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New South Wales Parliament
Standing Committee on Social Issues

Inquiry into Past Adoption Practices

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Point of View of this submission: (as well, this section deals with an aspect of promotion of adoption used in taking consent, and the sexual myths about mothers used during coercion to take consent)

The author graduated in medicine from Melbourne University in 1956. After commencing training in Psychiatry in London, I arrived in New South Wales in late 1971 to take up a position as Senior Medical Officer at Rydalmere Psychiatric Hospital in the first week of 1972, and, while in this position, to complete my training in Psychiatry in New South Wales, where I became a Psychiatrist in 1974.
In 1976 I returned to practice Child Psychiatry as NSW Health Department's Child Psychiatrist for Inner Western Suburbs of Sydney, until I moved to Newcastle in 1978 for family reasons and took up the corresponding position there, still flying to Sydney one day a week to continue my Sydney responsibilities until I was able to be relieved in 1983. I had a wider role in that I flew to Narooma monthly and later to Dubbo to conduct supervision and clinics. I was the first psychiatrist to be Consultant to The Adolescent Unit at Royal Alexandra Hospital for Children Camperdown. In 1986 I became Child Psychiatrist for the Central Coast and was based at Gosford Hospital until 1989 when I went into 'semi retirement', still keeping Visiting Consultancies in Newcastle and Gosford. I am now in part-time Private Practice and sit on the Mental Health Review Tribunal where, because of an administrative change, I am again to be an employee of The New South Wales Health Department from 1st July this year.

I was sensitised to the problems of mothers who had lost babies to adoption early in my medical career, when a young couple whose later children I delivered, spent much of their family resources (both money and emotions) searching for their first baby who had been adopted out against their will during their teen years. Their grief was profound and drove

their preoccupations and behaviour, particularly as they saved money for expensive private detectives who provided little help.

At Rydalmere I was concerned at the number of late adolescents and young adults who were requiring management for identity disorders and depression, and where there had been major dysfunction due to disturbance in an adoptive family.

In 1974 I was giving a lecture about preventable psychiatric morbidity to a large group of nurses about the possibility of using proven experienced parents as adoptive parents, when I received a hostile response. I was told that these babies were the 'right' of those who could not have children of their own, and people who were not wholly behind this were a danger to all the people who would never have any other opportunity of having children. From then on I took a much closer interest in the cultural prescriptions driving adoption practices in New South Wales, ironically at a stage when it was undergoing radical change due to the social renaissance that occurred after 1972.

Taking the Child Psychiatry role for the Inner Western Suburbs of Sydney (Burwood, Strathfield, Drummoyne, Ashfield and Croydon) in 1976, I was to find that adoptive families were a frequent source of referral. (I put this issue in here as it is pivotal to one illegal practice in the taking of consents of birth parents: that is to idealise adoptive families as necessary and desirable for babies, and to use such images repetitively in promoting adoption to the potential 'provider' of the baby) The long line of mentally ill, substance addicted, maritally divided couples (over both adoption and other issues), who hadn't grieved their own or their mates sterility whom I saw in trouble during child rearing crises when they didn't have the resources or will to see them through, disabused me of this notion very quickly. My colleagues and I wrote about this after waiting to take a future sample: *Adoptive Families in Distress* (the heavily edited version).

I looked around at the adoptive families I knew socially, and there were similar themes occurring there too, partly because the adoptive family had no training in dealing with the inevitable identity disorder of the adoptive child, because, once the adoption was confirmed, they were left to do whatever they would, with no help or guidance about the special difficulties. The cultural myth was that it would be *'just like having your own children'*. Adoptive parents were given misinformation, in that there was a cultural expectation that the baby would match the family because of *'skilled selection of babies'*, and that affluence and religion based upbringing would override other difficulties. Adoptive parents were given no help with hard testing behaviours in primary school age, with temperamental issues that might have been expected in the biological family, or differences in style of thinking and problem solving that were innate. They were not helped with their own grief, or their deeper feelings about bringing up somebody else's child, except for the myths around the 'abandoning' mother implying to the child that he or she was much better off with them. Overall I have seen more adoptive parents for this variety of help than I have seen 'relinquishing mothers'.

So, not only were the young mothers subject to promotion of adoption, but the promotion was in a large number of instances an outright lie, and when

there were capable people adopting, they had to deal with a child different in temperament and cognitive style from themselves through an intense identity crisis, not to mention the early damage to a baby who is born into a vacuum figuratively speaking, as there is no mother to hold and suckle, her noises have gone suddenly and there is no breast smell on which to imprint - many consider this separation as primarily damaging. When, as well as the inherent misfit, the adoption was associated with frank psychiatric illness in the adoptive family at the time of adoption, or later sexual abuse, it was difficult for Child Health professionals not to become both distressed and angry. Once the adoption was made, the Dept of Community Services signed them off and The Department of Health was distracted from other duties caring for them.

The author wrote 'Family Psychiatry and the Selection of Adoptive Parents' published in the Australian Journal of Social Work and it was used widely, but it was closing the gate after the horses. The Dept of Community Services (about 1980) started using me when they thought that refusals of adoptive parents might be challenged in Court (they hadn't succeeded in stopping anybody determined before that). I was prepared to give evidence for them. The people I met were mostly frankly mentally ill. (I heard the argument that the mentally ill, should not be discriminated against as far as adopting children was concerned)

It is important to discuss at this stage another myth that was used cruelly against original mothers. In 1997 I was disgusted to hear it still promulgated on a television show by a social worker who had worked in Crown St during 'the single mother's holocaust' from 1966 to about 1973. What she said was that the young mother could not readily go to Court to seek support from the father because a man taken there would have half a dozen others to say it could be them just as easily, or words to that effect. This was the myth that the young woman was prematurely sexualised, promiscuous and irresponsible. This myth was widespread and a source of creating a bad role for the pregnant single girl, particularly the teenager. Having seen a large number of relinquishing mothers by the nineties, there were many instances of first intercourse, (some of it rape), some of seminal spills in the vulva, but most numerous were those of 'the first boy friend' and profound ignorance about sex and contraception.

On the other hand the statistics will show that there was a virtual epidemic of sterility due to what was called 'Non-specific oophoro-salpingitis' (inflammation of the tubes and ovaries - and by 'non-specific' they meant it wasn't due to gonorrhoea or syphilis) which was later found to be due to the Chlamydia organism spread venereally. The use of high dosage contraceptive pills (the original ones used in the sixties and early seventies) was also a significant cause of sterility when premature menopause occurred.

The tragedy for the original mothers was that they were younger, and this false myth about their sexuality used by those who wished to take their consent, was to render them more powerless, guilty or shamed, and as a frank lever to humiliate them. Their seeking secrecy for their sexual involvement made consent taking easier.

At the Inner Western Suburbs I was also to see mothers who'd lost a child to adoption. It would only be after I'd seen them for some time, and after

there was much trust, that the depression and grief at the core of a family's problems would be shared. I wondered how often we were missing this, and started to ask about it tactfully and found more, but sometimes I found only shock and fear, and after that a barrier, which one would expect when the husband or later children did not know.

In the early eighties, I was sought out by ARMS for support and to see 'relinquishing mothers' and this continued, until permission was refused for me to take this wider role by a CEO on the Central Coast. When I retired I was sought out again by a wide variety of mothers who had lost children to adoption, including the Public Interest Advocacy Service who sought my opinion about damage to some of these women as a result of illegal and unethical adoption practices.

Cultural matrix extant in the 1960 s and early 1970s

It is important this section is not seen as an excuse for the flagrant flaunting of the 1965 Act by behaviour and decisions of those empowered in positions of public trust, or of cruel and unethical behaviour of Dickensian proportions visited upon young women in helpless circumstances.

Inability to have children

As already indicated, there were particulars leading to a large number of couples who were unable to have children. Effects of early contraceptive pills and Chlamydia infections have been already mentioned: the public were not as ready to come forward to have any venereal infection treated, ectopic pregnancy was common, and there was an extraordinary rate of premature hysterectomy performed in Australia that astounded medical statisticians in other countries. There were some causes in males such as infective disease of the genital tract which caused male sterility, again where the public would shun treatment, however there was little that could be done about mumps orchitis in childhood or adolescence. There were many instances where nothing could be found or where there were low sperm counts of unknown cause.
In the front line in managing adoptive families however, child psychiatry clinicians were aware of many couples who had marital and sexual difficulties, who led oppositional and divergent lives where the intercourse frequency was very low or absent. This type of ailing marriage where the couple were bound together in a hostile insecure situation is not to be confused with the unconsummated marriage which was also encountered, where the couple often had a strong loving bond, but difficulties related to having intercourse so well described in Michael Balint's book *Virgin Wives*.

