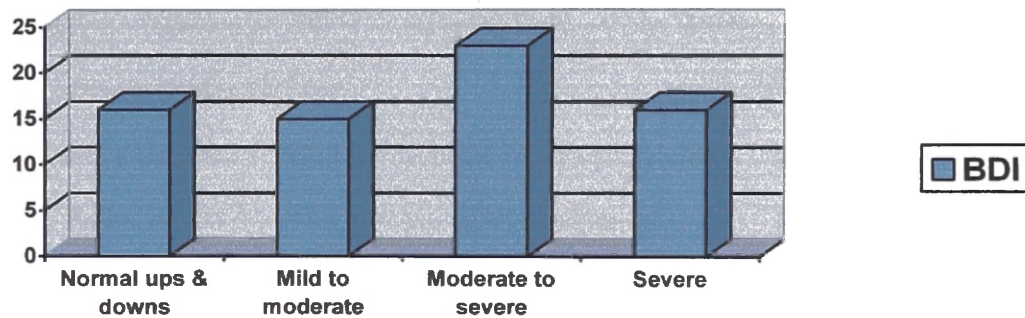
If yes, are you still in contact with your relinquished child?		
YES	45	62.5
NO	24	33.3
Have you received psychotherapy because of the relinquishment?		
YES	28	38.9
NO	44	61.1
If yes, did it help?		
YES	21	29.2
NO	9	12.5
Have you participated in any birthmother support groups?	Frequency	Percent
YES	31	43.1
NO	40	55.6
If yes, did it help?		
YES	29	40.3
NO	5	6.9

There are three instruments used in this research project; the Impact of Events Scale – Revised (IES-R) (Weiss & Marmar, 1997), the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Medical Outcome Health Form Short Survey 36 (MOS-36) (Devilley, 2004). Each tool provides a single number or a subset of numbers which determine symptoms of post traumatic stress syndrome

(PTSS)(IES-R), depression (BDI), and general health (MOS-36) as determined by the tool’s measurement or scale.

This study seeks to answer the question: #1. Are there symptoms of depression, psychological trauma, and physical illness in women who have surrendered an infant via open or closed adoption? Results of this study show a response of 16 out of 70 respondents are in category I, normal (23%); 15 in category II, mild to moderate depression (21%); 23 in category III, Moderate to severe depression (33%); and 16 in category IV, severe depression (23%). (Figure 2)

**Figure 2: Beck Depression Inventory (BDI) Score results of birthmother survey**



The Impact of Events Scale – Revised (IES-R) (Table 2) scoring method includes three subscales for Avoidance, Intrusions, and Hyperarousal. Interpretation of results is based on the sum total of all the subscales: minimum total score: 0; and maximum total score: 75. The higher the score reflects the greater the impact of the event. High scores on the impact of event scale after an event or injury is predictive of psychiatric morbidity and the post-traumatic stress disorder at 6 months after the event (Weiss & Marmar, 1997). For the assessment of posttraumatic stress disorder Weiss & Marmar (1997) assigned the following IES intrusion and avoidance clinical thresholds: less than 8.5

(low), 8.6-19.0 (medium), and greater than 19.0 (high). The mean score results for this study are avoidance: 13.72; intrusion: 16.18; hyperarousal: 9.59; and sum total: 39.45.

**Table 2: IES-R results of birthmother survey**

N = 72	Avoidance	Intrinsic	Hyperarousal	Sum Total
Minimum points possible	0	2	0	2
IES-R Results	13.72	16.18	9.59	39.45
Maximum points possible	28	32	24	77

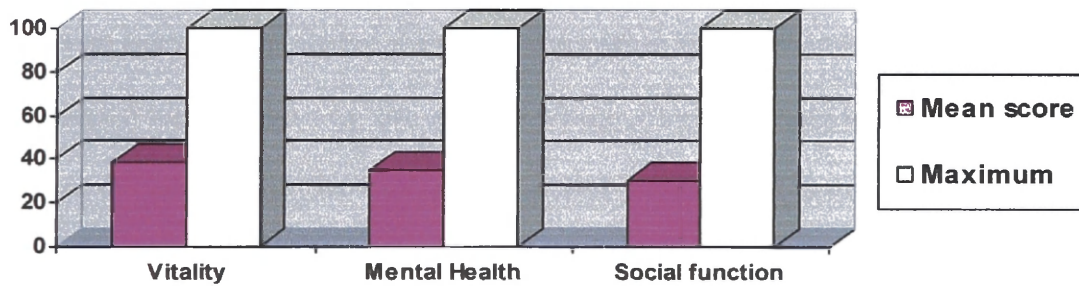
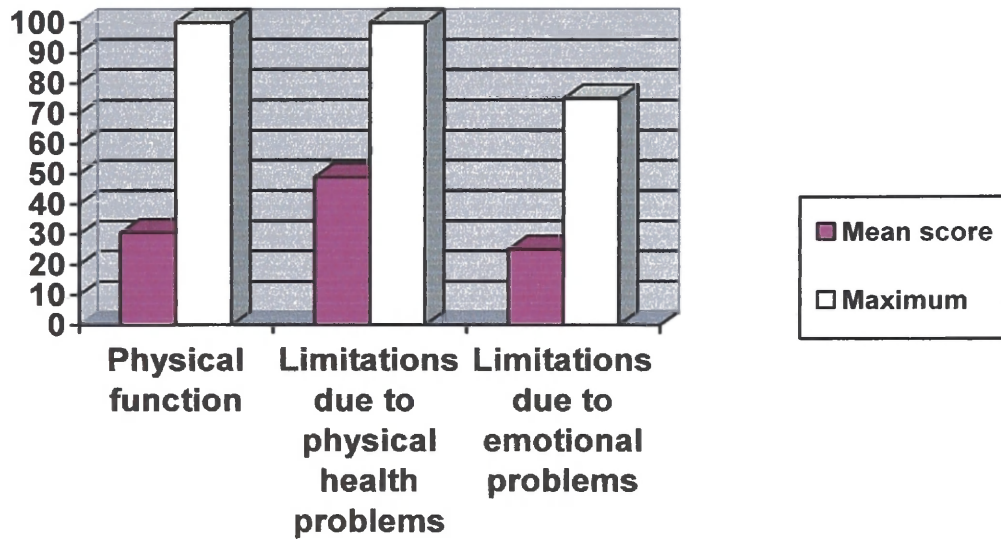
MOS-36 (Figure 3) results are based on a breakdown of the following subscales:

