Losing a child to Adoption in an Irish Mother and Baby Home: 
A Phenomenological Analysis of the Psychological Legacy

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Declaration

I hereby certify that this material, which I now submit for assessment on this programme of study is entirely my own work and has not been taken from the work of others, save and to the extent that such work has been cited and acknowledged within the text of my work and in the list of references.

Candidate Signature:

______________________________

Date: 10th July 2015
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Dedicated to my Mum and Dad Margaret and Pat Kavanagh and my own lost and loved child Maebhín.
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1. ABSTRACT

This research investigates the psychological legacy experienced by women who lost children to adoption in Ireland’s Mother and Baby Homes. It investigates how societal attitudes, including the shaming and silencing of unmarried mothers in Ireland, effected the psychological integrity of participants. It looks at the impact of shaming memories and traumatic experience on their lives, from the discovery of their pregnancy to the present day. This study suggests appropriate clinical interventions for these issues, which are informed by the findings and supported by existing literature in the area.

There are a number of studies exploring the experience of the birthmother in the adoption triad, and the legacy of forced adoption. However, there is currently no parallel study looking at the particular context of women in Irish society who stayed in Mother and Baby Homes. I am also not aware of any study, historical or psychological, which fully embraces the voices of the women themselves. This study begins to address this gap in current research.

Using Interpretative Phenomenological Analysis as a methodology, I interviewed five women who were in Mother and Baby homes between 1950 and 1980 in Ireland. I chose Interpretative Phenomenological Analysis as the methodology, as it is a qualitative approach focused on how people make sense of important life experiences. The IPA research approach supported an in-depth analysis of the language and imagery participants used to describe experiences, providing a rich insight into the significance, meaning, and life long impact of events.

I identified three subordinate themes across my participants accounts. These were: 1. Shunned, shamed and silenced - the combined dynamics of fear and shame, 2. An alteration in relationship to self and others, and 3. The enduring psychological and psychosomatic legacy of these experiences. This research explores symptom clusters of shame, trauma, and unresolved grief in the testimonies, and finds evidence of PTSD, dissociative experience and Complex Trauma across the accounts. It also finds that practices of captivity, coercion, and the use of catholic moral code as an instrument of shame, made a particular contribution to symptoms of Post Traumatic Shame for participants. What is evident from the findings, is that rejection from families and wider soci-
ety had a powerful life long impact, and that shaming interpersonal experiences extended beyond the time they spent in the homes. The dynamics of enforced secrecy is found to play a significant role in shaping participants experience, by reinforcing trauma over time, and hindering access to healing.

This research suggests that practitioners working with these issues need to be informed and experienced in the treatment of trauma, the dynamics of shame, and also around the psychological legacy of the process of adoption, particularly forced adoption for the birthmother. They need to take account of the environment within which these experiences occurred, how that social environment shaped their psychological experience, and how that environment has also changed. My findings aim to inform clinical approaches for services and individuals providing counselling and therapy for birthmothers affected by these issues.
2. Introduction and Literature Review

In June 2014, the skeletons of 800 babies were discovered in a septic tank on the grounds of a Mother and Baby Home in Tuam, Co. Galway (O’Doherty, 2014), prompting an inquiry into the practices within the ‘secret penitential jails’ (Goulding, 1998) of Ireland, where pregnancy outside of marriage was hidden behind high walls, and where the ‘problem’ (Earner Byrne, 2007, Clark, 2008) of the unmarried mother and her child was dealt with.

While the Mother and Baby Homes Commission of Investigation (2015)\(^1\) seeks to examine how mothers were treated, including issues of consent, adoption procedures, and alleged human rights abuses, the focus of this research is on the psychological legacy of that treatment, a significant gap in current research. I am also interested in the impact of a culture of shame around pregnancy outside of marriage in Ireland, and how shaming experience can in itself be traumatic. This study hopes to make a contribution to the formation of trauma and shame informed therapeutic rehabilitation for the survivors.