The difference in social power

The group of people who wanted babies (other women's) contained a large proportion from the middle class, as a result of both being employed, property and other assets, as well as social affiliations and status. In this culture respectability was highly valued. In dealing with adoption

agencies after 1965, these couples often related to the agency with a strong public display of praise and gratitude, and the agencies would have photographs of happy adoptive families with cards, and a sense that they had personal ties with many adoptive families as a result. Many agencies such as the Catholic hostel for unmarried mothers at Waitara had specially selected adoptive parents come to talk to the unmarried mothers about the benefits of adoption. Many of such families adopted two to four children. The relationships had a personal element to them and there was a sense of reciprocity experienced by workers in agencies, ante-natal hostels and maternity hospitals. The overall myth promulgated was: *"Isn't it wonderful we can find such loving homes for the unwanted babies."* For those with an angry adolescent adoptee in psychotherapy, this was black humour indeed.

Taboo and ignorance

During the sixties sexual matters were not easily spoken of, contraceptive information was difficult to obtain by the young and both 'the pill' and diaphragms were usually arranged with a GP who was hardly ever consulted by a young or single person. The purchase of condoms at a pharmacy was a major operation and their use was sporadic even among those who were more sexually experienced.

Ignorance of sexual issues was seen as a method to keep young people from being sexually involved until their early twenties, sexual abuse of children by adults was hardly ever exposed, and the young were often entrapped in situations they could not construe, or where intimate situations, sometimes associated with alcohol, left them pregnant before they had even begun to develop as a sexual person. Parents themselves were embarrassed about talking about sexuality and preferred to take a child to a 'Father & Son night' organised by the school and then not discuss the issue at home at all.

There were strong religious based proscriptions against sexual behaviour throughout the culture, even where there was no direct religious affiliation. Even Hollywood was chaste by today's standards and had not long given up twin beds and monomammary women as demanded by the older conservative producers.

To be pregnant was *prima facie* evidence of having broken those mores.

To be young and pregnant was an invidious position for a teenage girl to be in. When you look at their experiences you will see that some had compounded problems because of the crisis this created for their family, remembering that some left their homes and travelled elsewhere to cope with this on their own.

As the sixties turned to the seventies there was more compassion about these issues and some groups of society were more accepting of others. But against those who were powerless from their youth and lack of support, it was another issue to hold up and use in the lead up to 'taking consent'.

Abortion

Abortion was not an organised service with high medical standards. The tests for those to whom it was legally available were poorly understood,

and considerable stressful steps were required quite early on for it to be available.

Dilemmas for the family

Some families were under the threat of heavy shame, particularly those with outspoken condemnation of others on their records. When there was no cultural openness accompanied by snide gossip, families were also under the threat of being considered incestuous,

Many parents frankly rejected their children, or the dominant parent would issue a decree leaving no support for the child at all. Other parents would collude with agency staff without giving their pregnant daughter any idea of what was actually going to happen. On the other hand some parents took active steps to support the keeping of their grandchild, only to be subject to 'advice', exhortations and other pressure similar to that which was being used on their daughter. However I am aware of many instances when parents were assailed with 'professional advice' as to the 'best decision' for their daughter and grandchild which they could not withstand. They were **also victims of misinformation.** Not only were the young mothers not told of their entitlement to a pension similar to that of deserted wives or women whose husbands were in jail, but their parents didn't know of this either, and it is likely the prospect of an overstrained budget was another pressure upon them and precluded them even exploring the option of the baby staying at home. The one thing about the Supporting Mother's Benefit when it came early in the Whitlam era, was this **it was public.**

The grandparent's attitude and decisions were to be shaped by the promulgated myths of the advantages of adoption and the saccharine idealisation of this process at the time. It was easy with cultural bytes such as *'they are best brought up by two loving parents in a good home'*, or *'they match the child and parents so well'*, or *" after all we know the baby is going to a good family with the same religion."* ('byte' is my metaphor for easily transmissible cultural signals)

These cultural effects on the pregnant girl's parents were a highly significant contribution to the number of babies separated by adoption, but it is important that parents who acted out of the pressures of respectability and their own preservation from social shame above the interests and welfare of their daughter and grandchild should take some responsibility for this huge 'stolen generation'.

The cultural underrating of the destructive and often irresolvable effects of grief.

The next cultural issue to be considered is important because unlike many of the others discussed, it is still a major issue in the 1990s. That is the cultural underrating of the destructive and often irresolvable effects of grief.

The cultural byte then was: *"They will soon get over it and be glad they are able to start their life again afresh."* This was before the research of Maddison and Raphael that showed tenfold morbidity for the bereaved, and before the comprehensive study by Singh et al of the effects of the

Granville Disaster and the contribution of Ms Buttrose to disseminate some of this knowledge to the general community.
As I will address in a later section on morbidity, the grief at loss of the baby has been compound, lifelong, full of sadness, anger and searching, and has involved much decompensation into depression and preoccupied distancing from relationships, or the person becomes an inured defence against such grief. Nearly fifty percent were never to have another baby.
The practices of some hospitals around birth were to aggravate the grief profoundly. The cultural myth was: *"We have to stop her seeing the baby and give her sedative drugs - that will make it easier for her."*
Even superficial study shows these factors to be sticking points of aggravated grief. **The only ones it was 'made easier for' was for those taking the baby.** In a hospital like Crown St the institutional discipline to follow the hospitals practice was strict and regimented and even those who were appalled by its inhumanity were powerless to do anything but follow the institution's line. In contrast, in smaller hospitals, a compassionate member of staff could 'sneak' the young mother a 'look' or occasionally a 'hold' of her baby.
Certainly a process like this was a response to the intuitive knowledge that the extant bond with the baby would be developing further and the resistance to signing consent would be great indeed, despite the difference in power. This was all done before consent was taken, and in Crown St the young mother was subjected to large doses of barbiturate drugs until after the signing of consent.

<u>An Act of Parliament treated with contempt</u>

While those who drafted and passed The Act had made provision to cut across all these myths (if The Act had had any overview or policemen), the one myth it supported was : *"Adoption is exclusive and forever"*. , which was a reflection of the power and belief in the 'rights' of the childless lobby. Not only that but implicitly it underlined the destructive notion of ownership of children, which is inappropriate in or out of adoption. In family psychiatry this theme is the cause of destructive family patterns that go from generation to generation.
The mothers who had lost babies to adoption were never to see them again. (They were not to foresee the later legislation allowing reunion.) This aggravated their grief rather than ameliorating it. I must say here that in the late nineteen-eighties the Department of Community Services acted with great compassion in assisting the return to her original mother of an adolescent adoptee who had been grossly sexually abused by her adoptive father.

The professional practices in the administration and delivery of adoption services.

General

In the administration of traffic regulations and the law of the road there is an elaborate administration of regulations and Acts coupled with extensive licensing, police services, streamlined prosecutions for breaches, inspections and clear indications through education, publicity and signs as to the nature of breaches and penalties.

In the administration of the 1965 Adoption Act there was no administration to deal with breaches of The Act made by those who were, by the nature of the Act, its de facto administrators. It was a road with no signs, visible laws or police service The breaches were so outrageous in many instances, and the legal training of social workers, district officers and nurses so lacking, that I would be surprised if more than one in a hundred of those delivering adoption services had read The Act or was familiar with more than second hand information about it. Certainly in medicine and nursing there is often an omnipotence towards legal matters that is coupled with contempt.

The context of this was the gargantuan power difference between the de facto administrators and the mother to be.

On one hand was a young or very young person, with little social support, particularly without a partner or with rejecting parents, who must go to a clinic or hostel for general and ante-natal care, and be dependent during the period though late pregnancy, birth and the puerperium. There was a general stigma of guilt and shame, and further misinformation about being unable to cope with a baby for personal and financial reasons. She had to deal with a group of people who had an apostolic function to provide babies for the childless who were married and financially secure.

Add to this in some adoption services, the organised further isolation - sometimes actual incarceration, the taking of clothes, the threats of police action under the Child Welfare Act (sometimes these were carried through on slim evidence), the use of major drugs such as injections of Sodium Pentobarbitone, the continual repetition of self-esteem destroying shibboleths, the general display of adult confidence in the one outcome desired - signing the consent, and either not presenting alternatives, or the dismissal of these in a peremptory fashion: in this manner a flagrant power imbalance between the parties governed by The Act was created.

