Supplementary Submission: Proposal for Mental Health Services

The Broken Bond: Stolen Babies Stolen Motherhood Viewed Through a Trauma Perspective

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> Trauma is defined as: experiences that cause great stress, pain and/or fear for a person. Traumatic events can disrupt or disturb a person's health and everyday living … Some examples include rape, death or **disappearance of a family member … being harassed by authority figures** … (STARTTS Website: 2011).

Introduction

When the sacred bond between mother and infant is broken it is a traumatic event that inflicts life-long physical and emotional pain (Pierce: 1992; Verrier: 1997). In Australia during most of the 20th century there was a government sanctioned policy of forcibly removing the newborns of unsupported unwed mothers at or soon after birth. This was not only unethical and illegal, but violated their civil and human rights (Sherry: 1992; Harper: 1978; MacDermott: 1984). This article will discuss the past removalist policy and its effects on mothers, their now adult children and other family members, who carry the life-long psychological and emotional scars. It will also examine and discuss the underlying neuro-biological processes of birth and the affects of interfering in its completion. Contemporary science provides evidence that the impact is not confined to the traumatised, but is transmitted inter-generationally. The current treatment regime for those affected is flawed and needs to be refocused through a trauma perspective (Higgins: 2010). An alternative method will be put forward that is modelled on Judith Herman's trauma approach utilised by STARTTS, an organisation that provides treatment for tortured and traumatised refugees.

The article is divided into five sections. Section one provides an overview of the government sanctioned policy of forced removals and identifies the dynamics inherent in the practice that predisposed the mother-infant dyad to complex post traumatic stress disorder (PTSD). Isolation, terror, helplessness, secrecy and systematic oppression by authority figures are some of the key determinants discussed. Section two gives a neuro-psycho-biological explanation of the birth process, section three provides an insight into the effect stress/cortisol has on the developing foetus and an overview of the life-long cognitive, immune and hormonal deficits caused by interfering in such a powerful genetically based, environmentally determined sequence of events. Further the neurobiological distress, caused by separating mother and infant which leads to "neuronal rewiring", hyper-arousal and constant retriggering of the original trauma, will be discussed (Herman: 2000). Section four examines and discusses the flaws in the current treatment model and section five presents an alternative that is holistic and suited to the unique needs of mothers, their adult children, fathers and others suffering because of a government experiment that went horribly wrong.

Personal Involvement
I had a baby girl taken in 1969, against my will, whilst I was heavily drugged and physically held down. I never saw my newborn, she never saw her mother's face. The physical assault, the loss of my infant, the interruption of the birth process, the injection of a carcinogenic hormone to stop my body from producing milk, the injection of a mind altering barbiturate that knocked me unconscious, the brutality of the nursing staff was a torture from which I am still recovering. In 1976 my second pregnancy triggered a stress break down where I experienced severe panic disorder and agoraphobia (van der Kolk: 2005). I have been on a journey to find healing ever since

Section I

Overview of the Commonwealth's forced removals and assimilation policy through the prism of practices in a State Institution
This section will describe the treatment of unwed mothers at The Women's Hospital Crown Street (Crown St.). This was the hospital from which the author had her child taken and will serve as an exemplar for the treatment meted out to single mothers across Australia.

Pamela Roberts, head social worker at Crown St, 1964-1976, in a sworn affidavit (1994) detailed an internal Health Department Policy that dictated hospital procedures as it related to single mothers (Health Commission Circular: 1982). Before being admitted into Crown St an unwed pregnant woman had to first visit with a social worker (Roberts: 1994, p 1). This effectively placed her under the control of the social work department. Whether a pregnant woman had made up her mind or not about adoption her files were marked with a secret code: UB- or BFA, both meant: unmarried, baby for adoption (Roberts: 1994, p. 5). The code guided the medical staff months later in the way unwed mothers would be treated in the maternity ward. Legally no decision was to be made until 5 days after the birth. The main objectives of the policy are detailed:

> 1. The mother was to have no contact with her newborn; the baby would be whisked away to the nursery
>
> 2. During the birth a pillow would be placed on her chest, eliminating eye contact. The mother was not informed this would occur
>
> 3. In the days after the birth the mother would not be permitted access to her infant (1994, p. 6).
>
> 4. Be injected with stilboestrol (a carcinogenic hormone to dry up her milk) immediately after the birth so prohibited nursing. The mother was not informed this would occur (Roberts 1994, p. 8).
>
> 5. Be given barbiturates prior, during and after the birth without permission) (1994, p. 5).

> 6. Mothers would be transported to an annex of Crown St: Lady Wakehurst, without their consent, where they were drugged, incarcerated and had no way to access their infant who was kept back at the hospital (Roberts 1994, p. 6).

Pamela Roberts stated:

> The Internal Policy Manual aimed to ensure that the Social Work Department ran in accordance with the Hospital and Health Department policies and it existed to ensure that the policy was understood and implemented by the social workers … the usual practice was that the mother was not permitted to see the baby in the delivery room … in the days after the birth, the mother was not to see the baby. The Policy Manual would reflect these procedures.

Marking of the files with a secret code was illegal because it assumed the mother had consented to adoption prior to birth, legally no consent could be given until at least 5 days after the birth. It was discriminatory because unwed mothers were singled out for differential treatment based on their marital status (MacDermott: 1984). The marking of the files showed collusion between medical and social work staff and it was a system that was practiced Australia-wide. None of the above procedures were done for the benefit of the mother or her infant (Wessel: 1960, 1963; Lewis: 1965; AASW Manual: 1971). For instance the 5 day minimum time for mothers to sign a consent was the outcome of discussions between hospitals, social workers, state and federal Ministers (1961-1964) on the premise that more consents could be garnered if the mother was made to sign before leaving the hospital (Hon Asher Joel, NSW Legislative Council 1965, p. 3057 cited in McHutchison: 1984, p. 16; Langshaw: 1978). The same rationale was apparent when an adoption Bill was debated in the Victorian Parliament: "Mothers now leave hospital as early as five days after their confinement (Hon Archibald Todd: 1964, vol 274 Adoption of Children Bill, 14 April, 3649). Many unmarried mothers come from remote parts … It would be undesirable to have to "chase" the mothers to get their consent … The period of five days has been agreed upon after consultation with the almoners and the experts at the main maternity hospitals" (Hon R. J. Hamer: 1964, 14 April, vol 274, Adoption of Children bill, p. 3647).

Crown St was one of the nation's largest maternity and teaching hospitals and its practices reflected those in operation in other major maternity hospitals throughout the country. This is because the State Health Department Policy, discussed above, was guided by the Federal Health Department, an institution that consisted of Federal and State Health Ministers (Cole, unpublished thesis: 2011). Hence the internal policy outlined by Roberts was applicable to other Australian hospitals and government and non-government Mother and Baby Homes (which were regulated by the States) (Voigt: 1985, p. 82).

Indeed adoption was a Commonwealth project. In 1908 at a National Conference of Welfare Workers held in Adelaide, adoption was declared a national welfare policy (Mackellar: 1913, p. 204). The Federal Health Department, as explained above, directed internal health department policy at the State and Territory level from the

1920s onwards with the co-operation of doctors, social and welfare workers and hospital boards (Cole: 2011, unpublished thesis). The Annual Report of the Child Welfare Department proclaimed: "Today the influence of the Health Department is paramount in all questions of infant welfare" (Annual Report 1936 and 1937, p. 60).

The popularity of adoption, according to Dr. Rosemary Kerr (2005, p. 156) led to "Departments around Australia corresponding to create uniformity in adoption legislation" which began with reciprocal legislation between states that was fully implemented by 1948. Kerr states that a propaganda campaign was begun by the Child Welfare Departments to complement the legislation by normalising the trafficking of women and babies across borders and gain the support of the community by "constructing adoption as being in the best interests of the child and a service to the state".

The impetus for reciprocal legislation came when prospective Australian Capital Territory (ACT) adopters inquired of the NSW Child Welfare Department to adopt children from that State, obviously there was a shortage of adoptable infants available in Canberra. Their applications were refused. It seems that a particular ACT applicant sought assistance from the Commonwealth re the refusal of his application. The Prime Minister's Department contacted the New South Wales Child Welfare Department, on the 16th December 1940, asking whether arrangements could be made for a resident of the Territory to adopt a child born in New South Wales and if so to indicate the procedures to be followed. On the 23rd of March, 1941 the New South Wales Department wrote and informed the Prime Minister's Department that the law as it stood did not allow for adoption in their State by ACT residents. An overview of the correspondence between the Commonwealth, New South Wales Child Welfare Department and the Attorney-General's Department was detailed in a letter sent to the Minister of the Department of the Interior, in 1943 (Lind: 1943, 12 Nov, File 43/1/588). Since adoption was national policy the Prime Minister assisted potential adopters of the ACT by sending around a Circular instructing all State Premiers that either a Commonwealth Law would be passed, or if that was not constitutionally possible, then the States would have to enact amendments to State legislation that dealt with adoptions to allow individuals from the ACT to adopt from their State (Commonwealth of Australia, Prime Minister: 1940, File No. AS-412/1/7). West Australia already had a reciprocal arrangement in operation with the Commonwealth (Department of the Interior: 1941, 22 Dec). It does not state anywhere in the correspondence that the reciprocal legislation was being implemented for the best interests of anyone other than the adopters. In fact in a Memo from the Attorney-General's Department to the Department of the Interior it states: "I refer to your memorandum dated 14th July regarding the amendment proposed by the Director, New South Wales Child Welfare Department, to the Adoption of Children Ordinance 1938-1940 to facilitate residents of the ACT in obtaining children from the States for adoption in the Territory" (1941, 26th Aug).

At the time adopters could only adopt infants domiciled in the States in which they resided, though the Adoption of Children Ordinance 1938-1940 enacted by Sir Robert Menzies when he was Attorney-General did allow for the Minister for the Interior to transmit and receive adoption orders for registration purposes to and from other States

it could not be acted upon, except for WA, because there was no legislation or administrative mechanism in place to facilitate the process. The Prime Minister sought advice from the Attorney-General and was informed that the Commonwealth did not have the power under the Constitution to make laws with respect to adoption in the States (Knowles, Attorney-General's Department: 1941, 10 Dec, File No. 37/733). The Prime Minister informed the Premiers (Prime Minister: 1942, Jan 2, File No. AS. 412/1/7) of this fact and to overcome the obstacle the Prime Minister requested the Attorney-General's Department to communicate with Premiers in all States with a view to amending their legislation so that ACT adopters could adopt from their States (Burgess, Department of the Interior: 1941, 22 Dec). The Premiers obliged and the States from 1941 on, guided by the Commonwealth made amendments to facilitate adoptions for ACT residents. Since the implementation of reciprocal legislation was instigated and co-ordinated by the Commonwealth government and enabled an adoption order made in any State or Territory to take effect throughout the Commonwealth it is not surprising that it was referred to as a Commonwealth law (see footnote 13) irrespective of lack of constitutional powers to make any such a law.

Negotiations to implement uniformity between all States, so that, for instance, an adoption order made in South Australia was legal in Victoria, began when the matter was raised in a letter from the Prime Minister's Department (1944, 10th Nov, File AS. 412/1/7) to the Premiers stating it would be brought up at the next Conference of Commonwealth and State Ministers (Haddeley, NSW Premier: 1944, 22nd Nov). The issue of reciprocal legislation was given further impetus when the President of the Queensland Country Women's Association wrote to the Prime Minister on the 24th August, 1944 requesting "the necessity for uniformity throughout the Commonwealth in regard to laws relating to the adoption of children" (Daley: 1944, 1st Nov, File 43/1/588, Memo to the Prime Minister's Department).

Uniformity of legislation, that started with the Federal initiative of implementing the reciprocal legislation around the country was achieved by 1970. During the 1960s the Commonwealth and States met regularly to draw up a Model Adoption Act that all the States and Territories followed. W. C Langshaw, Director, Department of Youth and Community Services, discussed the Commonwealth State collaboration in drawing up the Model Act at a National Adoption Conference held in Melbourne (1978): "On the 29th of March, 1961 at a meeting of the Attorneys-General of the Commonwealth and the States it was agreed that Australia move toward the development of nationally accepted standards, policy and law in adoption. It was also agreed that the social welfare aspect of adoption should be considered and determined before work on the legal problems was undertaken … numerous discussions took place between the Commonwealth and States at Ministerial level and representations and proposals were received from many individuals and organizations. The Commonwealth Attorney-General's Department under took the task of preparing a draft of a model bill in the form of an ordinance for the Australian Capital Territory. All States and Territories passed legislation and the new so-called Uniform Adoption Law gradually was implemented between 1964 and 1970 (Langshaw: 1978, p. 47). According to McHutchison the Uniform Adoption Law "had some of the most harsh provisions in adoption legislation in the world" (McHutchison: 1985, p. 20).

Hon A. D. Bridges, NSW Minister of Youth and Community Affairs (1965) acknowledged the Commonwealth-State participation in the Adoption Bill that came before the NSW parliament: "Adoption is a process which depends upon a happy partnership between the professions of law and social work … It is for this reason that the discussions which have taken place over the last several years on a Commonwealth-wide basis have involved both the Attorneys-General and their officers and the Ministers for Child Welfare and their officers, since both groups have had important roles to play in the drafting of this bill as indeed, have those many voluntary organizations, which have been involved in the field of adoption and have made representations to me and to my predecessor on this question (Adoption of Children Bill, 8 Dec., 1965, p. 3041).
Langshaw stated that the Uniform Adoption Law "produced a very real uniformity in adoption standards and policy through out the country, and the resultant legislation [provided] a sound framework for the type of adoption practice envisaged by the Child Welfare League of America Standards for Adoption Service" (Langshaw: 1978, p. 47). The Child Welfare League Standards for adoption that Langshaw is referring to, were discussed by Joseph Reid, Executive Director of the Child Welfare League of American and Deputy President of the International Union for Child Welfare at various social work conferences and in published articles. Since it was these Standards the Australian government modelled its policy and legislation on and enacted through its various state governments it is worth noting what they were, briefly:

- An unwed mother and her child are not a family.
- The mother is not entitled to make her own decision.
- If family members do not support adoption, they should be counselled otherwise.
- It should always be presumed that adoption is in 'the child's best interest'.
- A service that must be rendered for infertile couples is the use of case work by social workers utilising psychological methods.
- Ensure mothers do not try to reclaim their babies (via both casework and legislation).
- Agencies should be politically active and lobby for law changes to reduce the rights of natural parents.
- Because the above principles are only partially accepted by the community, social workers must advocate strongly and publicly for their acceptance.
- Agencies must network with those in law and medicine to ensure the above principles are disseminated.

The Uniform Law was never designed to protect the rights of mothers and infants but to provide more newborns for adoption. This was acknowledged in a newspaper article by a Victorian Catholic Adoption Agency representative, Father Perkins, who stated: " … the number of children available for adoption would greatly increase when the new *Adoption of Children Act* came into force this year". This is exactly what transpired. After the new *Adoption Act* was introduced in New South Wales, Langshaw stated: "An increased number of illegitimates are handed over for adoption …This is contributing factor in the shortened waiting period undergone by childless couples. A few years ago this was estimated at four to five years. It is now no more than 12 to 15 months".

So positive were adoption enthusiasts they believed, after the introduction of the new legislation, and with the continued minimal impact of the pill on the rise of ex nuptial births, that there would be an increase in NSW from 5, 360 adoptions in 1968 to 6,177 in 1978. Hence there was an expectation that by 1978 that hospitals would need to have to take care of a huge increase in babies surrendered for adoption.

Joseph Reid, on whose principles Australian policy was based stated:

> It is not an unwarranted interference with the unmarried mother to presume that in most cases it will be in the child's best interests for her to release her child for adoption ... The concept that the unmarried mother and her child constitute a family is to me unsupportable. There is no family in any real sense of the word. The concept that the unmarried mother has an absolute right for self-determination is to me fallacious.

Mary McLelland, Supervisor of Professional Training, Social Studies Department, University of New South Wales at a Conference, (attended by adoption social and medical workers, representatives of adoption agencies, adoption lawyers and the Minister for Child Welfare), to herald in the new *Adoption of Children Act 1965* (NSW), reveals the policy now adopted by Australia replicated two of Reid's principles, 1. Ensuring the mother will not reclaim her baby and 2. The support of the infertile to form a family:

> The ultimate objective of adoption is such a planned change through helping to make a family where before *one did not exist*. But before the placement … [there] are other minor or contributory changes in the social functioning of various individuals where the social worker's part is well defined. The natural parents must resolve, if possible, conflicts about the surrender of the child, the child even if an infant … will need to develop to the point of readiness for placement

Mary McLelland, also made it clear that this state was following the above Principles that influenced Australian government policy when she stated the mother must be helped to her decision because:

> the responsibility for considering the interests and needs of the child is often beyond the capacity of the frequently immature, frightened and confused pregnant girl

It was also apparent from the following that the primary clients were infertile couples, and so again following Reid's principles that assistance be "rendered for infertile couples in the use of case work by social workers utilising psychological methods" McLelland states:

> the social worker's concern is with childlessness or infertility… not in its treatment, but in assessment or resolution of its effects on the marital

> relationship of the couple … They are also very rewarding points for intervention by the social worker

The stigmatisation of single motherhood is encouraged by Reid because the principles advocated by the Child Welfare Bureau are only partially accepted by the community therefore his instruction that: "social workers must advocate strongly and publicly for their acceptance" is followed in Australia. McLelland stated at the aforementioned seminar that to sections of society "out-of –wedlock pregnancies are quite acceptable" but her role as a social worker was to control illegitimacy by supporting marriage and married couples and not accepting single motherhood because it undermined the social functioning of society. She also advocated the media in the recruitment of adoptive parents to that end.

The principle that doctors, lawyers and social workers should work collaboratively to support adopters is re-stated by McLelland: "Direct service to the adoptive parents is the joint responsibility of doctor, lawyer and social worker".

Pamela Roberts, in a leading Journal on Hospital administration, indicates that the Australian policy of promoting adoption was well entrenched in the hospital system:

> During the ante natal period the patient should be *helped to come to a decision* about the future of her baby .... It must always be remembered that any reference to unmarried mothers and illegitimate children brings a strong emotional reaction in most people because *these are things* seen as a threat to the concept of the family as the unit of our society

Social workers and Child Welfare Departments vigorously promoting adoption via the media also reflected the policy and Principles adopted by the Australian government. Mary McLelland is quoted in newspaper article:

> A further modern day role of the social worker was to recruit adopting parents by stimulating interest among those suitable

The history of unwed motherhood in Australia during the 20th century, shows a shameful collusion, between Commonwealth and State governments. As outlined above there was collusion between parliamentarians, child welfare and health departments, social workers, religious and non-religious Mother and Baby Homes, and public and private hospitals. All working together, as Dr Rickarby succinctly states, "in a conspiratorial activity to abduct the infants of unwed, unsupported mothers" and provide them to those the state deemed 'fit': white, married infertile couples (Cole: 2011, unpublished thesis; Cole: 2009; Rickarby: 1998).

Yesterday's 'State Certified Wet Nurses' become Today's 'Birth-Mothers'

During most of the 20th century the infants of unwed, unsupported mothers were taken at or soon after the birth. Very early in the century, before bottle feeding was safe, mothers generally nursed their babies before they were forcibly taken (Moulds: 1982, p. 3; Kerr: 2005: Cole: 2011; Graham: 1973, p. 45). The crying, screaming and distress of mothers whose infants were dragged from their arms and breasts was a

common occurrence and one that 'infant procurers' wanted to eliminate (Moulds: 1982, p. 3; Slingerland: 1919, p. 157; Crown St Archives: 1977; Research participant in Cole: 2011). Not allowing mothers to see their infants was introduced at Crown St by a social worker sometime in the 1930s (Crown St Archives: 1977) supposedly to limit the distress of medical staff. During World War II the practice spread as military welfare officers pressured staff at hospitals and mother and baby homes to discharge women as soon as possible as they were needed back in service (McCabe: 1997). In Britain mothers were expected to wean their babies for at least six weeks, as that was the minimum time considered safe before separation. It was thought that if the infant and mother were separated too early it was exceedingly traumatic and caused psychological damage to the mother and physical damage to the infant (Roberts: 1994: Crown St. Archives: 1977; Fyfe & Stuart: 1954). Unfortunately for Australian mothers Roberts, even though she knew it was traumatic, continued the practice at Crown St until she retired in 1976 (Crown St Archives: 1977). In other institutions it did not stop until 1982 when a Health Department directive was circulated advising medical and social work staff that not allowing mothers' access to their infants was illegal and constituted placing mothers under duress to gain their consents (Health Commission Circular: 1982).

Mothers were not told of the hospital protocol. Roberts explained (1994) it was not policy to inform them that they would be unable to see or be permitted access to their infant at the birth or in the days afterwards. This kept the mother in a state of confusion and uncertainty; hence her fear and isolation were amplified.

The internal policy of the health department was universal and the practice so entrenched that medical and social work staff followed its tenets without question (Lawson: 1960; Report 22: 2000; Lewis: 1965; Borremeo: 1968: Noble: 1993, pp. 208-209; Chesterfield-Evans: 2000). Dr. Lawson advised his colleagues that when it came to adoption "the law should be the least of their concerns" because an unmarried mother and her family were 'unfit' to raise their own child (Lawson cited in *Medical Journal of Australia*: 1960). In fact forcibly separating a mother from her newborn was not only cruel, punitive and served no medical purpose (Wessel: 1960, 1963) it violated the civil and human rights of mothers and their infants (Sherry: 1962; Chisholm: 2000, pp. 178-179, p. 184; Wilson: 1973, pp. 74-75; Cole: 2008; Harper: 1978, pp. 111-112; MacDermott: 1984, p. 23)

It was assumed by some adoption workers and politicians that the fate of young unmarried mother's newborn depended on the decision of her parents. The reality was that after giving birth age was inconsequential (Chisholm: 2000, p. 178; Department of WA Health: 1972). Her rights at 14 were the same as if she were 34, because the act of giving birth entitled her to the full legal control and custody of her child and to deny her access was as unethical and illegal as it would have been to deny a married mother (Report 22: 2000, pp. 130, 184). It was the duty of professionals purporting to assist single mothers that they protect them from coercion even if it emanated from their own parents. Any decision regarding the infant had to be solely the mothers, free of duress and fully informed (Department of WA Health: 1972; Women's Weekly: 1954; Child Welfare Manual: 1958). The Human Rights Commission declared that "Denial of access presumes that the single mother should

be encouraged to part with her child because she is less fit as a parent than approved partnered mothers" (1984, p. 44; Chesterfield-Evans cited in Report 17: 1998, p. 67).

The Use of the Pillow To Prevent Bonding

Prior to Roberts taking over the position as head social worker the practice of using a pillow to stop mother and newborn having eye contact had been in operation for decades (Crown St Archives: 1977). A pillow was placed on the labouring mother's chest, or in front of her face or a sheet was drawn, the intent being to break the bond (Roberts: 1994; Noble: 1993; Report 22: 2000, p. 91, 98; Rickarby: 1998, p. 66). It was presumed, in that sphere of time, that bonding for the baby began at birth and if a mother saw her infant her maternal nature would be enlivened and she would "fight harder" to keep it (Slingerland: 1919, p. 157; Woodward: 2004; Rickarby: 1998; Kisilevsky et al: 2003, p. 222; Crown St Archives: 1977; Roberts: 1994). A further purpose was revealed in historical social work journals (Bernard: 1945). Social workers were advised that attachment between adoptive mother and the stranger infant would be enhanced if she was the first carer to consistently engage with the child and feed it. The impact of breaking the bond was never researched though anecdotal evidence of the damage caused was available for decades (Parker: 1927; Slingerland: 1919; Russell: 1938). Certainly those taking the babies were aware of the grief.

Dr. John Bowlby in 1953 stated:

> it should not be forgotten that emotionally mother and baby are one unit and the mother's protective feelings are especially strong while her baby is small. Therefore, if he is removed from her care she, at least, will suffer

The trauma caused by interfering with the birth process was so severe it silenced the mothers and traumatised infants (Verrier: 1993; Rickarby: 1998, pp. 67-68). The biology underlining the birth process, the interference with and resultant physical and mental health problems will be explained in detail later.

The act of not allowing mothers to see their infant imprinted on their mind that they were powerless and isolated, less than human and so 'unfit' that they weren't even afforded the dignity of completing the birth process (MacDermott: 1984, p. 44; Rickarby cited in Cole: 2008, p. 125). Some mothers were physically restrained either by being handcuffed to the bed, their legs tied to stirrups or physically held down on the bed by staff (7.30 Report: 2011; Cole: 2008; Cole: 2011, unpublished thesis). The key dynamics that predispose or cause post traumatic stress disorder (PTSD) were apparent in the state sanctioned policy: isolation; captivity; feeling powerless to alter outcomes; terror; confusion; life-threatening systematic oppression by authority figures (state oppression); degrading and inhumane treatment and loss of a loved one (STARTTS: 2011; Van Der Kolk: 2006; Aroche & Coello: 1994; Schore: 2003; MacDermott: 1984; Sherry: 1992). In this scenario a major component was the use of bullying, coercion and duress. This further exacerbated the mental health damage of mothers and Dr. Geoff Rickarby (1998) has applied the broader diagnosis for the psychiatric sequelae: Complex PTSD complicated by pathological grief.

Mothers were routinely drugged with copious amounts of mind altering barbiturates prior to, during and after the birth (Report 22: 200, pp. 104-106; Rickarby cited in

Cole: 2008, p. 124; Cole: 2008, p.p. 163-164; Rickarby: 1998, pp. 63-65). At Crown St, after delivery, mothers were given an injection of sodium pentobarbitone to knock them out and a carcinogenic drug: stilboestrol, to dry up their milk (Cole: 2008, p. 163; Report 22; 2000, pp. 107-108; Rickarby: 1998, p. 64). According to Dr. Geoff Rickarby (1998, p. 64) both types of injections constituted a major assault as the 'general consent to procedures' form that a patient signed on admission would not have covered being injected with a hormone to prohibit nursing nor a mind altering barbiturate. Pentobarbitone was used at the time for deep sleep therapy at the notorious Chelmsford Hospital. Rickarby stated that the drug "would make the foetus subject to hypothermia and gross distress at birth [and]… to drug people on that level with barbiturates was known then to be a dangerous practice" (Rickarby: 1998, p. 69).

According to Helene Deutsch, since 1924, the medical establishment has acknowledged that the process of birth is a traumatic event (Deutsch: 1925, p. 416), but she explains: "What is not so well known, outside obstetrics, is that mothers who are in a state of narcosis during delivery have 'a peculiar feeling of estrangement toward their children. Often the child can be regarded as something alien'" (1925, pp. 416-417). It seems the purpose of using such a large amount of drugs was another attempt to break the maternal bond. On the other hand some mothers stated that they experienced very painful births and they were told this was part of their punishment (Cole: 2011 unpublished thesis). It was presumed by some in the medical profession that if the birth was particularly painful it also interfered with the bonding process, this has been confirmed by recent research that evidences pain interferes with the production of certain hormones needed to enhance bonding (Odent: 2001; Kumar: 1997; Pitman: 2008; Jacobson & Bygdeman: 1998). So it seems that either sedating mothers into unconsciousness or allowing them to languish painfully without any relief were both used to interfere with bonding.