2.1 My relationship to this area

My interest in this area developed through my work with a client who had lost her son to adoption in Ireland many years ago. I was struck by the degree to which the shame and silencing of her experience had contributed to her struggle. For my client, the consequences of keeping her child were to risk loss of every support structure, and relationship hitherto known to her. Together, we grappled with some of the themes that are prominent in this research: The impact of the shame and secrecy surrounding pregnancy and adoption in Ireland, lifelong unresolved and disenfranchised grief, the trauma of separation from her child, and the belief that the adoption felt coerced rather than a freely taken and informed choice.

I am personally interested in how shame based experiences and memories can be triggered in a similar way to fear based traumatic memories, and how this can be symptomatically expressed

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\(^1\)Terms of Reference of the Mother and Baby Homes Commission of Investigation [mbhcoi.ie/termsofreference](http://mbhcoi.ie/termsofreference)
though dissociation, flashbacks, intrusive memories and avoidance. It would serve me personally and professionally to explore and experience ways of understanding and working with traumatic shame.

As a former student of Anthropology, I am interested in the cultural context for our work as therapists, particularly how different cultural contexts ascribe shame to experience, have specific targets of shame (Kaufman 1989, p.280), and how these social dimensions can also prohibit access to support.

2.2 Rationale for this study:

There are several studies pointing to evidence of a profound psychological legacy including PTSD among women who lost children to adoption. Kenny et al (2012) conducted a study of women affected by forced adoption in Australia, showing that 67% of the respondents showed a severe level of PTSD. Similarly, 99% of the participants in Judy Kelly’s (1999) study, reported that the experience of adoption was traumatic for the birthmother. A comparative study of the psychological legacy in the context of the Mother and Baby Homes in Ireland is both necessary and timely.

Recognising previously ignored PTSD is important, because as Judith Herman (1989) notes ‘… unrecognised PTSD can lead to a “diminished life, tormented by memory and founded by helplessness and fear”’(1989, p.49). Both Budden (2009) and Lee and Scragg, (2001, p.463) express the view that it is also important to notice shame based trauma, because stigma and shame are powerful deterrents for trauma survivors needing help. Significantly, due to silencing and shaming of pregnancy outside of marriage in Ireland, mourning in society was often denied to these mothers, who were ‘expected to do the decent thing and disappear’ (Kelly, 2005, p.20).

The psychological impact of the experience of women in Mother and Baby homes in Ireland has not previously been addressed by researchers. Neither is there a single comprehensive history inclusive of oral history and testimony available on the topic. While there are some significant pieces of literature internationally around the themes of adoption and loss (Robinson, 2000),
forced adoption (Higgins et al. 2014, Kenny 2012) and the experience of the birthmother in the adoption triad (Bloch Jones 1993 and 2000, Kelly, R., 2005, Kelly, J, 1999, Robinson, 2000), none of these publications deal with the unique circumstances of adoption in Mother and Baby homes in the Irish context. Neither do they apply our most recent understanding of PTSD and Complex trauma to the data.

2.3 Historical and Social Context of Mother and Baby Homes in Ireland

Mother and Baby homes were first established in Ireland in 1922. Predominantly run by religious orders, they received capitation grants from the state for the services they offered. While it was not required by legislation that women would be sent to these homes, it is known that parents, doctors and priests were often instrumental in facilitating an admission into these institutions. While unmarried mothers were officially required after the Adoption Act of 1952 to sign documents consenting to the relinquishment of their child, reports strongly suggest that mothers were often not allowed or encouraged to read, discuss or understand the import of these documents, and many children were taken without consent. (Graham, 2012, p. 95, O Fatharta, 2014)

The scale of this issue is important. Graham notes that even as late as 1974, seventy percent of babies born to unmarried mothers in Ireland were lost to adoption. The lack of facilities, social attitudes, and threat of poverty and even homelessness, contributed to the significant challenges facing a pregnant single woman in Ireland. Pregnancy outside of marriage was often met with a total withdrawal of previously existing social, emotional, financial family support.

The women interviewed for this study were pregnant adolescents at a time when contraception was not legally available to them, landlords ‘did not want an unmarried mother on his premises’ and there was little or no social welfare support available. Sex and pregnancy outside of marriage was largely considered to be sinful and a crisis pregnancy was problem to be hidden, frequently behind the walls and doors of an Irish Mother and Baby Homes.