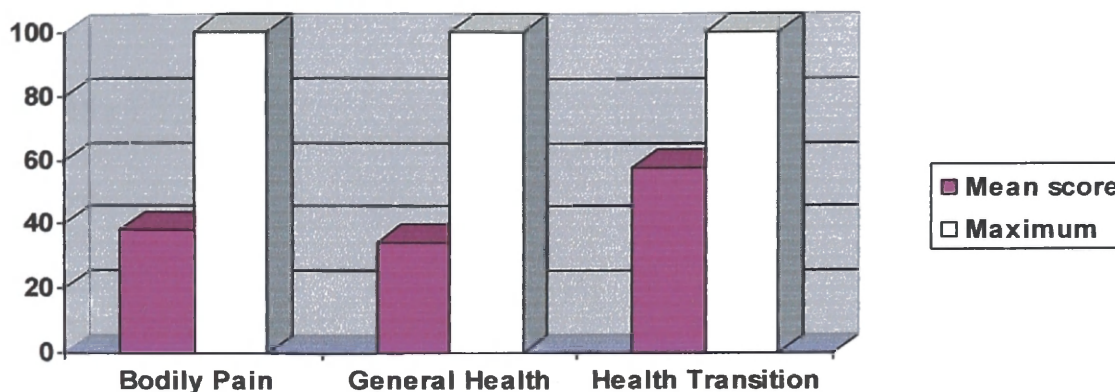
1. Physical functioning: Mean 71; SD ± 27
2. Role limitations due to physical health problems: Mean 12; SD ± 10
3. Role limitations due to emotional problems: Mean 8; SD ± 10
4. Vitality: Mean 36; SD ± 27
5. Mental health: Mean 51; SD ± 24
6. Social functioning: Mean 55; SD ± 26
7. Bodily Pain: Mean 62; SD ± 25
8. General health: Mean 55; SD ± 24
9. Health transition: Mean 58; SD ± 23

All of the scales are scored so that the least health has a value of 0 and the greatest health has value of 100. From these 8 scales a physical and mental component summary can be generated. Based on a 1990 general population survey from the National Opinion

Research Center, the average United States values for physical and mental component summary are 50 (Devilley, 2004).

**Figure 3: Medical Outcomes Scale – 36 (MOS-36) results of birthmother survey**

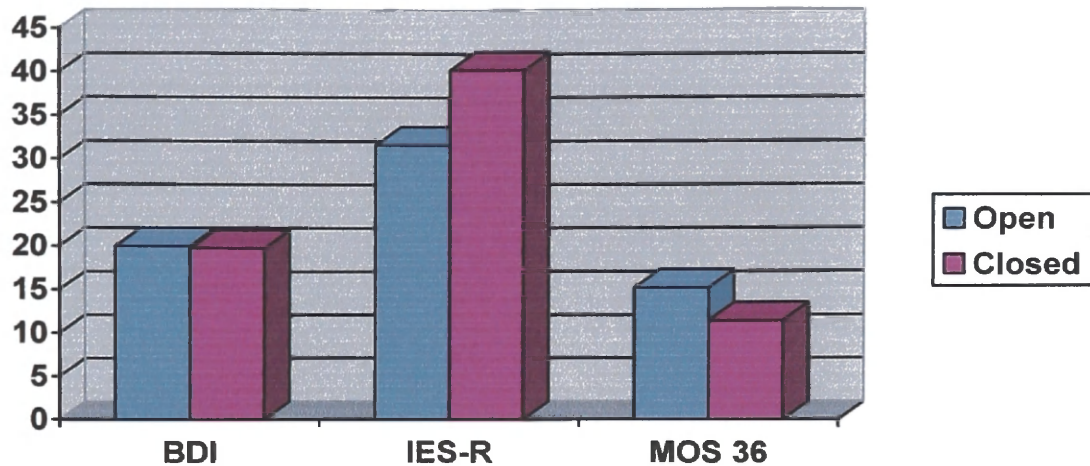




### GROUP STATISTICS

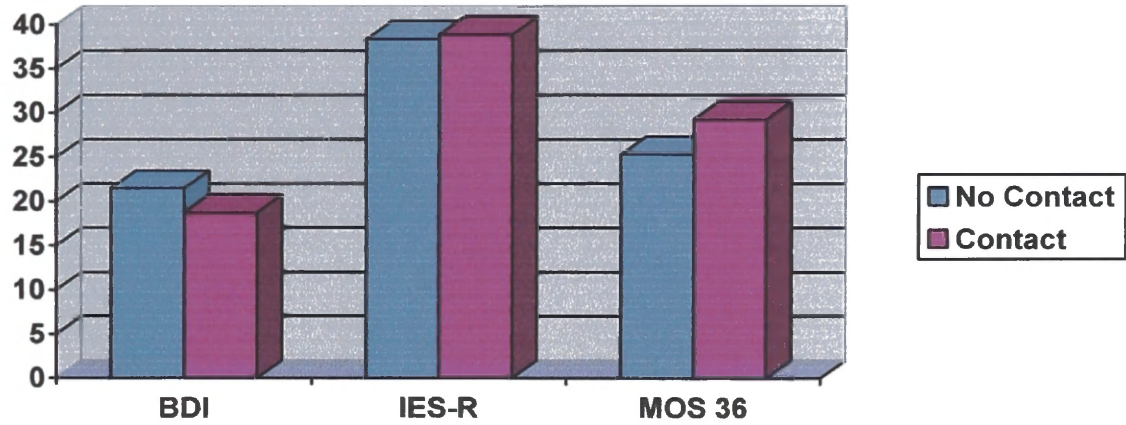
Question #2: Are there differences in symptoms of depression, psychological trauma, and physical illness between women who relinquished their child in an open adoption versus a closed adoption contact? T-tests were run to compare differences in symptoms of depression, psychological trauma and physical illness between women who participated in an open versus closed adoption. Results indicate differences on the trauma and general health scales for the women whose relinquishment was placed via a closed adoption (Figure 4). Higher BDI scores represent more symptoms of depression, higher IES-R scores reflect greater psychological trauma, and a lower MOS36 score denotes greater physical illness. Mean scores for the BDI were Open: 20.00 ( $t = 0.054$ ;  $df = 66$ ;  $p = 0.957$ ); Closed: 19.78, ( $t = 0.060$ ;  $df = 9.596$ ;  $p = 0.953$ ). Mean scores for the IES-R were Open: 31.63 ( $t = -1.127$ ;  $df = 63$ ;  $p = 0.264$ ); Closed: 40.23 ( $t = -1.263$ ;  $df = 9.854$ ;  $p = 0.236$ ). Mean scores for the MOS36 general health were Open: 15.2 ( $t = -1.364$ ;  $df = 66$ ;  $p = 0.177$ ); Closed: 11.4( $t = -1.095$ ;  $df = 8.089$ ;  $p = 0.305$ ).