Usually within 24 hours post-birth mothers were transported without their permission to an annex of Crown St: Lady Wakehurst, where they were kept drugged and incarcerated until they signed a form releasing their infant for adoption. Some mothers who continued to refuse to sign were told their baby had died whilst others had their drugs increased (*The Australian*: 1996; Cheater: 2009, p. 182; Elphnic & Dees: 2000, pp. 43-44; Critchley: 2006; Hermeston: 2000, pp. 227-228; Clausen: 1996; Cole: 2011 unpublished thesis). All were informed they would not be discharged until they signed the form (Report 22: 2000, pp. 131-132). After signing the mother had 'socially cleared' written on the bottom of her medical files (Cole: 2008, p.165). If she tried to leave before signing she was threatened by medical and social work staff that either the Department of Child Welfare or the police would be notified and she would be declared 'unfit' and her infant taken and placed in an institution (Report 22: 200, p. 132).

Justice Richard Chisholm (Report 21: 2000, pp. 178-179, 184-186, 188; Report 22: 2000, p. 132) identified the specific crimes committed by the social and medical work staff as: kidnap, false imprisonment, taking a child by improper means and the tort of deceit. The tort of deceit is acting in a way that is deceptive in order to deprive someone of something that is rightfully theirs with the intention of gaining an advantage. The adoption industry operated on market principles of supply and demand (Marshall & McDonald: 2001). Demand being much greater than supply the infant

was a much sought after ‘commodity’ hence criminal activities were engaged in to ensure supply was met (Lawson: 1960; Vincent: 1960; Report 22: 2000; Hindsight: 2011). There was also money to be made. Adoption workers not only maintained their employment but in many cases received gifts and donations (Cole: 2011, Unpublished thesis; McCabe: 2000, 1997, p. 508; Rawady: 1997; Sherry: 1992). One couple who gave evidence at the NSW Inquiry into Past Adoption Practices (1998-2000) stated that their doctor had sold their infant to a Jewish couple informing them the child was Jewish, which he wasn’t (Peter & Diane Stebbings cited in Report 17: 1998, p. 152).

Matron Ivy McGregor

In an article run in the Sunday Mail, titled 'Adoption Scam', dated August 27, 1995, it was stated that Matron Ivy McGregor was selling babies for 50 pounds each out of the Anglican home for unmarried mothers which she ran: St Mary's Home at Toowong. McGregor worked at the Home for 19 years: 1945-1964. McGregor illegally sold the babies to ex-pats residing in New Guinea. Adopters were supposed to be resident in Australia and of course baby selling was illegal.

McGregor was a prolific fund raiser constantly claiming the Home needed more money to assist the “unfortunate girls”, though researcher Bernadette McCabe states: “In view of St Mary's full bookings, government grants, generous and sometimes anonymous monetary donations, gifts of goods and produce, income generating nursing home facilities, and the fact that the property was an unencumbered bequest, the suggestion of financial hardship is not very convincing” (McCabe: 2000, p. 91).

Single mothers did not willing surrender their babies to strangers, McCabe explains: “the matron's personal knowledge of the adopting parents would place increased pressure on the unmarried mother to consent to the adoption ....”. The cosy relationship between ‘respectable’ married couples and the Anglican Matron is obvious: “flowers [were] delivered to the hospital by grateful adopting parents ... It was not uncommon for newborn babies to be shown off by adopting parents at St Mary's Home with the identity of the mother openly disclosed” (McCabe: 2000, p. 92). One mother incarcerated in the Home in 1964 was a 16 year old girl who stated that “she was told she had to sign papers giving her daughter up for adoption, even though she told the matron she wanted to keep the child.” This mother was not alone in her claims. Another mother states she was “coerced into signing away her daughter ... while she was still pregnant” (Sunday Mail: 1995). An adoptive mother claims she “can still see the distraught young mother [who] was made to give up her baby ... I can close my eyes now and I can see the look on that girl's face as she was forced to physically hand over her baby” (Sunday Mail: 1995).

McCabe describes Matron McGregor as “a discreet baby broker”. The Home was “run under the auspices of an archbishop, and some very prominent citizens. Under Ivy McGregor's directorship in ... 18 or 19 years it has been responsible ... for the placement of about 900 babies” (McCabe: 2000, p. 93).

The collaboration between the State and the Home was obvious with McGregor receiving regular government grants – 600 pounds to have the Home painted in 1955 (Homes Mission Echoes: 1956 cited in McCabe: 1997, p. 507) and an extensive renovation program undertaken in 1962 (Home Mission Echoes: 1960 cited in

McCabe: 1997, p. 507). According to McCabe both The Women's Shelter and St. Mary's Home expected pregnant women and unwed mothers to pay their Social Service Allowance (Anglican Church Archives cited in McCabe: 1997, p. 508). According to McCabe one of her research participants stated that she was charged a set fee in 1952 which was higher than her Social Service Allowance hence she was subsidised by her boyfriend (McCabe: 1997, p. 508). Therefore the Home was receiving payments from the Commonwealth via the mothers' Social Service Allowance, grants by the State, free labour from the women who were expected to be rehabilitated by the forced removal of their infant.

Reproductive Slavery

Adoptive parents treated the social workers that played god and provided them with an infant as heroes, whilst they saw the mothers that actually created the infant as a threat and wanted no contact (Mather: 1978, p. 108: McHutchison: 1985, p. 2). The adoption workers that took the newborns 'despised' the single mothers they publicly stated they "only wanted to assist". One social worker I interviewed stated that in the social work department where she did her training (1971), there were often degrading comments made about single mothers, she insists they were judged harshly and treated punitively (Cole: 2011 unpublished thesis). I would imagine it would be hard to steal an infant from someone you respected and liked. The following is an example of the mindset that existed amongst this extremely rigid, fundamental minority:

At a Conference held by the Victorian Council of Social Service in 1973 it was noted in the introduction and in a later chapter that six years before in 1967 at a seminar on services to unwed mother two single mothers *dared* to attend and their appearance caused "shock and even outrage" among the adoption workers (Wilson: 1973, p. 70). Some social workers who practised outside the field of adoption criticised their colleagues who worked in the industry. In 1978, Victoria Mather, who was a community social worker with Pregnancy Help, Brisbane stated:

> [The single mother] is one of the adoption triangle, but at the 1st Australian Conference on Adoption (1976) she barely rated a mention. It seems that no one wants to know her. We won't talk of her 'rights' because she hasn't any … she is seen as someone who has 'done wrong' and must bear the consequences of her wrong doing alone. Why is it that the woman is so castigated? … The adoption agencies only want her baby … She asks if she can pass on a gift [to her baby] an outfit that she has crocheted-she asks if the child will be told she loves it – we know that her gift and letter go into the wastebasket-we hear adoption workers telling us that when they give information to adoptive parents they say 'I don't want to hear it-from this day forward this child is "ours"- we don't want to know about its mother'. …why don't the [adoption workers] like her?-why can't they accept her?- and are all [the adoption workers'] misapprehensions, anxieties and fears passed onto the adoptive parents who in turn pass them onto the adopted child, this nebulous cloud of misapprehensions? … We have often heard references being made to the child who is given up for adoption as being 'unwanted'. Because a pregnancy was 'unplanned' it does not follow that the child was 'unwanted'. At Pregnancy Help we

> have had the opportunity to counsel hundreds of single pregnant girls. Our service does not confine itself to a single answer to their questions … Our counsellor accompanies the client for interviews with other agencies, ante-natal clinics and remains with them in labour if this service is desired… (Mather: 1978, pp. 107-109).

Social Mores

I would ask those apologists who continue to state that their abuse of single mothers reflected the social mores to take note of their colleague who knew them well in the 1970s and stop re-traumatising mothers with their lies and distortion of historical facts. Rose Rawady, social worker, states (1997, p. 400): "For there to be general reconciliation between [adoption workers] and natural mothers, it is essential that we own up to the part we played … in an oppressive health and welfare system which we collectively failed to question or challenge".

During the NSW Inquiry into Past Adoption Practices (2000, June, p. 182), Hon Dr. Chesterfield-Evans asked: "The people who were consent takers, who in a sense have come to us as apologists … have said they were cogs in wheels; that they were [subject to] the mores at the time … Justice Richard Chisholm answered: "… it is possible … there was a blaming attitude to the mother. Some of the practices that one hears about seem difficult to explain unless there were some sense of anger or hostility towards the mother …there was a very punitive attitude towards the mother …some of [the practices] were so cruel … the guidelines or social work texts or other sources of guidance as to what were accepted as ethical standards at the time" is what Chisholm believed would give guidance as to what constituted the social mores. The Child Welfare and Social Work guidelines that were **made public,** were very clear there was to be no duress or coercion used to gain a consent, the mother was the legal guardian of her child from the moment of its birth and had every right to see, touch and nurse her infant. Domestic and International law both supported the infant's right to be brought up in its family of birth. Adoption was supposed to be an institution for a child who had no family, or whose mother did not want or was incapable to parent her child. If social mores were reflected in professional guidelines and the legal system then those working in the adoption industry acted unethically, illegally and their behaviour did not reflect the mores of a 20th century democratic society (Chisholm cited in Report 21: 2000, June, pp. 182-187). Acts of torture and inhuman and degrading treatment can never be justified, they were inhumane at the time and remain acts of extreme cruelty and barbarity even if laws were passed to excuse such behaviours, such as was the case in Nazi Germany. In this instance the torture perpetrated on unwed mothers violated domestic and international law, violated the guidelines set out in Child Welfare Manuals and the principles that supposedly governed the treatment of clients by the social work profession. Most decent Australians would be insulted to know adoption industry workers blamed the barbaric treatment they meted out on defenceless mothers and infants as reflecting acceptable practice in Australia in the mid 20th century.

Adoption Acts Legitimise Institutional Baby Theft

It needs to be understood that legally no decision about adoption could be made before the fifth day, and then the *Adoption Act* only came into force if very specific

criteria were met. Mothers had to make informed consents that meant being warned of the psychological impact of having their child adopted, such as the grief, mourning and distress they would experience from the loss (Child Welfare Manual: 1958; Lancaster: 1973, p. 63; McLean: 1956; Harper: 1978, p. 113; Gough: 1961). They was also supposed to be apprised of the financial assistance that was available, accommodation and child minding if they had to work (McLean: 1957; NSW Child Welfare Dept Annual Report: 1957, p. 25: Child Welfare Manual: 1958; Child Care Committee (AASW Manual): 1971; Rawady: 1997; Progress: 1962 cited in McHutchison: 1985, p. 13). Then and only then if the mother was 'firm' in her decision, one not acquired through duress, coercion or fear of poverty, and only if *she insisted* that the form: 'Consent to Make Arrangements' for adoption was brought to her, did the *Adoption of Children Act* come into force. If the mother was in any way distressed, hesitant or under the influence of drugs no decision was to be made and like any other patient she was entitled to leave the hospital. Since none of the above criteria were ever met, the *Adoption Act* never came into force, therefore there were no 'forced adoptions' in Australia, rather there were thousands of kidnapped babies (Chisholm cited in Report 21: 2000, p. 178).

Entrenched Practice

From 1971 numerous studies proved that newborns kept with their mothers grew up to be more healthy, secure and confident than infants "snatched" away (Verny & Kelly: 1981, p. 114). Yet in Australia, as discussed, babies were taken from their unwed mothers from birth up until 1982 (Health Commission Circular: 1982). Elizabeth Nobel (1993, pp. 208-209) states: "When I was a student at a maternity hospital in Australia the doctor would say F.A, (For Adoption) and pass the baby behind his back where the waiting hands of the nurse would whisk it way. The mother never had one glimpse of the child she carried for nine months … Fortunately social pressure … has put a stop to this dehumanizing practice and the rights of the mother are now recognized and protected". So it seems the practice of removing the baby at the birth sight unseen was so entrenched that medical students were unaware that the practice was illegal. They were also unaware that assuming a newborn was up for adoption just because the mother was unwed, was also illegal.

'Brain Washing'

The above imposed, systematic form of torture served a number of purposes. It facilitated the adoption process (Woodward: 2004); it traumatised the mother into silence (Rickarby: 1998, pp. 66-67); it facilitated attachment between adopter and infant (Bernard: 1945) and it protected the staff from witnessing the mother's distress (Crown St Archives: 1977). What is not so well known is that it made the mother hyper suggestible (Sargant: 1951, pp. 313-314; Sargant: 1957, pp. 72-73; Beard: 2009, p. 23). It was well documented in the psychiatric literature that a traumatised individual found it difficult to speak because intense trauma induced disassociation and amnesia states, not only in the present, but for decades (Sargant: 1951, p. 315). The hyper suggestibility was further enhanced by military style mind altering drugs that interfered with higher cognitive abilities that impeded the decision making capacity (Sargant & Slater: 1940, p. 105; Sargant: 1942, p. 575; Beard: 2009, p. 25; Debenham, Hill Sargant & Slater: 1941, p. 108), this has been labelled: narco-induced hyper suggestibility (Sargant: 1957, p. 77; Rickarby: 1998, pp. 66-67). So when mothers were told "to go home and forget they gave birth" or that they "would go on

and have children of their own one day" or "you're selfish if you keep your child" or "you must choose adoption because it is in the best interests of your child" or "there is a wonderful married couple that can give 'the' baby all the things you cannot or the most touted and misused excuse: 'in the best interests of the child' (Report 22: 2000, pp. 83; Cole: 2008, 1997; MacDermott: 1984, pp. 3, 35; Roberts: 1969; *Australian Women's Weekly*: 1954, 8th Sept, p. 28) these suggestions were uncritically accepted and had the same effect as a post-hypnotic suggestion (Sargant: 1957, p. 77; Report 22: 2000, p. 174; Rickarby: 1998, p. 68; Beard: 2009, p. 26; Debeham, Hill, Sargant & Slater: 1941, p. 108). Dr. Geoff Rickarby has rightly labelled these techniques as 'brain washing' (1998, p. 65; Sargant: 1957) and states that this has further complicated and made worse the mental health problems of women decades after the original trauma was inflicted (1998, p. 62).

Repressed Grief: Long Term Mental Health Problems

Pamela Roberts (1969, 1973, pp. 97-98) and others (Gough: 1961; Betheras: 1973; Lancaster: 1973; Borremeo: 1967; Nicholson: 1966) publicly advised professionals to assist mothers through their mourning process because not to do so would cause later mental health problems. Privately, it was very different, if any mother dared to return to their social worker for support they were dismissed and told: "Why haven't you got on with your life, everybody else has" (Cole: 2008; Cunningham: 1996, p. 71). Thus isolation and powerlessness were utilized to silence women and unacknowledged grief and trauma left women with a pre-disposition for post traumatic stress disorder complicated by pathological grieving (Rickarby: 1998). When Ann Cunningham spoke with adoption workers who had worked in the 1960s they acknowledged "that the decision of adoption involved pain and suffering … [but] little was done to assist her in the process of grieving …". Cunningham inquired why? The workers' blamed "lack of time and resources … and the extensive case load [they] had … ". They admitted: "There were no ongoing support services … and little if any antenatal care …" (1996, pp. 21-22). The lack of antenatal and postnatal care was criticised by professionals who believed that the adoption industry's only concern was with the "harvesting of newborns" for their primary clients: adoptive parents (Rawady: 1997; Mather: 1978; Ansovic: 1997; Nicholson: 1966). Other critics commented that it was a total disregard for the rights of the mother and rather the treatment was designed as a form of punishment (Clapton: 2003, p. 23; Wilkinson: 1986, pp. 93-103; Voigt: 1986, p. 84; Mather: 1976, pp. 107-110; Wilson: 1973, p. 70; Wessel: 1960, 1963; Lewis: 1965; MacDermott: 1984, p. 3; Vincent: 1960). Unfortunately unexpressed and unsupported grief becomes pathological and rather than diminish intensifies with time (Condon: 1986).

An Oppressive Regime: Harassment by authority figures

The following is an excerpt from Dr. Geoff Rickarby's evidence given at the New South Inquiry into Past Adoption Practices (1998-2000). It substantiates the above detailed litany of human and civil rights abuses, the systematic harassment by authority figures and highlights the resultant mental health problems: Complex PTSD complicated by pathological grief.

> [Adoption workers] were pressing them as early as they possibly could … largely [unwed mothers] were drugged in one form or another … they were

> given … the drug pentobarbitone … they would have been in no state to [make any decisions] … the pressure was on them to sign the consent: they had been marked to sign the consent … as soon as the woman looked like saying "no" they were threatened with bringing on the Child Welfare and being [labelled] an 'unfit' mother … [unwed mothers] were in an incredibly powerless position dealing with a linked series of people who had marked them out in what was frankly, conspiratorial activity to abduct their babies …[this was done] by the people in the antenatal home; the nursing staff in the labour ward; the doctors in their prescribing of drugs; and the other professionals, in changing their attitude - the brainwashing procedures that went on for months beforehand … a number of different people working together to one end, to take the baby … the separation from their families, the baby being taken, their face covered, the power difference-was built up over months so that the young woman was put into a powerless, shamed position and then the drugs were added … then they came in asking for consent on the earliest possible day … they were so isolated … what we are dealing with here is a situation where each one [was alone] (Rickarby: 1998, pp. 63-67).

Section II: The Birth Process

Overview: Biological, Emotional and Psychological explanation of the Mother Infant Bond

Bonding begins in utero. That a pregnant woman has a developing and intense relationship with her unborn child has been known by women since time immemorial. A woman who gives birth to a stillborn will grieve profusely because she has already developed a connection with her infant. Her baby is a real person to her and she not only grieves the loss of the baby that was part of her, but all her hopes and dreams for her child (Condon: 1987, 1991, p. 44; Winnicott: 1966; Giles: 1970; Nicol: 1991, pp. 7-9). Margaret Nicol (1991, p. 67) states that it has been a convenient myth to believe that "the bond between mother and baby begins at birth". It has provided a shameful justification for the insensitivity of others to the grief of women who have lost a child to death or had it forcibly taken for adoption.

Bonding is a continuum not a singular event that occurs at birth. Attachment and bonding are two discreet phenomena. Attachment is the emotional connection between individuals (Verrier: 1993, p. 20) whilst the bond between mother and infant is far more complex and includes biological, emotional and psychological attunement. Synchronicity between mother and infant is a process that allows for 'genetic mirroring' which provides a sense of security and belonging in the infant (Sants: 1964; Schore: 2009, p. 192). This familiarity provides the infant with a healthy identity and sense of who he or she is (Sants: 1964). Identity therefore is biologically grounded, neuronally imprinted and results from satisfying a hormonally primed emotional need of being connected to one's mother (Buckley: 2008; Anand & Scalzo: 2000).

There is now a new appreciation of the complexity of the origins and maintenance of the mother-child bond and its long-term consequences (Lickliter: 2008, p. 397).

Harlow showed that maternal separation had a profound impact on subsequent behavioural, social and emotional development and Bowlby recognized the significance of this to human development (1958, 1969, 1973 cited in Lickliter: 2008, p. 398). It is now understood that the mother serves as a biological and emotional regulator for her infant, and if mother and infant are separated there are long term effects on her offspring, not the least being vulnerability to stress, hypertension, and ulcers. Recent findings in epigenetics are indicating that the mother-infant bond is an ongoing process that begins prenatally and proceeds postnatally. "The 'social bond' between infant and mother expands to become a multidetermined set of dynamic processes involving more than envisioned in traditional attachment theory … multi-levelled mechanisms contributing to long-term consequences on adult physiology and behaviour. These findings show that through interactions with her infant, the mother directly shapes the developing physiology and behaviour of her offspring, in part by regulating the activation and expression of specific genes (Lickliter: 2008, p. 401).

Biological

The mother and infant are a dyad, not two separate entities. A mother therefore is not interchangeable with a 'primary caretaker' who has not had the nine month history in which to develop such a deep connection on multiple layers of being (Verrier: 2008, p. 19; 1997, p. 11; 2011; Winnicott: 1966; Clothier: 1941; Pierce: 1992). The infant is biologically attuned to its mother, no other woman can take her place, and if separated from her will feel pain (Chamberlain: 1992; Verny & Kelly: 1981; Pierce: 1992) and that pain is remembered (Anand, Phil & Hickey: 1987; Chamberlain: 1989). There are signs of perception, memory and attention suggesting involvement of higher brain structures in the prenatal period (Kislevsky et al: 2003, p. 223). Prenatal memory is important for the development of attachment and other maternal recognition (Kisilevsky et al: 2003).

Neonates have various cognitive coordinative and associative capabilities in response to visual and auditory stimuli indicating that there is cortical function and that memory in newborns is highly developed and begins in utero Research has proven that the neonate is more sensitive to pain than a three or six month old infant (Anand et al: 1987). Anand et al (1987) state: "The density of nociceptive nerve endings in the skin of the newborn is similar to or greater than that in adult skin". If the newborn experiences pain it will produce elevated levels of endogenous opioids and will emit different cries dependent on different stressors, for instance: "Pain, hunger or fear can by distinguished reliably by the subjective evaluation of a … spectrographic analysis (Anand et al: 1987). Crying is the infant's means of communication and it is distinguishable, meaningful and purposeful.

Pain causes behavioural changes in newborn infants which have been found to be persistent and "may disrupt the adaptation … to their postnatal environment, the development of parent-infant bonding and in the long term lead to psychological sequelae". Memory is dependent on the functional integrity of the limbic system, the hippocampus, amygdala, anterior and mediodorsal thalamic nuclei and mamillary nuclei which are well developed and functioning in the newborn. Brain plasticity, involved with learning and memory is at its highest in the late prenatal and neonatal period (Anand et al: 1987). Pain also causes hormonal and metabolic changes. There

are marked increases in the release of hormones such as catecholamines, growth hormone, cortisol, aldosterone and other corticosteroids and suppression of insulin secretion. There are changes in plasma stress hormones such as cortisol which indicates neonates respond to stress and it has a very disruptive effect on their biology which in turn can lead to long term physical and mental health problems (Anand et al: 1987; Schore: 2003; Odent: 2001). Prenatal and postnatal experiences set up neuronal patterns, that is they "carve templates into limbic synaptic wiring patterns, which will determine emotional as well as cognitive 'grammars' and strategies and thereby optimize or limit cognitive as well as emotional capacity throughout life" (Sullivan 2006, pp. 590-591).

According to Kisilevsky et al (2003) prenatal memory has been evidenced by the re-playing of a piece of music during the pregnancy that the newborn responds to when exposed to post-birth. There is much evidence that the foetus learns the speech characteristics of its mother prenatally and prefers its mother's voice to other female voices after birth. It may be that by learning to recognise its mother prenatally the newborn infant has a "familiar" stimulus in its environment after birth to respond too. Prosodic nature of speech can be clearly heard inside the womb and the foetus has been shown to be able to differentiate between speech sounds in the womb. The newborn has a preference for their mothers' native language. Kisilevsky et al agreed that foetuses' differential responses to their mother's and a stranger's voice suggests that they indeed are capable of remembering and recognizing characteristics of their mother's voice (2003, p. 222; Hepper: 1996). The foundation for speech perception and language acquisition is laid before birth – "babies recognise and remember their mother's voice in the womb" (Kisilevsky et al: 2003, p. 222). Research has proven that the in utero auditory environment is rich and includes mother's heart beat, intestinal sounds, music and speech from the external environment. "That a baby knows its own mother at birth has been proven over and over" (Verrier: 1993, p. 20).

Psychological

On a psychological level the infant sees itself reflected in the familiarity of the mother's facial expressions, body language, vocal tones and patterns. Through mirroring the infant feels as if he or she fits, they don't feel alien. They are able to gain an authentic sense of self, self-confidence and build a strong sense of identity (Verrier: 1997, p. 14). The mother-infant interaction has long term consequences particularly in terms of sociability, aggressiveness and their capacity to love (Odent: 2001). It was observed as far back as the 1950s that mothers are a mirror for their babies, this has now been confirmed by contemporary neuroscience. "When the baby looks at his mother's face he is looking at him or herself (Winnicott cited in Klaus & Klaus: 1998, p. 75). The infant after birth still feels as if it is part of its mother. The mother similarly feels as if her infant is an extension of herself. She identifies with her newborn which Noble states (1993, p. 206; Winnicott: 1958 cited in Meadows: 1986, p. 175) corresponds to Winnicott's concept of "primary maternal preoccupation" which explains why a mother can by "feeling herself in his or her place, meet her infant's needs". Interestingly when a mother loses her infant through death or is taken for adoption she feels as if she has had a limb amputated (Baran, Panor & Sorosky: 1976, p. 99; Verrier: 1997), an infant mirrors this experience and feels as if the loss of its mothers is akin to losing part of itself (Verrier: 1993, 1997).

Psychobiological

Neuorscience has proven that maternal distress causes foetal distress, and provides scientific evidence for what was reported decades earlier. Research conducted in 1965 (Manlove) found many adoptees suffer from Attention Deficit Disorder (ADD) which was expressed in aggressive behaviours such as hyperactivity and sociopathic tendencies. Manlove (1965) proposed that the psychiatric sequelae was not an outcome of parenting or heritability but because of the adoption process and in particular the separation of mother and infant. During the pregnancy the pressure placed on women to relinquish, disturbed foetal development which led to impairing the newborn's ability to deal with stress, this was further compounded by exposure to the trauma of being separated from one's mother which the researchers contended led to the later development of physical and mental health problems.

Psychobiological research has proven that a mother operates as an external regulator of her infant (Hofer cited in Anand & Scalzo: 2000, p. 71; Schore & Schore: 2008, p. 10). According to Schore and Schore (2008, p. 10) Bowlby's attachment theory has now shifted to a regulation theory. The mother not only acts as a regulator of the infant's emotions, but of his or her metabolic, nutrient and behavioural mechanisms. These systems regulate the infant's activity level, sucking behaviour, oxygen consumption, sleep-wake cycles, circadian rhythms, hormonal, cardiovascular, enzyme production, temperature, immune and neuroendocrine responses (Hofer cited in Anand & Scalzo: 2000, p. 71; Chamberlain: 1998, p. 82). These functions are regulated by areas of the brain, located in the brain stem, midbrain, pons and medulla and are collectively known as the Reticular Formation (McCaffrey: 2008). The familiarity of the mother and her synchronicity with her infant is responsible for the healthy function of the reticular formation. Therefore it is not surprising that when the birthing process is interfered with it causes brain disorganisation and has catastrophic implications for the infant.

Neurobiological

During the pregnancy the mother becomes more right brained in her thinking, particularly in the last trimester (Condon: 1986, 1987; Condon & Ball: 1989). According to Condon this is to prepare the mother to intuit her newborn's needs and be more responsive Similarly the infant is primarily right brained and Schore (2001) states that the mother's regulation of her infant is dependent on the mother and infant's right brain synchronicity.