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2From transcript of Interview 2
2.4 Literature Review

Initial literature searches for this study focused on key terms concerned within the broad areas of theory and practices around trauma, shame-based trauma, complex trauma and PTSD. I expanded the literature search to articles and publications on the themes of Mother and Baby homes in Ireland, the experiences of birthmothers, adoption, adoption trauma and the psychological legacy of forced adoption. I also examined literature pertaining to social history, including attitudes to pregnancy and childbirth among single women in Ireland. Further literature searches exploring the themes of the psychological legacy of incarceration and coercion helped to inform my findings.

In this section, I will review and critique previous studies, highlight the existing gaps, strengths and weaknesses therein, and I will show how this study compliments or expands on existing knowledge in this area.

2.4.1 Literature on the Irish Social and cultural context:

Lindsey Earner-Byrne’s historical analysis of the Mother and Child Act (2007) includes an overview of the rigid moral code which gave context to the concepts of illegitimacy in Ireland. She notes how this concept extended to the mother ‘she was an illegitimate mother.’ (Earner Byrne, 2007, p. 172) R. Kelly (2005) in her study on reunion between mothers and adopted children in Ireland ‘Motherhood Silenced’, states that women invariably disputed their actual choice in the situation surrounding relinquishment. She noted that for the Irish mothers she met, not only was their motherhood silenced, but their grief was also invalidated.

Any study concerned with shame needs to take a broad view of the environment within which the shame was propagated and sustained. An examination of attitudes in Irish society, using the lens of ‘shaming environment’ (Middleton Moz, 1990) is of particular interest to this study. Patsy McGarry (in Fuller et al, 2006) comments that the Vatican’s ‘celebrate foot soldiers’ cultivated chastity as the greatest virtue in Ireland. In fact, Richard Clarke (2006) claims that Catholicism in Ireland is psychologically ingrained phenomenon. The notion of original sin, the perceived evil of the sexual instinct, the emphasis on sacrifice and self denial and fear of committing a mortal sin,
is described as part of an ingrained ‘Catholic consciousness’ (Fuller, L, 2005, p.44). When such rigid social rules exist, they can carry a taboo, or shame. In particular ‘Prohibited sexual actions are given the power to put shame at the core of the person’ (Timmerman, 2001, p.262). While the shaming environment around sex, sexuality and the experience of the unmarried mother in Ireland is well documented, the voices and experiences of those who were impacted are largely omitted from historical records or psychological research. This gives an indication of the power of silencing, shame and secrecy surrounding these issues.

2.4.2 Adoption and Loss: Relinquishment Trauma

The lifelong impact of adoption and forced adoption on mothers is explored in a number of studies (Higgins 2014, Kenny, 2012, Kelly, J., 2001, Robinson, 2000, Bloch Jones, 1993 and 2000) all strongly indicating a relationship between adoption loss and PTSD and complex trauma, unresolved grief, and many other psycho-pathologies including depression and anxiety. Merry Bloch Jones (1993 and 2000) proposes the existence of a ‘birthmother syndrome’, the common symptoms of which include unresolved grief, depression, symptoms of PTSD including flashbacks, diminished self-esteem, and self punishment. Similarly, Ruth Kelly (1999) points to significant somatic physiological symptomatology like secondary infertility (Andrews, 2010) and hysterectomies among mothers. However, for participants in this study, there are additional dimensions of experience worthy of exploration. Descriptions of the practices within the Mother and Baby Homes describe systematic shaming, atonement for sins (often through hard labour), forced incarceration, the stripping of identity and an insistence on submission. The removal of babies, often without an hours notice, was described by Goulding as ‘that horrific ritual…amputation without anaesthetic.’ (Goulding, 1998, p.42)

June Goulding’s personal account of her tenure as a midwife in the Mother and Baby Home in Bessboro, Cork (1998) describes a system of internment and penitence, while Mike Millotte, in his work on ‘Banished Babies’ (2012) examines the process of foreign adoptions in Ireland. Both Goulding and Millotte suggest that adoptions within Ireland’s Mother and Baby Homes were invariably forced. A literature search under the key terms ‘mother and baby homes Ireland’ yields less than a handful of results, once again indicating how the experiences of these women are inadequately researched, recorded and acknowledged.
2.4.3 Proposing a Dialogue between the Affects of Shame and Effects of Traumatic Experience:

While there is extensive literature on the affect of Shame (Kaufman; 2010, Kaufman 1989, Gilbert 1998, Middleton Moz; 1990, Lee and Wheeler, 1996), there is only a small number of recent articles beginning to call into question the DSM criteria for PTSD, especially insofar as it largely ignores the affective response and symptom of shame. Deborah Lee (2001, 2011) helps address this omission in her writing on the Compassionate Mind approach to healing shame and trauma, acknowledging shame as an important element of traumatic experience. Both Lee (2001, 2011) and Kaufman (1998) describe the psychology of shame as a sickness of the soul, inner torment, a disease of the spirit. The relational dimension of shame is also recognised by Kaufman as the affect of inferiority. However, Kaufman also largely ignores the context of shame based trauma in his work. For Caravalho, (2013), a major factor influencing the potential for healing shame memories, is a tendency among sufferers to actively avoid contact with those memories. While constriction is seen as a cardinal symptom of PTSD, it is also a symptom of shame (Herman 2012, p. 42).

Kenny (2012) states that the current DSM framework for PTSD can potentially omit the threat to psychological integrity as traumatic. (Kenny et al 2012, p. 19). This can lead to the underestimation of PTSD in the population. PTSD is widely recognised as a disorder where fear and anxiety is the predominant emotion. Judith Herman (1992) also describes trauma as fear-based; a threat to life or bodily integrity involving terror and helplessness. She gives little emphasis to shame as a significant element of the traumatic experience. (Herman 1992, p. 33) However, some researchers are now suggesting that shame is an important emotional factor underlying post traumatic stress. (Leskela, J., Dieperink, M., & Thursas, P. 2002, Buddha, 2010, Dorahy et al 2013, Stromsten, L. M. 2011. Samec, J. R. 1995, Herman, 1998). When shame is taken into consideration, we witness the threat of the annihilation of the social self, rather than the physical self. (Dorahy et al 2013, Budden 2009, p. 1034). Budden (2009) argues that the cluster of symptoms related to dissociation, PTSD and Shame go largely unrecognised in the DSM. This view is supported by Dorahy et al, who quote Wilson et al 2006 as stating that “states of post traumatic shame and guilt form the patologica nucleus of simple and complex PTSD.” (Dorahy et al 2012, p 72). Like trauma, shame is emotionally anchored in the fight or flight response. Social shaming and damning involves ‘diminished
personal value including the loss of face, esteem and self-worth, diminished wholeness, virtue and moral
integrity, and feelings of powerlessness, inadequacy, failure and smallness.’ (Budden 2009, p 2053)

Lawrence and Taft (2012) propose that it is important to examine dimensions of shame in PTSD,
noting that the DSM’s current diagnostic criteria fail to describe all traumatic experience. The
connections between shame and trauma are elucidated further by Carvalho et al (2013), and
Mostos and Pinto-Gueveira (2009), who show that shaming experiences in childhood can ‘be
loaded with intense emotional texture - and can assume a traumatic nature...’ (2013, p.3). They show
how shame episodes can be structured as traumatic memories, with intrusion, avoidance and hyper-arousal. Much of the literature mentioned here indicates dissociation as a common symptomatic impact of losing a child to adoption. Dissociation is also symptomatic of complex trauma
and PTSD. Soll’s work on adoption and trauma (2000), speaks of exiled mothers dissociative experience, how they ‘suppressed, numb out, shut down, turned off and tuned out.’ (Soll, 2000, p. 29).

There are suggestions in recent literature that if we fail to recognise shame as a significant factor
of PTSD, we may miss the importance of attending to the healing of the damaged or sense of defec
tive self in traumatised individuals. (Budden, 2009, p. 1036-7) Both Budden (2009) and Lee
and Scragg, (2001, p.463) emphasise that it is essential to notice shame based trauma, because
stigma and shame are powerful deterrents for trauma survivors needing help.