**Figure 4: Open vs. Closed adoption comparison of BDI, IES-R, and MOS 36**



Question #3: Are there differences in symptoms of depression, psychological trauma and physical illness between women who have current contact with their relinquished child (Yes) and women who do not have current contact (No)? T-tests were run to compare differences in symptoms of depression, psychological trauma and physical illness between women who have current contact with their relinquished child and women who do not have current contact. Women with continued contact results reflect higher scores on the trauma (Figure 5). Higher scores represent more symptoms of depression and psychological trauma and a lower MOS36 score denotes physical illness. Mean scores for the BDI were No: 21.48 ( $t = 0.0997$ ;  $df = 65$ ;  $p = 0.322$ ); Yes: 18.77 ( $t = 0.974$ ;  $df = 41.939$ ;  $p = 0.336$ ). Mean scores for the IES-R were No: 38.33 ( $t = -0.098$ ;  $df = 62$ ;  $p = 0.922$ ); Yes: 38.86 ( $t = -0.108$ ;  $df = 51.093$ ;  $p = 0.915$ ). Mean scores for the MOS36 general health were No: 25.3 ( $t = -1.336$ ;  $df = 65$ ;  $p = 0.186$ ); Yes: 29.3 ( $t = -1.313$ ;  $df = 45.381$ ;  $p = 0.196$ ).

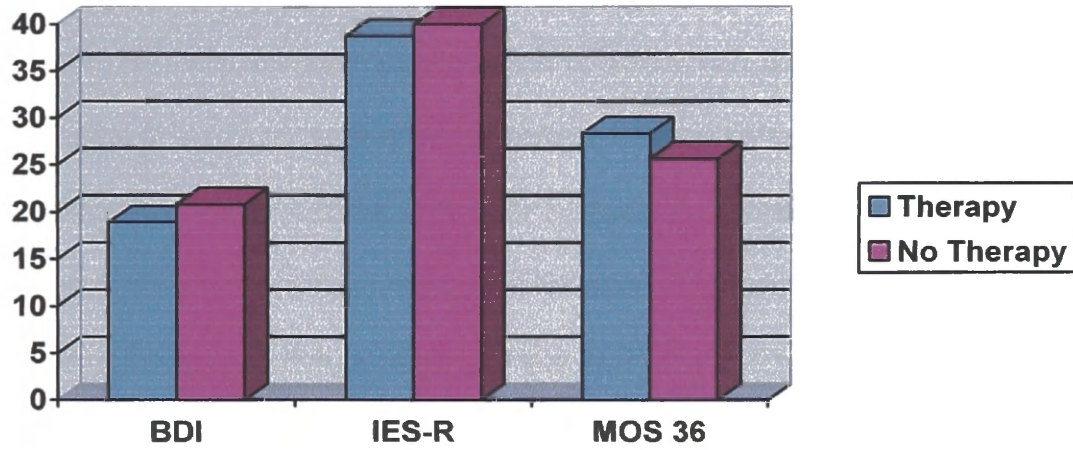
**Figure 5: Currently in Contact Mother – Child relationship vs. No Current Contact comparison of BDI, IES-R, and MOS 36 General Health scores**



Additionally, t-tests were run to compare differences in symptoms of depression, psychological trauma and physical illness between women who received psychotherapy (Yes) and those who did not (No). The women who had not received psychotherapy scored higher on all three scales (Figure 6). Higher scores represent more symptoms of depression and psychological trauma and a lower MOS-36 score denotes physical illness. Mean scores for the BDI were No: 20.83 ( $t = 0.757$ ;  $df = 68$ ;  $p = 0.452$ ); Yes: 18.89 ( $t = 0.739$ ;  $df = 53.156$ ;  $p = 0.463$ ). Mean scores for the IES-R were No: 39.95 ( $t = 0.245$ ;  $df = 64$ ;  $p = 0.807$ ); Yes: 38.69 ( $t = 0.251$ ;  $df = 58.076$ ;  $p = 0.802$ ). Mean scores for the MOS36 were No: 28.3 ( $t = 0.916$ ;  $df = 68$ ;  $p = 0.363$ ); Yes: 25.7 ( $t = 0.881$ ;  $df = 50.203$ ;  $p = 0.383$ ).



**Figure 6: Psychotherapy vs. No Psychotherapy for the relinquishment  
comparison of BDI, IES-R, and MOS 36 General Health scores**



## Chapter VI

**Discussion**

The main use of the Neuman Model in practice and in research is that its concentric layers allow for a simple classification of how severe a problem may be. For example, since the line of normal defense represents dynamic balance, it represents homeostasis, and thus a lack of stress. If a stress response is perceived by the patient, then there has been an invasion of the normal line of defense and a major contraction of the flexible line of defense. Infection or other invasion of the lines of resistance indicates failure of both lines of defense. Thus, the level of insult can be quantified allowing for graduated interventions. (Neuman & Fawcett, 2002)

This study investigated the relationship of multiple role stress to the psychological and socio-cultural variables of the flexible line of defense. If multiple role stress had occurred, then the normal line of defense had been invaded. Questionnaire instruments were used to operationalize the psychological component with perceived role as being a birthmother; the socio-cultural component with social support, the normal line of defense as being perceived multiple role stress. (Neuman & Fawcett, 2002)

Upon analysis, conclusions could be made about the normal line of defense based upon the psychological component and socio-cultural component. By dichotomizing the data of open vs. closed adoption and continued relationships vs. no relationship, however, further correlations could not be described. Thus the relationship between the normal line of defense and the psychological and sociocultural components could only be described by taking into account the developmental component. It indicates that the components of

the flexible line of defense interact in very complex ways and it may be difficult to over generalize their interaction.