In studies of abuse, whether domestic violence, sexual abuse, or political abuse, the factor behind heinous abusive behaviour has always been the perpetration of such behaviour in the context of a gross power imbalance and the continuance of such behaviour because of the lack of checking factors. In many centres the abuse leading to the taking of these mothers' babies was in this category.

Consent

One issue which could easily be obscured is that of common law issues of informed consent. But at the time there was much focus of the issue of 'signing the consent'. The thirty day period to revoke this was of such small moment to those administering adoption practices that it was virtually ignored as a threat to adoption as it was easily deflected by such strategies with adult professional power as: "You don't want to do that to your baby dear"; "You wouldn't be able to cope dear" and the variation of this, "We would have to take you to Court because you are incompetent to care for your baby." (Crown St used this before consent taking) "It's too late, the baby is already gone", or the variation on this that the adoptive parents would be highly distressed; "The baby is sick and will need a lot of medical attention you could not pay for."; "What would you do for money or food? The baby will turn out very badly by a girl like you trying to bring him up.":

Young mothers heavily brain-washed (and I use this term in full consideration of those practices which lead to the term becoming part of living English) hardly ever sought legal help, were readily bluffed into thinking that such powerful professionals were acting legally, and would have great difficulty in getting the correct papers to the Supreme Court as required. I have heard numerous accounts of them contacting on the telephone as they were asked to, and all they received were the usual phrases before being disconnected. Face to face they were put off or stalled by stubborn negative receptions, frequently giving them the 'round robin' journey to other professionals, and backed by threats of police or D.O.C.S. which were mostly bluff. Many who were backed up by supporting parents or their partner as the father of the baby were also successfully deterred. This was sometimes enabled by making a display of the consent signing (as an alternative to having them drugged out of their mind on the fifth day.) when they were told things such as "You know you will never see your baby again when you sign this." as a good way of ensuring the thirty days were quarantined, or the warning "You know you are likely to regret this." as a way of underlining the signing being final and of normalising the 'regret'. One mother who was in the Catholic system and hadn't been allowed to see the baby at all: after the signing of consent, was given the baby to take out with her boyfriend's mother. In practice, taking the consent was the pivot and the thirty days were inconsequential.

However you will hear of many cases of worse practices, numerous instances where the thirty days was not known about, those who received the consent while it was held in the hand of the consent taker where they couldn't read it, those who thought they were signing registration papers, and a legion who were drugged at the time. Many cannot remember giving consent and some are quite certain they didn't and their baby was taken anyway.

It is salient that **no mother went to the professional's office and say she was ready to give consent.** The professional went to her bedside and

indicate that it had become time for a routine 'signing of the papers'. This has been described to me scores of times as being put in the manner that there was only one inevitable answer "Yes." possible. The assumption was that the young woman would do what the professional required and this was carried through with power and confidence. Responses of "I don't want to." or similar responses, were treated with a confident "You will have to eventually." What was meant to be a meaningful encounter in terms of The Act was usually shamefully brief. No attempt was made to ensure **capacity** to consent, the **volition** was all supplied by the professional, and the **information** was rarely read and even more rarely discussed. As far as 'capacity' was concerned, acute grief or a high barbiturate level or being without legal advice were the least of the consent takers concerns. Even if a supporting relative or friend was brought in to share the reading, there would have been a semblance of legality.

However this focus on 'the consent form', distracts from numerous common law issues of informed consent.

The usual hospital consent forms to medical procedures would have been put before them on admission.

However the procedures they would undergo before the fifth day of signing consent to adoption had many aspects that should have required extraordinary attention to informed consent over and above any consent to medical or surgical procedures, some because they were part of 'the adoption production line' (as at Crown St) and others because they were extraordinary departures from usual obstetric practice.

Such issues were the placing of screens to avoid them seeing the baby, or pillows over the face, the immediate separation from the baby who was often taken outside to even have the cord tied(the mother, ironically, was the baby's legal guardian), the administration of the drug Stilboestrol by injection (and later by mouth) to dry up the milk, and the use of powerful hypnotic drugs such as Sodium Pentobarbitone.

The **capacity** of these girls and young women was highly diminished during the crisis of labour, and the authoritative use of power by the professionals further diminished their capacity. Their **volition** to protect themselves was at a low ebb due to their dependant and extraordinary circumstances of birth, the immediate loss of their baby, and the drugs used on them. The **information** about what was being done and why, was often cursory, totally absent, or misinformation. This was particularly salient in those who lost a baby to adoption when they went into labour with every intention of keeping the baby. The inquiry will surely have some examples of such instances before it.

Associated practices: isolation, incarceration, suggestion, forced labour, repetitive inductrination, humiliation, and moral coercion, including social role subjugation.

It is more important for the inquiry to hear these issues directly from those who experienced them, but I include a brief account here, although The inquiry will spend considerable attention to hearing and evaluating evidence on this section.

It is pivotal in that without these 'associated practices' a great proportion of the babies would have been kept by their mothers. While rigid and harsh separation practices were used by many hospitals and services, many others used the 'associated practices' to secure their end - the taking of consent.

Superficially the living in a hostel, convent or other prenatal institution, was said to be preferred by the girls to *'hide their shame'*. However, the practice allowed for the breaking of their usual first order social support, particularly their family and peer group. Here they had a new peer group in the same predicament. And their parents were replaced by a new group of 'parents' who would repetitively feed them bytes of the myths and use 'guilt and shame keys' to bring them to a state of low self-esteem. Where this was superficially kind or warm, regression was promoted, and, as the Chinese and North Koreans had found in the Fifties, this was the most effective form of mind changing possible. Where they were harsh there were attempts to please them in the only way possible - be ready to sign the consent, and it is the long term effects of these imprinted suggestions that are marring their lives twenty or thirty years later - particularly those who have never had subsequent children, an outcome associated with going through this treatment.

You will hear that some were restricted to the building without street clothes, some who worked hard in laundries and toilets, some were literally locked in during various phases of their pregnancy, and some had suggestions repeated in such a manner that they doubted they would ever be a good mother for a child, or they would harm any other child they had, or destroy the life of their partner. These elements of damage were over and above the damage they were to suffer from the loss of their baby. Over forty per cent had no further children, and those of us seeing the children they did have later were aware that these associated practices were often the principal cause of family dysfunction, even considering the mother's post-traumatic fear of losing another child and crippling pathological grief decompensating to depression. **It was if these factors were post-hypnotic suggestion of the most compulsive kind.** Some were consciously mediated, but others acted through the unconscious, creating compulsive attitudes and behaviours only accessible to significant psychotherapy.

Those who became aware in their later life of the results of their development became very angry as they realised the ramifications and sequelae of their treatment at this time. Saddest of all are those still in the humiliated state as they were at the time, but with a wall of defences that have become a false personality. In short, instead of a person, there is Denial, Reaction Formation, Isolation of Feeling, and the rationalisations satirised by Voltaire in his opus 'Candide'. These are the tens of thousands out there who need any positive help the Inquiry might stimulate, even if only to stimulate their self esteem and fellowship with other victims.

Although these issues are less like the neon signs of Crown St malpractices, it could be one of The Inquiry's valued tasks to further delineate such factors and their consequences.

Unethical and unlawful practices

While I personally consider that all of the previous section of this report describes a linked series of unethical practices, there is controversy about what is lawful and unlawful let alone what is unethical. I have reason to believe that the combined resources of the Parliamentary Inquiry will better be able to judge the elements of breaches of law and ethic in both this material and in all the material presented to them.

However I must draw attention to some issues that might be overlooked.

First - Crown St.

One issue is the role of the medical staff, as without their prescription of scheduled drugs the whole pattern of abuse would have been entirely different.
The commonly used offending drugs were Sodium Pentobarbital, Amytal, and Stilboestrol.
I studied a number of Crown St files and I also had the occasion to study Chelmsford files. The similarity was striking, the barbiturate drugs the same and in similar dosage (although not of the same frequency to produce deep-sleep over weeks). The Senior Psychiatrists at Chelmsford and Crown St were the same. I was aware of collusion between the two when I uncovered a letter by Dr Harry Bailey from microfiche kept at Paddington, ordering the abortion at Crown St of twin foetuses (close to viability) of a Chelmsford patient by hysterotomy. This was duly carried out without this woman's consent and she was wondering twenty years later whether her babies were still alive with somebody else.
In this manner the Crown St files of relinquishing mothers had more in common with Chelmsford files than they do with the files of other relinquishing mothers'.
At Crown St drugs were also used for control in the ante-natal period, for many days usually, but sometimes drug control went on for many weeks. Chloral Hydrate, Sodium Pentobarbitone, Amytal were all used. A 200 mgrm dose of Sodium Pentobarbitone was given intramuscularly within some hours of the birth, this was often repeated during the first five days, but often backed up by oral doses of Pentobarbital or Amytal.
These barbiturates were relatively quick acting, caused extreme sedation, stuporose states and delirium was frequent, sometimes due to withdrawal as much as intoxication.