2.4.4 Socially determined Shame

A number of writers highlight the importance of witnessing and healing the socio-cultural under
pinnings of shame based trauma. (Matos and Pinto, 2014, Leeming, 2004, Herman, 2012, Kelly,
is paramount, a social threat is created which can be experienced as traumatic. (Lee, loc.1668 ·
Kindle Edition). When a social threat is activated, psychological defensive strategies including
dissociation, submission, and a leaning towards relational appeasement, can ensue. (Matos and
Pinto, 2014) While Stromsten (2011) views social shame as having some adaptive functions, such
as the regulation of social behaviour, he recognises that social shame can by its very nature im
pede an individuals ability to access support and recovery, since their traumatic injury is borne of
socially sanctioned behaviour. (Stomsten, 2011, p. 36) For Kelly (2009) this interpersonal social and political context in which trauma is experienced is relevant, because this dynamic can determine how blame is attributed, can mitigate against finding a support system, and effect the way in which a survivor can rebuild their lives following the trauma. (Kelly, 2009, p. 244) It is her understanding that socio-political forces contributed to the traumatisation of birthmothers.

The response of a community, when positive and supportive, has powerful potential to resolve trauma and promote healing, and the ‘strongest antidote to traumatic experience’. (Herman, 2012, p. 70, p. 214) The implied polarity, is that when a community is not available for support, a traumatised individual is further isolated from healing, being witnessed and supported. As avoidance is a significant marker of PTSD, reduction of avoidance is important in healing. (Carvalho, 2013)

2.4.5 Captivity and Coercion

Literature describing the practices within mother and baby homes in Ireland frequently refer to institutions where women were incarcerated, treated as ‘inmates’ and ‘offenders’. Indeed Goulding says Bessboro was ‘more like a penitentiary than a nursing home’ (Goulding 1998, p. 23) She describes conditions where breastfeeding women were not allowed to wear a bra or have analgesic in childbirth. (Goulding, 1998, p. 98), “the whole situation was one of utter shame and degradation.” (Goulding 98 p. 45). She also describes the practice of forbidding women to use their own names, disclose their identities, or have contact with anyone outside of the home. If a woman ran away, she was brought back by the Gardaí. ‘Once they enter the gates they lose all rights about themselves, their bodies, their souls, and also all rights to their children or their whereabouts.’(Goulding 1998, p. 194)

The regime she describes is punitive, and abusive. The institutionalisation, condemnation and de facto incarceration of birthmothers in these institutions is confirmed by Earner-Byrne (2007), who makes the point that segregation was seen as an appropriate approach to an unmarried mother in Ireland, carrying with it the ‘implications of detention: the loss of freedom as a result of sin.’ (Earner-Byrne, p. 182) Bloch Jones comments on this dimension of separation and displacement, where women were isolated like prisoners, and how this was ‘almost as traumatic as
their unwanted pregnancies’ for many women. (Bloch-Jones, 1993, p. 44) A notable absence in existing literature is commentary on the particular effects of an Irish institutional environment embedded with a punitive Catholic moral code.

Christine Cole, a prominent researcher into forced adoption in Australia, emphasises that we must broaden our understanding of confinement of the unmarried mother in institutions to include the significant psychological captivity. (Cole 2011, p. 68, 71), where mothers were caught with no hope of release from an enforced dogma telling them that they were selfish to keep their children, or ‘social pariahs who had willingly given away their children.’ (Cole, 2011, p. 68, 71, MacDermott: 1984, p. 3; Mather: 1978). Captivity, whether psychological or physical, promotes complex PTSD and learned helplessness. (Van der Kolk: 2005; Herman: 2002, p. 377). Cole notes that the institutionalisation was for a defined period of time, however the psychological captivity and resultant Complex PTSD can extend throughout the lifespan.

While Soll (2000) is writing about mother and baby institutions in the United States, he says that it is important to consider coercion as an aspect of a mother’s experience, insofar as it played a role in the surrender of children to adoption. (Soll, 2000, p. 59) He concludes that the surrender of a child to adoption in this environment was a ‘gun to the head’ situation, which ‘typically includes some kind of psychological turmoil or even mental trauma in the victim…. the victim has no real choice, no free choice, no fair choice.’ (Soll 2000, p. 60) He encourages against a reductionist view which assumes that women chose to ‘give their child up’ for adoption, even if they signed adoption papers.