With regard to Question #1: Are there symptoms of depression, psychological trauma, and physical illness between women who participated in an open versus closed adoption? Results of this study show a response of 16 out of 70 respondents are in category I, normal (23%); 15 in category II, mild to moderate depression (21%); 23 in category III, Moderate to severe depression (33%); and 16 in category IV, severe depression (23%) (Beck, et al., 1961). From this it can be interpreted that indeed some women who have participated in adoption as a birthmother do have symptoms of depression. Recall the average United States values for physical and mental component summary are 50 (Devilley, 2004), which indicates the women in the sample are above the national mean and have more physical illnesses.

Additionally, the themes discovered in the comment section of the survey suggest that the birthmothers whom were aware of their symptoms of depression, trauma, and/or health concerns were interpreting their symptoms to be related to the event of relinquishment. The contributory effects of the initial loss, subsequent years of avoidance, and grief or unresolved grief due to secrecy are reflective of the Neuman Model where the stress perceived by the birthmother has impact on her health. There were 29 women who chose to provide additional comments to the survey. All 29 listed some concern related to depression, trauma, or physical health. Twenty women felt there was a direct correlation to their health and the relinquishment (i.e.: "I was on anti-depressants for several years, several times. I should now go and seek medical attention but feel why bother? I do not want to take medication for the rest of my life!!! My life

will never be the same.”), six did not state any correlation (i.e.: “I suffer with fibro, depression, PTSD and a number of day to day issues due to physical and mental problems.”), and three specifically felt that their illness was not due to the relinquishment (i.e.: “My comments regarding my health have to do with a damaged shoulder and nothing to do with the adoption.”).

Question #2: T-tests were run to compare differences in symptoms of depression, psychological trauma, and physical illness between women who participated in an open versus closed adoption. Results reflect higher scores on the trauma and general health scales for the women whose relinquishment was placed via a closed adoption. Higher BDI and IES-R scores represent more symptoms of depression and psychological trauma and a lower MOS36 score denotes physical illness. The mean scores and resulting probability (p) values were not statistically significant. From these results no relationship of differences in symptoms of depression, psychological trauma and physical illness between women who participated in an open versus closed adoption can be determined.

Question #3: T-tests were run to compare differences in symptoms of depression, psychological trauma and physical illness between women who have current contact with their relinquished child and women who do not have current contact. Results from women with continued contact reflect greater symptoms of depression, than those women who do not. The mean scores and resulting p values were not statistically significant. From these results no relationship of differences in symptoms of depression, psychological trauma, and physical illness between women who have current contact with their relinquished child and women who do not have current contact can be determined.

The survey responses and the additional comments provided by participants pointed to the relinquishment of a child as a traumatic life event associated with enduring effects on the birthmother. While it is unclear what percentage of birthmothers are traumatized by relinquishment, evidence supports that for many, the magnitude and extent of the psychological effects of relinquishment are far-reaching.

The findings of this research are consistent with the information reviewed from existing literature describing the effects of the birthmothers' unresolved grief. This study explores the birthmothers' current perceptions of how their choice to relinquish has affected their health. Measurements of depression, trauma, and areas of physical well being were utilized and attempted to identify how her sorrow might be currently manifested in her life. While this study does not explicitly explore whether or not they feel resolved about the losses they have suffered, many of the additional comments provided this insight. Existing studies of the birthmother confirm overwhelmingly that there are long-enduring effects of having experienced the loss of a child to adoption (Deykin, Campbell & Patti, 1984; Gediman & Brown, 1991; Rothenberg, Goldey & Sands, 1971; Sorosky, Baran & Pannor, 1984; Stiffler, 1991).

One of the pioneer studies about the post-adoption experience of the birthmother was conducted by Deykin, Campbell and Patti (1984). They determined that those unhealed losses manifested themselves in areas of troubled, failed or multiple marriages, infertility, struggles with parenting, and low self-worth. Stiffler (1991) suggests the birthmother may experience emotional numbness, a sense of powerlessness and emptiness, and may suffer from low self-esteem. She can be wrought with feelings of guilt, shame, and anger, and may suffer from anxiety, depression, agoraphobia, eating

disorders, or chemical dependency. Whatever her circumstances, she has neither forgotten, nor stopped loving her child, and her grieving is a potentially life-long process (Stiffler, 1991).

One study estimates that one out of fifty women living in the Western World has chosen to relinquish her child for adoption (Stiffler, 1991). Because of the social stigma attached to relinquishing a child, it has been accepted practice to encourage the birthmother to bury the experience and to quickly "get on with her life" (Gediman & Brown, 1991). The general agreement among those who offer suggestions for healing is to assist the birthmother to free herself from the secrecy with which she has lived, to validate her feelings and express her denied emotions, to create rituals for grieving, to develop new relationships with supportive people, to participate in support groups with other birthmothers, and, if she feels the need after her healing has begun, to search for her child (Gediman & Brown, 1991; Panuthos & Romeo, 1984; Roles, 1989a, 1989b; Stiffler, 1991).

This magnitude of loss is difficult for a birthmother to overcome. For those who seek help, it is up to the mental health and medical practice to give them the permission and tools for grieving that they have long been denied. Continued research about how deeply the birthmother has been affected by the relinquishment of her child will help society become more aware about how to deal with adoption in the future. Since the literature falls short of providing suggestions for services for birthmothers who want to heal, the next step is to raise the consciousness within the medical community about her needs and create services for her recovery.

## LIMITATIONS AND ALTERNATIVE EXPLANATIONS

While the study explores depression, trauma and health effects of birthmothers, alternative explanations for the findings exist. Comments provided by the participants' reveal that they have experienced other losses of close family members, and could mirror or exacerbate effects attributed to loss. Participants may be in various stages of reunion with their relinquished child, which is a stressor that would affect study results. There are questions in the demographics that were not asked which would impact the results as well. It may be significant to know if the birthmother searched or the relinquished child searched in the cases where a reunion exists and if the meeting was wanted by the birthmother.