Schore (2001a, p. 204) states that adult brain pathology has its beginning in disorganisation of the brain due to attachment failures. This leads to impairments of the early development of the brain's stress coping system which in turn leads to a predisposition to PTSD, disassociation and impaired brain function (Schore: 2001, p. 201). Therefore separation from mother interferes with that crucial window of opportunity and has a cascading effect on the infant's brain development. This provides biological evidence for Verrier's (1993, p. 71) conclusion that adoptees are pre-disposed to PTSD and often present with symptomolgy that has been labelled: adopted child syndrome (Kirschner: 1997).

Early Relational Trauma on Brain Development

Once an infant is removed from his or her mother it is placed in an unfamiliar, therefore traumatic, environment. This can produce atypical patterns of neural activity and interfere with the organization of cortical-limbic areas and compromise brain-mediated functions such as attachment, empathy, and affect regulations. Stress alters the development of the prefrontal cortex and arrests its development. Damage to the amygdala (involved in the fight and flight mechanism) in early infancy is accompanied by profound changes in the formation of social bonds and emotionality. The effects are long lasting and often increase over time. "Impaired social functions of the amygdala are implicated in autism and would include autistic posttraumatic developmental disorder". It is also implicated in generalised anxiety disorders. Relational traumatic events can interfere with the development of the infant's coping systems, and later deficits in emotional arousal: an "impoverished conscious experience of emotion". Most critical is the interference with social bonding. Early neurological damage of this prefrontal cortex causes a failure "to acquire complex social knowledge during the regular developmental period and an enduring impairment of social and moral behaviour due to a disruption of the systems that hold covert, emotionally related knowledge of social situations" (Schore: 2001, pp. 220-222). Australian research indicated that the mothers of children diagnosed with some form of autism were "More likely to have experienced obstetric difficulties during pregnancy, labor, delivery, and the neonatal period (Glasson et al: 2009, p.624). Maternal stress predisposes women to complications during pregnancy and around the birth process. Research in the neurobiology of violent behaviour has found links with birth complications and maternal rejection (Raine et al: 1994). Childhood neurological problems, such as detailed by Schore, appear to increase the propensity for later violence (Cannon et al: 2002, p. 496).

The importance of supporting the infant mother dyad and not interfering with the critical period around birth is further supported by research that found for instance that mothers given barbiturates around the birth have children pre-disposed to later drug addiction (Jacobson: 1990). Other research indicated that high levels of autism were found in children born at a particular hospital that induced birth and used a cocktail of sedatives, anaesthesia agents and analgesics during labour (Buckley: 2008). How many of the mothers who were subjected to the forced removal of their infants suffered not only cruel and inhumane treatments, such as being used as teaching specimens for trainee doctors, but were given unnecessary drugs, induced births with large amounts of pethidine, unnecessary episiotomies, unnecessary vacuum extractions or had their babies pushed back up the birth canal because the doctor hadn't yet arrived. There has been no research into the outcome of these unnecessary medical interventions that were combined with the brutal separation at the birth, for our now adult children.

Conclusion

Babies begin hearing their mother's voice from about 30 weeks (Klaus & Klaus: 1998, p. 42) and at birth they prefer their own mother's voice over other women's and after a week they prefer their father's over another male's (p. 46). Not only is the foetus imprinted with the pattern of the mother's speech, but "her emotions are etched on its psyche" (Verny & Kelly: 1981, p. 25). Schore (2001, p. 206) cites various research studies that indicate maternal stress hormones doubled the risk of hyperactivity in infants, negatively affected foetal brain development and reduced the

later postnatal capacities to respond to stressful changes. This outcome is because the stress hormones affect the foetus's hypothalamic-pituitary-adrenocortical (HPA) axis and thereby produce an enduring neurophysiological vulnerability. The wiring of the brain begins in the prenatal period (Schore: 2003). Schore states that we have to move on from the conventional notion that biological variables influence behaviour and environment to the more modern notion that behavioural and environmental variables impact on our biology (Schore: 2003, p. 13).

If a baby is removed from its mother and placed in a nursery it encounters two unknown states: silence and stillness, for which it has "no genetic encoding for handling" (Pearce: 1992, p. 122). The experience of being separated from mother's body, with whom it is still completely identified (Pearce: 1992, p. 117) is traumatic for the infant. Stress hormones continue to be produced whilst the infant screams and even when he or she goes quiet (Pearce: 1992, p. 122). According to Pierce hundreds of studies have proven that after the birth it is necessary for the mother and child to remain with each other. Verny & Kelly (1981, p. 112) concur with Pierce stating that "in the last 10 years research has proven that the worst kind of birth is where the child is unceremoniously snatched and deposited in a nursery with other terrified children".

Review of the birth process

Skin to skin contact is needed to complete the birth. It shuts down the stress hormone production that begun as the infant made its descent down the birth canal. The reticular formation of the newborn is completed and learning begins immediately. If the infant is removed from its mother the reticular formation is incomplete, adrenal overload occurs and shock ensues. There is a particular cry that an infant emits when it is separated from its mother (Christensson et al: 1995), but if he or she cannot locate her within 45 minutes the infant goes quiet even though the adrenal glands still release stress hormones. Dr. Joseph Pierce states that this process is genetically encoded, and is a "final survivor manoeuvre nature provided for the abandoned infant". If the infant is not traumatised by being removed from its mother, rather than ten weeks to smile the infant will smile at his or her mother soon after birth (Pierce: 1992, p. 123). He states it is the "barbaric birth practices" that cause a baby to be developmentally delayed (Pierce: 1992, p. 124). The trauma of separation at birth has not only detrimental life long effects to both, but to society. Pierce stated that in California in 1979 the first scientific study to look at the root cause of crime and violence was undertaken. In 1982, it published a Report stating that "the first and foremost cause of the epidemic increase of violence in America was the violence done to infants and mothers at birth. The Report concluded: 'It is the primary cause of the explosive rise of suicide, drug abuse, family collapse, abandonment and abuse of infants and children …'" (Pierce: 1992, p. 126). The following section will look at the importance of keeping mother and infant together.

Mother is Home

According to Pearce (1992, p. 112) the mother's left breast is home with her familiar smell and heartbeat, to which the infant is highly attuned (Verny & Kelly: 1981, p. 28) and which is the major signal to shut down the stress hormones. The flight and flight hormones (catecholamines) peak at birth and contact with mother is critical to shut down the hormones otherwise there is a risk that the baby will go into psychological

shock which will prevent the activation of specific brain functions. Dr. Buckley proposes that separating mother and infant at this critical time may permanently miss-set the entire hypothalamic-pituitary-adrenal (HPA) axis which mediates stress responses and immune function throughout life (Buckley: 2008).

Mother-Infant Dyad

In utero the infant responds physically to each phoneme spoken by the mother "the infant is thoroughly imprinted by her speech" (Pearce: 1992, p. 117). Not only is her speech imprinted but the foetus's "moving body parts are coordinated with its elements" this includes pauses or changes in sound patterns (Klaus & Klaus: 1998, p. 60; Verny & Kelly: 1981 p. 21; Klaus & Kennell: 1982, p. 63; Condon & Sander: 1974). Hence mother and infant "rhythms and responses" enmesh long before birth. This synchronisation develops along with the foetus and when the infant emerges into the world synchronisation leads to feelings of familiarity and security. So "within a few minutes after birth, a cascade of supportive confirmative information activates every sense, instinct and intelligence needed for the radical change of environment; the vital reticular formation is complete and functioning" (Pearce: 1992, p. 117). The infant recognises the mother's smell as soon as the amniotic fluid drains from the nostrils. Her smell "is another strand in the completion of the senses" (Pierce: 1992, p. 113).

Therefore it is the familiar voice and smell of the mother that eases the infant into its new environment and provides reassurance that all is well (Verny & Kelly: 1981, p. 28; Klaus & Klaus: 1998, p. 9). Verny & Kelly state (1982, p. 74): "Bonding after birth is not a singular and isolated phenomenon, it is the combination of a bonding process that began long before in the womb".

If the mother and infant are not disturbed and the infant is placed immediately on the mother's stomach it will first lick its hands, this reminds it of the taste and smell of the amniotic fluid (Klaus & Klaus, 1998, p. 20). Around the nipple area an oily substance is released that smells the same as the amniotic fluid (Klaus & Klaus, 1998, p. 11). The infant guided by the secretion will crawl towards the left breast and begin to nurse while locking its gaze with that of its mothers (Klaus & Klaus: 1998, p. 21, 23). This activates the sense of taste also helping to complete the reticular formation. According to Pierce (1992, p. 113) if this process is interrupted it can lead to "impaired muscular movements, curtailed sensory intake and a variety of emotional disturbances and leaning deficits". The act of nursing causes large amounts of oxytocin to be released in the mother's body which "helps contract the uterus, expelling the placenta and closes off many blood vessels in the uterus" thus preventing haemorrhage (Klaus & Klaus: 1998, p. 11).

The one visual circuit that is genetically encoded is the infant's ability to recognise and respond to a human face six to twelve inches away (Pearce: 1992, p. 113). The approximate distance from mother's breast to her face. According to Chamberlain a newborn can pick out its mother's face from a gallery of other faces a few minutes after birth (Chamberlain: 1998, p. xiii).

> So within a few minutes after birth, under ideal conditions, a cascade of supportive, confirmative information activates every sense, instinct, and

> intelligence needed for the radical change of environment; the vital reticular formation is complete and functioning. All of this has been dutifully signalled to the heart, which organizes the triune brain into synchronous response and locks the news about the new environment into the infant's permanent memory, a memory that will influence all its future interaction with that environment. The six to twelve-inch distance from a face that activates the infant's visual system, and correspondingly its reticular formation, also places it in direct proximity to its mother's heart. Consider that a single heart cell can, given the proper spatial proximity, communicate with another cell, even across a physical barrier. Thus, in the same way, the heart, made up of many billions of such cells operating in synchrony, can communicate with another heart given the appropriate proximity. Nature's imperative is, again that no intelligence unfolds without a stimulus from a developed form of that intelligence. All evidence indicates that the mother's developed heart stimulates the infant's newborn heart, thereby activating a dialogue between the infant's brain-mind and heart. Then the newborn knows all is well and that birth has been successfully completed (Pierce: 1992, p. 114).

Example of mother child bond

The above scenario so eloquently described by Pierce (1992, p. 115) has recently been supported by an event that received world-wide attention: a mother who brought her dead infant back to life.

In 2010, a premature infant showed no signs of life when delivered at 27 weeks gestation at a Sydney Hospital. Since the importance of a mother spending time with her stillborn is well researched (to make the death a reality and assist in normal grieving) the infant was given to his mother (Nicol: 1991). The mother unwrapped her son's blankets and placed him on her chest so she and husband could say their goodbyes. Following two hours of cuddling and being spoken to by his parents, their son: Jamie began to gasp. He opened his eyes, the mother cried out: "It's a miracle". Later the infant's father stated that the mother: " … instinctively did what she did. If she hadn't done that, then Jamie wouldn't be here". The baby held out his hand and grabbed his mother's finger. He opened his eyes and moved his head from side to side. Five months later, their baby boy is healthy and doing well. Jamie's parents spoke of the importance of skin-to-skin bonding between mother and baby. The article elaborated how in Britain mothers are now encouraged to have skin-to-skin contact as it helps with feeding, bonding and settling the child (Smith: 2010, 26 & 27Aug: Kalla: 2010, 26th Aug).

The nursing and the skin to skin contact enhances the closeness and bond between mother and baby (Klaus & Kennell: 1982, p. 56). Klaus & Klaus state (1998, p. 11) that "mother and baby appear to be adapted for these first moments together" and if the baby is taken away, even for a short time "***she*** can feel isolated and abandoned" (Klaus & Klaus: 1998, p. 19). Allowing the birth process to proceed naturally lays the foundation for a lifetime of feeling secure and connected and of being able to develop meaningful relationships (Buckley: 2008; Odent: 2001).

The birth process is a hormonal bath that creates a dependence of mother and infant on each other

Overview

Just prior to birth there is a surge of adrenalin that keeps mother and infant wide eyed and alert and assists with the last push of the baby into the world. The neonate's first cry causes a surge of prolactin that not only enables greater flow of milk but enhances the effect of oxytocin and bonding (Chamberlain: 1989, p.82; Odent: 2001, 2006; Pittman: 2008; Fisher: 2005). It is the combination of the oxytocin and prolactin that ensure that love is directed to nurturing and "mothering" and sexual desire is suppressed (Odent: 2006; Fisher: 2005). Oxytocin causes a reduction in stress and later stress-related diseases. Around the time of birth oestrogen, progesterone and prolactin reach all time highs in the mother and circulates in the foetus. Removing a baby from its mother interferes with this complex hormonal process and stress and love are mutually exclusive. If the bonding sequence is interfered with it can have life long effects on the infant's social skills and ability to form meaningful relationships (Fisher: 2005)

The Hormonal Bond

During the birth process the increased levels of prolactin, oestrogen and endorphins will be the highest a woman will ever experience. This promotes a hormone high in both mother and infant which in turn creates a dependency on each other. This is a time of powerful imprinting and is part of humanity's survival mechanism in that mother and infant are intimately bound together, time apart becomes painful, like a withdrawal from a drug addiction. It cannot be artificially created, no social mother can recreate this powerful and natural event (Odent: 2006). A co-habiting male will also experience an increase in oxytocin as the female enters her third trimester. The hormone also effects the male's behaviour, he becomes more protective of mother and child. The signal for increase of oxytocin in males is believed to be caused by the mother's release of pheromones.

Labour hormones are produced deep within our mammalian or middle brain, the primitive part of our brain that is connected with instinctual behaviour, to aid and ultimately ensure the survival of our offspring (Buckley: 2008; Fischer: 2005; Pitman: 2008). Synthetic hormones do not have the same effect (Odent: 2001; Fischer: 2005) therefore the formation of a mother is an event programmed by nature to perfectly attune this particular woman with this particular infant and cannot be artificially created. No other human can take her place. Her worth can no longer be devalued, as it has been for the majority of the 20th century by scientists who consistently infer that mothering can equally be done by a "primary caretaker". A term that has come into common usage with a patriarchal/scientific view of motherhood that discounts the 9 months in utero, and has promoted a theory that coincides with the male perspective that one attaches to a child after birth. Hence the importance of the mother who gave life was diminished as it was considered that anyone, male, female or stranger could substitute for the real mother.

Oxytocin: the Mother hormone

Oxytocin production not only enhances the psychological connection between mother and infant but has biological and behavioural impacts. During pregnancy a rise in

oestrogen increases proliferation in oxytocin receptor sites in the brain in the area specifically concerned with maternal behaviours. This prepares the brain to be highly sensitive to later increases in oxytocin hence enhances bonding. In the period just after birth oxytocin level peaks this literally re-wires the brain to be more focused on the infant's needs rather than on one's own. Prior to a pregnancy a female's behaviour is focused on grooming to attract a mate but once the baby is born this focus is redirected to nurturing her newborn (Palmer: 2011). Linda Palmer states (2011): "Oxytocin is one of nature's chief tools for creating a mother".

Oxytocin functions to "integrate autonomic states with social behaviour". It is proposed that this occurs because oxytocin decreases stress, increases trust and integrates "psychological and physiological states that enable calmness and approach" (Feldman: 2007, p. 966). Therefore the hormone is associated with empathy and closeness. If the mother and infant are separated cortisol is produced and negatively impacts on oxytocin levels which has long-term effects on the infants' cognitive, neurobehavioral and social-emotional growth.

Fear and stress during pregnancy or labour can interfere with the process because it causes reduction of oxytocin and prolactin (Dahlen: 2011; Pitman: 2008; Odent: 2001). In turn this can interfere with the bonding sequence and therefore the synchronisation between mother and infant. Infants whose mothers are out of sync are more likely to be insecurely attached; feel rejected and predisposed to mental health problems. While their mothers are more likely to be abusive and fail to meet their infant's needs (van der Kolk: 2005, p. 2; Kemp: 1971) .

Oxytocin enhances endorphin production which is a natural form of pain relief and produces feelings of calm. Low oxytocin, on the other hand, makes birth more stressful and therefore painful. The birth canal contracts, contractions lessen, all of which increases the need for medical interventions such as episiotomies (Dahlen: 2011). Oxytocin sensitises the mother to the infant's odour and enhances the mother's connection with her infant. High levels of oxytocin are positively correlated with levels of trust, empathy, face recognition and ability to read emotional cues.

Oxytocin: The Love Hormone

Oxytocin ensures greater attachment between mother and father. Persistent regular body contact and other nursing acts by parents produce a constant, elevated level of oxytocin in the infant which in turn provides reduction in the infant's stress-hormone responses. The resulting high will control the permanent organisation of the stress-handling portion of the baby's brain- promoting lasting "securely attached" characteristics in adolescent and adult life. Low levels of oxytocin produce insecure characteristics which include anti-social behaviour, aggression, difficulty forming lasting bonds with a mate, mental illness and poor handling of stress. Prolonged high oxytocin in mothers promotes lower blood pressure and reduced heart rate as well as certain kinds of artery repair, reducing lifelong risk of heart disease (Palmer: 2002). High levels of oxytocin are associated with lower risks of cancer. Women who have caesareans and birth inductions make it more difficult to complete the bonding process as it prevents the release of hormones that cause a woman to 'fall in love' with her child. Michelle Odent states: "What we can say for sure is that when a woman gives birth with a pre-labour Caesarean section she does not release this flow

of love hormones, so she is a different woman than if she had given birth naturally and the first contact between mother and baby is different". Odent also believes that taking painkillers such as general anaesthetic or an epidural can negatively affect bonding in the first crucial hours (Odent cited in Cook: 2006, 13th July). How much harder is it for a woman who has never given birth to "fall in love" with her infant, to give her infant a sense of security by the familiarity of her smell, heartbeat and the sound of her voice. After all over the 9 month gestation period the foetus has internalised his mother's heartbeat, odour, voice tone and speech patterns, emotion and thought patterns, bodily rhythms. Her womb has been his or her world, it is all that is familiar and secure, it is home (Verny & Kelly: 1981, pp. 74-76; Verrier: 1997, 2008)..

It is not only the infant that is effected by the presence of the mother, but the mother by her infant. The bond that forms with conception primes mother and infant to intuit and to respond to each other in a dance-like synchronicity that impacts both in a profoundly deep psychological and biological way (Verny & Kelly: 1981, pp. 74-76).

When mother and infant have skin-to-skin contact a surge of oxytocin is released in both, so their bond is enhanced and the surge of adrenalin, to ensure alertness through the birthing process, is shut down causing both feelings of relaxation and love. Dr. Pierce explains:

> Besides sending out a major bonding signal to the infant's system and shutting down the adrenal hormone production a major dormant intelligence is activated in the mother, causing precise shifts of brain function and permanent behaviour changes. Ancient mammalian nurturing intelligences and latent intuitions are awakened in her (possibly related to the cyngulate gyrus area in the upper regions of the limbic system). The mother then knows exactly what to do and can communicate with her infant on an intuitive level. The mother's own defensive birth postures can relax to higher cortical structures. Nature's agenda is a dynamic in which the infant stimulates a new block of intelligences in the mother, which then enables her to respond appropriately and nurture her infant. These birth intelligences awakened in the mother are not learned nor can they be taught. They are archetypal and primal knowing, a complete wisdom that opens spontaneously if the mother is given the proper structural coupling with her infant. No deadly separation anxiety or psychological abandonment so disruptive to development occurs (Pierce: 1992, p. 116).

The love that links a woman to her baby is the deepest of human bonds (Nicols: 1991, p. 3). The following is an example of its depth. In this case it was the baby that brought her brain-dead mother back from a death-like coma (Doyle: 2011).

Emma took her 19 day old daughter, Eloise, out for a walk in her pram. A car struck both and Emma was left with such severe injuries that doctors told her husband, Yoshi, that she was brain dead and they wanted to switch of her life support machine. Yoshi refused he believed that Eloise could reach her mother. Intuitively he thought the way to achieve this was by placing Eloise directly on Emma's chest for

skin-to-skin contact. ". The following is an excerpt from the televised interview of Yoshi by Channel 7's Melanie Doyle (Mel):

Mel: "This is a story about a little girl who brought her mother back to life. What happens next is the only proof you'll ever need that there is a very special connection between a mum and her baby … In the 2 months since the accident Yoshi has had a rare insight into the bond between a mother and her child. He began to believe that their baby could bring his wife back to life … What made you take Eloise in and put her on Emma?

Yoshi: I honestly believed that if one person could get her through this it was that little girl – there were only two people in this battle, Emma who was trying to pull herself out and Emma who wanted to pull her mother out.

Mel: Every day Yoshi would take Eloise to the hospital so she would hold her mother, touch her, skin-on-skin.

Yoshi: I had to really rely on this little girl, who was so small, to find my wife. (On the video it can be seen that baby Eloise is trying to communicate with and reaching out and kissing her mother who is lying in a coma).

Mel: At first nothing happened but then on one visit Emma's eyelids began to move … On another visit she smiled and then she moved her hand

Yoshi: Eloise really dug in and found her mother from somewhere because I think Emma was very lost for a long time

Mel: And then 12 weeks, 84 days after falling into a coma Emma woke up, holding Eloise in her arms. Do you have no doubt that it was Eloise that woke her up?

Yoshi: Absolutely, I am glad that I had her because I would have lost my wife that day … people talk about miracles, to me that was a miracle, just the love

Mel: The need. As a mother just the need they have for their child is overwhelming, they need each other

Yoshi: They stared, they just stared at each other, it was like as if they were saying: "I missed you"

Mel: There is no clear medical explanation as to why Emma woke up, what doctors are wondering is whether the connection with Eloise was strong enough to pull her mother out of a deep coma. It's a bond that medical science can't measure, but it is a bond that every mother has with her child … Do you think that baby Eloise saved her mother's life?

Doctor Clayton-King: I think she did, I think that baby is a miracle.

Mel: Dr. King is a brain and head injury specialist who has studied Emma's injuries.

King: People respond quicker to family members and people they know and that can only be much greater with a mother and baby. There's the smell, the touch, the sound of the baby. I think that all those things are important.
(The video flashes to Emma who is now standing and talking and participating in a rehabilitation program).

Mel: Look at her now, two months ago she was on a life support machine. Today she is being a mum again, Emma's speech is returning along with her sense of humour. It is now four months since the accident

Yoshi: That little girl saved two people … she has saved her mother and she has saved me

Mel: Out of the darkness the old Emma is shining through.

Section III: Overview of the Damage

Stress during Pregnancy impacts on brain development

> Dr. Geoff Rickarby described the treatment by medical and social work staff during an unwed mother's pregnancy as: "… cruel and unnatural …" (1998: p. 62).

Stress on the mother during her pregnancy and around the birth will negatively impact her newborn. According to Sullivan et al (2006, p. 583) this will have a "unique impact on adult mental health". Early emotional memories are stored in the brain particularly if encountered at critical periods such as prior to and around the time of the birth. The first hour after birth is possibly the most critical in the life of the infant and has a profound and life long effect on the mother (Odent: 2006; Fischer: 2005; Pitman: 2008)

> *Stress on mothers during pregnancy*, *interruptions or disturbances of the child-parent interaction* lead to behavioural disturbances, including the so-called hospitalism syndrome, and later can result in severe and permanent deficits in speech, behaviour, personality development, intellectual and social capacity and mental disturbances (italics added, Sullivan: 2006, pp. 590-591).

Pregnant women, who had been close to the World Trade Centre during September 11th 2001, gave birth to babies who had elevated levels of stress agents in their saliva (Yehuda, et al: 2009; Chemtob et al & Sarapas, et al cited in Kellerman: 2005). This suggests that effects of maternal PTSD on cortisol can be observed very early in the life of offspring and highlight the "in utero effects as contributors to biological risk factors for PTSD" (Yehuda, et al cited in Kellerman: 2005).

Verny & Kelly (1981, pp. 12-13) states that the unborn child is aware and leads an active emotional life from about the sixth month on: "The foetus can see, hear,

experience, taste and, on a primitive level, even learn in utero. Most importantly, he can feel ... What a child feels and perceives begins shaping his attitudes and expectations about himself … The chief source of those shaping messages is the child's mother … Chronic anxiety or a wrenching ambivalence about motherhood can leave a deep scar on an unborn child's personality. On the other hand, such life-enhancing emotions as joy, elation and anticipation can contribute significantly to the emotional development of a healthy child". Dr. Verney (1981, p. 14) concludes that parents can actively "help shape the personality of their unborn child. They can actively contribute to his happiness and well-being, and not just in utero, nor in the years immediately following birth, but for the rest of his life". Hence external circumstances that negatively impact on mother have a profound effect on her unborn infant.

Child Welfare Authorities that monitor a young, usually poor, mother through her pregnancy to determine if she is 'fit' to be a parent, the threat of having her child removed at birth hanging over her head, do her unborn child a great disservice. Everything she feels her baby feels. If we are to assist pregnant women who find themselves in a difficult situation supportive services should be provided. It may cost in the short term but the ripple effect on the mother, her infant and subsequent generations will provide enormous social and economic benefits to the community in the long term (Cole: 2009).

According to Odent (2011):

> Our health to a great extent is shaped in the womb and among the most important factors is the emotional state of pregnant women. In a situation where they feel powerless, can neither escape nor fight and are depressed and unhappy the maternal body releases high levels of the stress hormone cortisol. Cortisol is an inhibitor of foetal growth and has life-long consequences for the child.

The dominant attitude of the medical professional can negatively impact on the pregnant mother's emotional state particularly when negative messages are given associated with specific risks, such as unmarried women being told … 'You're too young to be a mother; you cannot adequately provide for an infant; children of single mothers are an at risk group'. "These statements issued to vulnerable pregnant women could contribute to the situation they warn against" and become self perpetuating prophesises. Odent states that those interacting with a pregnant woman should be mindful of what they say because it has what he has labelled, the nocebo effect: a negative effect on the emotional state of pregnant women and indirectly on their families. "It occurs whenever a health professional interferes with the imagination, the fantasy life or the beliefs of pregnant woman" (Odent: 2011).

Barker (1997) has emphasised how adult vulnerability to disease may be programmed during the foetal period. Glover (1997) examined a number of studies on the effects of maternal stress on the developing foetus and stated:

> Ante-natal maternal psychological problems are linked with complications of the pregnancy … ante-natal stress or anxiety are linked with

> prematurity, or low birth weight … smaller head circumference … Stress has a similar magnitude of effect to smoking … Prenatal stress significantly worsened the scores on the neonatal neurological examination. It is possible that raised maternal stress hormones constrict the uterine artery causing impaired blood flow to the baby which in turn generates a fetal stress response. Maternal stress also predisposes the infant to be less resilient to stress. Several groups have suggested that a hyper-responsive HPA axis is the primary defect with changes in monoamine systems being secondary … maternal stress in pregnancy has long-term neurodevelopmental effects on the infant, and these may include an increased predisposition to later depression.