2.4.6 Disenfranchised Grief

Herman’s (2012) widely accepted Tri-phasic model for healing complex trauma includes the essential phase of mourning, remembering and working through. Mourning is the interpersonal dimension of grief. This phase of healing trauma, is bypassed when the grief is denied an interpersonal witnessing and supportive dimension. For Doka (2012) suppression of mourning happens when society weighs social prohibition on the bereaved. (Doka, 2012). Disenfranchised grief alienates a person from support, society and also the processing of traumatic inner experi-
ence. Literature on the subject indicates that for mothers who lost children to adoption in Ireland’s mother and baby homes, grief was not recognised as part of the process she was to experience. (Kelly, 2005, 16) Ruth Kelly’s study describes the life long impact of distorted, disenfranchised and unvalidated grief for these mothers who lost children to adoption in Ireland. (Kelly, 2005, p.89)

A number of writers point to evidence that suggests that grief for the loss of a baby through adoption gets worse over time, triggered by subsequent losses (Blanton & Deschner, 1990, Condron, 1986, Winkler and Van Keppel, 1984, Robinson, 2001. Soll, 2000, p. 33, Cole 2011, Rickarby, 1998). In fact Robinson (2001) argues that because of this, normal models of grief counselling are largely ineffective for this population. (Robinson, 2001, p. ii) For Soll (2000), it is not the case that children were discarded by birthmothers, rather that mothers were discarded by the process of adoption. (Soll 1000, p. 31) When a baby dies in other circumstances, this trauma is met with support and understanding in the community, however, when a baby is lost through adoption, the devastation is not recognised. When there is no recognition of the birth, there is no recognition of the loss. (Andrews, 2010, p.12, p.91)

Robinson (2001) makes the point that the grief of mothers who lost children to adoption has particular qualities; encompassing intra-psychic disenfranchisement. She explains that mothers also disenfranchised their own grief because they felt responsible or at fault for the loss. They suppressed their own grief, because society was re-enforcing a belief that they were not entitled to grieve. (Robinson, 2001, p. iii)

2.4.7 Secrecy and Psychological Exile

The impact of maintaining secrets on mothers who lost children to adoption was one of isolation, making it difficult to fully enter society again. Birthmothers experienced a psychological exile. (Bloch Jones, 1993, p. 21) Bloch Jones claims that the women she interviewed repeatedly mentioned feeling damaged by the obligation to keep their pregnancies secret, feeling that the keeping of the secret was more important that they were. (Bloch Jones, 1993, p. 68) For Nancy Verrier, (1993) the keeping of secrets exacerbates other feelings of shame, anger and guilt, and impedes
the grieving process. (Verrier, 1993, p. 127) Robinson (2000-2003) largely concurs with this view, stating that for many mothers, secrecy has been a major factor in their lives and has impacted other relationships post relinquishment, as well as their sense of themselves. (Robinson, 2000, p. 148).

2.5 Aims and Objectives of Current Study

2.5.1 Aims: To identify and explore the spectrum of psychological experience emerging in this particular context and extending throughout the lifespan.

2.5.2 Objectives: To inform practitioners in their development of a framework for effectively conceptualising and treating symptoms presenting as a consequence of these experiences.

2.5.3 Key Research Questions

a. What was the impact and psychological legacy of these experiences?

c. Are symptoms of PTSD, complex trauma or traumatic shame evident, and if so, what was the role of shame in the traumatic experience?

d. What is the role of secrecy and silence in the enduring psychological legacy of these experiences?
3. Methodology

3.1 Rationale for Research methodology

I chose Interpretative Phenomenological Analysis as the methodology most suited to this research. IPA is a qualitative approach focused on meaning making; how people make sense of important life experiences. It looks at the significance and understandings of the experience and particular phenomena, engaging with a person’s reflections on the experience. (Smith et al, 2009, p.3) It is informed by hermeneutics - the theory of interpretation. The philosophy of Phenomenology holds as a founding principle the attempt to examine experience within its own context and its own terms. (Smith et al, 2009, p. 12).

I aimed to find a homogenous sample for this research. My questions were open, exploratory and focusing on the meaning of events. I constructed a schedule for a semi-structured interview. I was interested in participants thoughts, feelings and understandings around the experiences explored.