Missing demographic information is also a limitation for this study. Further analysis could have been beneficial and had impact on the results. The wording of the questions seemed to come across as negative to some participants. Myself a birthmother and perhaps biased, another limitation, the use of already existing tools, was deliberately sought out to avoid increasing measurement error. I had also listed the tool titles on the survey, which led to an interpretation that I am looking for negatives (i.e. depression and trauma). Additional limitations include computer HTML complications, data input errors and resulting effect on interpretation of data and time allotted for collection of surveys. Additional time to collect the data would have greatly increased the response to the surveys. The internet has a method of updating search engines to determine websites appropriate to requests. My website did not come up in the returns for inquiries into birthmothers. Today, now that the major search engines have had time to update, my website comes up as the first option; unfortunately the time of collection has lapsed.

Finally, the limitation of unequal population of participants is due partially to the randomness of an internet research project and partially due to the support groups that were contacted and asked to participate. This study used biased samples of women who have self-selected by volunteering to report. I would avoid these errors and limitations in future studies that I would undertake in this area.

### **IMPLICATIONS FOR PRACTICE**

Misinformation held by social workers, mental health specialists and primary care providers concerning the effects of relinquishment may contribute to the pathologization of the birthmother, inadequate services, and inappropriate treatment plans. Birthmothers may suffer from a chronic stress syndrome associated with the relinquishment. As research continues in the area of the mind-body connection, the impact of stress and/or trauma on health is of prominent interest.

There is a growing need for primary care providers to be trained in the special needs of the adoption triad. Practitioners must examine their own assumptions and belief systems concerning relinquishment. It is essential that birthmothers be permitted to tell their stories in a nonjudgmental setting. According to one birthmother's experience, "I've had recurrent depression since the relinquishment. [I have had] Three serious depressions as an adult. Two of those required me to be off work. [I am] Currently not on medication. I've not had a serious depression in 10 years. Last one was in the second year of our reunion. Reunion has made a HUGE difference. The main effect on my life of relinquishment has been the amount of energy taken up just coping with the experience and the loss. For years even counselors & psychiatrists informed me that the



relinquishment couldn't be the cause of my problems--had to be childhood stuff rather than the loss of my first child. Amazing that they could not see that event as traumatic!"

Clearly, health care providers must be sensitive to the depth of the trauma and the shame that birthmothers may have been subjected to. Understanding the implications and assumptions imbedded within the language of adoption and relinquishment may also facilitate the therapeutic relationship between primary care provider and birthmother.

### **FUTURE RECOMMENDATIONS**

Further studies regarding impact of relinquishment on birthmothers are recommended. It would be pertinent to identify factors associated with birthmothers' unresolved grief resulting from the relinquishment of their children for adoption. This could lead to further exploration into issues related to family of origin, relinquishment experience, self regard, marriage and intimate relationships, fertility and sexuality, parenting, and relationship with the relinquished children. Future studies could include longitudinal studies to determine if time has effect on variables, interventional studies to determine positive and/or negative impact of support services, comparison of triad responses to study and determine need for supportive services, and a follow up study in 20 years to compare open adoption responses to closed adoption responses after similar time expanses.

It is time to recognize the psychological and social barriers that the birthmother perceives to have impact on the relinquishment experience. Many researchers have noted the scarcity of research that exists on birthmothers. As adoption continues and reunions increase the need for informed counseling, preventative counseling, and education will

also increase. Nurse practitioners can be pivotal to addressing this need in the medical community.

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APPENDIX A

APPROVAL LETTER FROM HUMAN SUBJECTS COMMITTEE



THE UNIVERSITY OF MICHIGAN-FLINT

OFFICE OF RESEARCH  
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UNIVERSITY OF MICHIGAN – FLINT  
Human Subjects Review

November 2, 2004

To: Thomas Schaal, Ph.D.  
Nursing Department

From: Marianne McGrath, Chair, Human Subjects Committee

A handwritten signature in black ink, appearing to be "MM", written over the name Marianne McGrath.

Re: Differences In Feelings Of Depression, Psychological Trauma And Physical  
Illness In Women Who Have Surrendered An Infant Via Open Or Closed  
Adoption (Approval #29/04)

This is to inform you that the human subjects review and approval requested for "Differences In Feelings Of Depression, Psychological Trauma And Physical Illness In Women Who Have Surrendered An Infant Via Open Or Closed Adoption" has been approved by the Human Subjects Committee. Should you wish to make any changes in the use of human subjects which differ from the recent amendments or original approved proposal, you must inform this committee prior to making these changes. If you are seeking funding for this proposal, it is your responsibility to ensure that your proposed use of human subjects in your funding application is consistent with that approved by this memo.

This approval for your project is valid for a period of twelve months. If your project extends beyond this period (twelve months), please re-submit your proposal for consideration.



Appendix B

Letter to Online Site Moderator

Dear Site Moderator:

I am contacting you in hopes of receiving permission to post a research based website to your Online Birthmother Support Group. I am conducting a study to compare feelings of depression, psychological trauma and physical illness related to birthmothers, women who have surrendered their infant to open or closed adoption. This study is part of a Master of Science in Nursing Thesis project for the Family Nurse Practitioner program at University of Michigan – Flint. I am hoping to gather information to enable health care providers to better screen for complications associated with birthmother trauma and allow for a more holistic health care model.

The survey is available online at:

[http://www.geocities.com/bmomsurvey/Birthmother\\_Survey.html](http://www.geocities.com/bmomsurvey/Birthmother_Survey.html)

Please feel free to review the site to determine if I may have permission to invite members of your online support service to participate in the survey. Thank you for your consideration regarding this request.

Sincerely,

Sandra Mens Manssur  
University of Michigan – Flint  
School of Nursing  
Flint, Michigan 48504  
(810) 762-3420  
[SMens@UMFlint.edu](mailto:SMens@UMFlint.edu)

Appendix C

Letter to Potential Subjects

Dear Survey Participant,

I am conducting a study to compare feelings of depression, psychological trauma and physical illness related to birthmothers, women who have surrendered their infant to open (ongoing relationship) or closed (no contact or ongoing relationship) adoption. This study is part of a Master of Science in Nursing Thesis project for the Family Nurse Practitioner program at University of Michigan – Flint. I am hoping to gather information to enable health care providers to better screen for complications associated with birthmother trauma and allow for a more holistic health care model. Would you please assist me in this study by filling out a questionnaire and survey? Your experiences are very important to me and will help establish a basis for communication with health care professionals regarding this topic.