Stress around the birth

Being taken from one's mother is internalised by the infant as being 'unwanted' and rejected (Verrier: 2008, pp. 7-8; Noble: 1993, p. 206). "So deep runs the connection between a child and its mother that the severing of that bond results in a profound wound for both, a wound from which neither fully recover" (Verrier: 1991). Verney stated that adopted children start life with a handicap-the sense of rejection by their own mothers, however devoted the adoptive parents may be. An adoptee's disturbed sense of self shows in a sense of mistrust, depression, anxiety, and difficulties in relationships (Verney cited in Noble: 1993, p. 209).

Anand & Scalzo (2000, p. 75) state that just prior to birth and after is when the underlying neuronal circuitry is most susceptible to disruption and any disturbance of the birth process "may have greater impact on subsequent neurobiological and behavioural development" that any other time in life.

The minutes after the birth are described as a critical period where infants who are not disrupted by being separated from their mothers remain in a state of quiet alertness (Klaus & Klaus: 1998 p. 23; Anand & Scalzo: 2000; Odent: 2009). This period of quiet alertness lasts on average about forty minutes and is a crucial part of the bonding sequence: "where [the infant] looks directly at the mother's face … and eyes and responds to [her] voice …. If the baby remains in close contact with her mother in the first hour, she will remain in the quiet alert state longer and cry less (Klaus & Klaus: 1998, p. 23). The mother at this time is "uniquely open emotionally to respond to her baby" (Klaus & Klaus: 1998, p, 21). Michelle Odent (2009) states that there has been multiple scientific studies that confirm that the period surrounding birth is important for the development of the capacity to love oneself and others. Hence the quality of our relationships throughout life can be profoundly effected by what happens around our birth.

Separation from mother is a birth trauma and if combined with a complicated birth and/or exposure to drugs the individual is predisposed to suicide, drug addiction and violent criminality (Buckley: 2008). Jacobson et al (1987) conducted research that indicated trauma surrounding birth may 'imprint' on the infant and predispose him or her to certain patterns of behaviour that remain masked throughout most of adult life, but are triggered during conditions of extreme stress. Odent (2001) states that the mother-infant relationship represents the prototype for the relationship with the self and all other social relationships, thus highlighting its importance to subsequent

behaviour. Therefore the trauma of being denied this relationship on top of birth complications or a painful birth combines to leave the infant predisposed to severe psychological and emotional problems. Other research also linked (de Maus: 1995) feeling unwanted and birth complications, with later behavioural problems. For instance, teenagers who felt unwanted, committed four times the number of violent crimes as those who felt wanted. 'Unwantedness' or maternal rejection has important relevance to adoptees. At a feeling level the neonate cannot discern between a mother who has no choice in her infant being taken or a mother whose maternal instinct is impaired and rejects her baby (Kumar: 1997).

In 1954 an intergovernmental committee reported that taking an infant prior to six weeks of age caused it physical damage (Fyfe & Stewart: 1954, p. 10). Current psychobiological research provides evidence that supports this as interaction between a mother and infant immediately after birth is essential for the development of "gene products controlling cellular and neuron transmitters and of cortical neurons (Anand & Scalzo: 2000, p. 74). Simply put: separating an infant from its mother can cause brain damage. So not only is the infant pre-disposed to mental health problems, such as major psychoses like schizophrenia, autism, anxiety, depression and altered responses to pain (Anand & Scalzo: 2000, p. 70; Schore: 2001, p. 206; Deutsch: 1982; Palmer: 2011), but to learning difficulties such as Attention Deficit Disorder (ADD), hyperactivity, memory and concentration difficulties (Manlove: 1965; Schore: 2001). Research on adoptees, has supported these finding for decades (Schechter: 1960; Simon & Senturia: 1966; Offord et al: 1969; Lindholm & Touliatos: 1980; Bohman & von Knorring: 1979; Austad & Simmon: 1978; Otford et al: 1969).

Separation from mother may have a profound effect on the infant's cognitive abilities because the hippocampus, a structure within the brain important in learning and memory, "is one brain site where development is affected by stress and bonding hormone levels" (Vazquez et al: 1996 cited in Palmer: 2011). Raber (1998 cited in Palmer: 2011) states:

> The level of the stress hormones circulating in an infant affects the number and types of [hippocampus] receptors … Nerve cells in the hippocampus are destroyed as a result of chronic stress and elevated stress hormone levels, producing intellectual deficits as a consequence and can lead to obesity and depression and memory deficits later in life such as dementia and Alzheimer's.

Further support for the damage stress hormones cause infants came from research conducted by Carlson et al (1997). They stated: "Children with the lowest scores on mental and motor ability tests have been shown to be the ones with the highest cortisol levels in their blood". The effect from birth trauma and related stress stretches through life. Dr. Linda Palmer, biology scientist, states: "Even short separations from mother leads to elevated cortisol in infants, indicating stress … and prolonged separation to decreased immune function". Dr. Palmer cites numerous animal studies that demonstrated that isolation from mother has "permanent brain consequences". Animal research that inferred similar outcomes for children has now been substantiated in recent research on humans (Feldman et al: 2007; Gunnar et al: 1996, 1998: Spangler & Grossman: 1993). Dorn et al., (1999, p. 137) found in a pilot study

that adolescents who suffered from premature puberty had high levels of cortisol, amongst other hormones, which effected mood and behaviour. The research participants had increased incidence of anxiety, depression, behavioural problems and lower scores on various intelligence tests.

In 1982 (Deutsch et al) in their research sample of 200, found that 17% of adoptees had been diagnosed with ADD. This figure represented an eight-fold increase in a non-ADD control group and in the general population. The research predicted that approximately 23% of all adopted children would be expected to have ADD. This was considered to be an under-estimate as the sample included females, whilst males have far higher incidences of ADD. According to Deutsch et al (1982) the symptoms of ADD may be sequelae of separation anxiety in adoptees, the damaging effects of which have been discussed in prior research (Yarrow: 1964, 1965 cited in Deutsch: 1982, p. 236). Further research supports Duetsch's findings (Dalby, Fox & Haslam: 1982; Nichols & Chen: 1998). Zill's (1985) research show that there was an increased vulnerability of adoptees to learning and behavioural difficulties. In a research sample from a national health survey data from 15, 416 families – children adopted at infancy displayed a greater prevalence of behavioural and learning problems in comparison with their non-adopted peers. 13% of the adopted children as compared with 5% of the non-adopted children had been treated by a psychologist or psychiatrist at some time-the figures were 10% versus 3% for treatment within the past year. Adopted children had a higher behaviour-problem index score and lower academic-class-rating score than did non-adopted children.

Sullivan concludes "based on the work of Spitz (1945) Bowlby (1954, 1959) Mary Ainsworth (Ainsworth, Boston, Bowlby & Rosenbluth: 1956; Ainsworth: 1962) and Skeels (1966) early traumatic experiences, such as the loss or the separation from one or both parents, can be one of the major factors for developing anxiety and depressive disorders in adulthood" (cited in Sullivan et al: 2006, p. 594). In the long term painful experiences in neonates could lead to psychological sequelae and several researchers have found that newborns have a much greater capacity for memory that previously thought. Long-term memory requires the functional integrity of the limbic system … these structures are well developed and functioning in the newborn. Memory begins in utero (Chamberlain: 1989) and therefore whatever happens to the mother impacts the foetus and provides a perspective through which s/he will perceive all subsequent events.

Disassociation and its effects on foetal development

If a mother is fearful enough or has mental health problems that cause her to disassociate from the pregnancy the unborn child is severely impacted. Verny & Kelly (1981, p. 27) state that:

> It is akin to ignoring an infant who has a biological and emotional need to feel loved and wanted even more urgently than we do. He has to be talked to and thought of, otherwise his spirit and often his body begin wilting. Studies on women with severe mental health problems such as schizophrenia and psychotic women who have not connected with their infants on any level have children with far more physical and emotional problems than the babies of mentally healthy women.

This understanding should give women intending to be surrogate mothers cause to reflect. Babies need to be interacted with, spoken to and to feel loved and wanted. In a recent television program on surrogacy women referred to themselves as: 'gestational carriers'. They made comments such as: "I am not [really] pregnant … It's not mine … I was the oven for the bun". This form of disassociation from the developing foetus is extremely detrimental on many levels. Other comments made by those who benefited from the surrogacy arrangement showed their ignorance of the bond between mother and child: " … the surrogacy Mum has no biological connection to the kid … nine months of incubation, isn't it more important when that baby comes into the world how the parents look after them". Unfortunately for the infant, it is not. Nine months may not seem long to adults but to the infant it is an eternity.

It is apparent that surrogacy is a service designed to meet adult needs, unfortunately the long term effects on the infant are not considered (Insight: 22nd March, 2011). Research indicates that disassociating from the infant predisposes it to long term psychological and physical problems. According to Verny & Kelly (1981, pp. 27, 29) the way the mother feels towards her unborn infant:

> begins to define and shape his emotional life …What is forming are broader more deeply rooted tendencies, such as a sense of security or self-esteem. From these thoughts specific character traits develop later in childhood … the personality of the unborn child … is a function of the quality of mother-child communication …if communication was abundant, rich and nurturing, the chances are very good that the baby will be robust, healthy and happy

Unfortunately unwed pregnant women whose babies were targeted for adoption were encouraged to disassociate by being told they were carrying 'the' baby for a "lovely married couple". It was believed this would facilitate the removal of the infant at the birth if she was brainwashed into believing her baby was a separate individual with its own needs (McLelland: 1967). This type of coercion led mothers to feel exploited, helpless and develop a sense of unreality that was further reinforced when she never saw her infant (Gough: 1961, 1971). The conditions under which these mothers laboured were akin to what might be aptly labelled: 'reproductive slavery'.

Science can now explain why all the love in the world is not going to make up for the absence of the infant's mother (Verrier: 2008; Chamberlain: 1989, 1998; Odent: 1998, 2001; Jacobson: 1987; Raine et al: 1994; Pearce: 1992; Buckley: 2008; Salk et al: 1985). Verrier concludes that it is impossible for a stranger to replace the mother, "I don't believe it is possible to sever the tie with the biological mother and replace her with another primary caregiver, no matter how warm, caring and motivated she may be, without psychological consequences for the child (and the mother). An infant or child can certainly attach to another caregiver but the quality of that attachment is different from that with the first mother …" (2008, p. 19).

Identity

Noble states (1993, pp. 206-209) that adoptees and premmies both have problems with trust because of the sense of abandonment they felt being denied the natural conclusion of the birth process. She states "

> The touching, the need to feel the mother's skin is very important in the establishment of I and the other, a sense of boundaries that is crucial to self-identity. Many adoptees and their mothers later express deep regret at never seeing or touching each other. Adoptees who relive their birth often cry out in agony for 'just a moment of touch', never having felt body contact from their mother on the outside. The primal loss can give a rise to a lifelong feeling of deprivation (Noble: 1993, p. 208).

Nobel explains that adoptees start life with a sense of rejection, it does not matter how adoption is explained they "feel" it on a cellular level as abandonment. "An adoptee has a disturbed sense of self as well as mistrust, depression, anxiety and difficulties in relationships" (1993, p. 209). This is explained biologically by interfering with the production of oxytocin. Oxytocin, as previously explained, is connected with feelings of trust and calm and separating mother and infant leaves both with elevated levels of adrenalin, and the oxytocin surge is waylaid, hence there is a biological reason why both mothers and taken infants have serious problems with trust issues and maintaining intimate relationships. How can one have a healthy relationship without trust? It is therefore not surprising that 30 to 40% of children found in special schools, mental health facilities and residential treatment centres are adopted and according to Noble (1993, p. 209) at the Yale Juvenile Psychiatric Institute the number of adoptees is 60%. Considering adoptees only make up approximately 1% of the population they are grossly over represented in clinical settings (Harper & Williams: 1976).

Adoptees have a "vulnerability to separation" resulting from the "abrupt, premature separation from the mother" this occurs before the infant distinguishes between self and others, and results in "incredible vulnerability to the sense of self" and damages "the ability to trust". Issues with trust and betrayal can interfere with adoptee's later ability to form intimate relationship. An adoptee copes with the threat of rejection and abandonment through distancing and detachment hence testing of love is a phenomenon in almost every adoptee (Jones: 1997, p. 65).

It has been accepted practice that telling the child he or she is adopted at an early age assists the adoptee with identity formation. According to Jones being told one is adopted does not necessarily make things easier for adoptees because:

> It compounds the trust and betrayal issues with the first parents with trust and betrayal issues with the adoptive parents. Research indicates that most adoptees did not believe the "story" that the birth mother loved her baby so much that she gave her up out of love. Instead, this simply resulted in further distrust and confusion, leaving the need to know still unmet … Issues of rejection and worth are linked closely to issues of trust and betrayal … adoptees suffer lifelong feelings of rejection and being unlovable, adoptees can feel second-hand, flawed, unworthy, or expendable. The adoption story of being chosen or mother loved you so

> she gave you up further denies the adoptee's feelings of loss and mourning for the loss is repressed (Jones: 1997, p. 66).

Usually the adoptee is told they are adopted once and the subject is never again raised. It becomes taboo and is associated with shame and humiliation and since it is at the core of who an adoptee is they feel intrinsically "bad" and in an effort not to feel that way they deny their reality. They pretend that they are "as if born" to their adoptive parents, as that is what they intuit their adopters want as it what is being communicated by making their ancestry unmentionable. So there is tremendous denial around their adoption and a build up of hostility towards their forebears who they must not acknowledge or make real. Unfortunately having no links with your past has profound affects on your identity.

The continuity of a past and present is necessary for identity formation and without this an individual feels displaced, insecure and identity is ephemeral rather than solid. The security of being rooted in one's genetic past is not there. It is analogous to us all being links in a family's genetic chain, one that stretches backwards and forward indefinitely, the adoptee has lost this sense of linkage and connection. Jones states this leaves them struggling to achieve a coherent life narrative. Loss of the authentic self and identity negatively impacts on their self esteem. Jones states: "A non-adopted person sees her own past and future in the faces, lives and portraits of her relatives" this psychobiological reality is denied an adoptee (Jones: 1997, p. 66).

If the birth process is interrupted or interfered with it is not only the infant who will experience identity problems, but also his or her mother:

> Immediately after birth, the mother is still physically and psychologically at her most open. Her baby constitutes for her a powerful symbol of her motherhood, her individuality, her new family, the beauty and wonder of nature, and the perfection of her own body and her procreative powers. To hold, touch, gaze at her newborn unhindered is to internalize these messages, to incorporate her newborn through all her sensory channels into the transformed identity with which the mother will emerge from her initiation experience. Often this bonding experience is powerful and positive enough to entirely override, in the mother's conscious perception of her birth experience, any negative feelings of powerlessness, humiliation, or pain she may have been experiencing before her baby's birth (Davis-Floyd: 2011).

One can only imagine the damage done to the mother's identity when she is denied finishing the birth process and the opportunity to fulfil her motherhood by receiving her infant into her loving arms.

Conclusion

It is the separation at birth that Verrier acknowledges causes a primal wound and either causes or predisposes the adoptee for later psychological problems such as PTSD (Rickarby: 1998, p. 68). Becker et al (2007, p. 617) stated: "For a newborn one of the most stressful experiences is separation from parents and exposure to an unfamiliar environment". Research in 1960s (Schecter et al) indicated that far higher

rates of adoptees were being treated in psychiatric settings and that parental loss correlated with suicidal tendencies (Greer: 1964, 1966). Greer (1966) found that children who had lost both parents were four times more likely to attempt suicide. Current research has indicated that being separated from one's mother is "a most devastating event" and leaves one "emotionally and psychologically crippled" (Pearce: 1992). Ensuring the bond between mother and infant is not interfered with has broader social outcomes. For instance insecure attachment patterns have been "documented in 90% of maltreated children" (van der Kolk: 2005, p. 2). This was discussed in the literature by Kemp (1971) who noted that abused children were not only situated in the lower socio-economic group, but existed amongst all classes and creeds and was predicated on attachment disorders. Considering bonding is founded on the biological and psychological connection of mother and infant it is not surprising to find that adoptees and stepchildren were identified by Kemp (1971) to be more vulnerable to abuse. Van der Kolk (2005, p. 2) states that the key features of disorganised attachment are:

- Increased susceptibility to stress (e.g., difficulty focusing attention and modulating arousal)
- Inability to regulate emotions without external assistance (e.g. feeling and acting overwhelmed by intense or numbed emotions)
- Altered help-seeking (e.g. excessive help-seeking and dependency or social isolation and disengagement).

Separation from mother at birth causes physical damage (Fyfe & Stewart: 1954) and pre-disposes the infant to the following:

- Suicide (Jacobson & Bygdeman: 1998; Greer: 1964, 1966: Melhem: 2011)
- Suicide (if separation/rejection is combined with a traumatic birth: breach, forceps, induction) (Raine et al: 1994; Salk et al: 1985)
- PTSD and Complex PTSD (Melhem: 2011; van der Kolk: 2005, p. 1; Sullivan et al: 2006, p. 594)
- Mother is familiar even brief separation can alter brain chemistry (Ziabreva et al: 2003, p. 436) Newborn knows mother's smell, voice - Infants can discriminate between familiar and novel environments immediately after birth (Ziabreva et al: 2003, p. 433). Newborn knows milk-taste (Hepper: 1996).
- Separation causes flood of stress hormones – mother needed to complete birth, calm infant, stop stress hormones – failure leads to anxiety, depression and cognitive deficit (Bowlby: 1980)
- Separation from mother plus birth complications led to 4 times the increase in violent crimes in teenagers (DeMause: 2009)
- Brain development impaired – with brief but repetitive separation from mother (Sullivan et al: 2006, p. 593)
- Prolonged separation can lead to: attention deficit hyperactivity syndrome, schizophrenia or criminal aggression (Sullivan et al: 2006, p. 593)
- Most stressful event for mammals is separation from mother: causes brain changes, alters physiological function and development of limbic system, (amygdala & hippocampus) regulation of emotional behaviours, learning and memory function and the expression of behavioural and endocrine response to

stress through life (Becker et al: 2006, pp. 617-629; Carrasco & Van de Kar: 2002)
- Anxiety and Depression (Sullivan et al: 2006, p. 94; Edelston: 1943 cited in Van der Horst & van der Veer: 2008)
- Anxiety and Depression (Sullivan et al: 2006, p. 594; Anand & Scalzo: 2000, p. 70; Schore: 2001, p. 206; Dorn et al: 1999, p. 137; Ziabreva et al: 2003, p. 440)
- Mood Disorder (Becker et al: 2006, p. 627)
- Maternal separation predisposes to depression and anxiety (Maciag et al: 2002, p. 580)
- Impaired capacity to love either oneself or others (suicide, drug abuse and anorexia nervosa) (Odent: 2006, 2011)
- Drug and Alcohol problems (Buckley: 2008; Odent: 2001; Raine: 1994)
- Schizophrenia (another factor implicated was stressful prenatal events) (Odent: 2006; Anand & Scalzo: 2000, p. 70; Schore: 2001, p. 206)
- Violent criminal behaviour (birth complications combined with separation/rejection) (Raine: 1994)
- Men (not women) who had traumatic births (combined with maternal separation/rejection) were five times more at risk of committing suicide by violent means (Jacobson: 1998; Odent: 2006)
- Women given barbiturates during labour, infant statistically significant of becoming drug-addicted in adolescence (Jacobson: 1990)
- Women given barbiturates (3 doses or more) during the perinatal period - infant at risk of becoming drug addicted by 4.7% (Nyberg et al: 2000)
- Predisposes infant to mental and physical problems later in life (Barker: 1995; Glover: 1997)
- Interferes with brain functions: effects learning cognitive functions and memory (Barker: 1995; Palmer: 2011; Vazquez et al: 1996 cited in Palmer: 2011; Raber: 1998; Carlson et al: 1997; Anand & Scalzo: 2000, p. 70; Schore: 2001, p. 206)
- Emotional and behavioural difficulties (Palme: 2011)
- Short separations cause raised cortisol (indicating stress), Prolonged separation decreased immune function (Palmer: 2011)
- Vulnerability to stress hypertension, and ulcers (Lickliter: 2008, p. 401)
- Effects gene expression (Lickliter: 2008, p. 401)
- Trauma can be transmitted to subsequent children and predispose them to Secondary PTSD (Rowland-Klein & Dunlop: 1997)

Recent research (Melhem: 2011) found that the loss of a parent predisposes a child to later psychiatric sequelae including suicide. This is particularly the case if there is no acknowledgement of the grief or support in finding its resolution. This supports previous research indicating the loss of both parents, as well as loss of being able to complete the bonding sequence with, and loss of all that is familiar: mother, predisposes adoptees to pathological grief, depression and suicide.

Research specifically targeting adoption identifies mental and health problems in the adoptee such as

- Suicide (von Borcyzyskowski et al: 2006; Slap et al: 2001; Elmund: 2007; Garrison: 1996-1997; Schechter: 1964) (adoptees have 3 times the risk of suicide than non-adopted peers)
- Suffers Primal Wound (Clothier: 1941; Verrier: 1992; Brazelton: 1982)
- Disassociation (Pierce: 1992; Verrier: 1997, p. 185)
- Lifelong grief (Verrier: 2008)
- Drug & Alcohol problems (Bohman and von Knoring: 1979; Bellamy: 1993; Schechter: 1964)
- Adoptees twice as likely to present with psychiatric problems in later life (Dress: 1988; Bohman and von Knorring: 1979))
- Post Traumatic Stress Disorder (Hoksbergen: 1997, p. 25; Verrier: 1997, p. 187, p. 183)
- Hyper arousal, hyperactivity (Verrier: 1997, p. 184; Schecter: 1960)
- Feelings of rejection (Helwig & Ruthven: 1990; Verrier: 1997)
- 2-3 times more likely to have psychopathic conduct disorder behaviours (Kernberg: 1985/1986)
- ADD (Menlove: 1965)
- Vulnerability to stress (Kirk, Jonassohn &: 1966)
- Impaired capacity to love (Verrier: 1993)
- Impaired capacity to form intimate relationships (Jones: 1997, p. 65)
- Trust issues (Jones: 1997, p. 65; Bertocci & Schechter: 1991; Partridge: 1991; Helwig and Ruthven: 1990;)
- Testing behaviours (Rickarby: 1997, 1998; Helwig & Ruthven: 1990)
- Fears of rejection and abandonment (Jones: 1997, pp. 65-66; Verrier: 2008, pp. 7-8; Noble: 1993, p. 206)
- Repressed mourning (Jones: 1997, p. 66)
- Genetic Bewilderment, Identity Confusion (Sants: 1964; Jones: 1997, p. 66; Brodzinsky & Schechter: 1992; Sorosky, Baran and Pannor: 1975; Stein and Hoopes: 1985; Hamilton: 1990; Bertocci & Schechter: 1991; Helwig and Ruthven: 1990; Wellisch: 1952)
- Personality Disorders (Bohman &von Knoring: 1979;)
- Learning Problems (Kirk, Jonasohn & Fish: 1966)
- Hyperactivity: ADD and impulsivity (Deutsch et al: 1982; Dalby, Fox & Haslam: 1982; Nichols & Chen: 1981; Eiduson & Livermore: 1953; Simon & Senturia: 1966)
- Impulsivity, low frustration level (Kirschner: 1990; Lifton: 1994)
- Sexual acting out (Sechechter et al: 1964)
- Emotional and behavioural difficulties (Zill: 1985; Palme: 2011; Phillips: 2006)
- Juvenile crime (de Maus: 1995)
- Stealing (Bostock: 1961; Humprey & Ounsted: 1963; Schecter: 1960)
- Aggressive symptoms (Menlove: 1965; Bostock: 1961; Eiduson: 1953; Neuder: 1956; Newkirk: 1953)
- Over represented in psychiatric clinics (Clothier: 1943; Schecter: 1960; Harper & Williams: 1976, p. 43; Goodman, Silberstein & Mandell: 1963; Holman: 1953; Humphrey & Ounsted: 1963; Pringle: 1967; Kirk, Johassohn & Fish: 1966; Menlove: 1965; Schechter, Carlson, Simmons & Work: 1964; Simon & Senturia: 1966; Sweeny, Gasbarro & Gluck: 1963; Toussieng: 1962; Austad and Simmons (1978))

- Mother's depression impacts on infant (Hipwell et al: 2000)
- Loss of opportunity to finish birth process – (birth is a crucial period) (Kovach: 1964)
- Maintaining infant with mother if supported, even if she is drug addicted is less traumatic for children than placing in foster care (Roberts: 1999)
- Rejection (Bertocci & Schechter: 1991; Verrier: 1997)
- Loss un-grieved (Eagle: 1990)
- Resentment because of the expectation to be grateful (Butler, 1989, p. 177; Lifton: 1990; Henderson: 2000, p. 261, 265; Sass & Henderson: 2000, pp. 351)
- Abandonment due to premature removal from mother (Hamilton: 1990)
- Low self esteem (Brinich: 1990; Frankel: 1991)
- Prenatal experiences shape how subsequent life experience are perceived. Births can be perceived as highly traumatic if the perinatal period has been experienced as traumatic … Anger and rage are related to perinatal bonding deficits and cannot be resolved solely by talking therapies The two emotions are linked with low self-esteem, shame, guilt and disempowerment (Emerson: 1996, pp.. 12-13)
- Mental Health professionals ignorant of the trauma inherent in adoption (Sass & Henderson: 1999, 2000; Post: 2000, p. 361; Hartman & Laird: 1990, p. 221) Whilst it is estimated in the U.S. that 10% of psychiatric visits are adoption related cited Post: 2000, p. 362) only about 7 mins per semester is spent on educating professionals about the psychological sequelae caused by adoption. Many professionals do not acknowledge adoption as being a precipitating factor but rather expect the adoptee to feel grateful (Sass & Henderson: 2000, p. 352)

Damage identified in intercountry adoptees:
Similar findings, if not more dire, are emerging about intercountry adoptees. This is also attributed to the trauma of being separated from their mothers and other family members, cut off from their homeland and brought up in an alien culture. Intercountry-Adoptees suffer 5 times the rate of suicide as their non-adopted peers, and apparently it is not just when they are in their teens, the tendency increases with age. So concerned were the researchers that they advised adoption professionals to warn adoptive parents of the suicide potential and to familiarize them with the danger signs.

The research also indicated that intercountry adoptees experienced high levels of drug and alcohol problems; males: significant rates of ADD and females: significant rates of depression, anxiety, schizoid and delinquent behavior. Children generally were shown to have problems with scholastic difficulties due to hyperactivity and concentration problems. Finally adopted delinquents were admitted to institutional care for juvenile delinquents mainly for treatment for antisocial behaviour and acute crisis in the family. Even early intercountry adoptee studies noted a high rate of disruption (failed adoptions) of intercountry adoption – up to six times that of locally born adopted children. A major Australian study of 102 Vietnamese children adopted in New South Wales during the 1970s reported that the majority of children placed between the ages of 4 to 6 had difficulties bonding or establishing family relationships as did 40% of the children placed at 18 months and above. Further, researchers stated

that the difficulties faced by the adoptee are "a life companion through-out the many life cycles, from the time of the adoption to death".

In recent governmental inquiries adoptive parents groups wishing to promote adoption put forward the argument that bringing in more overseas children will assist with Australia's ageing population, but the Swedish research indicated that a significant percentage of adoptees are not capable of living independently from their adopters and do not go on to have children.