Another issue at Crown St was the issue of 'clearing'
This referred to the step by step process leading up to signing consent, thus gaining permission for discharge from the secondary institution where the mother had been moved. The notion was that staff had to pay attention to the details of the process and make certain that consent was properly signed before the mother was allowed to literally return to an ordinary life outside of their power and imagined jurisdiction.

Threats of using The Child Welfare Act were used more for resistant consenters than on evidence that the baby would be 'at risk'.

Apologists for Crown St point to the statistic that a significant proportion of single women kept their babies between 1965 and 1975. As babies being relinquished dropped to a single figure percentage of earlier years over 1973 to 1975, ask to see the figures broken down year by year. As the younger the mother the greater the power imbalance, ask to have these statistics broken down by age.

It is important to note here that Crown St was not the only hospital to have a harsh regime and abusive practices, but it comes to notice frequently because of the weight of numbers of adoptions which occurred from there.

Second: Taboos

The Parliamentary Inquiry will hear of many senior professionals associated with the above practices. Few of them will have been leaders and many will have gained employment with an institution where they quickly had to conform to institutional culture and practice. It will be important to see past these people to those who exerted leadership in full knowledge of the unethical and unlawful practices of the time, where the end: the provision of babies for adoption: justified the process necessary. It will be important that their destructive role by such leadership be looked at whatever their affiliations. The senior Josephite nun who controlled the adoption of thousands of babies is one example, and another group who would generally be seen as untouchable in this respect is The Salvation Army.

Non-adoption alternatives

Women who know I am interested in adoption have told me their experience when they nearly had their baby adopted out. The outstanding theme of their stories is not that of professional advice about adoption alternatives, but one of being rescued by a senior relative or partner giving them courage and support, or by stubborn refusal to sign documents and or calling the bluff of those who tried to separate them from their baby. I am not impressed for this reason either of the statistics of single women who kept their baby or of sophistry around the issue of alternatives for the single mother.

Nor have I had any account from an original mother from the late 60s/early 70s relinquishment period of a professional directing her to consider one of these alternatives, only of a relentless push towards adoption using a variety of promotional alternatives and the abusive tactics described in the earlier section.

I am aware that from about 1973-74 there was an emphasis on training of social workers and other allied professions to be comprehensive and professional about putting forward these alternatives, but even then they had to adapt to the culture of the institution that employed them. The credit for these changes should go to the Universities and not the Institutions.

However this changed attitude and practice certainly contributed to the number of adoptions dropping like a stone in this period, although

changed social mores and the Supporting Mother's Allowance were significant issues - but so also was the drop in pressure as the *in vitro* fertilisation programs were succeeding.

The legal difficulties for the mothers in gaining recompense

The vast majority of mothers who lost a child to adoption are not seeking recompense, but recognition of what was done to them and recognition of the extent of their suffering. As their children have been brought up on myths of their mother's inadequacy, immorality, and rejection of their babies, they need a firm clear statement to undo some of these attitudes. However there are some who lost babies despite the determination to keep them, those to whom flagrant abuse has occurred who require recompense as part of the process outlined in the previous sentence. Their legal difficulties come about through failure to set aside The Statute of Limitations no matter how extensive the damage or blatant the abuse.
It would appear that their legal advisers have great difficulty in predicting legal outcomes, establishing negligent practice in a culture of abuse, or looking to common law failures of duty including the issue of informed consent and the abrogation of their right to use the thirty day period to revoke their consent. The failure of one case over issues of the adversary not being able to produce witnesses to balance their testimony over what should have been a small part of their case, left them with a sense of dismay, injustice and betrayal.
Recompense will be discussed further in the section on distress assistance.

Measures to assist persons experiencing distress due to adoption practices

General Issues

Distress is associated with mothers' grief, specific issues of damage, and problems about continuing their life despite this, and then in relating to their child as an adult and the complex feelings and stresses which occur as they come to reunion (which many times is delayed or never occurs) and then relate to a young adult with very complex feelings about them often largely based on destructive misinformation, frequent identity damage with secondary self-destructive behaviours, and learned testing behaviours then to be practiced on the mother who lost them. Many mothers are very frightened of the child they will meet; so are the children, but those children who have made it to being an autonomous adult handle it better and often constructively take the lead in the reunion situation.

Straightening the record

In general mothers say they particularly want help in straightening the record, a full and compassionate account of their plight and the treatment to which they were subjected which is fully communicated to their child. They want competent counselling from people who are not identified with the perpetrators. Many are desperate for this and will travel hundreds of kilometres or even from interstate for this. Special training of such counsellors would be required, although there are some among their number who have professional qualifications who may work through their own effects of loss to be able to help their peers. Generally peer groups are very supportive, but it is very difficult for them to be organised, as, in my experience, most groups are funded by individual savings from social security payments.
Those who have exposed themselves are aware of the high level of distress among the great majority who are frightened of rejection or social stigma and who are unable to come forward.

Damage.

A variety of measures are required depending on the nature of the damage leading to distress and the type of distress associated with the individual's response to such damage. A list of the varieties of damage follows:

1/ Pathological Grief

2/ Personality damage associated with the defences used against grief, against post-traumatic stress phenomena and against depressive decompensation

3/ Personality damage associated with the isolation of the birth experience and loss of the baby, where this is a secret and there is no significant other who is there to share the feelings and unresolved issues associated with the loss.

4/ Axis 1 Psychiatric Disorder

- 4.1 Post-Traumatic Stress Disorder
- 4.2 Major depression
- 4.3 Dissociative disorder
- 4.4 Panic Disorder (and other anxiety disorders)
- 4.5 Dysthymia
- 4.6 Situational Stress Disorder (often associated with reunion)
- 4.7 Alcohol Dependent Disorder
- 4.8 Prescription Drug Dependent Disorder
- 4.9 There are other drug dependent Disorders which are uncommon among these mothers.

(please note that **4.7, 4.8 & 4.9** will be dealt with under **7/** below)

5/ Personality damage associated with psychiatric illness as a sequel to loss of a baby to adoption

6/ Personality damage associated with long-term Pathological Grief

7/ Aggravation and precipitation of a wide variety of physical illnesses which are related to stress.

8/ Disorder and incapacity in human relationships

9/ Educational failure and poor employment status

10/ Failure of bonding with subsequent babies

This list refers only to common reactions involving large numbers of mothers: the Inquiry will hear also of additional problems

Comment upon each of the listed categories of damage giving rise to distress

1. Pathological Grief

'Normal grief' is facilitated when the loss is timely, not of high ambivalence and where the needs of the bereaved are well enough met and there is adequate social support available. Even in major loss there is an early acceptance that the loss is final and the implications of the loss and the feelings engendered are eventually bearable, leading to the mourning process: the going over piece by piece the nature of the changes in the bereaved's relating, expectations and orientation to new directions. Eventually comes some degree of acceptance when the lost one can be thought of without inhibition and the bereaved is future oriented. This usually takes about three to six months.

*Note * : Where 'stages' of grief are used, these are not necessarily progressive; there is reversion or hovering between them, cyclic traps between them occur, and mourning may be commenced briefly only to regress and go through earlier phases all over again.*

avoidance of babies full-stop, an inability to experience warm attachment to others in case they lose them, overprotection, rationalisations and continued idealisation of authoritative figures such as nuns and social workers, the inability to communicate intimate subjects to others, the inhibition of sexual expression because their loss of the baby was in the very earliest part of their psycho-sexual development, or other defensive patterns: these and others have all become part of their adult personality in a rigid manner. There are heavy restraints against further development or a flexible view of their own potential and possible roles. These people get by, but in a very limited manner because of their experience of loss. Mostly their defensive positions will inhibit them from coming forward, but they represent a large proportion of mothers.

3/ Personality damage associated with the isolation of the birth experience and loss of the baby.