Your participation is anonymous and completely voluntary. You are free to not answer any questions or not participate. There is no compensation for your participation. Your participation would only require this one time evaluation. Completion of the questionnaire and survey will take approximately 30 minutes. I would appreciate your completed forms by January 31, 2005.

Thank you very much for your participation in this study. Group data and results of the study will be posted on this website. Individual result will not be posted as the survey process is completely confidential and your anonymity is ensured. Please feel free to contact me at any point with questions or concerns regarding this project.

Sincerely,

Sandra Mens Manssur  
University of Michigan – Flint  
School of Nursing  
Flint, Michigan 48504  
(810) 762-3420  
[SMens@UMFlint.edu](mailto:SMens@UMFlint.edu)

Survey available online at:

[http://www.geocities.com/bmomssurvey/Birthmother\\_Survey.html](http://www.geocities.com/bmomssurvey/Birthmother_Survey.html)

Appendix D

Letter to Participant Post Survey

Thank you - Survey is received

Thank you for your interest and participation in the study. Your involvement in this research may assist in learning about health issues related to birthmother trauma and be of future help to others in this position. I understand that questions related to your relinquishment may be stressful. It is this researcher's goal to provide support as needed. To this end, the survey is presented within the support group environment. I have also included additional networks for birthmothers should you choose to seek out additional support. I am also willing to make myself available to discuss concerns. I am a registered nurse, an experienced moderator for birthmother support groups and myself a birthmother. Please feel free to contact me via the address provided below:

Sandy Mens Manssur  
University of Michigan – Flint  
Department of Nursing  
Flint, Michigan 48504  
(810) 762-3420  
SMens@UMFlint.EDU

Internet birthmother support services:

Birthmother Support

[www.bmom.net/](http://www.bmom.net/)

[www.birthmother.com/](http://www.birthmother.com/)

[www.angelfire.com/tx/AdoptionSearch](http://www.angelfire.com/tx/AdoptionSearch)

[www.birthparentforum.org/aboutus.htm](http://www.birthparentforum.org/aboutus.htm)

\*I have not utilized all the services listed. They are provided for informational purposes.

Survey results will be made available after May 31, 2006 at  
[http://www.geocities.com/bmomsurvey/Birthmother\\_Survey.html](http://www.geocities.com/bmomsurvey/Birthmother_Survey.html)

Appendix E

Demographics

**BIRTHMOTHER RESEARCH DEMOGRAPHIC QUESTIONNAIRE**

**INSTRUCTIONS:** Below are some questions which will help us to understand the information provided by participants. Please supply the information in the space provided. For "Yes/No" responses, please circle your response.

1. In what year did you give birth? \_\_\_\_
2. How old were you when you gave birth? \_\_\_\_
3. What is your current age? \_\_\_\_
3. What is your current relationship status?
  - Single
  - Married
  - Divorced
  - Living with someone
  - Separated
  - Widowed
4. How many other children do you have? \_\_\_\_
5. Have you raised any other children you have had? YES NO
6. Was the adoption a closed adoption? YES NO
7. Have you searched for your relinquished child? YES NO
8. Have you been reunited with your relinquished child? YES NO
9. If yes, are you still in contact with your relinquished child? YES NO
10. Have you received psychotherapy because of the relinquishment? YES NO
11. If yes, did it help? YES NO
12. How long were you in therapy?
13. Have you participated in any birthmother support groups? YES NO
14. If yes, did it help? YES NO



Appendix F

IMPACT OF EVENTS SCALE - REVISED

**IMPACT OF EVENTS SCALE - REVISED**

**INSTRUCTIONS:** Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to surrendering a child to adoption. How much were you distressed or bothered by these difficulties?

		Not at All	A little bit	Moderately	Quite a bit	Extremely
1.	Any reminder brought back feelings about it.....	0	1	2	3	4
2.	I had trouble staying asleep.....	0	1	2	3	4
3.	Other things kept making me think about it.....	0	1	2	3	4
4.	I felt irritable and angry.....	0	1	2	3	4
5.	I avoided letting myself get upset when I thought about it or was reminded of it.....	0	1	2	3	4
6.	I thought about it when I didn't mean to.....	0	1	2	3	4
7.	I felt as if it hadn't happened or wasn't real.....	0	1	2	3	4
8.	I stayed away from reminders about it.....	0	1	2	3	4
9.	Pictures about it popped into my mind.....	0	1	2	3	4
10.	I was jumpy and easily startled.....	0	1	2	3	4
11.	I tried not to think about it.....	0	1	2	3	4

12.	I was aware that I still had a lot of feelings about it, but I didn't deal with them.....	0	1	2	3	4
13.	My feelings about it were kind of numb.....	0	1	2	3	4
14.	I found myself acting or feeling like I was back at that time.....	0	1	2	3	4
		<b>Not at all</b>	<b>A Little Bit</b>	<b>Moderately</b>	<b>Quite a Bit</b>	<b>Extremely</b>
15.	I had trouble falling asleep.....	0	1	2	3	4
16.	I had waves of strong feelings about it.....	0	1	2	3	4
17.	I tried to remove it from my memory.....	0	1	2	3	4
18.	I had trouble concentrating.....	0	1	2	3	4
19.	Reminders of it caused me to have physical reactions such as sweating, trouble breathing, nausea, or a pounding heart.....	0	1	2	3	4
20.	I had dreams about it.....	0	1	2	3	4
21.	I felt watchful or on-guard.....	0	1	2	3	4
22.	I tried not to talk about it.....	0	1	2	3	4

Appendix G

Beck Depression Inventory

**BECK DEPRESSION INVENTORY**

**INSTRUCTIONS:** This questionnaire consists of 21 group statements. After reading each group of statements carefully, choose the number (0, 1, 2, or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, choose each one. Be sure to read all the statements in each group before making your choice.

1.     0        I do not feel sad.  
       1        I feel sad.  
       2        I am sad all the time, and I cannot snap out of it.  
       3        I am so sad or unhappy that I cannot stand it
  
2.     0        I am not particularly discouraged about the future.  
       1        I feel discouraged about the future.  
       2        I feel I have nothing to look forward to.  
       3        I feel that the future is hopeless and that things cannot improve.
  