We can learn a lot from the Scandinavian research; they are about twenty or thirty years ahead of us with their intercountry adoption program. So what they are experiencing is a fairly reliable indicator of what we can expect in the decades to come.

Research identifying damage in mothers

> In our clinical work, we have often been struck by the excruciating and recurrent pain experienced by women who have surrendered their babies for adoption (Weinreb & Murphy: 1988, p. 23).

- Suicide (Rynerson: 1982; Winkler & van Keppel: 1984; Gair: 2007; Weinreb & Murphy: 1988, p. 23; Nichols: 1966; Logan: 1996, p. 616)
- Complex PTSD (Rickarby: 1998; Wells: 1993; Kelly: 1999; Stifler: 1991, p. 250; Verrier: 1997, p. 183)
- Most traumatic event in life (Edwards: 1995, 1999; Winkler & van Keppel: 1984)
- Profound and negative impact on life (Anderson: 1987; Deykin, Campbell & Patti: 1984; Millen & Roll: 1985; Pannor, Baran, & Sorosky: 1978; Rynerarson: 1982; Schaefer, 1991; Silervman, Campbell, Patti & Style: 1988; Sorosky, Baran, & Pannor, 1984; Stiffler: 1991
- Pathological Grief (Winkle & van Kepple: 1984; van Kepple et al: 1987; Condon: 1986, 1991; McHutchison: 1986; Condon & Frost: 1996 Rickarby: 1998; Weinreb & Murphy: 1988, p. 23; Nicholson: 1966; Blanton & Deschner: 1990; Logan: 1996, p. 615; DeSimone: 1996; Stifler: 1991, p. 250; Millen & Roll: 1985)
- Disenfranchised Grief (Robinson: 2000)
- Susceptible to ill health (van Keppel et al: 1987; Nicholson: 1966)
- Powerlessness (Condon: 1986; Dermott: 1984; Edwards: 1995; Cole: 2004, 2011; DeSimone: 1996; Silverman, Campbell, Patti & Style: 1988; Carr: 2000; Jones: 1993, pp. 12-13)
- Catalyst for multiple relationship losses (loss of parents, partner, friends, self) (Logan: 1996, p. 622)
- Disassociation (Logan: 1996, pp. 618, 623; Rickarby: 1997, 1998; Stifler: 1991, p. 250; Andres: 2007)
- Disassociate during pregnancy (terrified to feel) (Andrews: 2007)
- Feel disconnected (Andrews: 2007)
- Primal wound caused by separation from newborn (Andrews: 2007; Verrier: 1997)
- Attachment difficulties with subsequent children (Carr: 2000)

- Depression (Condon: 1986; McHutchison: 1986; Nicholson: 1966; Rickarby: 1998; Logan: 1996, p. 615; Howe et al: 1992; Weinreb: 1995; Edwards: 1995, 1999; Wells: 1993)
- Anxiety, social anxiety and phobic states (Rickarby: 1998; Nicholson: 1966; Frost & Condon: 1996, pp. 58-59; Stifler: 1991, p. 250; Wells: 1993)
- Aggression, Anger (Nicholson: 1966; Weinreb & Murphy: 1988; Frost & Condon: 1997, pp. 58-59; Logan: 1996, p. 615
- Intensity of anger with time (Winkler & van Kepple: 1984; Condon: 1986, p. 118; Frost & Condon: 1996, p. 55)
- Personality Disturbances (Nicholson: 1966)
- Guilt (Weinreb & Murphy: 1988; Verrier: 1997; Condon & Frost: 1997, pp. 55-56; Winkle & Van Kepple: 1984; Logan: 1997, pp. 615, 620; DeSimone: 1996
- Low self esteem (Nicholson: 1966; Weinreb & Murphy: 1988, p. 23; Condon & Frost: 1997, p. 556
- Mood Disorders (Nicholson: 1966; Weinreb & Murphy: 1988, p. 23
- Rejection (Rickarby: 1998; Verrier: 1997; Logan: 1996, p. 618)
- Chronic Fatigue (Nicholson: 1966)
- Undue weeping (Nicholson: 1966)
- Difficulties with subsequent children (over-protective or aloof) (Weinreb & Murphy: 1988, p. 23; Roberts: 1969; Cole: 2004 Unpublished Honours, 2011 Unpublished thesis; Deykin, Campbell & Patti: 1984)
- Difficulty with intimate relationships (Verrier: 1997; Roberts: 1969)
- Secondary Infertility (Andrews (1 in 5) Verrier (50-60%) will not have further children (Andrews: 2007; Verrier: 2005 cited in Andrews: 2007: Weinreb & Murphy: 1988, p. 23; Edwards: 1995, 1999 (33% of Edwards sample did not have further children) To avoid children likely not to marry & if do more likely to divorce (Carr: 2000); Women go into abusive relationships (Andrews: 2007)
- Loss of trust in others and self (Verrier: 1997; Carr: 2000, p. 340)
- Shame imposed (Verrier: 1997; Rickarby: 1998, p. 68)
- Shame felt for being unable to keep child (Silverman: 1981)
- Identity problems (Verrier: 1997)
- Obsessive Compulsive Disorder (Parker: 1927; Nicholson: 1966)
- Searching Behaviour (Parker: 1927; Logan: 1996, p. 620; Condon: 1984; Deykin, Campbell & Patti: 1984; Millen & Roll: 1985)
- Chronic anxiety: not knowing where child is or whether dead or alive (Logan: 1996, p. 620)
- Loss of or excessive appetite (Nicholson: 1966)
- Serious psychological problems if did not see baby (Edlin: 1956; Condon: 1991, p. 46)
- Isolation (Rickarby: 1998, p. 68; Andrews: 2007; Weinreb: 1995)
- Self-blame (Weinreb: 1995)
- Feelings isolated intensified if grief not validated (Frost & Condon: 1997, p. 55-56)
- Drugs interfere with bonding sequence (Kovach: 1964)
- Multiple Losses (loss of child, grandchildren) (Andrews: 2007)
- Impact from separation from infant life-long (Andrews: 2007; Condon: 1986; Rickarby: 1997; Weinreb & Murphy: 1988)

- Mental Health Problems (Logan: 1996, p. 616) (33% of the sample referred for psychiatric treatment compared to the general pop. Which is only 3%)
- Psychosomatic illnesses (Condon: 1986)
- Intense need to be in control (Jones: 1993)
- Deeply regretted the loss of the child (the 'best interests' argument did not make up for multiple losses and separation) Cole: 2004, 2011; Edwards: 1995, 1999)
- Women sexually abused report similar feelings around loss of child (Logan: 1996, p. 619)
- Lack of support by mental health professionals to mourn intensifies grief response (Put it behind you: it happened a long time ago) (Logan: 1996, pp. 623; Winkle & Van Kepple: 1984; Hughes & Logan: 1993; Howe et al: 1992; Henderson: 2000, p. 261)
- Mental Health professionals ignorant of damage hence minimise it (Deykin et al: 1984; Sorosky et al: 1978; Logan: 1996, p. 622; Weinreb: 1995: Henderson: 2000, p. 262; Sass & Henderson: 1999)
- Open adoptions – mothers had poor adjustment and did worse than mothers whose child had died: despair, social isolation, more physical symptoms (study done 5 years after loss) (Blanton, Deschner: 1990) (study 4 years post loss, more openness significantly related to grief and depression) (Brodzinsky: 1992)
- Bias of mental health professional – do not want to assist mothers: ("They have sinned, suffered and should be left alone", Pannor et al 1977, p. 58)
- Trauma triggers – loss or birth of subsequent child (Logan: 1996, p. 619)
- Being pressured into relinquishing during the pregnancy affects the manner in which the mother and child interact – hence has long term impact on infant's cognitive and social abilities (Henderson: 2000, p. 263; Verny & Kelly: 1981)
- A "substantial percentage of surrogate mothers have previously had either a termination of pregnancy or relinquished a baby for adoption suggests that such women may be attempting to resolve a psychological problem or conflict in what is potentially a very maladaptive way" (Condon: 1991, p. 45)

Note: Mary Nicholson wrote a manual (unpublished) for social workers at Carramar: Church of England Home for Delinquent Girls (operated as an Unmarried Mother and Baby Home). Pamela Roberts stated "The sort of experience the mother has over the delivery of her child, the care she receives at the time and the attitude of all members of the staff who care for her, will very probably have a significant effect on the whole of her future attitude to sex, marriage and motherhood". Yet with this knowledge she presided over the hospital that carried out the most inhumane and barbaric practices on mothers and their infants (Rickarby: 1998).

Impact on Fathers

More than half remained in contact with the mother
44% got married to the mother
25% remained married
22% had negative impact on their marriage
Almost all reported they considered searching

665 initiated a search
Fathers who had been coerced (doctors, adoption agency parents were 5 times more likely to be opposed to adoption (Deykin, Patti & Ryan: 1988 cited in Clapton: 2003, pp. 34-36)

- 83% felt it was a distressing experience (Cicchini: 1993)
- Majority searched (Cicchini: 1993)
- Fathers retained emotional and psychological feeling of responsibility for the child (Cicchini: 1992)
- Some fathers reported the loss as worse than a death as there was no finality (Clapton: 2003, p. 116)
- Pathological grief (Clapton: 2003, pp. 117, 119)
- Searching behaviour (Clapton: 2003, p. 118)
- Anger and Guilt (Clapton: 2003, p. 118; Coles: 2008, pp. 43-44)
- Some Fathers don't go on to have further children (Coles: 2008, p. 44)
- Feelings of powerlessness (Coles: 2008, p. 44)
- Shame (Coles: 2008, p. 44)
- Never forgot child (Cicchini: 1993; Clapton: 2003; Coles: 2008, p. 44)
- Feelings of lack of control (Coles: 2010, p.151)
- Unable to forgive oneself (2008, p. 223)

Subsequent Siblings Impacted

- Grief, depression and anxiety (Hipple & Haflich: 1993)
- Difficulty with attachment (Nicol: 1991; Cole: 2011, unpublished thesis)
- Unresolved grief (Brabin: 2011)

Crisis of Infertility

Infertility a life crisis that leads to depression, anxiety and untreated: irresolvable grief (Marshall: 1984)
Failure to resolve grief can lead to compulsive need to adopt (Marshall: 1984; Harper & Aitkin: 1981)
Resentment can develop towards child because of unresolved grief around infertility (Harper & Aitken: 1981)
Government advised to delink infertility with adoption and provide appropriate mental health services (Marshall: 1984, pp. 8-9)

Adoptive Families

- Not warned of difficulties in adoptees through the life cycles
- Failure to implement support services for adoptive families in distress (Rickarby & Egan: 1980; Rickarby: 1978)
- Disruption in adoptive families estimated between 10-25%

Biased Research

Despite the fact that adoption is widely conceptualized as a lifelong process (Brodzinsky et al: 1998) researcher has focused almost exclusively on child samples as opposed to adult adoptee (Freundlick: 2002 cited in Zamostny et al: 2008, p. 665).

Research done a few years after child is taken does not account for the intensity of grief developing over the years as the child develops, nor the triggering of distress by events such as subsequent birth, or losses – therefore it is unreliable and misleading and is often used to promote adoption to teenagers to relinquish their infants (McLaughlin, Pearce, Manninen & Winges: 1988; Donnelly & Voydanoff: 1996 cited in Zamostny et al: 2008, p. 666).

In the United States the promotion of adoption has been scientifically researched (Mech: 1986) to obtain the highest numbers of infants for the adoption market. This is very unfortunate for these usually young, poor mothers, because indicators of intense grief are coercion and imposed shame (DeSimone: 1995).

Repressed Grief becomes Pathological Grief

> Their grief was so profound that they could not concentrate … the pathological grief goes on for years … and sometimes gets worse in their later life as they come up to some crisis, their child's birthday or some stage of their own or the child's development … the grief … decompensates at any time into psychiatric disorder … they were isolated … and had no person to support them … they were so shamed by the process and so humiliated that it was very difficult for them to recover or to communicate … (Rickarby: 1998, pp. 64-21).

Pathological Grief

There is no universal definition or description of pathological grief. It is usually based on intensity, onset, quality and duration. Factors surrounding the loss of someone, such as being unexpected, sudden and violent are taken into consideration in diagnosis. Whilst normal grief goes through anticipated stages pathological grief does not. It can take three forms: Chronic grief: Indefinite prolongation of grief with exaggeration of symptoms; Inhibited grief: Most symptoms of normal grief are absent; Delayed grief: Painful emotions are avoided for a time (Gentile: 2004, p. 3). Some symptoms include, crying, searching and yearning, preoccupation with thoughts, disbelief and shock. It can intensify posttraumatic processes such as denial and re-experiencing (Gentile: 2004, p. 4). Some researchers argue that it is an extreme form of separation anxiety: "Syndromes of pathological grief are functional disorders in which normal attachment behaviour and physiology which are evoked by a loss become aberrant" (Jacobs cited in Gentile: 2004, p. 4). There can be an overlap with PTSD in that there is an impact on the primary relation network and one's sense of safety in the world (Marwit cited in Gentile: 2004 p. 4). Bereavement associated with a traumatic loss is associated with traumatic grief, inadequate farewells and sudden loss. Relieving the trauma takes psychological priority over grieving and there is a need to work through the effects of trauma before the individual can grieve After a major loss there is increased risk of heart disease and suicide there is vulnerability of a wide range of health problems and substance abuse, endocrine responses, immunological changes and sleep disturbance increase in adrenocortical activity related to separation, circadian rhythm abnormalities and sleep pattern disturbances (Gentile: 2004, p. 6) Treatment supports the expression of grief after relief from the trauma.

Parallels between loss of a newborn by death and by adoption
A mother's loss of a child by adoption has been descried as having similarities with the loss of a child by death (MacDermott: 1984, p. 36; Shawyer: 1979) though others have maintained because the child is not dead there is no resolution and the grieving goes on gaining in intensity rather than diminishing with the years (Condon: 1986; Rynearson: 1982, p. 340). Grief associated with the loss of a baby was recognised in nursing literature as early as 1962 (Yuen: 2009).

It is now unquestioned that mothers who give birth to a stillborn suffer intense grief. This research is applicable to mothers who have their babies taken for adoption. In Australia research was first published in 1970 that discussed grief pertaining to delivery of a stillborn (Giles: 1970). This was a research study conducted at King Edward Memorial Hospital in WA (Nicol: 1991, p. 4). It found the loss of a newborn had a major impact on the health and well-being of women and their families. Yet that hospital continued to forcibly take the newborns of unwed mothers by the hundreds.

The study (Giles: 1970) acknowledged that mothers of stillborns suffered not only with grief but feelings of failing as a mother and a woman. Additionally mothers tended to blame themselves and felt they were blamed by others for their child's death, this led to feelings of guilt and shame. According to Brabin (2011) the element of self-blame is a common occurrence for a mother who has suffered a perinatal loss. Brabin (2011) explains: "She wants to get on with finishing the process begun, to bring home a baby". But of course there is no baby to bring home.

Wing et al (2001) state that it was not only the mother that was identified as having a grief reaction, but fathers as well. Bereaved parents often sought medical treatment for depression and sleeplessness. Women though, experienced a grief reaction with greater intensity and for a longer duration than their male partners (Wing et al: 2001, p. 62). Over the years it was understood by the medical and psychiatric community

> The death of an infant, either through miscarriage, stillbirth, newborn death, or sudden infant death syndrome, has long been recognized as one of the most stressful events that adults may experience … adults experienced significantly higher intensities of grief following the death of a child than following the death of a spouse or a parent … the loss of a child can be extraordinarily stressful for mothers and fathers … bereaved parents often experience a grief that is unexpectedly pervasive, intense, complex, and enduring. The death of an infant is also accompanied by a multitude of secondary losses, including the loss of hopes and dreams, the loss of the experience of raising a child, and the loss of one's sense of safety in the world (Wing et al: 2001, p. 61).

Giles (1970) identified psychiatric sequelae that resulted from the loss: shock; guilt, shame, numbness; disbelief and feelings of unreality. Later research indicated that these feelings were experienced long after the death (Wing et al: 2001, p. 62). According to Wing et al (2001, p. 62) shock serves as defence mechanism "insulating parents from the full impact of their child's death". The numbness and feelings of disbelief could lead to feelings of depersonalisation. Other grief reactions were

denial, anger, depression, anxiety, intense feelings of sadness, appetite problems, fatigue, gastrointestinal problems, headaches, dizziness and chest pain. Wing et al state that a traumatic event, such as the loss of a child "can shatter parents' fundamental beliefs in their own future safety and in the future safety of their family and children. Hence bereaved parents may feel extremely vulnerable and anxious for extended periods of time" (Winger et al: 2001, p. 64).

Many family members could not relate to the extended mourning period and this lack of empathy left the bereaved parents feeling abandoned. Additionally parents stated that they felt isolated when family and friends avoided any discussion about the loss of their infant (Wing et al: 2001, p. 65).

Other negative impacts can be sexual difficulties. Parents may fear engaging in intercourse because of its association with the loss of their infant. Australian research on mothers who had their child taken for adoption found that of a random group of mothers 19% experienced secondary infertility (Andrews: 2007) whilst for mothers in support groups the percentage was much higher: 60-70%. Nancy Verrier reported the same high incidence for mothers of North American support groups (cited in Andrews: 2007). In my research nearly all of the mothers had difficulties in their subsequent relationships. For those that did have subsequent children they were terrified they would lose that child so were either over protective or paradoxically aloof, as if that somehow insulated them from their feelings (Cole: 2011 unpublished thesis). There is a similar outcome for parents who have a stillborn: "postnatal period following perinatal loss is typically fraught with anxiety related to fears that 'this baby will die too', often entailing maternal depression and guilt (Brabin: 2011, pp. 3, 5).

Many mothers, as stated above, who had their babies taken report that the loss of their first child negatively impacts on their attachment with subsequent children, this phenomena has been substantiated by research (Carr: 2000). Research done on parents whose infant died have also found similar findings: "The experiences of perinatal loss can trigger a past-learned insecure or disorganised coping style in the mother impacting on the relationship with the new baby" (Brabin: 2011; Nicol: 1991, p. 160). It also sets up a condition labelled 'vulnerable child syndrome'. Brabin (2011, p. 4) cites UK researchers who found that infants next-born after a stillbirth showed significantly increased disorganised attachment to the mother … and concluded that they are at greater risk of increased psychological and behavioural problems in later childhood. This difference was strongly predicted by maternal unresolved grief with respect to the previous loss (p. 4). This phenomenon is transferred generationally and can be physical with feeding problems … anxieties reflected in attention disorders, behavioural inhibitions … restricted capacity to manage stressors …". Mental health professionals are advised to work with mothers who have suffered a perinatal loss with effective therapy "for maternal anxiety management" that addresses the anxiety and depression that is encapsulated in the statement "what if this baby dies too" (Brabin: 2011, pp. 3, 5). There has been no research on the effect of maternal grief on subsequent children of mothers who had their infants taken. Certainly the research from perinatal loss infers that support is needed for our subsequent children.

The death-like scenario experienced by the mother is mirrored by the taken infant. Verrier (1993, p. 6) states that adoptees experience the loss as "a kind of death, not

only of the mother, but of part of the Self, that core-being or essence of oneself which makes one feel whole".

Worse than Death

> When you have a baby somewhere else and you have lost your interaction with the baby that was inside your body, the grief grows and comes up in waves **there is no comparison** with that long-term loss … There is no doubt that the loss of the baby is the pivotal issue … (Rickarby: 1998, p. 69).

"There is no funeral, there is no single event like the death to be marked. The grief and the bereavement of the mother is ongoing … major events rekindle sorrow" (Weinreb & Murphy: 1988, p.23). Margaret McDonald, adoption social worker, stated that the experience of having a child taken for adoption was reported by mothers as "worse than death" (McDonald: 1986 cited in the *Woman's Day,* 21st April, p. 58). Two mothers I interviewed for my PhD, had lost one child by death and another by adoption. They stated that the adoption loss was worse because there was no resolution, there was no body to bury, just the continued unknown. Research supports their claim (Ryndearson: 1982, p. 340; Condon: 1986, MacDermott, p. 36; Winkle and van Keppel: 1984; McHutchison: 1986). Mothers experienced the loss as if their child was kidnapped. They were not told where their child was taken, who they were with, if dead or alive, or well treated or not, they found the state sanctioned conspiracy of silence oppressive and overwhelming (Cole: 2011, unpublished thesis; Report 22: 2000, p. 153).

> After eight years of being missing, 13 year old Daniel Morecombe's remains were found, his father Bruce stated: " … it might sound bizarre but death, in some circumstances, perhaps death is easier to cope with as a parent - [it is the not knowing], so as grave as that sounds there are some things worse than death and that's what our mind was playing with over that whole journey and it is only relief - relief is probably the description we could use to describe finding Daniel's remains …" (ABC: 7.30 Report: 2011, Aug 29).

Post Traumatic Stress Disorder (PTSD)

> According to Rickarby the cruel and unnatural treatment left these women with " … post traumatic stress phenomena …" (p. 72). PTSD usually went along with the pathological grief … PTSD is when there is a major trauma which imprints itself on their minds. They are preoccupied with their trauma and, in many ways, the grief occurs because they are preoccupied with the loss .. the grief often decompensates into severe depression (1998: pp. 64-71).

Traumatic events often trigger the emergence of a variety of stress-related psychopathologies including not only acute stress disorder and PTSD but also depressive and anxiety symptoms (Sullivan et al: 2006, p. 595).

PTSD survivors suffer from extreme physiological responses to sounds, images and thoughts associated with specific traumatic events (Askovic & Fisher: 2011). Physic changes can occur and effect heart rate and blood pressure. Survivors can exhibit symptoms of hyper arousal and under arousal such as physic numbing and dissociation. "Hyper arousal causes memories to be split off from consciousness and to be stored as visual images or bodily sensations. Fragments of these "visceral" memories return later as physiological reactions, emotional states, nightmares, flashbacks, or behavioural re-enactments (van der Kolk & van der Hart: 1989).

Underarousal is a technique whereby individuals who feel trapped and in danger will engage in 'hiding behaviours' as a survival mechanism. "Endocrine measures in chronic PTSD show low serum cortisone which is an indicator of the over-activation of the parasympathetic nervous system. And may elicit behaviour responses such as social isolation and withdrawal, constricted affect, denial and cognitive impairment and dissociation. PTSD sufferers cycle between states of two extreme reactions "they either freeze in response to minor stressors or they overreact". They cycle between panic and disassociation. The condition is accompanied by memory disturbances such as hypermnesias (flashback) and amnesias.

Stress and grief cause memory loss, immune system depression, elevated blood pressure, and imbalance in hormone production (Baron, et al: 1990, pp. 344-352; Bollentino: 1997, pp. 87-111; Seligman: 1998; Visintainer: 1982) and can even lead to cancer (Susic: 2005). The relationship between helplessness and depression has been well studied (Baron et al: 1990) and its association with suppression of the immune system because of the release of corticosteroids and catecholamines to counter stress. In this way depression is related to impaired immunological functioning (Baron et al: 1990, p. 3).

Complex PTSD

Complex PTSD is associated with a unique and paradoxical neuroendocrine profile in that corticotrophin-releasing factor (CRF) levels appear to be increased even though cortisol levels have been found to be low. This set of findings distinguishes the hypothalamic-pituitary-adrenal (HPA) axis alterations in PTSD from those observed in studies of acute and chronic stress and major depressive disorder, as the latter conditions are associated with increase in both CRF and cortisol levels. A consistent observation in PTSD has been that of hyper suppression of cortisol in response PTSD may be characterised by an enhanced negative feedback inhibition of the HPA axis. When a person is repeatedly subjected to traumatic events, or the trauma accumulates because the person is always on high alert, or hypervigilant, the cortisol can not contain the stress hormones released and the accumulated trauma further reinforces the inability to respond appropriately to stress (Yehuda: 2002, p. 30). This modification of the stress response can predispose one to become hyper sensitive to stress, susceptible to be re-triggered by external stimuli or an internal state that reminds one of the original trauma and this mal-adapted stress response can be passed on to subsequent generations who in turn are predisposed to developing PTSD.

Developmental Trauma Disorder

Adoptees who have suffered the trauma of the broken bond and then are abused throughout their childhood might well fall into the category of Developmental Trauma Disorder (van der Kolk: 2005, p. 3; Verrier: 1997).

Lack of screening

Not all adoptees went to loving homes. There are a number of reasons why this occurred. Though adoption had become national policy in 1908 (Mackellar: 1913, p. 204) no research was conducted in Australia on the effects on those whose lives it impacted on until the 1970s, nor was there investigation into any special problems adoptive parents may encounter rearing someone else's child. As late as 1965 there were complaints that Australia could not contribute data to an international adoption project because no research had been undertaken (Lancaster: 1973, pp. 66-68; Gregory: 1973, pp. 54-55). Adoption was only ever perceived as a panacea for solving two social problems, infertility and illegitimacy (Roberts cited in Kennett: 1970), therefore it was never properly scrutinised. Most importantly once the child was adopted the State relinquished all oversight and the plight of the child was never investigated (Cole: 2011 unpublished thesis).

Helene Deutsch, a psychiatrist and colleague of Freud, wrote about the psychological problems of infertile women (1933, p. 47) and those driven to work out unconscious needs by adopting (1945, pp. 395, 397. 420-423). Psychological problems associated with infertility though were rarely mentioned in social work literature (Deutsch: 1930 cited in Clothier: 1943, pp. 542-543) as they did not fit into the adoption agenda. On the other hand Deutsch's theory that unwed mothers were neurotic and therefore unfit to parent was mentioned extensively (Young, 1945, Vincent 1961; Clothier 1943, 1959; Littner 1956. pp. 21-33; Shapiro: 1956; NSW Social Workers Manual: 1971). Whenever problems with adopted children were mentioned in Child Welfare Annual Reports, they were dismissed as either related to the child's hereditary or that screening potential adopters needed tightening (Cole: 2011 unpublished thesis). The truth was the screening process remained rudimentary up until the 1980s. If a couple were rejected by the Department they could apply to the Supreme Court to have the ruling overturned or they could apply to a religious organisation such as a Church of England or a Catholic Mother and Baby Home (McCabe: 1997; Rickarby: 1998, p. 63). Adopters were the primary clients of adoption workers (Pannor & Barran: 1984, pp. 245-250; Pannor & Baran, A & Sorosky, A: 1978; McLelland: 1967, p. 40; Harral: 1941, p. 420; Report 22: 2000, p. 61; McHutchison: 1985; Child Welfare Manual: 1958; McLelland: 1976, p. 9; MacDermott: 1984, p. 38), as they were considered to be offering a service for the infant and the state. Therefore it was presumed that they "must be good people" to take on the burden of raising another's child.

Dr. Geoff Rickarby, worked with adoptive families in distress during the late 1960s and through the 1970s and he stated that screening came down to two factors: infertility and having a marriage licence (Rickarby cited in Report 17: 1998, p. 70).