This is quite a different condition from 2/ above. Here the issues are guilt, shame and secrecy. These elements become fixed as part of the personality which is arrested in development. This is also the original mother who puts a veto on her lost child contacting her. In many cases nobody knows her secret, but in many cases her husband knows, but not her children. She is highly frightened and vulnerable about this and in many cases the children's cousins told them a decade ago, but they know they must not say they know. She is left with the cultural bytes she received twenty years ago and the social attitudes of that time.
Some of these mothers long for reunion and when it is approaching go into a highly disturbed crisis state and sometimes seek help. Others have made up their mind to live their secret right through, and, when contacted by their lost child, give a frightened 'go away' message that is devastating and permanently damaging for the adoptee.
Generally I help them tell their husband and children, and the improvement in their general personality and expression of feelings, their relationship with both the adoptee and their other children are enhanced. A woman with residual damage from 'shame and guilt culture' is in dire need of help, and has a much better outcome than those people described in 2. above. However the two states are not mutually exclusive and The Inquiry will hear about some people who show features of both types of damage. This type however respond much better to therapy, encouragement and support, particularly when their family is fairly well functioning. Those with an understanding partner tend to have a very good outcome indeed.

4/ Axis 1 Psychiatric Disorder

General
Axis 1 refers to the DSM IV Diagnostic Classification from the U.S.A. used here in Australia, in which psychiatric diagnoses are made along 5 axes. It is common for most to have more than one disorder. This is partly because diagnoses like Major Depression occur when the other disorder or Pathological Grief overwhelms them.

'Pathological grief' refers to distinct and major failure of this process.
After loss of the baby, the first stage of shock, numbness and disbelief may persist because the mother cannot face the finality of loss of her baby and the feelings of rage, guilt, depression that might overwhelm her. The numbness and disbelief are protective against this emotional second stage of grief. This may persist for a long time and may be associated with naive beliefs that the baby will be returned or some 'nice' social worker will appear to help the return.
Many find the next stage, which they enter after they accept finality of the loss, produces such anger and despair they revert to the first stage, and I have seen this see-saw between the two occur over two or three decades, and associated with decompensation in Major Depression.
Others stay in the second stage of major feelings: they cannot accept the implications of their loss **and thus cannot mourn**. This arrest is not understood and people readily become irritated with them as they return to the issues of their arrested grief. At The Inquiry there will be many with this type of damage and their presentations will represent for them the first attempts to look at implications of their loss in the social world. Such damage is to be seen in the context that when a mother loses a child from babyhood to middle age, and the loss is untimely and has other bad outcome features, the most stable and mentally healthy person becomes similarly afflicted.
Others are stuck in the stage of mourning, going back again and again to the same issues where they cannot get satisfactory answers.
There are supra-pathological variations of pathological grief, particularly where grief is totally inhibited and denied, and the grief goes underground coming out in unconscious release, such as in over-protection of other children, binding and intrusive behaviours, irritability, and unexplained depression. The mechanisms of defence become part of the personality. In particular a large proportion go over some elements of blocked grief again and again; sadly the repetitive nature of their talking about the blocked area of their grief is a measure of their damage, but to the listener who have long ago understood the issue from the first telling, it can be tedious or irritating. It is most productive for the listener to ask themself internal questions as to why the block is there, what alternative is untenable, and how the mother otherwise might develop.

There is suppressed grief where the person keeps their grief in secrecy, but fully conscious, distraught, and has their weeping times when alone, and their breakdowns on anniversaries or special days.
Pathological grief is related to other forms of damage because it frequently decompensates as defences are inadequate and the psychiatric disorders such as Major Depression, Dysthymia and Panic Disorder supervene. Pathological Grief is almost universal among these mothers and underlies the other issues of damage discussed below.

2/ Personality damage associated with defences.

The defensive style: whether it is alert avoidance of anybody who might take one of their children or otherwise alienate them, or a shut down

4.1 Post-traumatic Stress Disorder

In this disorder the trauma of separation or fearful experience of being emotionally isolated during obstetric trauma is so severe that this experience is imprinted and intrudes into dreams and waking experience in an uncontrollable manner. The experience is so aversive and so reinforced by the repeated intrusion that the young woman becomes hyperalert and vigilant to anything where a repetition of the circumstance is possible or is threatened. Elaborate avoidance behaviours develop and some may be symbolic or associative. Some of these avoidance behaviours can become secondary psychiatric conditions such as a phobic avoidance of hospitals as an aspect of their PTSD, or very deep seated fears of becoming pregnant again.

The avoidance of hospitals is very serious, because these women may neglect their health or be unable to visit a close relative who is seriously sick. If they have a personality problem as well such as 2/ and 3/ above their P.T.S.D. may become fixed and still extant decades later. If overwhelmed by P.T.S.D., Major Depression can be precipitated.

4.2 Major Depression

This is the more severe of the two depressive disorders listed here (Dysthymia is the other) and the criteria require there to be severe depression most of the day for at least two weeks at a time.

In mothers who have lost a baby to adoption such Major episodes frequently are triggered by the baby's birthday, Christmas, close contact with children (particularly for the childless), as the decompensation of factors aggravating Pathological Grief and PTSD, and sadly and destructively, following the birth of subsequent children. (I am aware of instances where the same reaction has occurred with the birth of grandchildren too.) Major Depression then takes the form of a malignant Post partum depression, and strangely is often not diagnosed because the mother mostly does not tell of the association unless she is asked directly. Bonding failure with the subsequent infant is then a major problem.

The mother's subjective experience is one of being overwhelmed by the memories of her lost baby, the first birth and its circumstances, and the subsequent time in and out of hospital without her baby. She is terrified this will happen again, and is pining and searching in her mind for the lost baby. It is difficult for her to focus on the real baby. This is so different to the public myth: *"She'll have another baby and will really be over it then."* To those who work with these women such public ignorance is galling, particularly when such phrases represent the general community attitude.

Suicide is a sequel of Major Depression and should be the subject of a research project in studying this group of mothers in NSW. This should be easy because of the distinct category of the birth registration. So also should research into their overall death rate which will give another indication of their mortality also associated with Item 7/ below.

4.3. Dissociative Disorder

This serious disorder takes a number of forms. In essence it occurs when consciousness is so overwhelmed by shock and unbearable feeling that

there are splits or discontinuity of consciousness. It is sometimes confused with the serious biological illness - Schizophrenia, but it is distinct and quite unrelated. It is more related to Multiple Personality Disorder, although the split aspects of consciousness do not have their own identity as in M.P.D..

It is characterised by a total splitting off of the stream of consciousness associated with the untenable events, and the formation of a false self who continues every day amnesic to the events split off. There is often evidence of a true self co-existent with the false self who is not amnesic. The false self is usually very limited in function, not in touch with emotional life within the self or in interchanges with others. I have seen the condition also in parents who have lost a child suddenly as a result of accident.

One mother dissociated the events of her pregnancy, labour and puerperium totally and her family colluded with this. It was only decades later that a remark of her mother's about the baby precipitated the beginnings of a breakthrough of her true self and return of her memories. Another woman lost a month of memory in the time immediately after giving birth, and many have lost days or weeks of experience around the time of the baby's birth. It is found more commonly if you ask about it.

A related phenomena described is a generalisation of the loss of relationship with the developing child. When subsequent children came to their late teens there was a blocking out of their development from baby to young adult.

4.4 Panic Disorder

This is characterised by sudden onset of bodily symptoms of fear which is experienced as if an unknown disaster is about to happen immediately. It may be focussed on the rapidly beating heart, tightness in the throat, difficulty of breathing and there is an impulse to escape to the most secure circumstances possible. It is associated with major activity of a basal brain nucleus and the sympathetic nervous system.

In the mothers it is related to high levels of stress at anniversary days or special days such as Mother's day, it occurs during searching behaviours or when there is the prospect of a reunion. It is important to note that searching behaviours occur throughout the time of the child's development, not just near or after the eighteenth birthday and they are mostly fruitless, or can end in embarrassing dead-ends. These behaviours are a usual aspect of Pathological Grief. Panic disorder is also related to high levels of feeling which are otherwise bottled up, and to uncertainty and insecurity about relationships and the future. There is also a familial tendency to develop such disorders, and it can be seen in adoptees too.

At other times the anxiety is focussed on the subsequent children, and sometimes it is precipitated by a bereavement within the greater family. There is often a strong element of separation anxiety in the presentation, and as such it will present more as an agoraphobia where there is a major need to be with a protective person to prevent it.