3.2 Participant Characteristics

I purposefully selected participants for this study who were part of a network or support group for women who had lost children to adoption in Irish Mother and Baby homes. The rationale here is that support would be available to these women following our interviews. I contacted women who were part of the Coalition of Survivors of Mother and Baby Home and also the Irish First Mother’s Support Group. The women were in four different Mother and baby Homes in Ireland. As participants were in support group networks, they represent women who have publicly acknowledged their loss, and have spoken about it, at least to the other members of the group. All of the women are Irish. Two of the participants had experiences of two different mother and baby homes. Three of the women were contacted via referral from facilitators of these support groups. Two others responded to an open invitation I posted on a support group internet forum. Some snowballing occurred, where women who were interviewed referred other participants to me for interview. I met two of the women in their homes and three others in the location where they attend support group meetings.
Table 1. Summary of Biographical information for Research Sample

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age at time of Pregnancy</th>
<th>Age at time of Interview</th>
<th>Mother and Baby Home</th>
<th>Year of entry and Length of time in Mother and Baby Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah</td>
<td>18</td>
<td>66</td>
<td>Home A</td>
<td>1967 - 8 Months</td>
</tr>
<tr>
<td>Ruth</td>
<td>18</td>
<td>60</td>
<td>Home A and B</td>
<td>1973 - 7 months</td>
</tr>
<tr>
<td>Leanne</td>
<td>17</td>
<td>81</td>
<td>Home C and D</td>
<td>1951 - 2.5 Years</td>
</tr>
<tr>
<td>Bernie</td>
<td>17 and 19</td>
<td>59</td>
<td>Home B and D</td>
<td>1974 Home B 4 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1975 St Patricks 4 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total 8 Months</td>
</tr>
<tr>
<td>Grainne</td>
<td>24</td>
<td>60</td>
<td>Home B</td>
<td>1979 - 3 Weeks</td>
</tr>
</tbody>
</table>

3.3 Research design and related considerations

IPA analysis is thorough and detailed. The approach is idiographic, using a purposefully small sample, with an emphasis on the particular. It is committed to understanding particular experiential phenomena from the perspective of particular people in a specific context. (Smith, Flowers and Larkin, 2009, p. 29)

I transcribed the interviews verbatim and used *Atlas.ti* software for line by line coding. I drew on the following strategies of analysis:

1. Close line by line coding of experiential claims, understandings, meaning making
2. Identification of emergent patterns and themes emphasising points of convergence and divergence between participants
3. The development of a structure indicating a possible network/link or relationship between emergent themes
4. Organisation of data throughout process - from initial comment, to cluster of themes, to final structure of themes.
5. Development of a narrative bringing themes together

6. Inclusion of my reflections as researcher, my own perceptions, conceptions and processes

(Smith et al., 2009, pps., 79-80)

I listened to the audio recordings and read the transcripts several times, making initial notes on the use of language in the recordings. I was interested in the way participants spoke about issues such as their experience of giving birth. I made descriptive (key words, phrases and explanations), linguistic (use of language and metaphor, pronouns) and conceptual comments, exploring the shift in participants focus to over arching understanding of phenomena. (Smith et al., 2009, p. 88) I looked for emergent themes, reflecting the participants experience and my analysis and interpretation of their experience, and then created cluster groups of connected or related themes. I was interested in the frequency of emergence of particular themes and how themes were recurrent for participants. (See Appendix D)

I then created a graphic diagram representing the structure of the themes presenting from data analysis of the transcripts, following a reflexive engagement with the transcripts and themes.

**Ethical Considerations**

Core principles of ethical practice were upheld throughout this study. This includes principles of avoidance of harm, informed consent, protection of the confidentiality and identity of participants.
CHAPTER 4. FINDINGS

In this section, I will present a summary of the experiences of women who lost children to adoption in Ireland’s mother and baby homes. This is followed by a reflection on my process and experience as researcher, and a description of the themes from the research. My findings are based on the central themes emerging from a phenomenological interpretative analysis of the interviews.

I found three superordinate themes across my participants. These were: Shunned, Shamed and Silenced - the combined dynamics of fear and shame, An Alteration in Relationship to Self and Others, and ‘It never leaves you’ the enduring psychological and psychosomatic legacy of these experiences. I have presented findings under each of these headings. A summary of the superordinate and sub themes are provided in the table below.