3.     0        I do not feel like a failure.  
       1        I feel I have failed more than the average person.  
       2        As I look back on my life, all I can see is a lot of failures.  
       3        I feel I am a complete failure as a person.
  
4.     0        I get as much satisfaction out of things as I used to.  
       1        I do not enjoy things the way I used to.  
       2        I do not get real satisfaction out of anything any more.  
       3        I am dissatisfied or bored with everything.
  
5.     0        I do not feel particularly guilty.  
       1        I feel guilty a good part of the time.  
       2        I feel quite guilty most of the time.  
       3        I feel guilty all of the time.
  
6.     0        I do not feel I am being punished.  
       1        I feel I may be punished.  
       2        I expect to be punished.  
       3        I feel I am being punished.
  
7.     0        I do not feel disappointed in myself.  
       1        I am disappointed in myself.  
       2        I am disgusted with myself.  
       3        I hate myself.
  
8.     0        I do not feel I am any worse than anybody else.  
       1        I am critical of myself for my weaknesses or mistakes.  
       2        I blame myself all the time for my faults.  
       3        I blame myself for everything bad that happens.
  
9.     0        I do not have any thoughts of killing myself.  
       1        I have thoughts of killing myself, but I would not carry them out.  
       2        I would like to kill myself.  
       3        I would kill myself if I had the chance.
  
10.    0        I do not cry any more than usual.  
       1        I cry more now than I used to.  
       2        I cry all the time now.  
       3        I used to be able to cry, but now I cannot cry even though I want to.

11. 0 I am no more irritated now than I ever am.  
 1 I get annoyed or irritated more easily than I used to.  
 2 I feel irritated all the time now.  
 3 I do not get irritated at all by the things that used to irritate me.
12. 0 I have not lost interest in other people.  
 1 I am less interested in other people than I used to be.  
 2 I have lost most of my interest in other people.  
 3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.  
 1 I put off making decisions more than I used to.  
 2 I have greater difficulty in making decisions than before.  
 3 I cannot make decisions at all anymore
14. 0 I do not feel I look any worse that I used to.  
 1 I am worried that I am looking old or unattractive.  
 2 I feel that there are permanent changes in my appearance that make me unattractive.  
 3 I believe that I look ugly.
15. 0 I can work about as well as before.  
 1 It takes an extra effort to get started at doing something.  
 2 I have to push myself very hard to do anything.  
 3 I cannot do any work at all.
16. 0 I can sleep as well as usual.  
 1 I do not sleep as well as I used to.  
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.  
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I do not get more tired than usual.  
 1 I get tired more easily than I used to.  
 2 I get tired from doing almost anything.  
 3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.  
 1 My appetite is not as good as it used to be.  
 2 My appetite is much worse now.  
 3 I have no appetite at all anymore.
19. 0 I have not lost much weight, if any, lately.  
 1 I have lost more than 5 pounds.  
 2 I have lost more than 10 pounds.  
 3 I have lost more than 15 pounds.  
 I am purposely trying to lose weight by eating less. \_\_\_\_\_ yes \_\_\_\_\_ no
20. 0 I am no more worried about my health than usual.  
 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.  
 2 I am very worried about physical problems and it is hard to think of much else.  
 3 I am so worried about my physical problems that I cannot think about anything else.
21. 0 I have not noticed any recent change in my interest in sex.  
 1 I am less interested in sex that I used to be.  
 2 I am much less interested in sex now.  
 3 I have lost interest in sex completely.

Appendix H

Medical Outcomes Survey

**Medical Outcome Short Form (36) Health Survey**

**INSTRUCTIONS:** This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please pick one box.)
  - Excellent
  - Very good
  - Good
  - Fair
  - Poor
  
2. Compared to one year ago, how would you rate your health in general now? (Please pick one box)
  - Much better than one year ago
  - Somewhat better now than one year ago
  - About the same as one year ago
  - Somewhat worse now than one year ago
  - Much worse now than one year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Please circle one number on each line.)

	ACTIVITIES	YES, LIMITED A LOT	YES, LIMITED A LITTLE	NOT LIMITED AT ALL
3(a)	VIGOROUS ACTIVITIES, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b)	MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c)	Lifting or carrying groceries	1	2	3
3(d)	Climbing SEVERAL flights of stairs	1	2	3
3(e)	Climbing ONE flight of stairs	1	2	3
3(f)	Bending, kneeling, or stooping	1	2	3
3(g)	Walking MORE THAN A MILE	1	2	3
3(h)	Walking SEVERAL BLOCKS	1	2	3
3(i)	Walking ONE BLOCK	1	2	3
3(J)	Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?  
(PLEASE CIRCLE ONE NUMBER OF EACH LINE.)

		YES	NO
4(a)	Cut down on the AMOUNT OF TIME you spent on work or other activities	1	2
4(b)	Accomplished less than you would like	1	2
4(c)	Were LIMITED in the KIND of work or other activities	1	2
4(d)	Had DIFFICULTY performing the work or other activities (for example, it took extra effort)	1	2

5. During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious?)  
PLEASE CIRCLE ONE NUMBER ON EACH LINE

		YES	NO
5(a)	Cut down on the AMOUNT OF TIME you spent on work or other activities	1	2
5(b)	Accomplished less than you would like	1	2
5(c)	Didn't do work or other activities as CAREFULLY as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? Please pick one box.



- Not all all
- Slightly
- Moderately
- Quite a bit
- Extremely

7. How much PHYSICAL pain have you had during the past 4 weeks? (Please pick one box)

- None
- Very mild
- Mild
- Moderate
- Severe
- Very Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework?) (Please pick one box)

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item. (Please circle one number on each line.)

		All of the Time	Most of the Time	A Good Bit of Time	Some of the Time	A Little of the Time	None of the Time
9(a)	Did you feel full of life?	1	2	3	4	5	6
9(b)	Have you been a very nervous person?	1	2	3	4	5	6
9(c)	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
9(d)	Have you felt calm and peaceful?	1	2	3	4	5	6
9(e)	Did you have a lot of energy?	1	2	3	4	5	6
9(f)	Have you felt downhearted and blue?	1	2	3	4	5	6
9(g)	Did you feel worn out?	1	2	3	4	5	6
9(h)	Have you been a happy person?	1	2	3	4	5	6
9(i)	Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.) Please pick one box.