4.5 Dysthymia

This diagnosis is used for depressive symptoms that recur regularly but which do not meet the criteria for Major Depression. They occur often as a result of a personality constellation such as 2/ and 3/ above when there is a sense that defences do not work as they are supposed to, or that hiding unhappiness from others only aggravates the overall condition. It is frequent when there is a chronic fixation in the emotional second stage of grief - and mourning is difficult or impossible. The chronic unhappiness of wanting the baby who will never return produces the outward phenomena of the syndrome, so it is a frequent accompaniment of Pathological Grief. It is important to note that many mothers who have made quite a good adjustment in relating to their adult 'baby' after reunion, still have this grief for the baby they never held, whose milestones they never observed.

4.6 Situational Stress Disorder

This Axis 1 disorder frequently occurs during the months before and sometimes during the years after reunion. Its name is self explanatory and it is characterised by crisis behaviour, day to day decompensations into depression or anxiety, disorganised behaviour and labile emotions.

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5/ Personality damage associated with psychiatric illness as a sequel to loss of a baby to adoption.

This is a group who have had psychiatric illness as set out above for so long that it has become entrenched in the personality

6/ Personality damage associated with long-term pathological grief

This occurs when grief is arrested at one phase, denied, or is characterised by another salient defensive mechanism, or, oscillates between two phases depending on how much grief is tolerable according to circumstances and support. These grief behaviours and repeated experience of feeling become so regular and fixed that they supervene the previous personality to the degree that they become permanent personality characteristics.
Some of these are not adaptive such as irritable preoccupation with particular people who were instrumental in their baby's loss, and others are compulsive, such as vicarious care of those similarly affected. If this is done with some insight it is more adaptive, but often it is pursued by projecting their own pain onto the others and having a personal set of solutions which are not necessarily adapted to the needs of others.

7/ Aggravation and precipitation of a wide variety of physical illnesses which are related to stress.

(Included here are those secondary to attempts to cope with grief by using prescription drugs (particularly benzodiazepines) and other substances - alcohol and THC, to suppress bad feelings associated with unresolved grief.)

The common theme is that severe and protracted grief has been consistently shown in research studies to be associated with major poor health outcome. Many thought this was marginal and would be difficult to demonstrate. Maddison, when he was working in Boston, showed it to be of the order of 1000% increase as measured by The General Health Questionnaire; this was repeated by Raphael in New South Wales in the early seventies with similar results.
Depression has also been shown to be similarly correlated and there is a death rate among the depressed that is of a similar order to that from heart disease.
There have been numerous confirmations both of the order and quality of health deterioration after bereavement and the range of disorders involved is wide. Cancer has been one that has been documented, and one principal explanation of that is changes in the immune system. Illnesses such as asthma, peptic ulcer and colitis have all been part of public awareness as being aggravated by stress. This is mediated through stress and the response of the neurones in the hypothalamus that release Corticotrophin Releasing Factor to stimulate the pituitary gland. There are more obvious links between unresolvable grief via the cigarettes, alcohol, benzodiazepines that are used to modify unbearable feelings and bad health outcomes that are the sequelae of these. Eating disorders and dietary problems are common. Similarly both the depressed and pathologically grieving are vulnerable to risk taking behaviours. This includes driving on the highways and the relationships they will accept. There are other direct connections such as inappropriate avoidance of health management and those responsible for it. Again, research funds are required to study the health of this group.

8/ Disorder and Incapacity in Human Relationships

It is important here to consider the direct links between loss of a baby to adoption and the disorders and incapacities in relationships.
The first issue to consider is the significant and often abrupt change in self-esteem. Many were shocked when they realised they were to be seen as immoral, unreliable and promiscuous. Some never saw themselves as a mother even well into pregnancy only to acquire a new view of themselves and enjoying it after the baby moved intimately inside them.
But as the adoption promotion rolled over them, the integral part of this was 'their own **unfitness** to be a mother and their not **deserving** to be a mother' because of their conceiving outside of social mores. This process was repetitious, many faceted and continually reinforced. In the hospital where they gave birth they were given many messages of being inferior,

worthy of contempt and were readily discounted. In this respect the nursing profession were major contributors to their damage in self-esteem. Many of these young women were not self-assertive: any self-assertiveness remaining was targeted as part of the 'focus on consent' campaign. **Gone were all the elements of self assertiveness, they were on their own, dependent, made to feel immoral, and also given the false view they were in the wrong, with no rights and legally helpless.**

When they took on the suggestions of their 'betters', their lack of assertiveness was amplified.

Then there was the issue of Pathological Grief. Relating in an intimate and trusting manner is difficult indeed when there is any element of grief overlaying personal development. Preoccupations and intrusive themes destroy initiative and the sense of betrayal by their own family and agency professionals was there at one level or another. **(The young woman with poor self-esteem and low assertiveness might take decades or forever to drop her denial and collusion with the beliefs pedalled by the agency)**

Nearly all of them have a shattered sense of trust. It was their own families as well as the professionals who left them this way. They saw protecting themselves from such a disintegrating loss as essential. There was a detachment from others, a distance or general withdrawal, many could not become close to their subsequent children as losing them would be catastrophic. Many of their spouses were aware of the distance, distressed by it, but found their unease difficult to pin down or express.

So many were very circumspect about close relationships and becoming pregnant again - many stayed without partners for a long time or permanently. In the competitive stakes of assortive mating, low self-esteem, distrust and poor self-assertiveness are heavy handicaps: they have to rely on the initiative of a potential partner and may acquiesce to a relationship in a quite different manner than they might otherwise have done.

It is important to say here that those who have high quality partners who are supportive and privy to the distress from their loss, fare very much better than those without a caring sounding board to share their life. Many of these mothers accepted partners with whom they could not share their experience or distress, and many accepted men who were exploitive of their passivity or came from families where gross power imbalance was everyday and who would use them to perpetuate their own family expectations of marital relations.

Those whose grief is arrested where the predominant affect is rage, and where mourning has not occurred, will inevitably take out that rage in their close relationships. This may be to a partner who can absorb it, and the process might be quite conscious and open to discussion, but often the rage is not as conscious, the lost baby often idealised and the subsequent child will never to come up to that idealisation.

Those with frank psychiatric illness had the inevitable effect of this disability on relationships. Depression is not easy to understand when there is a need for a family to function with leadership by the wife. Withdrawal during grief or depression has a profoundly destructive effect on the development of children. Maternal fear and panic is passed on to children as core insecurity.

When there is a family secret, children have an intuitive sense of something mysterious and dangerous behind ordinary family life. They often then project their own explanation of what is hidden, and this is usually something born of violence and jeopardy, depending on their stage of development and the television they watch. It promotes insecurity and a sense that attachments may be broken.

I have discussed above the recrudescence of grief during a subsequent pregnancy and confinement and the subsequent bonding failure with the baby. After a while when we found family dysfunction with a mother being depressed and preoccupied, or overprotective with anxiety about losing a child, we knew to gently search for this as a likely antecedent, only to back off if we read acute distress that it might come out.
There are some mothers who themselves had pre-existing mental illness, sometimes constitutional and sometimes as a result of child abuse. The experience of loss of a child always exacerbated their condition and the subsequent relationships they formed. Many of these people were highly confused during the experience and their behaviour became disorganised to being chaotic.

All the relating difficulties as a result of their loss add up to special difficulties when these people come to reunion eighteen to thirty-five years later. I find that their understanding of young men in the eighteen to twenty-five year age group is clouded by their own earlier experiences, their difficulty in imagining the stages of development their son has gone through and their own fantasy life in which he is still a young child. They seem to have a much easier time with their daughters if the latter are mature. However daughters who are immature in matters of autonomy, sexuality and dependence create almost insurmountable problems vis a vis becoming empathic with their mother and also her reciprocating. It is warming to find the girl friends and young wives of the young adoptees, sometimes creating a special understanding and accepting of the mother who lost their partner as a baby.

9/ <u>Educational failure and poor employment status</u>

While the Inquiry will hear from some mothers who went back to their school after their confinement only to be turned away and rejected, more usual were those who went back to their studies, but were preoccupied, lacked concentration, could not find meaning in their studies or have motivation to organise them to an education goal. We know they were grieving unsuccessfully and often depressed. Examinations are difficult under such circumstances. Single minded study is even more difficult.
Fortunately there were many more jobs around twenty-five years ago. Most of them were unskilled, but provided a regular income. There were thoughts of going back to study and achieve some of the goals they had before, but this was easier considered than achieved. It is interesting that in their forties some of them are able to go back to late secondary and early tertiary education.
The cultural myth was, *" Having a young baby would destroy their life and education. Adoption will leave them free to continue it."* I know a

few who got back to their education usually after some years, but only a tiny minority whose studies were not set back significantly if not totally. Some of the mothers you will hear from are highly intelligent. Among those who come to the Inquiry they will probably be over represented. Research conducted on their occupations and income, and then compared with women of the same age would answer clearly whether their education and employment prospects were damaged. If a random sample of 'relinquishing mothers' were taken for such research an even greater disadvantage might be demonstrated.