Rickarby elaborates "I was highly distressed about the failure of procedures for selecting adoptive parents. I was striking a large number of adopted children … who had been adopted by people with mental illness or were in very frail families". He said that in many cases one of the parents had wanted to adopt but the other had been ambivalent or against it. Rickarby goes on to state that these families were ill-

prepared to deal with the gross identity problems, testing behaviours, acting out or other behavioural difficulties that adoptees experience. They did not know how to deal with children who were so unlike them in personality, temperament and thinking styles. He said adopters had been told that bringing up an adopted child is the same as bringing up one of their own "but of course it wasn't" (Rickarby: 1998, p.70). Many parents found the teenage years particularly difficult and Rickarby authored journal articles alerting the adoption industry that it had serious problems that needed addressing. When the number of infants available for adoption declined rapidly after 1972 the Department of Community Services employed Rickarby to assist with court proceedings so that seriously disturbed individuals could not overturn their rejection and proceed with an adoption (pp. 63, 70). Interestingly Rickarby notes he saw very few children/adults who were kept by their single mothers (p. 70).

Adoption was no panacea it was a disaster as far as mental health problems were concerned (Schecter: 1960; Schecter et al: 1964, pp. 109-118; Lawton & Gross: 1964, pp. 635-644; Offord, Aponte & Cross: 1969, pp. 110-116; Simon & Senturia: 1966, pp. 858-867; McWhinnie: 1969; 1967; Triseliotis: 1973), but Rickarby was the only one stating that adoption was NOT in the best interests of the child. In the early 1960s, in the U.S. when Dr. Schecter began speaking out about the mental health problems, he was subject to a backlash. Schecter states that adoption industry workers, particularly social workers were up in arms. He gives an example: "If I wasn't bald headed by the time I went into one meeting with them, I would have been scalped totally … At least seventy-five of them shook their fists at me for daring to suggest their practices needed looking into" (Schecter circa 1960 cited in Lifton: 1988, p. 44).

It was not only Dr. Rickarby that was concerned about inadequate screening even adoptive parents complained. For instance in a newspaper articles an adoptive couple stated: "At the time when we adopted, we thought the inquiry into our background made by the welfare people was superficial … adopting two years later we did not go through any re-investigation. There was no follow-up to see if we were fit to have a second child. I think this is a weak link in the adoption system" (Mr. & Mrs J cited in the Daily Mirror: 1967, Oct 17).

As late as 1975, in a submission prepared by a group of obstetric social workers for the government, it was claimed that child welfare officers were not sufficiently trained to screen potential adopters and that adoption should no longer be about meeting the needs of infertile couples (Crown St Archives: 1975). Pannor et al (1975) stated "It is difficult to know why a process as final and irreversible as traditional relinquishment and adoption was so little questioned by professionals in the field".

Biased Research

During the 1970s and beyond there has been scientific research conducted here and abroad that highlights the damage adoption has caused adoptees and their mothers, but unfortunately it is either ignored, minimised (Collins: 2006) or countered with research that insists that relinquishing mothers do better than mothers that kept and adoptees do better than children who are raised by single mothers (Benson et al: 1994). This research is then circulated by vested interests such as pro-adoption/

anti-abortion groups, adoption agencies (Pierce: 2005), adoptive parents and is often found to be funded by right wing Christian think tanks (Fagan:1996; Benson1994). Therefore it cannot be considered to be unbiased and/or reliable. Unfortunately it is then regurgitated ad nauseum for a political agenda: the promotion of adoption over family preservation. This is not surprising when adoption in the U.S. is a multi billion dollar unregulated business (Riben: 1988).

Benson et al's research project, that suggests adoptees do better than children raised with their biological families, has been criticized as being methodologically flawed and of distorting, misusing and misrepresenting expert H. David Kirk's previous work to provide "comforting conclusions". The fact the research was self published by the institute that wrote it, that it wasn't appropriately reviewed by its funding body the "National Institute of Mental Health" Kirk states is "an indictment of the public granting agency that sees fit to finance research of this caliber" and has resulted in "questionable research methods resulting in inapplicable if comforting conclusions". One of the main critiques of adoption research is that even though it affects the adoptee through his or her entire life cycle the majority of studies are done on adolescents who are still living at home with their adoptive parents. Most studies also include self reporting of the adoptive parents. This methodology is questioned because of bias of the informants in that adopted subjects may have been influenced, either covertly or overtly, by the prescience of their parents during the period when they filled out the questionnaires. The subjects may have been reluctant to criticize their parents, Moreover, there may have been subtle and, at times, not so subtle pressure to describe themselves in a positive or socially desirable way. Brodzinsky (1987, p. 398) stated that to ignore what is "becoming increasingly clear to adoption caseworkers, mental health professionals, and researchers, alike …that there is prenatal vulnerability, as well as intrapersonal, familial, and socio-cultural stresses associated with adoption that render adoptees more vulnerable to a host of emotional and school-related problems …To ignore or distort this situation …as Marquis and Detweiler have – is to look at adoption through rose-coloured glasses".

In other instances research findings are misinterpreted or distorted to conclude that relinquishing mothers do better than mothers who keep their infants which is then used to promote adoption to vulnerable, young unwed mothers.

The first "classic study" on adoption was done by Sophie van Theis, who would often provide her friends with children for adoption (Herman: 2008; Robinson: 1962). The study was pivotal to the promotion of adoption in the early 20th century. Titled: *How Foster Children Turned out*, it basically determined if adults were "capable of managing themselves with ordinary prudence" which coincidently was the measure used to determine if individuals were feebleminded or not (Mech: 1965, p. 14).

According to Jones (1997, p. 64) there is now copious research on damaged adoptees, but there is "surprising little literature which addresses the special psychological circumstances of adoptees … One almost begins to wonder if this blind spot …if because to some extent the adoptees and family's fantasy is that the adoption does not exist; that she is really the biological child of the adoptive parents".

There have been a number of researchers who have critiqued the methodology of pro-adoption based research. Specifically very small studies that cannot be generalised and do not take into consideration the body of research that has repeatedly confirmed the psychiatric sequelae adoption causes (Brodzinsky: 1987; Ryburn: 1999). Other researchers have criticised the misinterpretation of their research findings to put adoption in a positive light without exposing any of its complexities and psychological problems (Kirk: 1997; Henderson: 2000).

> If we were genuine about the child coming first, we would be doing everything we could to ensure mothers could keep their babies … For many years, research has existed on the impact of adoption on adoptees, but this research to this day has largely been ignored or undervalued … Are natural mothers, in particular those from overseas informed that they may find themselves in a state of unresolved grief and regret for the rest of their life if they give their child up for adoption? … Are natural mothers informed of the research results about the possible impact of adoption on their baby? Why do we ignore the research? … the need to maintain the status quo that is, that adoption is a good thing and the belief that to meet the needs of the childless couples solves everything …overseas research and Australian research indicates that there are a higher proportion of adopted persons in the psychiatric and prison system and constitute homeless youth.

Accumulation of Trauma

Early life experience alter behavioural and brain development (Sullivan et al: 2006). According to van der Kolk (2005, p. 1) chronic maltreatment has pervasive effects on the development of the brain. "Developmental trauma sets the stage for unfocused responses to subsequent stress leading to dramatic increases in the use of medical, correctional, social and mental health services". Abused and traumatised children suffer from "a crisis of loyalty" and they organise their behaviour to survive within their families. They generally keep secret their treatment and deal with their abuse with compliance (p. 2). According to van der Kolk (2005, p. 4) the PTSD diagnosis does not

> Capture the developmental impact of childhood trauma: the complex disruptions of affect regulation, the disturbed attachment patterns, the rapid behavioural regressions and shifts in emotional states, the loss of autonomous strivings, the aggressive behaviour against self and other, the failure to achieve developmental competencies, the loss of bodily regulation in the areas of sleep, food and self-care; the altered schemas of the world; the anticipatory behaviour and traumatic expectations; the multiple somatic problems, from gastrointestinal distress to headaches; the self-hatred and self-blame and the chronic feelings of ineffectiveness (p. 3) … Developmental Trauma Disorder is predicated on the notion that multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults or witnessing domestic violence have consistent and predictable consequences.

Complex PTSD

Complex PTSD results when not only has there been a traumatic event but bullying, harassment and coercion are involved.

Common symptoms of PTSD and Complex PTSD that sufferers report experiencing

- hypervigilance (feels like but is *not* paranoia)
- exaggerated startle response
- irritability
- sudden angry or violent outbursts
- flashbacks, nightmares, intrusive recollections, replays, violent visualisations
- triggers
- sleep disturbance
- exhaustion and chronic fatigue
- reactive depression
- guilt
- feelings of detachment
- avoidance behaviours
- nervousness, anxiety
- phobias about specific daily routines, events or objects
- irrational or impulsive behaviour
- loss of interest
- loss of ambition
- anahedonia (inability to feel joy and pleasure)
- poor concentration
- impaired memory
- joint pains, muscle pains
- emotional numbness
- physical numbness
- low self-esteem
- an overwhelming sense of injustice and a strong desire to do something about it

Trauma transmitted Generationally

Unfortunately trauma is not confined to the 'taken infant' and his or her mother. Modern technology has revealed that trauma is transmitted transgenerationally.

Epigenetics

Tangible evidence now exists that proves environmental changes or stresses impact on genes, this is called the science of Epigenetics (Craig: 2010). This includes traumatic emotional experiences.

Science has revealed that genes can be turned on or off by environmental cues without changing the DNA, this is because it has survival value. For instance when humans began to settle, grow grains and drink milk the genes needed to produce enzymes to make their proteins digestible were spontaneously turned on. If a person is exposed to a traumatic event it can effect the protein transmission of the gene, this too has survival value has individuals are responsive to and always learning from their environment (Ridley: 2011).

Inherited PTSD

It was once thought that traumatic experiences were passed on to future generations through social interaction and learned behavioural responses. This model of trauma transmission was not very helpful in explaining why children of holocaust survivors, who suffered no trauma themselves, and had a very good relationship with their parents, suffered reoccurring nightmares of being tortured and mental health problems such as depression and anxiety and unable to cope because of a war in which they took no part. This phenomenon was not confined to holocaust survivors but also effected children of war veterans, victims of sexual abuse and torture. Additionally it was not only children who were effected but grandchildren and beyond (Kellerman: 2011, p. 1). New research indicates that traumatic experiences of parents may lead to a general disposition to PTSD in their offspring. Kellerman explains (2011, p. 1): "Family and twin studies have found that risk of PTSD is associated with an underlying genetic vulnerability and that more than 30% of the variance associated with PTSD is related to a heritable component. This heritable component can be observed in the epigenetic marks that affect gene expression patterns in the nervous system". This would help to explain how children who have not themselves been traumatized tend to manifest inherited emotional problems (Kellerman: 2011, p. 3). Epinegenetic transmission is a psychobiological explanation for transgenerational transmission of trauma.

Epinegenetic transmission of trauma

> We cannot take mothers from infants without seriously increasing the psychological burdens which the next generation will have to bear (Winnicott: 1942, p. 465 cited in van der Horst & van der Veer: 2008, p. 327)

When a person is traumatised, particularly if a component of the trauma is fearing for one's life, a process occurs whereby cellular material affixes itself above the gene. The DNA itself is not changed but the affixed material called the epinegenome instructs the gene to turn off or on, become loud or soft, hence the gene remains the same but the way it acts, or its expression has been altered. This alteration is transmitted to the next generation via the sperm and ovum. Hence the trauma may be passed from generation to generation. Hollick states (2011) "Even more remarkable our state of mind in the weeks leading up to conception can affect the egg and sperm through genomic imprinting. Thus generational trauma can be inherited genetically as well as culturally". The psychological symptoms of the generation who suffered the trauma are replicated in the next generations. So grandchildren can suffer the PTSD symptoms of their grandparents, such as: intrusive images, nightmares, anger, restricted emotional range, fear of death, depression, guilt, anxiety, pain, paranoia, social problems and concerns of safety and suffering (Harvery: 2007; Wardi: 1994 cited in Kayfetz: 2007).

Transmission of PTSD vulnerability to subsequent generation involves disruption to neuro-biological systems such as the hypothalamic-pituitary-adrenalin function (fight and flight) and cortisol levels (stress response mechanisms) along with hippocampus (memory) and amygdala functions (emotional control) which are known to be negatively impacted by chronic stress. Not only are psychiatric sequelae passed on to

subsequent generations but the traumatic experience, because it effects neuro-biological systems, can manifest itself in physical problems such as heart disease and cancer.

Kellerman (2005) explains the process: "Heritable changes in gene expression often occur as a result of environmental stress or major emotional trauma and would then leave certain marks of the chemical coating, or methylation, on the chromosomes (Meaney & Szyf: 2005 cited in Kelerman: 2011, p. 3). The coating becomes a sort of 'memory' of the cell and since all cells in our body carry this kind of memory, it becomes a constant physical reminder of past events; our own and those of our parents, grandparents and beyond. This kind of epigenetic cell memory can possibly explain how 'elements of experience' may be carried across generations" (Kellerman: 2011, p. 3).

According to Shunsuke Ishii of the RIKEN Tsukuba Institute: "Our genes encode proteins, but whether and how these genetic instruction are ultimately read and expressed depends on how those genes are chemically modified and "packaged" … … Epigenetic changes may influence basic cellular functions as well as metabolism, behaviour and diseases …and may play a role in heart disease, diabetes, and in psychological diseases, such as schizophrenia". Stress can change the fate of future generations and influence DNA without changing the gene sequence (Cell Press: 2011, June 24)

Professor Eva Jablonka of Tel Aviv University's Cohn Institute stated: "Epigenetic research suggests that the effects of stress … can be passed on to future generations … Two individuals may have identical genes, but the genes present very different characteristics. They can be genetically identical but different epigenetically … Stress is enormously important … It can affect the development of cancer and other chronic diseases, and may also have long term impacts on ecology … genes do many things, and gene expression patterns can be heritable … Stress can create near invisible effects on gene expression, effects that can be passed from mother or father to child, through microRNA, tiny RNA discovered about a decade ago which work as cellular "micro-managers" (Elsevier: 2011, Mar 31).

> Parents can pass on all kinds of 'acquired' (or epigenetic) characteristics, especially if these are based on powerful life-threatening experiences, such as survival … from torture … Such environmental conditions would leave an imprint on the genetic material …and pass along new traits even in a single generation … Children of traumatised populations can have a latent susceptibility to PTSD which could be triggered by a current stress. PTSD is latent and can be turned on and the person may suffer from severe depression or panic attacks often that seemingly arise without a cause (Kellerman: 2011, p. 4).

The above phenomena can be related to the brutality of separating a mother from her newborn. It is proposed that the trauma inflicted, on the drugged and bullied mother by authority figures who were part of an oppressive system, whilst she was helpless and unable to escape, will be passed down to subsequent children and grandchildren. The infant taken likewise suffers a deeply traumatic event and that will be passed on

down. Therefore the need for well trained trauma specialists is essential. The financial and social cost to the government if it does not provide assistance will be far greater as the resultant mental and physical health problems are transmitted to subsequent generations.

Section IV:
Mental Health Service Flaws and Trauma Triggers

Why current mental health services are failing:

- The federal and state governments (except WA) and all complicit institutions have not apologised to the mothers, fathers, adoptees and family members affected by the policy of brutally separating mothers from their newborns. Without acknowledgement and validation there can be no healing
- There has been no recognition of the truth therefore there is no possibility of recovery (Herman: 1992)
- No public education of the history of the stolen white generation, hence no awareness of the violations of our civil and human rights - the general community's ignorance is apparent when comments are made such as: "Why are there so few infants available for adoption … we need to overhaul the system so more couples can adopt" – we feel threatened by a repeat of an unjust history – such statements re-traumatise (trauma triggers)
- Failure of government and mental health professionals to acknowledge that the systematic and oppressive regime of forced removals of newborns was/is torture
- Mental health treatment is fragmented: there is no overall or holistic approach and practitioners are not educated about the severity of the trauma, they are ignorant of the fact that many women and adoptees are presenting with complex PTSD further complicated by pathological grief (Post: 2000)
- Lack of provision of trauma specialists
- Lack of trauma centres focussed specifically on dealing with victims of forced removals
- Lack of trauma specialists working with victims/survivors to lobby government for better social policy outcomes
- Ignorance of the ripple effect and that subsequent children and grandchildren can be carrying trauma related psychiatric sequelae
- No understanding of trauma triggers i.e. promotion of adoption; mother's day; birthdays; losses such as death and separation; rejection; being told by professionals "You are not really the mother" or "The parents that raised you are your real parents"
- No training of professionals who treat victims of forced removals/torture (doctors, nurses, social workers, government employees)
- Government support of pro-adoption media personalities – it is akin to saying the theft of your child was okay and the government sanctions the continuation of the abuse
- Lack of funding for non-political support groups, lack of oversight of activities of support groups, no integration of support groups with skilled trauma specialists/services
- Provision of counsellors who are involved in child removal practices

- Difficulties developing trust with mental health workers because they do not validate the depth of the trauma/torture

Dr. Geoff Rickarby (1998) comments on how mothers are re-traumatised by current government funded mental health services:

1. Taking mothers into situations as part of a group without any assessment of their grief status, distress, personality or psychiatric disorders.
2. In group situations, requiring mothers to conform to attitudes, transactions with others, and styles of thinking about adoption, without any sensitivity to the mothers' position or to crises in their feelings brought up by the professionals, adoptees, and adoptive parents, let alone the aggravation of post-traumatic stress phenomena and depression as a result of these group contacts. These organisations have `a party line' which is against the interests of original mothers becoming validated or healed.

"Whenever I see a therapist, it's doesn't help – I have to educate them"

Many mothers and adoptees have stated that they cannot find adequate mental health services to deal with the level of trauma and grief from which they are suffering (Aust Institute of Family Studies Teleconference: 2009, 10th Sept). The government funded post adoption resource centres are more focused on assisting mothers and adoptees conduct searches and facilitate reunions than treating complex PTSD. Rose Rawady, a social worker, who worked with the support group ARMS in South Australia commented on these organisations stating that: "Clients often state they are very reluctant to seek services from state government agencies. Contact with such agencies often re-stimulates their grief and memories from the time of relinquishment, which pose considerable barriers in any counselling work they might need to do with the works of those agencies" (Rawady: 1997, p. 394). Many mothers and adoptees find that going to individuals who are still involved in facilitating adoptions is re-traumatising. The author has been involved with a number of support groups and women have complained that when they have sought help from psychologists and psychiatrists very few understand that adoption has caused them trauma. I majored in psychology in my undergraduate degree at university and the topic of adoption was never raised. A U.S. research project found that 10% of adults attending psychiatrists and psychologists were seeking attention for issues relating to adoption whilst only 7 minutes a semester was spent on the topic (Post: 2000). In Australia (Harper et al: 1976), research indicated that nearly 12% of the patients of a facility for children with psychotic and serious mental health issues were adoptees yet one wonders how much time is spent teaching mental health professionals in this country of the psychiatric sequelae of mothers, adoptees and family members effected by the trauma of separation?

Trauma Triggers

> So you have the trauma and the loss. Many of them had quite traumatic experiences and crises in the hospitals. This then sets up a super alertness to never have anything like that happen again. For some of them it was a deep-seated fear of pregnancy or sexual relations and for others it was a terrible fear that something would happen to their child, that they would lose another chid. There was anxiety … panic, that would come back

> …when various triggers came up, for example, listening to the news and hearing somebody else losing a baby or something happening to a baby, or going to hospital. I know mothers who could not go near a hospital which was a very dangerous situation … The major depression came along in both PTSD and pathological grief which can break down into major depression very easily. Major depression was often one of the most common reactions, although severe dissociative disorder, where they would block out … part of their lives … The pathological grief … gets worse … . (Rickarby: 1998. pp. 64-71).

A person can be easily triggered if there are external reminders of the trauma or if their emotional state replicates the internal state produced during the traumatic event. This is a biological event as much as a psychological one. Reminders of the past or trauma triggers, "are particularly relevant for understanding and treating traumatised individuals. A reminder of the past will automatically activate certain neurobiological responses and trauma survivors are vulnerable to react with irrational-subcortically initiated responses that are irrelevant, and even harmful, in the present. Traumatised individuals may blow up in response to minor provocations; freeze when frustrated, or become helpless in the face of trivial challenges … sensory triggers reinstate hormonal and motoric responses relevant to the original trauma; one of the most critical factors that renders a situation traumatic is the experience of physical helplessness-the realization that no action can be taken to stave off the inevitable".

Instead of being able to successful negotiate the stressful event by activating the flight or fight response the person becomes immobilized. 'Inescapable shock' ensues because the individual is unable to affect the outcome. Unfortunately for trauma survivors the "physical immobilization becomes a conditioned behavioural response" and there is a propensity for trauma to become a self perpetuating cycle where the survivor continues to find themselves in situations or in relationships that are abusive. "Describing traumatic experiences in conventional verbal therapy is likely to activate implicit memories, that is, trauma-related physical sensations and physiological hyper-or hypo-arousal which evoke emotions such as helplessness, fear, shame and rage" (van der Kolk: 2006). According to van der Kolk (2006) interpersonal trauma often results in fear of intimacy therefore the therapeutic relationship could evoke implicit memories of hurt, betrayal and abandonment. Therapy therefore needs to help people feel a greater sense of calm and control and rather than trying to understand the traumatic narrative it is much more "about remembering how one survived" (van der Kolk: 2006).

According to Askovic & Fisher (2011) "the primary goal in treatment of PTSD is to help people to distinguish the past from present. Traumatic experience needs to be located in time and place. These events must find their home in the past and stop haunting the present. The unbounded, non–verbal nature of implicit memory, as well as the emotional and behavioural patterns it kindles, makes this difficult. It also limits the effectiveness of therapeutic techniques that rely on verbal recollection and 'working through'. At least early in treatment, verbal therapies may be calling on the wrong side of the brain" and have the potential to re-traumatise because of the way the memory has been stored. In these instances non-verbal treatment such as neurofeedback may be of assistance. Recent research indicates that "traumatic

memories can be understood as patterns of neuronal activation previously associated with a fear reaction". The pattern of firing can be triggered by cues. The two areas involved in storing the memory of the traumatic event are the amygdala and hippocampus. The hippocampus is engaged in storing explicit memory of the traumatic event in a form of the autobiographic narrative (underwritten by neuronal patterns), the amygdala and its neural connections encode implicit (non-verbal and unconscious) memory, memory that serves to warn of danger. Prolonged stress can negatively impact on short term memory while at the same time produce "very powerful implicit, unconscious memories that are difficult to decode, to trust, or to extinguish". To put it more simply a traumatised person may suffer blanks of memory, but at the same time experience panic attacks associated with the trauma that is locked in the hypothalamus and amygdala but not available for conscious recall.

"The capacity of the prefrontal cortex to quiet the amygdala can fail in situations of overwhelming stress, making stress-linked learning stronger and more resistant to extinction" (Askovic & Fisher: 2011). Therefore recalling a traumatic memory to 'talk it through' can overwhelm the prefrontal cortex, which is the part of the brain normally involved in cognitive behavioural therapy or 'talking' therapies.

Overview of Triggers for Mothers with Complex PTSD

Triggers for some mothers are: the word adoption; adoptive parents; consent takers; anyone currently working in the adoption field; institutions formerly used to facilitate adoptions; books, newspaper articles and/or radio broadcasts that either promote adoption and/or make excuses for unethical and illegal past practices; use of stigmatised stereotypes by media; people who fail to acknowledge their complicity in past abusive practices and instead make excuses for their behaviour, such as they did what they did because "it was the social mores" (Marshall & McDonald: 2001; Hindsight: 2009, 2011). Blaming society for one's past illegal practices is not only a trauma trigger but unethical. Many decent people would be deeply offended by the accusation that they participated in the forced removal of newborns or would have agreed to having mothers drugged, bullied and assaulted to provide infants for married couples (Cole: 2008). Social worker, Rhonda Ansiewicz (1997, p. 346) points out that: "The history of adoption has been fraught with pain. In many documented cases, the profession can be accused of gross human rights abuses against the mother and subsequently the child. No longer can the profession hide behind its claim they operated out of the values of the time. Individuals and institutions are responsible for the displacement of women and their children and must be accountable".

Another re-traumatising trigger is being subjected to pro-adoption media campaigns where celebrities such as Deborra-lee Furness are feted by the media and adoption is once again promoted as a win/win situation that ignores the pain and loss of the original parents. Furness's campaign for a designated week to celebrate adoption outraged many who had their children taken. The campaign was supported by a number of politicians one of whom was Bronwyn Bishop. Bishop made outrageous statement such as "all children under five who have a parent who has used drugs, even if not using them now, should have their children immediately taken and adopted out" (Bunce: 2007; Cole: 2009). Once again threatening the poor and disadvantaged with child removal as a tool of social control (Wilkinson: 1986, p. 94; Cole: 2011, unpublished thesis).

Regardless of how society regarded unwed pregnancies in the past, *you deserve the title and honor of mother* (Verrier: 2011)

Birthmother: Trauma Trigger

The lexicon of adoption is devised to diminish the importance of the family of origin and to elevate the status of the social family. Throughout history a mother is the person who birthed the infant. The social parent was known by a number of titles: stepmother, foster mother, adoptive mother, and/or guardian. In an age where children are created or provided for adults, and adults take ownership of an infant: "He is ours!" a language has been produced to sanitise the exchange (Ludbrook: 1993 cited in NSW Law Reform Commission No 34: 1994, p. 35). Language defines our reality and has been used extensively to diminish the position of the mother in relation to her 'taken' child. She is no longer referred to as mother, but as a birthmother; biological mother or some other descriptor. Elite men (for e.g. Bowlby, Spitz) viewed relationships with newborns from their perspective. They believed that women attached the way they did: post birth. They had no concept of what it is like to intimately connect with another human the way a woman connects with her baby. Since patriarchal based science was dominated by men attachment theory developed to reflect the male's experience. Hence attachment theory postulated that anyone who provided the infant nourishment and consistent attention could substitute for the real mother and was given equal status and the title: 'primary caregiver' (Verrier: 1997, p. 11).

Many mothers consider the term birthmother as stigmatising and degrading. It is not only traumatising but reaffirming of the schizophrenic life she has been forced into. She gave birth, but she is considered a non- mother. In many cases she is expected to have no relationship with her now adult child because she did not get the opportunity to be his or her parent. She was only the incubator, "the oven for the bun" (Insight: 2011). Many adoptees, influenced by the state propaganda campaign that they were 'unwanted' are angry, they feel abandoned and make statements such as: "I only have one mother and that is the (adoptive/foster/step) mother that brought me up". This is felt as a punishment by the mother for not been given the opportunity to be available, particularly at the birth. Many mothers are put in situations where they are expected to pretend they are 'just a friend'. Being labelled a birthmother is meant to keep her in her place, it creates a social space for the adoptive mother to take an exclusive position. It must be realised that forcing a mother to pretend she is not is crazy making and reinforces the disassociation that the original trauma created.