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

11. How TRUE or FALSE is each of the following statements for you?

(Please circle one number on each line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
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11(a)	I seem to get sick a little easier than other people	1	2	3	4	5
11(b)	I am as healthy as anybody I know	1	2	3	4	5
11(c)	I expect my health to get worse	1	2	3	4	5
11(d)	My health is excellent	1	2	3	4	5



APPENDIX I  
DEFINITION OF TERMS

**Definition of Terms:**

**Adoptee:** An adopted person.

**Adoption:** A court action in which an adult assumes legal and other responsibilities for another, usually a minor.

**Adoption agency:** An organization, usually licensed by the State, that provides services to birth parents, adoptive parents, and children who need families. Agencies may be public or private, secular or religious, for profit or nonprofit.

**Adoption plan:** Birth parents' decisions to allow their child to be placed for adoption.

**Adoption reversal:** Reclaiming of a child (originally voluntarily placed with adoptive parents) by birth parent(s) who have had a subsequent change of heart. State laws vary in defining time limits and circumstances under which a child may be reclaimed.

**Adoption triad:** The three major parties in an adoption: birth parents, adoptive parents, and adopted child. Also called "adoption triangle" or "adoption circle."

**Agency adoption:** Adoptive placements made by licensed organizations that screen prospective adoptive parents and supervise the placement of children in adoptive homes until the adoption is finalized.

**Birth parent:** A child's biological parent.

**Bonding:** The process of developing lasting emotional ties with one's immediate caregivers; seen as the first and primary developmental task of a human being and central to the person's ability to relate to others throughout life.

**Closed adoption:** An adoption that involves total confidentiality and sealed records.

**Confidentiality:** The legally required process of keeping identifying or other significant information secret; the principle of ethical practice which requires social workers and other professional not to disclose information about a client without the client's consent.

**Disclosure:** The release or transmittal of previously hidden or unknown information.

**Family preservation:** A program of supportive social services designed to keep families together by providing services to children and families in their home. It is based on the premise that birth families are the preferred means of providing family life for children.

**Genealogy:** A family's genetic "line", family tree, or a record of such ancestry.

**Grief:** A feeling of emotional deprivation or loss. Grief may be experienced by each member of the adoption triad at some point.

**Identifying information:** Information on birthparents which discloses their identities.

**Independent adoption:** An adoption facilitated by those other than caseworkers associated with an agency. Facilitators may be attorneys, physicians, or other intermediaries. In some States independent adoptions are illegal.

**Infertility:** The inability to bear children.

**Loss:** A feeling of emotional deprivation that is experienced at some point in time. For a birth parent the initial loss will usually be felt at or subsequent to the placement of the child. Adoptive parents who are infertile feel a loss in their inability to bear a child. An adopted child may feel a sense of loss at various points in time; the first time the child realizes he is adopted may invoke a strong sense of loss for his birth family.

**Matching:** The process of finding prospective families specifically suited to meet the needs of a waiting child, not to be confused with "placement".

**Maternity home:** Residences for pregnant women. The number of homes has decreased over the past three decades, and existing homes often have a waiting list of women. The women who live in a maternity home may pay a small fee or no fee to live in the home and they often apply for public assistance and Medicaid payments.

**Non-identifying information:** Facts about the birth parents or adoptive parents that would not lead to their discovery by another person.

**Open adoption:** An adoption that involves some amount of initial and/or ongoing contact between birth and adoptive families, ranging from sending letters through the agency, to exchanging names, and/or scheduling visits.

**Passive registries:** Type of reunion registry system. Passive reunion registries require both parties to register their consent for release of information before a match can be made. Once a match occurs, both parties are notified. These systems depend on both parties registering, a match being found, and the follow-up notification by a registry administrator.

**Post-legal adoption services:** Services provided subsequent to legal finalization of the adoption. There are primarily four types of post-legal service providers: social service agencies, private therapists, mental health clinics and self-help groups.

**Post-reunion issues:** A range of feelings from euphoria to despair possible after the reunion of birth relatives. Family members in reunion may feel a "let down" or a range of feelings including guilt, anger, jealousy, confusion or happiness that may be related to completion of the reunion process and the beginning of a process whereby family members do or do not negotiate an ongoing relationship.

**Post-traumatic stress disorder (PTSD):** A condition in which victims of overwhelming and uncontrollable experiences are subsequently psychologically affected by feelings of intense fear, loss of safety, loss of control, helplessness, and extreme vulnerability and in children the disorder involves disorganized or agitated behavior.

**Relinquishment:** Voluntary termination of parental rights; sometimes referred to as a surrender or as making an adoption plan for one's child.

**Reunion:** A meeting between birthparent(s) and an adopted adult or between an adopted adult and other birth relatives. The adopted adult may have been placed as an infant and thus has no memory of the birthparent(s).

**Search:** An attempt, usually by birthparent, adopted person, or adoptive parent (but sometimes by volunteers or paid consultants) to make a connection between the birthparent and the biological child.

**Search and consent procedures:** Procedures, sanctioned in State law, that authorize a public or private agency to assist a searching party to locate another party to the adoption to determine if the second party agrees to the release of identifying information or to meeting with the requesting party. If consent is given, the disclosure of information may then be authorized by the court. In some states counseling is required before information is received.

**Semi-open adoption:** An adoption in which a child's birth parents and pre-adoptive parents may exchange primarily non-identifying information. After the child is placed in the adoptive home, contact with the birth family may involve letters or pictures or other communications sent through the intermediary of the adoption agency or the attorney who assisted in the placement.

**Surrender:** Voluntary termination of parental rights. An action taken by birth parents to voluntarily "make an adoption plan" for a child or "relinquish" a child for adoption.

**Surrender papers:** Legal document attesting to the signator's voluntary relinquishment of parental rights to a child.

**Termination of Parental Rights:** The legal process which involuntarily severs a parent's rights to a child.

**Traditional adoption:** Most often used to refer to a domestic infant adoption in which confidentiality is preserved. Equivalent to a closed adoption.

**Voluntary adoption registry:** A reunion registry system which allows adoptees, birthparents, and biological siblings to locate each other if they wish by maintaining a voluntary list of adoptees and birth relatives.