10/ Failure of bonding with subsequent babies

This subject has been introduced earlier in the submission.
In summary the subsequent pregnancy rekindles the grief and distress around the loss of the first baby. Post-traumatic stress phenomena, and the anguish of pining regret and anger often retroflexed against the self for not being able to fight harder becomes a major theme. Thoughts and feelings are intrusive and preoccupation is compulsive.
It is difficult for them to 'see' the new baby through all this. It is difficult to remain with feelings about now, whether it be distress at feeding problems or joyful pride in the new born.
Later there is anguish at every milestone of the next child as the sense of missing the lost baby is hard to suppress and conjecture, often idealised, is continually in mind.
There is often intolerance of normal developmental difficulties in the new baby, sensitivity to others wanting to take him over. I have on numerous occasions heard of major anxiety in mothers that their mother or mother-in-law wants their new baby or even their sister wants them after some brief help while they are sick. They are not able to use family day care mothers and often opt for more impersonal and less satisfactory creches for child minding. If they must use a carer, they are highly anxious about any attachment of the baby to the carer, and will suddenly change to the detriment of the baby.
Without being paranoid in the psychotic sense, they are highly alert to any complaint that might be made about them to D.O.C.S or any other authority, and are highly anxious if any Family Law Court issue might threaten their continuing care. They have conscious fears and many dreams about losing their child in various manners.
Similarly they are very afraid of sickness or death taking their child and often go to extraordinary lengths to overprotect their child.
On the other hand their blocked feelings of grief come out on their child who is usually imperfect compared with the child lost to adoption. Sometimes they are harsh and use emotionally incontinent checking measures. Then they become shamed and guilt ridden at what they have done. It is during these times they seek help from Child Health services or private doctors, but in many cases just present the surface of the problem without telling of the real issues.

Definitive Action

Public declaration of significant findings

This needs to be a public account of major and common effects of past adoption practices, specifically addressing the power and coercion applied and the helplessness of those who lost their baby.
A special version of this should be published and focussed at adoptees, particularly to disabuse them of the myths that the public have held about their mothers, and indicating the abuse, coercion and damage their mothers had to bear.

Public Education about possible and likely **long-term effects** of loss of a baby to adoption. This should be focussed upon the tens of thousands of those suffering without protest.

Public Education about **the difficulties faced by adoptive parents** and how little preparation there was for this role or how little the help available. This should also include issues of grieving sterility, ongoing and hidden low self-esteem, and the protracted effects of the insecurity created by raising another woman's child. There were recurrent problems in dealing with special difficulties of the adoptive relationship at each stage of development and subsequent testing behaviour by the adoptee. Many wouldn't recognise that over compliance with adult wishes was a sign of false self development and personality damage. But the type of help they were getting was platitudes, untested cultural myths and did not address their real difficulties. However, some did well to become a secure family: all the more congratulations to them to have done this despite the difficulties.
Any help to insecure adoptive families to come to terms with these factors will help a mother with reunion.

More general public education measures should be spread widely and use such contacts as popular magazines and inserts in the daily press.

Remedial therapy for personality damage and psychiatric illness.

There are a wide range of requirements. Some need to be involved in groups run by their peers or receive counselling from the peers who have some professional counselling training. Others need counselling from professionals who are not associated with adoption apologists. The financing of this will need support. At present the Victim's counselling service keeps proper control of counselling requirements for victims including a report to assess the need for counselling and then an agreement to finance a counselling contract. While there is some intrusion into privacy by this method, it is a responsible way to channel public money to provide essential help for those to whom it is overdue.

However for some with life changing trauma, particularly around their mid to late teen-age years, who have combinations of psychiatric illness and personality damage, there is a requirement for weekly psychotherapy by a highly trained psychotherapist over 2 to 5 years. While a few psychiatrists will do this for Medicare rebate that is unusual and there is generally a gap. If it is done by a professional from another discipline it works out even more expensive. There needs to be some way of subsidising these people, because they have very little chance of having the therapy they need without it.

There is also the requirement to train a wide range of professionals into the particular aspects of trauma, grief arrest, and circumstances of personality damage these mothers suffer. I see many of them who say: "I went to Ms Bloggs, but she had no idea what had happened to me or what it has done to me." or: "My GP Dr Doe tried to help me, but he doesn't seem to have any idea what it would be like to go through that."

Help with reunion

For some there is a new series of traumas when they try to bring about reunion. (Also there is huge trauma for adoptees who want to find their mother, only to be rejected by a shamed woman with personality damage who is unable to overcome her fear and the thought of more humiliation for her 'mistake')

Some face veto, and we have found from those who overrode the veto, or those who met by accident, despite the veto, that the veto is a family issue from the adoptive family, sometimes driven by frank exercise of adoptive parental power.

Problems contingent on the adoptive family

While there are a minority of secure adoptive families, the vast majority are highly insecure and have dealt with their insecurity by establishing family myths, attitudes and requirements that are inimical to the original mother.

When you meet or even hear of a **secure adoptive family**, you will see a family who have allowed the adoptee to grow up in a manner that fits his or her own nature and aspirations, control is not a big issue to them, they lead by example rather than by establishing concepts about the adoption to create 'gratitude', guilt or identity confusion. They are aware of the adoptee's need for identity and are supportive about reunion. They are able to develop a relationship with the mother that is overall accepting and has an element of open-minded curiosity. I have known an adoptive family to provide remarkable support for the family of their adoptee's mother as she was dying and thereafter.

Such secure adoptive families are far outweighed in numbers by each of the other two groups. Both may contain adoptive parents with personality disorder or psychiatric illness.

In one of these the adoption has been such a negative experience or the **adoptive family so disintegrated**, that the adoptee has long separated and gone his or her own way in life, sometimes in trouble, sometimes dead

from suicide or drug overdose, sometimes married early, sometimes working in a far off place.

The other situation is **the insecure adoptive family.** They are insecure about their own lives and how they have weathered the inevitable crises in bringing up the adoptee, they are insecure about relating to the adoptee in the future, and they defend their insecurities by using a palisade of defences usually around the cultural attitudes of the 1960s many of which are listed earlier in the submission. There are many binding behaviours: fostering dependency, undermining confidence and the young person's sense of capability, and by developing 'gratitude' and guilt. Many wealthy adoptive families blatantly do it with the check book up their sleeve. The mother who lost her baby is pictured as rejecting, morally slack and incapable. Those that do this more openly are often easier for all to deal with, but there are subtle forms of it that create an invisible cage around the adoptee.

Those **who do not tell the adoptee at all are a sub-group of the above,** but I have only struck four over the last fifteen years. People like to talk about this one because it is one small aspect of adoption information which is well known and many have previously thought about it. It creates its own special problems, but in my experience this situation makes up less than 1% of adoptive families and seems to gather a huge amount of attention that distracts from the pressing problems of the other 99 point something percent of people in distress. But I will say that the culture has long known this to be a dangerous situation, and the disaster comes as the cousins or others tell the adoptee in primary school years and the whole secret is carried on in a disintegrating charade. I know of one case where the adoptive parents were successful in hiding the information for 25 years or so, with highly distressing consequences for the 'relinquishing mother' and giving the adoptee a totally false facade to her life. I am aware that The Inquiry might hear about this instance directly.

The mother must therefore go to reunion with all the load of her own damage from losing her baby to adoption and cope with whatever she may meet in the adoptee's damage, and have the most likely contingency to be a disintegrated or insecure adoptive family.

It is 'a very hard ask'.

The good outcome factors are supportive friends and family, having worked through her own personality problems or illness, knowledgable counselling, some awareness of the needs and stages of development of young adults, a secure adoptive family, and her own preparedness, no matter how late, to be a mother to her adult child. However the difficult meetings that turn out successfully seem to hinge on the qualities and compassion of the adoptee, and often their awareness of the similarities in temperament and style of thought of their biological parent.

To train counsellors for this role, needs a group of special people who can be moderately objective, aware of the anguish entailed and able to negotiate with highly insecure adoptive families. *In the interim time before open adoption/fostering arrangements become universal, it is important to introduce adoptive children to their biological parents at a younger age*

and not wait until all the myths and prejudices are formed into hard defences.