Mixed Groups: trauma triggers

Placing adoptees and parents together for group therapy is problematic. Both are carrying a great deal of emotional baggage and hold unconscious patterns of anger because of feelings of abandonment (Anderson: 1982; Cunningham: 1996, p. 70). Placing adoptive parents, adoptees and natural parents together for counselling is potentially a trauma trigger for mothers. For instance placing women who were exploited for their reproductive labour with those that benefited from it may re-traumatise them . Working with mothers and adoptees in a clinical setting should be framed through a "trauma perspective" and both groups need trauma specialists who deal with them as two discreet groups (Higgins: 2010, p. 3). The Post Adoption

Resource Centres are better placed to provide ongoing support for adoptive parents and those who are in the process of searching.

Lies that continue to Traumatise

Not only were benefits available from both the Commonwealth (Oude Vrielink: 1973, pp 20-27) and State authorities (Graham: 1973, pp. 28-33), but there were non-government organisations that provided food, cash payments, clothes or assisted in finding emergency housing if needed (Crown St Archives: 1953).

The *Unemployment and Sickness Benefits Act* 1944 (later incorporated in the *Social Services Consolidation Act* 1947) came in into operation on 1 July, 1945, the legislation also provided for the payment of what was termed 'special benefit'. The maximum rates payable were the same for both unemployment and sickness benefit. The rate of special benefit was determined by the Director-general but was not to exceed that for unemployment or sickness benefit, whichever was the more appropriated in the circumstances. Special benefit was payable from such date and for such period as the Director-General determined. An unmarried person 16 years of age was entitled to 15 shilling per week. An additional benefit of 5 shillings per week was payable in respect of the first child to any person qualified to receive unemployment or sickness benefit having the custody, care and control of one or more children. Mothers were also entitled to claim under the child endowment scheme and maternity allowance. Provision was made for a seven-day waiting period during which unemployment or sickness benefit was not payable. An unemployed beneficiary could transfer to sickness benefit or vice versa without loss of continuity of payment. The *Unemployment and Sickness Benefits Act* enabled the payment of 'special benefit' to person who by reason of age, physical or mental disability or domestic circumstances or any other reason were unable to earn a sufficient livelihood for themselves and their dependants and did not qualify for a pension or unemployment or sickness benefit. The *Social Services Consolidation Act* 1947 made a change in the Special Benefit. Claimants and recipient were no longer subject to the provisions giving the Directory-General power to make the payment of benefit condition on complying with any requirement that he should undertake medical or rehabilitation treatment or vocational training.

A single mother with children was entitled to assistance with health insurance under the Subsidised Health Benefits Scheme (Oude Vrielink: 1973, p. 25). The Child Welfare Department assisted women to take out affiliation orders, if these were not successful mothers could claim a composite allowance from the Department of Labour & Industry & Social Welfare and the Child Welfare Department (circa 1950s). She could obtain assistance with a layette from the above Departments as well as assistance from voluntary agencies such as the Food for Babies Fund, Legacy Club and other non-government organisations. According to Crown St social workers (1953) "On the whole statutory provisions for girls in the last six weeks of their pregnancy and the six weeks following confinement are liberal. They are entitled to Sickness Benefit and to the Maternity Allowance, if they are unable to find employment they can obtain Unemployment Benefit or assistance from the Department of Labour & Industry and Social Welfare" (Crown St Archive: 1953). Some of the functions of the latter Department were: provision of food, clothing, medical services, blankets and housing for the unemployed. In 1956 the social

welfare provisions were transferred to the Department of Child and Social Welfare Department (State Records: 2011).

In 1968 single mothers could apply for the Deserted Wives Benefit under the *State Grants Act* (Wilson: 1973, p. 70) and in 1969 Pamela Roberts explained that in NSW a single mother was entitled to $1 less than mothers on a Class A Widow's Pension (Roberts: 1969). The claim that there was no financial assistance is bogus. What has aided social workers in making such false claims is that the States had various Benefits provided by different departments that changed over the decades along with the fact the Commonwealth Department of Social Services provided additional cash assistance – so amounts changed to whether a State or Commonwealth Benefit is referred to, and whether all the Benefits: State, Commonwealth and child allowance that mothers were entitled to are combined (Oude Vrielink: 1973; Graham: 1973).

For instance pregnant women and single mothers could claim Special Benefits, or assistance under Destitute or Child Welfare provisions or alternatively unemployment or sickness benefits (Roberts: 1969*; The Australian Women's Weekly*: 1954; Hickman: 1972; Oude Vrielink: 1973, p. 22; Graham: 1973; Cole: 2008). In 1968, 40% of payments made under the *State Grants* (*Deserted Wives) Act* were to unmarried mothers. In 1968, Special Benefits were payable to confinement cases in lieu of Unemployment Benefits and as of June 1972, 74% of Special Benefits were paid to unmarried mothers (Oude Vrielink: 1973, p. 26).

Some benefits were received prior to the birth and for a short time after then the mother would move to another benefit. What is clear is that financial assistance was sufficient if women were informed of these Benefits and that they could and did maintain their infants (*The Australian Women's Weekly*: 1954; Hickman: 1972; Cunningham: 1996). Roberts states that in NSW in 1969 a single mother was entitled to $22 per week (Roberts: 1969). Commonwealth allowances on top of that were $4 for one child with an additional $4 if paying rent (Oude Vrielink: 1973).

A senior social worker with the Commonwealth Department of Social Service explained: "The Department offers … no specific benefit or service specifically designed for single mothers", but she goes on to list the number of cash benefits under varying welfare schemes that were available in the late 1960s and prior to the introduction of the Sole Parents' Pension (July, 1973). Interestingly the Commonwealth officer makes the point: "The services which are available are not always made use of" (Oude Vrielink: 1973, p. 21). Rose Rawady, social worker, explains why (1997): "it was common practice not to inform mothers of available assistance. In fact many who asked were told there was no financial assistance, or if the mother knew that some assistance was available they were told it was not enough to live on and were not informed of which departments to contact to obtain it". Not informing mothers of assistance not only placed mothers under duress it failed to meet the criteria of giving mothers the opportunity to make an informed consent therefore the *Adoption Act* did not come into force.

Social Mores: Trauma Trigger

Another bogus claim is that the barbaric treatment meted out to unwed mothers and their infants reflected social mores and that all unwed mothers had no choice but to

'choose' adoption. The research I undertook as part of my doctoral thesis did not support this assertion. Mothers who kept their babies had no instances of social exclusion and on the whole found their family and friends supportive. All the unwed mothers, except one, I interviewed, whether they kept or had their infants taken, reported feeling stigmatised, denigrated and abused by those working in the adoption industry.

Blaming societal stigma and lack of finances seems to infer that women took the easy way out, things were difficult so they gave away their babies. Hearing this is traumatising because it misrepresents what really happened and it protects the abusers. The harvesting of so many babies for adoption can be blamed on the human and civil right violations and the traumatisation of young mothers. The 'social mores' excuse is a justification for individual's abusive behaviour, just like those who state; "I was only following orders". Rose Bernstein reviewed a number of studies done on unwed mothers who kept their infants between 1955 and 1965 and concluded that nearly all of the women interviewed did not experience severe social penalties. "Being a single mother did not result in poorer family relationships or bring censure from friends, neighbour or colleagues … the vast majority of unwed mothers reported that their friendships remained stable and many were married soon after to the baby's father or to another man …. Very few women had tried to conceal the baby's status by calling themselves 'Mrs' (Berstein: 1971, pp. 96-97, 106-107). This is not to say that a minority and in particular the clergy, adoption workers and families that did not support their daughters and grandchildren were not cruel and prejudicial, but as most of the mothers that present for mental health treatment were victims of this bigoted minority one may tend to generalise their behaviour to the entire community. For instance I for one did not know there was an Aboriginal stolen generation until 1989, and I certainly would not have supported the barbaric practices perpetrated to steal their children and babies. If one looks at the rhetoric coming from right wing fundamentalists in Australia and the United States very little as changed from their perspective since the 1970s. Charles Murray (1995) called for the return to the 'good old days' of the 1960s when single mothers adopted out their children, because adopted children did better than those raised by their single mothers.

In 1976 the Minister for Youth and Community Affairs, W. C. Langshaw commissioned research on the number of single mothers keeping their infants from 1923 to 1976. It was found that approximately 60% of mothers did keep their babies and according to social workers were able to manage on the assistance provided (Cunningham: 1976; Women's Weekly: 1954, 1971). This figure includes the years when the most abusive practices occurred, 1967-1972 and when more babies were taken than at any time prior or after. Mrs Margaret Wilson, social worker with the Central Methodist Missions stated (1973): "Community attitudes towards the single mother and her child have changed during the past few years … Now, not only is there wider acceptance of her, but due to the granting of the pension to single mothers in 1968 she is officially recognised". One wonders what decade, more precisely, what section of the community's social mores are ex-adoption workers referring to (McDonald & Marshall: 2001)? In a survey conducted at the Queen Victoria Hospital in the 1960s 70% of married women had practised pre-marital intercourse and only 6% had used contraception (Murray: 1973, p. 77). Single mothers therefore, could

been seen not as an aberration, as they are still painted, but as ordinary members of a society with the distinction of being very healthy, fertile young women.

Counselling: a trauma trigger?

The epidemiological foundation on which social work theory rests as it pertained to single motherhood was that an unmarred mother was too neurotic to make her own decision about keeping her baby and she and her infant did not constitute a family (Reid: 1957; McLelland: 1967, p. 42; MacDermott: 1984, p. 3; Young: 1954). Therefore social work literature encouraged the profession to "point out the reality of her situation and its difficulties" in keeping her baby and it was their duty to "*assist* her to come to a decision" as it assumed that the infant was better off with a married couple (Cole: 2008; Roberts: 1969, p. 58). Counselling was the social workers' tool of trade and without it, according to a Human Rights Commission Report, there would not have been so many babies available for adoption (MacDermott: 1984, p 39).

The success of their 'counselling' was predicated on the damage it inflicted on the young woman's identity (Cole: 2007). No more could she view herself as a competent, intelligent human being that had the ability to mother her own infant. She had to perceive herself as less than, an inferior, a person of shame and disrepute. Strangers were supposedly better equipped to parent her child. Social workers saw unwed mothers as 'sluts' and they wanted them to see themselves that way (Mather: 1976). Margaret Kornitizer, author, colleague and friend of Pamela Roberts, stated that "some may find nothing wrong with sex outside of marriage", but she went on, it was up to social workers to provide a moral compass and to ensure that it was stigmatised so the institution of marriage was in no way threatened. Roberts expressed similar sentiments in Journal articles as did Mary McLelland, Supervisor of Professional Training, Social Studies Department, University of New South Wales (Kornitizer: 1959; McLelland: 1967, pp. 42, 49; Roberts: 1968, 1969).

Mental Health Professionals, especially those who use 'talking therapies' and/or counsel mothers in a clinical setting, should be aware that their first experience with this therapeutic model was very negative and that the power differential was heavily weighed in favour of those working in the adoption industry (Rickarby: 1998; Rawady: 1997, p. 388). Rickarby explains:

> The power difference was built up over months so that the young woman was put into a powerless, shamed position and then the drugs were added on top of that … it was all done in a situation where the power difference was built up to an incredible pitch (Rickarby: 1998, p. 66).

When working with individuals who suffer from Complex PTSD it is very important to co-author their treatment plan. Sufferers need to feel as if they are in control and as there is already a power differential built into a client/professional relationship this could trigger the powerlessness, lack of control, helplessness and inability to determine outcomes that was inherent in the relationship between the mother and authority figures in the adoption industry (Rawady: 1997, p.p. 387). It is important to realise that the counselling/'brain washing' was part of the torture used to defraud mothers of their newborns (Rickarby: 1998; Chisholm in Report 21: 2000). The counselling sessions had a pre-determined goal, to shame, isolate and humiliate. To

influence the pregnant young woman by making suggestions that she would be responsible for harming her infant if she was selfish enough to insist on keeping it (MacDermott: 1984, p. 3; Mech: 1986). This was done in a situation where the pregnant woman was already in a vulnerable position and felt psychologically trapped. Captivity is very much a dynamic that pre-disposes one to PTSD, and this is not confined to being trapped in a physical location. Psychological captivity, is more potent than physical captivity when it comes to causing PTSD.

TRAUMA TRIGGER: Failure To Acknowledge Forced Separation Of Mother And Infant Was A Regime Of Torture

Torture: deconstruction of the brutal separation of mothers from their infants and infants/adults from their families

Torture is defined by the *United Nations Declaration Against Torture* as:

> The deliberate use of physical or psychological methods that cause a person severe pain and suffering with the intention of punishing, intimidating …. The torture must be perpetrated by a public official or at his or her direction.

The World Medical Association definition:

> The deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield.

The STARTTS website offers further clarification of the elements of torture and its societal purpose:

> Fear is an essential element of torture. When torture is used, a whole society, not just the individual who is being tortured, lives in fear. Other society members are afraid that it will happen to them. In this way, torture is a tool of social control used by a system that rules individuals and societies through fear.

Threatening to remove children was/is a social control mechanism in use in Australia:

> The child as a hostage in the war waged by the state against irregular families. The absolute weapon of those who inspect how families run their lives is to take away, or threaten to take away, their children (Wilkinson: 1986, p. 94).

Social Control

There are many statements made in social work and medical literature and at a political level that indicates the removal of infants from unwed mothers was used as a tool of social control to ensure that the institution of marriage was not threatened, that morality would not be 'weakened' and that it was a used as punishment and a warning to other women (Daniels: 2010; Piddington: 1923 cited in Reekie: 1998, p. 81;

Reekie: 1998, pp. 26, 47, 73; Brooks & Brooks: 1939; Wessel: 1960, 1963; Lawson: 1960; Lewis: 1965; Vincent: 1960; Wilkinson: 1986; Voigt: 1986; McHutchison: 1985; Cole: 2011 unpublished thesis).

At the Direction of Public Officials

The Health Department issued instructions to medical and social work staff regarding the treatment of unwed (particularly unsupported) mothers in hospitals (Roberts: 1994; Cunningham: 1996, pp. 20-22, 24-25; Parliament of Tasmania: 1999, pp. 7-9; Lawson: 1960). These instructions included not allowing mothers to see or have access to their babies and of persuading/pressuring them and their families to adopt.

Punishment

Punishment of the single mother sent out a strong societal message – do not be sexually active outside marriage (Swine & Howe: 1995, p. 3). The social work profession acted as moral controllers on behalf of the state (Wilkinson: 1986, pp. 93-103; Voigt: 1986, pp. 80-92; Rawady: 1997; Smith: 1963; Boehm: 1948). Maintaining the patriarchal/nuclear family was one of the profession's founding tenets (Slinderland: 1919, p. 25) and it did so in a very judgmental and punitive way (Lewis: 1965; Cole: 2008; McLelland 1967, pp. 42, 48; Roberts: 1968, p. 13, 1994; Roberts: 1977; MacDermott: 1984, pp. 39-40; Shawyer: 1979. A perusal of their literature makes it clear that their treatment of unwed mothers was dehumanising and demeaning and was never done in their best interests, to say so now is insulting and traumatising. According to van der Kolk, "dehumanising and degrading treatment leave psychological scars well beyond those engendered by the threat. This is particularly true when surrender and obedience are enforced" (van der Kolk: 2006, p. 2).

Unwed mothers were considered by workers in the adoption industry to be less than animals as Kasanin and Handshin (1941) stated: "No special effort should be made to make it possible for the child to remain with the mother since the child does not necessarily mean the same thing to her as it does to the average woman". It was common knowledge by those in the profession that unwed mothers were vulnerable to abuse and were being abused (Davoren: 1976, pp 121-122; Lewis: 1965).

June Smith, a mother who had her child forcibly taken in the early 1960 stated: "Those who stole our babies literally took them from their mother's wombs, breasts and arms before any consent to adoption had been signed (illegal abduction). They showed no compassion, and displayed only coldness and disinterest in us. They took our babies and then discarded us, cruelly uttering that we would have our 'own' baby later. Many mothers did not have another child due to the trauma they experienced in losing their firstborn (June Smith cited in Cole: 2008, pp. 115-116). It is not surprising that the rate of suicide for females doubled during the 1950s and early 1960s when the number of adoptions peaked (Hassan: 1995).

Isolation Terror Helplessness Drugging Captivity and Confusion

Adoption was facilitated by isolating pregnant women in maternity homes, isolating them when they were admitted to hospital, not informing them of what was going to happen to them, and keeping them ignorant of the practice of using a sheet or a pillow to obstruct their view of their infant at the birth (Roberts: 1994). Uncertainty during

traumatic event leads to feelings of helplessness (van der Kolk: 2006). Not allowing mothers to see their babies and drugging them with hypnotic barbiturates, before, during and after the birth kept women in a terrified and traumatised state (Rickarby: 1998, pp. 62-73). Falsely imprisoning women and their infants and kidnapping newborns at birth were all part of a regime of torture. Isolation whilst in captivity violates a profound need of humans to share the company of others. Importantly mental isolation may occur even when others are present. Feeling disconnected and detached is common to many traumatised survivors (van der Kolk: 2006, p. 2). Isolation, shaming and blaming have long been used as techniques to break down an individual's will and manipulate them (Sargant: 1951, p. 313).

Psychological Captivity

Unwed pregnant women, were not admitted to a maternity hospital unless first interviewed/counselled by a social worker (unless the 'counselling' was done by staff in an Unmarried Mother and Baby Home) (Roberts: 2004, 1969: Cole: 2008). Thereby the majority of pregnant women were funnelled through the social work department where they were exposed to its pro-adoption bias (McLelland: 1967; Roberts: 1969; *The Australian Women's Weekly*: 1954; Crown St Archives: 1953; Reid: 1957). In this way they were placed in positions of powerlessness from which they were unable to escape, this sense of being held captive, isolated and powerless peaked when after the birth, mothers were unable to see or hold their babies. The counselling was coercive and shame-based with its sole purpose NOT to assist mothers keep their infants, but to facilitate their removal (Mech: 1986; Rickarby: 1998; Cole: 2008; MacDermott: 1984, p. 39; Woodward: 2004).
Authority figures (matrons; doctors; nurses; welfare officers) working within the adoption industry engaged in a 'brainwashing' exercise (Rickarby: 1998; Cole: 1997) to ensure the mother felt disentitled to her baby (MacDermott: 1984, p. 39), even though it was known, in that sphere of time, that pressuring a mother to relinquish her infant caused her major mental health problems (Nichols: 1966; Roberts: 1994; Rynearson: 1982, p. 340).

Mothers were in a desperately vulnerable position, on the one hand they were led to believe they were selfish if they kept their infants and on the other, considered social pariahs who had willingly given away their newborn, they were positioned in an inescapable trap (MacDermott: 1984, p. 3; Mather: 1978). Captivity, whether physical or psychological, is a key dynamic in learned helplessness and predisposes one to complex PTSD (van der Kolk: 2005; Herman: 2002, p. 377). Mothers' and adoptees' find it very difficult to overcome their PTSD when they experience ongoing psychological captivity. This has taken the form of coercive control within the public sphere of politics by virtue of having to suppress their trauma and grief, act normal and 'get on with their lives' whilst forced to carry the shame and blame for what was done to them as the government, and those involved in the stealing of our children, refuse to take responsibility and apologise.

A social worker I interviewed for my thesis stated that she had done her social work placement at The Women's Hospital Crown St. (NSW) and part of her training consisted of how to 'counsel' mothers to 'give up' their infants. She was told that her counselling role was to serve two purposes: make the mother feel selfish if she kept her baby and make her feel as if keeping her baby would damage it (MacDermott:

1984, p. 3: 1983). This was done by a asking a set script of questions. In order to psychologically distance the mother from her infant. The baby was never referred to as your baby, but as 'the' baby (Cole: 2011, unpublished thesis). Hence 'the' baby was being carried by the mother for the idealised married couple who could give the infant everything its mother could not. As discussed previously this was akin to forced surrogacy and can only be described as gross exploitation. It also encouraged women to disassociate from their baby, a process now known to cause emotional hardship and cause the infant mental health and behavioural problems later in their life cycle (Verny & Kelly: 1981, p. 27).

Conclusion

It was known that a mother's maternal instinct was at its strongest around the birth (Kisilevsky et al: 2003, p. 222) and this was used by those working in the adoption industry as a weapon against her (Mech: 1986; MacDermott:: 1984, pp. 38- 40). This is what counselling was meant to achieve, to coerce and brainwash a pregnant woman into believing that keeping her infant would damage it. What normal mother wants to inflict harm on her baby? A review of social work literature reveals that social workers were expected to form a relationship with the pregnant woman, thereby making it easier to manipulate her (Cole: 2008). Therefore they created a bogus relationship founded on deceit and lies with the intent to defraud the mother of her infant and to provide it to a married couple (Chisholm: 2000, p. 178, p. 184). Hence for many mothers their ability to trust has been negatively impacted and consequently trusting a mental health professional is no easy task (Carr: 2000, p. 340).

Counselling at PARC

When the New South Wales Post Adoption Resource Centre (PARC) was established it was to assist persons through the emotional journey of reunion and with searching This was the outcome of the law being changed in 1991 to allow mothers and their adult children the opportunity to meet if they so desired. PARC is a joint project of the State Government and the Benevolent Society. PARC was set up to assist the adoption industry's former primary clients: adoptive parents (Pannor & Barran: 1984, pp. 245-250; Pannor & Baran, A & Sorosky, A: 1978; McLelland: 1967, p. 40; Harral: 1941, p. 420; Report 22: 2000, p. 61; McHutchison: 1985; Child Welfare Manual: 1958; McLelland: 1976, p. 9; MacDermott: 1984, p. 38) deal with any difficulty they might experience as a result of their adult children participating in reunions with their original parents. This was especially the case as adopters had been reassured by the government that the 'taken' child would be exclusively "theirs" and all ties with their biological kin would be extinguished (Dees: 1983; Moulds: 1982; McHutchison: 1985). PARC's website states:

> Group Counselling: Groups offer you the opportunity to discuss issues surrounding adoption, search and reunion; Family Therapy: Our family therapists are familiar with the particular needs of both local and intercountry adoptive families (PARC: 2011).

Many mothers have complained that they cannot afford to pay for the services and further resent doing so when they believe the government is responsible for the pain they are suffering. It is apparent that the counselling and support services are not focused on dealing with severe trauma

Government's Ignorance of Trauma

PARC was located at what was formerly Scarba House, where babies awaiting adoption were housed. The institution was operated by the Benevolent Society and had a close connection with The Women's Hospital Crown St. The author is aware of one mother who has taken legal action against the Benevolent Society as she had her baby adopted out from the Home and her signature on the Consent to Adopt Form was found to be forged. Setting up a service for those traumatised by past removal practices at a location formally used in such a way is further evidence of the ignorance of the deep trauma inflicted on mothers by past practices and of triggers that re-traumatise.

The staff initially employed by PARC also reveals the lack of sensitivity, real concern and expertise to deal with the problems of mothers, fathers and adoptees. For instance the centre has never employed trauma specialists even though for decades research indicated that mothers suffered from pathological grief and trauma. By 1993 (Wells) victims of past adoption practices were diagnosed in medical literature as having PTSD (Condon: 1986; McHutchison: 1986; Winkler & van Kepple: 1984; Parker: 1927; Kornitizer: 1959; Roberts: 1972; Gough: 1961; Roberts: 1968; Borremeo: 1968; Nichols: 1968; Wells: 1993), which was later more precisely identified as Complex PTSD complicated by pathological grief (Rickarby: 1998).

Mental health problems of adoptees had been documented for decades (Fyfe & Stuart:1954; Clothier: 19; 1943; Verrier: 1992; Schechter: 1960; Toussieng: 1958; Benedek: 1938; Gough: 1961; Humphrey & Ounsted: 1963; Schechter, Carlson, Simmons & Work: 1963; Lemon: 1959; Livermore: 1961; Kirk, Jonassohn & Fish: 1965; McWhinnie: 1967; Ounsted: 1970; Triseliotis: 1974).

Ann Cunningham (1996) in her Report to the Tasmanian government advised:

> There are many mothers who because of their past associations with the government adoption service chose not to access their counselling facility. They contend that any counselling offered must be independent and not associated with the adoption agency … with recent recognition that many of these mothers may be suffering from post traumatic stress disorders, trauma counselling should be offered … (p. 74) … It is acknowledged that the symptoms of PTSD can be intensified when the person is exposed to a similar situation resembling the original trauma … It would appear that one of the key symptoms of PTSD is the avoidance of any reminders of the trauma (p. 72).

Hence using former consent takers as counsellors is re-traumatising and setting up in locations that were used to take infants is also re-traumatising both practices show a complete lack of awareness of the effects of past removal policies. Effective treatment relies on social workers taking "responsibility for their role at the time and later on …and adoption myths and practices" being exposed (pp. 73-74).

Support Groups

A person who has suffered the trauma of having a child taken and suffers from complex PTSD may find relief in a support group but the support group is not the place to clinically treat them. The same can be said for adoptees. Support groups have a very important role to play in the overall treatment model, but are only part of the solution.

In the past untrained counsellors, associated with support groups, themselves affected with severe PTSD, have re-traumatised those they have attempted to 'counsel'. Many mothers and adoptees have complained to the author of being bullied by malicious web posts if they did not 'toe the party line' or even if they just used politically incorrect language. Mixing members who come for support with those whose interest is primarily political has not served the interests of either faction. Mothers and adoptees are a highly vulnerable minority and as trauma victims susceptible to being re-traumatised by re-victimisation and bullying. Support groups have played an important function over the decades when mothers had no assistance from the government, were maligned by former adoption workers and disbelieved by society. Mothers and adoptees were thrown together to support each other as best they could. Because of the conspiracy of silence that has existed around the abusive and illegal treatment of mothers and adoptees there has been little oversight of the outcomes or of the activities of the groups that provide support. It is only now that the Australian Institute of Family Studies has been commissioned to determine what mental health services are needed to best support this vulnerable group. Before any support groups are funded there should be a vigorous inquiry into their methods of support, their past history of working with individuals and if what they have done has been helpful or damaging. Another important point is that the inquiry should not only involve present group members who may feel a sense of loyalty and fear further social isolation if they speak out, but of the many women who made enormous contributions in an early incarnation of the organisation either through research or political lobbying but have been made invisible because the organisation in its current form has taken over ownership of their achievements and run campaigns to vilify their former members.

The government should only fund groups that are subject to independent oversight, have been thoroughly investigated and work in tandem with a specialised trauma service. Mothers and adoptees are well suited to act as consultants to the government on issues that affect them and in producing more equitable social policy but not to work in a clinical capacity, with very damaged individuals. Additionally consultation should be sought broadly not from one organisation, and not from an organisation that draws its membership from other groups that already have representation, are already funded and are seen by the government as being separate entities, and to whom it has already apologised. Finally consultation should not be sought from individuals and groups who have bullied and further traumatised other mothers and adoptees. It is obvious that a bully will not have the best interests of other mothers and adoptees as a priority; rather their own self interest has taken precedence.

At present there seems to be no mechanism in place whereby individuals who have been bullied and abused by a support group can make a complaint and that complaint investigated. This is a serious oversight as individuals who suffer from PTSD already are at a high risk of suicide how much more if they are bullied, as being bullied of

itself causes PTSD and substantially increases the risk of suicide (Bully OnLine: 2005).

Since the most common mental health complaint that victims of past adoption practices suffer from is PTSD the illness is further compounded by the bullying, therefore this is a mental health as well as a legal issue. If a group has become toxic and has a history of abusing individuals it should be disbanded and not allowed to advertise itself as a support group. The situation at present is highly unsatisfactory with group members of one group in particular "ganging-up" on individuals who they want to isolate and stigmatise/slander. If individuals speak up they are threatened with legal action and/or have their name and details put up on the group's website. Derogatory remarks have been published on the group's website and facebook page about individual's appearance, their achievements, confidential information made public, their address revealed all in a climate of hate mongering that of itself could put the individual at risk not only of ongoing psychological abuse but of being put in physical danger.

Section V: Mental Health Services for Survivors of Torture and Trauma

My Journey

Briefly as a member of the white stolen generation I suffer from complex PTSD complicated by pathological grief.

I have been on a journey of recovery since 1977. I initially worked with a psychologist I moved on to various counsellors, psychiatrists, cognitive behaviour therapists, phobia experts, hypnotists, relaxation therapists, engaged in various forms of trauma therapy: Eye Movement Desensitization and Reprocessing (EMDR), Thought Form Therapy, Neuro Linguistic Programming (NLP) as well as grief therapy. After I had a reunion with my stolen daughter I began to experience severe depression and contracted a blood disorder. I was unable to work for 12 months. Later when seeking assistance in 1994 I contacted the post adoption resource centre and was referred to an untrained counsellor connected to a political support lobby group. I was overwhelmed with the information given and found it very difficult to process. There was no understanding of providing appropriate clinical trauma protocol. Unfortunately the re-traumatising 'counselling' and the birth of my first grandson triggered another series of panic attacks. Around this time I booked myself into a Private Hospital to undergo intense psychotherapy, grief and inner child work. I have spent tens of thousands of dollars. Nothing worked. Every therapy I tried re-triggered and re-traumatised me. Being ill and unable to work I had to sell property to financially survive. Many women find as they age their psychological and physical problems put them in dire financial straits.

Just after my mother passed away February, 2010, I was informed about a trauma centre: The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) that specialised in treating refugees. In March, 2010, I met Ms Askonvic, a trauma specialist, who worked at the centre to discuss developing a proposal for the government to provide similar services for mothers and their subsequent adult/children, both stolen and kept.

According to Mirjana Askovic, women who had their babies forcibly taken are victims of organised violence and fit the description of victims of torture and trauma. Ms Askovic, agrees with Dr. Geoff Rickarby's, psychiatric diagnosis that as a group we present with complex PTSD further complicated by pathological grief (Rickarby: 1998; Edward & Rynearson: 1982, p. 340; Condon: 1986). She supports the author in her view that a centre should be set up, staffed by trauma specialists, that is focused on the needs of this particular population. This would include subsequent siblings who have been effected by their mother's trauma and the loss of their sibling. The focus is not on adoption per se, it does not include providing services for adoptive parents, this is about the damage caused by separating mothers and their newborns in the context of their surviving that torture.

Mirjana offered to treat me outside her usual work hours and for that I am deeply grateful. My treatment will be discussed later in this section.

The STARTTS approach

The model used by STARTTS is a Bio-psychosocial frame work of rehabilitation. The individual treatment model is holistic, dealing with biological and social sequelae. It includes the psychological and social effects of PTSD, such as depression, anxiety and the effects these mental disorders have on individuals and their relationships. The model addresses not only the needs of the individual, but their family, and the person's integration into their community.

STARTTS uses an adaptation of Judith Herman's trauma model. Herman puts individual experience in a broader political framework and argues that psychological trauma can be understood only in a social context. Herman states (1992) that when dreadful events happen to a person their first impulse is to deny them. This happens not only on an individual but also on a social level. Society often 'tunes out' when exposed to horrible events and injustices, but for the person to heal their truth must be told. Therefore the approach includes a political dimension whereby trauma specialists work with their clients to educate the community and lobby government to implement more useful social policies and gain justice. Herman states that it is only when the truth is fully recognized can survivors begin their recovery. The person then feels integrated in their society and empowered to work towards more beneficial outcomes.

Herman states the fundamental stages of recovery are:

1. Establishing safety

2. Reconstructing the traumatic story

3. Restoring the connection between the survivor and his/her community

The approach at the individual level includes clinical interventions, such as psychodynamic psychotherapy, neurofeedback, narrative practice, counselling, cognitive behaviour therapy, psychiatric assessment and treatment and physiotherapy referral. STARTTS trauma specialists work with three levels of impairment which

are the core issues of PTSD: grief, loss and trauma. The trauma specialist is well trained and understands the need to develop a relationship based on trust with their client. It is also important that he or she intuits which treatment modality is right for the particular client and that it is introduced at the appropriate time. The focus is to ensure the person is not re-traumatised, moves at their own pace and feels safe working with the specialist. Hence the program designed for each individual is based on his or her needs. Trauma specialists working with STARTTS must always consider the ethnicity of the person they are working with, for instance if he or she is member of an ethnic group that was responsible for the torture of the ethnic group of the client they would not work with them, irrespective of how qualified the specialist is, to do so would re-traumatise the client. So the background of the professional and the client are important considerations when building a therapeutic relationship.

Understanding and validation of the client's trauma is an essential part of the therapeutic process. A traumatised person experiences feelings of powerlessness and a lack of autonomy therefore interventions and specific strategies are developed to "cater for the manifested needs of clients, often in partnership with the clients themselves" (Aroche & Coello: 2011). For instance art therapy may be useful in assisting clients to focus and relax (Rappaport: 1998). Some individuals may benefit from specific trauma based approaches such Eye Movement Desensitization and Reprocessing (EMDR) and Thought Field Therapy. Neuro Linguistic Programming (NLP) may be used to help re-frame the original trauma.

The biological part of the model would include psychiatric assistance with appropriate medications and neurofeedback to modify neuronal pathways, referrals to physiotherapists, massage therapists and acupuncturists. The psychological utilises 'talking therapies' and therapies specifically targeting trauma whilst the social aspect includes improving interpersonal relationships, strengthening family support, participating in support groups and engaging politically to achieve better social policy, community justice and adequate services. Victims of political violence and oppression may have deep fears about dealing with government officials so some clients may need help interacting with government departments or filling out legalistic forms and applications. So rehabilitation is undertaken in a much broader context utilising a bio-psycho-social model.

Individual Care for Mothers and Adoptees

Many mothers and adoptees suffer from anxiety, depression, pathological grief, panic disorder, phobias and memory loss amongst other psychiatric sequelae. This is not surprising as according to Aroche & Coello (2011) in the aftermath of traumatic experiences in a context of organised violence victims suffer from PTSD symptomatology which includes concentration and memory problems, sleep disorders, irritability, anxiety and depression, difficulty in group situations and with perceived authority figures. Some mothers have revealed that they also have difficulties in institutional settings, or with authority figures such as doctors. For instance some refuse to go to hospitals or take prescribed medications or go for pap smears. Their experience in the hospital and with medical staff around the birth of usually their first child was so traumatic that their feelings of not being in control have become internalised and that they find it very difficult to trust anyone or anything to do with the medical system. It was authority figures that they see as being complicit in the

theft of their babies so dealing with governmental agencies or signing any contracts or filling out forms can be overwhelming and something to be avoided. STARTTS runs training seminars to educate professionals who deal with PTSD sufferers, such as dentists, doctors, physiotherapists, massage therapists and natural healers to help them understand their special needs.

An adult adoptee who suffers from what van der Kolk (2005) has described as Developmental Traumatic Stress had to undergo a bone marrow biopsy. Because of her traumatic life she developed an auto-immune disease which is triggered by complete anaesthetic and could cause her to go into anaphylactic shock. Therefore she can only tolerate partial anaesthetic and to endure this needed a support person to be present. The organisation of the support person was stressful and took a lot of negotiation with medical staff.

Family Counselling for Mothers and Adoptees

The STARTTS approach, adapted from Judith Herman's trauma model, incorporates individual therapy with developing healthier interpersonal skills, so includes family therapy and building strong social networks. A supportive family environment plays an important role in the rehabilitation of PTSD survivors. Aroche & Coello (2011) state: " … any process that degrades the ability of the family to act as an effective system of social support will undermine the survivor's process of recovery".

Unfortunately this is another area that has been compromised for many mothers and some adoptees. It must be remembered that gaining a baby for adoption depended very much on undermining any familiar support the mother had. It was known by those working in the adoption industry that if the mother was supported she took her baby home (Young: 1954). The government policy was to undermine that support (Lawson: 1960; Cunningham: 1996) and persuade grandparents that keeping the infant was not in their daughter and grandchild's interest. Dealing with mothers' sense of isolation and feelings of being an outcast from her family and society need to be resolved in trauma work. A holistic approach addresses the problem as a complex interplay of different factors in terms of intervention and therapy, hence a model that focuses on a variety of strategies that target not only the individual, but the current family environment is needed. This includes working with current partners subsequent children and grandchildren.

Integration back into society: Mothers and Adoptees

STARTTS works with traumatised refugees to integrate them into their new environment. Group counselling and encouraging them to attend support groups are utilised to achieve this end.

It may seem strange to suggest that many mothers and adoptee need assistance in feeling a part of and connected to their community when they have been part of it their entire lives. That is until it is realised that many mothers felt alienated from others after having their infant taken. They lost their ability to trust and felt completely betrayed by society. The betrayal was not only by their family but by those who held themselves out as authority figures, or representatives of the broader community: doctors, nurses and social workers. Mothers' experiences of being isolated and dehumanised, of having their human and civil rights violated have left life long

emotional and psychological scars that have not yet been adequately acknowledged or validated (Sherry: 1992). Hence women continue to feel isolated and alone even amongst their kin and society.

> Restoration of the breach between the traumatized person and the community depends, first, upon public acknowledgement of the traumatic event and, second, upon some form of community action. Once it is publicly recognized that a person has been harmed, the community must take action to assign responsibility for the harm and to repair the injury. These two responses—recognition and restitution—are necessary to rebuild the survivor's sense of order and justice – (Herman: 1992, 1997, pp. 69-70).

Identity Problems

Refugees often suffer identity problems because of the loss of all that was familiar. "There is a miss-match between internal representations of reality and the external reality with its subsequent loss of reference points and accompanying identity problems" (Aroche & Coello: 2011).

Both adoptees and mothers have identity problems. The adoptee, because he or she has been taken from everything that is familiar: his or her mother. According to Dr. Verny the experience is analogous to arriving on the moon, alone. The infant has internalised its mother's odour, taste, heartbeat, voice, emotional and speech patterns as home, a point of familiarity, safety and wholeness. When born the infant kept with its mother does not feel any disconnection it feels just as at home as it did within the warm waters of the womb. Verny stated at a conference for adoptive parents:

> The importance of these findings cannot be over-stressed. It used to be thought that an infant adopted at birth "never even knew his mother". We now know this is not true. He has a 9 month history with her, in which bonding has likely taken place, and in which most certainly he has become accustomed to her sound, smell, chemistry and interaction with him. There is no doubt that when that child is born and he or she is put to live with someone else, it is as if you and I from one moment to the next were placed on the moon (Verny: 2001)

The mother's identity is permanently changed, she can never go back to who she was prior to her baby's birth (Cole: 1997). She finds herself in alien psychological territory, she is certainly a stranger in a strange place Her motherhood is more than made invisible, it is annihilated, therefore her identity as mother is annihilated. She has been imprinted psychologically and biologically with the concept of unworthiness and being a failure. Not only who she is, but who she thought she would grow to be, her hopes and dreams have been lost. She can never go back to being the care free teenager, the hopeful young mother or the 'good' woman. She is set adrift on an ocean of pain, grief and loneliness. She feels betrayed and her trust in all that she held to be true has gone. She can no longer count on her parents, society or even herself. The world has become a frightening and dangerous place. She has been subjected to an oppressive regime of social control she no longer feels safe in her self, family or country (Wilkinson: 1986, p. 94; Voigt: 1986, pp. 82, 85). The grief for her taken

child is overwhelming, but that is not her only loss. She grieves for the loss of her dignity, the person she was, her parents, her family, friends, partner – she has lost her sense of connection (Weinreb & Murphy: 988, p. 23). They betrayed her, her body betrayed her and she feels as if she betrayed herself. She clings on to the idea that she sacrificed herself to save her child, but deep inside she knows she has lost both. The pain is so great she disassociates, she represses memories, years pass and she finds she has become a spectator of a life lived by the stranger who now inhabits her body.

She wonders how she will stop the gross pain. Many mothers and adoptees flirt with the idea of suicide, some succeed (Gair: 2008; Greer: 1964, 1966; von Borcyzyskowski et al: 2006; Slap: 2001). Trauma victims often blame themselves for their failings; this is even more the case with mothers who internalised the brain washing that it was their fault their child was taken (MacDermott: 1984). A mother whose newborn dies feels guilt (Brabin: 2011), a mother whose child is taken and feels she has contributed to that loss carries more than guilt, she carries shame and self loathing. Mothers are not biologically prepared to deal with such an abhorrent event as having their infant taken by strangers, sight unseen to places unknown. This intensifies feelings of lack of self esteem and control and as a consequence many mothers experience panic disorder and phobias.

Low self-esteem and damaged relationships

Aroche & Coello (2011) explain that organised violence and torture can result in people developing particular sequelae which "tend to foster the development of conceptual frameworks and behaviour patterns that, although have immediate adaptive value in terms of survival, can have long term pathological consequences … The psychosocial consequences of exposure to state oppression are characterised by … social polarisation, weakening of personal autonomy and self confidence … and affect people well beyond the original context in which they were developed".

Motherhood in our society is tightly woven with a woman's sense of self and if a mother has been brainwashed into believing that she was unfit and undeserving to parent her own child then her worth as an individual has been undermined (Voigt: 1986, p. 84). Her feeling of security and safety in society, compromised. Feelings of low self-esteem, inadequacy, shame and being a failure deterred many from developing further relationships (Cole: 2008; Nicholson: 1966; Rawady:1997; Verrier: 1997) or having further children (Andrews: 2007). Many who did venture into relationships experienced domestic violence or emotional and psychological abuse. Many women were re-victimised by members of their family of origin and found the loss of their infant destroyed their relationship with parents. Many mothers if they did have subsequent children found it difficult to bond because of fear they would lose that child, or paradoxically would be over protective for the same reason (Cole: 2008; Cole: 2011, unpublished thesis; Weinreb & Murphy: 1988, p. 23). Many found reunions an emotional nightmare where they walked on egg shells whilst some refused to see their children because of fear of further pain and loss (Anderson: 1982).

My Journey (cont.)

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the

> empowerment of the survivor and the creation of new connections ... The first principle of recovery is the empowerment of the survivor. She must be the author of her own recovery." (Herman: 1992, p. 133)

During my meeting with the trauma specialist, psychologist Mirjana Askovic, could see that I was highly agitated and hypervigilant. I inquired about neurofeedback training, which a friend of mine, a former refugee tortured by the Chilean Pinochet regime, had undergone and from which he experienced great improvement. I felt a rapport with Mirjana who is a very warm and caring person. Being able to trust the person I am working with is very important as the other therapies I had tried, not only hadn't worked, had worsened my condition. I was still getting over the grief of my mother, I was disassociating quiet badly. I sensed this as a numbness, heaviness and lethargy, it effected my memory and concentration. In fact I would oscillate between feeling highly agitated, anxious and numbness. My startle response was off the chart, if there was a loud noise I not only jumped it literally caused me physical pain.

Over the next few months we met for weekly sessions and I began my neurofeedback training. The last thing I wanted to do was to revisit the past and bring up more feelings or work through old issues. I was feeling overwhelmed with life in the here and now. Even after the first session I felt 'Maybe this time" and shed a few tears at the thought I might find some relief at last. I felt positive about the treatment because I had lost faith in 'talking therapies' that relied on bringing up pain to find relief. I no longer believed in the aphorism: "No pain no gain". Being in a highly agitated state I was vulnerable to being re-traumatised therefore I felt neurofeedback training would be more beneficial, as did Mirjana.

Because I was getting over the grief of my mother passing, and other family difficulties the neurofeedback targeting my hyperarousal symptoms was utilised to keep me on an even keel.. Once my brain was stabilised and I began to feel calmer I began more intensive training. This included narrative practice. This consisted of reviewing my life, identifying stressful events and talking about each chronologically. After talking about the event, I was asked to describe how I felt at the time and how I felt now about what happened. I was instructed to give myself a positive suggestion to counter the negative one the event had imprinted on my psyche. Then another modality of the neurofeedback training was introduced. The intention was to induce a very deep meditative state. This is when the re-wiring of the brain takes place. Once I had started the neurofeedback I only needed to focus on the event for a few minutes then I was instructed to allow myself to let go and become as relaxed as possible. I was also given special breathing exercises to do each day to assist in calming the body.

I have found that overall I am feeling more relaxed and centred. I have noticed that I am not experiencing such extreme swings between agitation and numbness. The intensity of the numbness is decreasing and I am starting to feel more connected to others and to my self, rather than being stuck in my head. This connection feels stronger at times but if I am stressed I will disconnect again, but I am now aware when this happens. Also if I disassociate I am aware that I have done so, whereas before I was not as it had become such an automatic way for me to survive Because I am still on my healing journey and have a way to go yet the changes are gradual and fluctuate.

Overall I feel more stable and have far less intrusive thoughts. The death of my mother re-triggered the trauma caused by the loss of my daughter. It is only now that I am not crying every day, or feel as if I want to hide away and totally withdraw because life has become overwhelming. It took enormous strength on my part to complete my PhD. I had to take a semester break last year and at that time I did not believe I would get it finished. Thankfully angels come when you most need them and with Mirjana's help I was able to complete my thesis in March. I will discuss in more detail in the next section the two therapies I engaged in and that were most appropriate for me.

Neurofeedback

> Relieving the trauma from the brain takes psychological priority over grieving and there is a need to work through the effects of trauma before the individual can grieve (Gentile: 2004, p. 6).

Neurofeedback is a way of freeing the physical brain of trauma, normalising blood flow and allowing better communication between parts of the brain by retraining neuronal circuits, that through shock have closed down. It is used for depression, anxiety disorders, rage, substance abuse and obsessive compulsive disorder, PTSD, conduct disorder, racing thoughts, night terrors. In the US the brain scientists that developed neurofeedback provide free training at their EEG institute to Veterans for rehabilitation of their PTSD.

STARTTS has undertaken research into 50 traumatised clients and found that there was excess frontal lobe alpha/theta in 70% of clients. The clients had been diagnosed with PTSD and their symptomolgy consisted of: affect disregulation, oppositional behaviour, obsessive thinking, attentional difficulties, depressed mood, sleeping difficulties and impulse control issues. There has been previous research that indicated links between dysfunction of the neural circuits associated with emotion regulation (Goldin et al: 2008; Etkin et al: 2006); panic disorder (Kent et al: 2005); social anxiety (Lorberbaum et al: 2004) and PTSD (Lindauer et al: 2004) (STARTTS: 2011). The findings also indicated an excess of temporal lobe alpha in many cases. Excess temporal lobe alpha could be linked to the dysfunction of the emotion and memory processing consolidation network.

Trauma effects communication between different parts of the brain and individuals who have PTSD have physical repercussions such as too little blood flow in effected brain regions and a dysfunctional mirror neuron system. The mirror neuron system "plays an important role in bonding and attachment" (Lacoboni: 2005 cited in EEG STARTTS website: 2011) and dysregulation can cause social phobia and play a part in antisocial and borderline personality disorder. It can also affect memory, such as transference from short to long term and control of spatial memory and behaviour; recognition and recall of familiar places, people, and events (Schendan et al, 2003 cited in EEG STARTTS website: 2011).

Narrative Practice

Narrative practice is used for problems such as depression, anxiety, trauma, adoption and post adoption issues (Sydney Narrative Therapy Centre: 2011). Briefly the therapy is used "Instead of employing traditional concepts of motivation, unconscious

processes or categories of psychological damage, this approach proposes that we perceive our lives as a continuing series of stories" (Yuen: 2009) that can be viewed from multiple perspectives with more positive outcomes for the future.

Narrative practice is about discovering the responses to trauma, such as how a person survived. Focusing on a person's agency rather victimisation, reappraising one's self in a more positive light by looking at the strengths and the way they survived rather than focusing on the trauma and the damage. Yuen states: " …the specifics of [trauma] can be 'too painful', 'exhausting', 'very difficult' or fear-invoking. … a persons' life should not be … defined by a disabling trauma story, an inquiry into only the effects could trap them in the immediacy of their past distressing events. Thus is remains crucially important in my work to do whatever possible to avoid re-traumatisation of the people consulting with me" (Yuen: 2009, p. 10). A person is encouraged when speaking of their trauma to first do so from an "identity' of strength or put simply the identity they had and the responses they used to survive the trauma "versus a territory of identity of worthlessness and damage" in this way the details of the trauma can be examined without being re-traumatised (Yuen: 2009, p. 11). Yuen states it is totally unnecessary to re-traumatise a person when they recount their story. She states there are "multiple response to trauma" and the key is to assist the person to find the one which is most helpful (Yuen: 2009, p. 14).

Review of Neurofeedback combined with Narrative Practice: My treatment protocol

Overview

The part of the brain, the amygdala, that has encoded the memory of the trauma, is not contactable by speech. The hippocampus which works with the amygdala, is the part of the brain that encodes memories in a series of narratives, that gestalt-like make up the narrative of our life. When we experience a traumatic event the hippocampus can become disorganised and its narrative ability of storing information disturbed. Therefore trauma has a major effect on our memory and the way the brain responds when that memory is recalled.

The formation of memories relies on encoding neuronal patterns in the amygdala and the hippocampus. In other words memories are stored by a number of neurons that fire in a specific pattern, which is then encoded permanently in brain structures. When we experience a deep trauma, the neuronal pattern, or configuration of neurons firing in an organised way, is set down in the hippocampus and the amygdala. The amygdala is particularly concerned with our survival, so when a traumatic event, particularly one that is life-threatening, is coded as a neuronal pattern in this section of the brain it is very hard to extinguish and it is non-responsive to verbal communication. When an outer event or an inner state reminds us of the original trauma the neuronal pattern set down when the trauma happened is triggered. When using talking therapy approaches the same phenomena occurs and the memory and/or the emotions connected to the event cause the encoded neuronal pattern to refire and the trauma may be re-triggered. Research indicates that complex trauma causes the brain to fire too fast in some areas, to slow in others and that parts of the brain are not communicating effectively with or are cut off from other parts of the brain. Neurofeedback uses a computer program to

retrain the brain so new neuronal patterns are encoded that cause one to feel stable and calm.

My Protocol
The Neurofeedback is used to put me into the deepest level of relaxation possible, similar to a very deep meditative state. The narrative approach is used to assist my hippocampus reorganise my life path and combined with the Neurofeedback to retrain my brain and 'release' the fear/terror from my amygdala. My goal is to use the retraining/rewiring of my brain to change my ecology of self with the intended outcome of balancing my HPA axis and regain a healthy stress response, and a healthy integration of my identity. The hoped outcome is to interrupt the cycle of re-victimisation that I have and is common amongst trauma survivors and "lighten my epigenetic load".

Integration of Clinical and Community Development
There is a need to integrate both clinical and community development approaches in a complementary relationship. Examples of this would be the development of a partnership between an organisation staffed by trauma specialists with their primary clients: mothers and adoptees to lobby the government for changes to policies, participating in awareness raising campaigns, targeting the general community and training mainstream service providers to provide services tailored for this particular population's unique needs.

It is important that traumatised persons are assisted to resolve their PTSD on both humanitarian and societal grounds. "As a group they are at risk of secondary victimisation as trauma inflicted via state oppression interferes with an individual's ability to access and utilise their internal resources and full potential" (Aroche & Coello: 2011), it effects their health and living standard and their opportunity to contribute as productive members of society.

Conclusion
It is deeply frustrating and gives many women, including myself, a sense of absolute worthlessness to know that for decades we have spoken out about having our children stolen, disclosed the severe mental and physical health problems we suffer, including high rates of suicide, yet the only real acknowledgement we have received has been the apology from the West Australian government: 19/10/2010 and just recently an apology from the Catholic Church. Many women are now in their 70s and suffering poor health and as one social justice activist stated: "I want to be here when what happened to us is acknowledged, I don't want to miss the train". I pray she "doesn't miss the train". The refusal of state and federal governments to apologise and provide adequate mental health services is inexplicable. Why have the Aboriginals, the victims of institutional abuse, foster care and child migrants all been apologised too and the community educated about their plight, yet we have been ignored and excluded? Are we so inconsequential? After all we had our babies stolen from our wombs, were exploited by a failed government policy and then except for a few brave souls who have spoken out on our behalf, ignored.

Many women find it hard to feel part of a society that continues to abuse and isolate them by refusing to validate their suffering. I have received emails asking: "Is there a

cover up? Why do we get so little media coverage when what happened to us was so inhumane and unjust while movie stars who promote adoption get so much attention? Just recently a mother and an adoptee appeared on Channel 10s, 6.30 pm program and were interviewed by George Negus (July 27, 2011). They spoke out about the abusive treatment they had suffered because of past adoption practices and their life-long pain.

Only days after Deborra-lee Furness appeared on the same program promoting intercountry adoption. The segment featured an adoptive mother discussing the 'red tape' and the bureaucracy that was holding her up bringing in a child from Cambodia. There was no real discussion about the reason for her difficulty, yet even a superficial inquiry would have revealed that the Cambodian intercountry adoption system was closed down because of corruption. Children had been kidnapped and trafficked, identity papers forged while lots of money changed hands.

I received many emails from distressed mothers and adoptees stating they felt it inappropriate that Furness promoted adoption only days after victims had bared their souls about the pain they had suffered at the hands of a corrupt domestic adoption system. It seemed to them that the civil and human rights abuses of the mother and adoptee were trivialised and Furness had turned their suffering into a debate about adoption. Victims of past State sponsored torture do not want to engage in a debate about the merits of adoption. We want the truth to be told and healing for those who have suffered life-long pain, humiliation and mental and physical health problems.

We reject any apology that makes excuses for the wrongdoer, such as they only acted out of kindness or because of social mores. I was there and there was no kindness, there was only cruelty, contempt and avarice for the baby I was carrying. A respectful apology enables the victim to move on and is constituted of particular elements: truthful acknowledgment of the injustices inflicted; taking full responsibility for the pain and damage caused and expression of deep regret. Without these key elements an apology can be harmful and may even enhance the imbalance that already exists between perpetrator and victim (Staub et al: 2005, p. 301). In our case that includes the Australian State. An apology has the power to promote reconciliation, and those who have felt alienated from their own society need to once again feel secure, safe and connected. Only an apology of substance will assist us in our healing process.

Therefore it is time the Federal government owned up to its responsibility, acknowledged the pain, suffering and abuse it has caused to its most marginalised of citizens with a sincere and heart felt national apology.

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