Latter day apologist organisations

I see women who have been to contact organisations who offer to assist in reunion where original mothers are trained to approach the adoptive family and say they just want to be their child's friend, or "like a sister", that they can never replace their child's 'true parents' in the child's life, and generally behave in a self-effacing obsequious manner, and only relate to their adult child in a manner that meets the adoptive family's approval. These organisations often use the term 'birth mother' which some say, "Well, at least they are saying we are some sort of mother." But others are humiliated and wounded by this term at it is a contradistinction implying that they are mother by virtue of giving birth only. These original mothers say it is an imposed name and is inherently untruthful--there are no other terms like this such as 'birth brother' or 'birth family'. It is reminder, they say, of their humiliation and is there to maintain their diminished status.

Because of these practices and others such as creating mixed groups of adoptive parents, adoptees and original mothers before they are ready or the power imbalance addressed, I am highly sceptical of the apologist agenda and the sophistication, orientation and training of these organisations.

The process makes the mothers angry and revives the feelings associated with their original abuse. In my view such organisations, some of which are latter day versions of those responsible for the original abuse, should be disbanded or, at least, have their funding cut off forthwith.

Those counselling the mothers after reunion need a clear idea of the testing behaviour with which adoptees mostly respond. Some of this is due to their stage of development, but it is often an aspect of their identity disturbance, and when this has been insecure they have responded by testing their adoptive parents to see for security's sake how deep the bond goes. Unfortunately it makes a habit of testing behaviour, and it is difficult to give up. But it is important to know that in the adoptive situation the person with no idea of their real roots needs such interpersonal strategies to know who is close to them and who they might trust.

Anglo-Saxon culture and heredity.

It is important too, to realise that this is Anglo-Saxon culture. We tend to forget that Anglo-Saxon culture is noted for its success for over a thousand years in the successful understanding of practical genetics: they didn't know what genes were, but said "It's in the blood." and whether they knew about genes or not, they produced the mostly highly productive strains of horses, dogs, cattle, poultry, pigs, pigeons, grains, fruit- trees, oak trees, vegetables and berries to name only some, that are the backbone of the world's agricultural development and commerce in the Twentieth Century.

In such a culture it is important to know what is 'good blood' and 'bad blood', how temperament in dogs is a pivotal issue above colour or face, which animals are resistant to disease, which ones to weakness or stunting of growth. In whatever manner such a culture sees the same issues in humans, and however regrettable some of the ethical issues that arise from such deeper cultural fantasy, it is still a major issue because while horses race at Randwick, footballer's sons repeat their father's glory, and brothers play in the New South Wales eleven, it does not leave the centre of the cultural stage.

The adoptive parents are aware that the genetics are different: this is some of their insecurity. The child wants to know what his or her genetics are. It is fascinating to hear of a child and their biological parent becoming close enough to say to each other, 'And you get that rash just there too." or "I make jokes like that: I can't seem to help it." or "I can't eat pineapple either." This may seem trivial but such minor issues underlie an area of understanding and identity that the rest of the community take for granted. I can remember an adoptee where I had been very worried about suicide for many months, telling me about her meeting with her Great-grandmother. I doubt that anybody who doesn't know the anguish of being an adoptee cut off from your roots, would know what an unbelievable experience meeting a great-grandparent of the same sex would be.

For the mother who is afraid to tell her subsequent family, or the adoptee who defends by conformity to his adoptive family's requirements, this is a deep-seated issue they have to struggle against, a denial of a pivotal preoccupation which most of the community forget. The counsellor must give them the opportunity to explore this and not suppress their curiosity. However a cruel situation is the adoptee (usually male) who will go to a meeting to satisfy his curiosity but will have nothing else to offer and never contact again.

Accountability

The identification of those with pivotal senior leadership roles who administered, (or de facto administered) The Act of 1965 in major hospitals and organisations responsible for adoptions, specifically in the years 1965 to 1974 is necessary. It will be important for the mothers to see that considering the gross damage to their lives and their baby's lives that there is responsibility somewhere behind an Act of Parliament, even though they were damaged by numerous people ignoring The Act or riding roughshod over treasured legal principles.

Those with Pathological Grief arrested around irresolvable anger at humiliation, repugnant neglect of their needs and even smug abuse: they need to have some idea of how it happened and know the faces of those who organised the taking of their children. In 1997 I gave the paper: *Adoption Grief: Irresolvable Aspects*. The grief is irresolvable for a number of reasons, but certainly one of them pivots on this issue of accountability. Without such identification and while public ignorance then and now about the abuse committed on them still exists, these women live in an Orwellian world where 'doublethink' is everyday. How can

they resolve their grief while the public is taken in by the apologists' myths, rationalisations and excuses.

Sophistry

From many quarters and for over twenty-five years, I have heard from professionals, "It was for their own good." and "They were relieved when they signed the consent." and "That's what they really wanted." and "I wasn't involved but I know the professionals all had good intentions." But the mothers say, "It was the only thing that would keep them away from us. It was our only peace and they said we'd have to sign it anyway." or, "I didn't know there was any way I couldn't." or, "I tried it for two days and they got worse. I was hoping for somebody to come and help me keep my baby."

Some professionals said, "We didn't prescribe the drugs." or "We didn't think they were drugged." or worse still, "I didn't take any consents", or various other responses: "They were free to go any time they signed themselves out. All the young women at our institution wanted to give up their babies; it wasn't like Crown St." and the usual ones of the genres: *"There weren't any labour wards there. We were only playing leap-frog"*, or *"I was only obeying orders."*

The Inquiry's collection of these excuses is likely to rapidly outstrip mine. Nevertheless, considering the massive loss and damage to tens of thousands of lives in New South Wales and the pain and distress that is ongoing now, these excuses can only be expected to draw more anger and contempt.

Recompense

Most of these women want recognition of the coercion and humiliation they underwent, and public acknowledgment of their helpless situation and subsequent damage, rather than pecuniary compensation.

Some see the official birth certificate as an affront as the only links for their child are to the adoptive family, and would like to see acknowledgments of original parents on birth certificates.

They also want as satisfactory reunion as they can manage.

Many women who have taken early steps to seek recompense would have been served well had this Inquiry been instituted some years ago, as seeking redress would not have been the only avenue they could have taken to have their grievances heard. The magnitude of redress required is such that many will continue to seek it, but others will be helped if such issues as Accountability and Assistance with Distress are dealt with adequately.

For those who want redress, The Inquiry will be in a position as a result of wide knowledge of their circumstances to make known some of their legal difficulties.

These are:

To provide widespread knowledge of why The Statute of Limitations was virtually impossible for these women to comply with. Many were so

damaged with Pathological Grief, Dissociative Disorder and Depression that it was the last thing they could think of. Many others were developing hard shelled defences against their feelings, and others were retreating under a shell of secrecy driven by shame and guilt. Few had any sophistication about the law.

With this in view, their legal representatives can be given knowledge of the wide range of illegalities perpetrated on these women. In most there would be 16 or 29 (or some other number of illegal acts), some of them under Common Law, some criminal, such as Common Assault, some Statutory contempt in the sense that prescribed procedures and information were not known to the de facto administrators of The Act or these were ignored, some issues of breach of duty, and others of breaches of Administrative Law.

To take a theme example rather than a specific one: if it is not fair for a frankly damaged woman to take action about 'offence eleven' because the evidence to rebut her story is dead along with a potential witness in the concatenation of illegal acts, what about 'offence number six' where Sodium Pentobarbital has been given to her at 8.30am on the morning she is recorded as having given consent to adoption and the documents are there to leave this fact undeniable?

Consideration should be given for an Act to be introduced to Parliament to clarify the set of circumstances in which these women were abused, and to take account of the wide variety of offences that were committed against them in such a way that the legal process would be seen to be fair by them and the general public. Such an Act could by-pass a lot of lengthy and costly legal process which hardly any of these women can afford, and even specify, like the Acts for Workmen's recompense, or motor vehicle accident recompense, a scale of damages they might receive depending upon the degree of damage, thereby making the whole process relatively uncomplicated.

Other funds required

Legal aid for damage cases with merit

Publication funding: wide spread distribution of small publications are necessary for health professionals and the general public to understand what happened, and also publications especially pitched to adoptees.

Travelling funds for reunions: The baby has grown up on Cairns or Holland and reunion is unaffordable by either party.

Training funds. This is for trainers to meet with a younger untainted non-apologist group of counsellors with specific knowledge about losing a baby to adoption and carry through systematic instruction on how these women's needs might be met.