<table>
<thead>
<tr>
<th>Table of Super-ordinate Themes</th>
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<tbody>
<tr>
<td><strong>Superordinate Theme</strong></td>
</tr>
<tr>
<td>Shunned, Shamed and Silenced - the combined dynamics of fear and shame.</td>
</tr>
<tr>
<td>An Alteration in Relationship to self and others</td>
</tr>
<tr>
<td>‘It never leaves you’, the enduring psychological and psychosomatic legacy of these experiences</td>
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</table>
4.1 Overview of participants’ experiences of the loss of a child to adoption in a Mother and Baby Home.

All of the participants comment on the shame and fear which surrounded disclosure of their unplanned pregnancy. Their stories follow similar trajectories, firstly rejection by the family, then the often fearful and isolating regime in the home where their child was lost to adoption, followed by a life of exile, secrecy, and separation from the truth of their experience and from their child. In the aftermath of these experiences, they were all told to get on with things, forget about it, and pretend it didn’t happen. Instead they found that their lives had changed beyond recognition. Silently, and sometimes out of full awareness, they grieved, felt psychological and physical pain, and eventually found a way to function as best they could in this altered world.

The environment in the Mother and Baby Homes is described as punitive, hellish, austere and cold. This was a prison from which they had no hope of escape. When the women described the homes, they predominantly recalled how the homes felt to them, the smells including the ‘smell of fear’, the coldness and profound sense of isolation and loneliness. Two women describe how they will never forget the sound of huge doors closing behind them, and how that meant ‘My life was over’. They felt that they were criminal in the eyes of the law, shameful in the eyes of their families, and fallen sinners in the eyes of their Catholic God.

In the interviews, the women recount many traumatic memories and events that continue to evoke great distress. These include the phenomenological experience of living in an atmosphere of fear, coercive control, incarceration and powerlessness, and their children being taken away. One woman describes the room where they breastfed as a ‘cow shed’, where they sat on stools and breastfed their children when the feeding bell sounded. This image captures the experience of a functional dynamic of mother-as-breeder rather than a psychological and biological attachment bond.

Some of the participants’ accounts of the childbirth experience are harrowing, including being locked in a ‘cell’ overnight alone while in labour. One woman described how her body was
'ripped apart', and another stated that she was unaware she had been ‘sewn up’ after childbirth, and was never able to have another child.

A strong common thread throughout all participants’ stories, was the impact of familial and societal attitudes which shamed, hid and silenced them. The secrecy and the shaming environment affected the grieving process, the healing of trauma, their self-esteem and relationships, and their sense of belonging in their families and country of origin. The interviews describe how healing this deep sense of shame is an ongoing challenge.

4.2 Shunned, Shamed and Silenced - the combined dynamics of fear and shame.

‘You were shunned, you were rejected, you were noted, you were like… outside’.

(Leanne - Interview 3)

The participants of this study relate the experience of being sent to a mother and baby home, with the combined and clustered affects of terror and shame. The very act of being brought without explanation to a mother and baby home, communicated to them that having sex and becoming pregnant was disgraceful, and that they were ‘bad’. Many of the women made reference to their difficulty in talking about their experiences to this day, because of the shame and fear they still carry. Conveying the sense of the shaming environment in which she became pregnant, Sarah noted that ‘a murderer would not suffer the same out-spell from society’ as a woman who committed the crime of having sex outside of marriage in Ireland. This shaming environment both within and outside of the homes, is repeatedly asserted as a significant and psychologically damaging experience.

4.2.1 Rejecting and internalising the labels of ‘sinner’, ’evil’, ‘worthless’

The participants refer to the way in which the ‘cruel, uncaring, bitter’ nuns spoke to them as verbal and emotional abuse. One of the most frequently occurring themes recorded from the interviews is ‘hatred of nuns/perceived evil of nuns’, which appears a total of 47 times. Many women repeated the ‘mantra’ they heard within the homes; ‘you filthy whore, you dirty bitch, nobody will love you, nobody will want you,… you’re used goods, you’ll never be anything… you’re here because nobody
loves you.’ As they related this to me, it was as if they had learned these words by rote. There was an ingrained quality to the delivery of these words, indicating the frequency and repetition with which they had heard them. To give context to the impact of this shaming ‘mantra’, Sarah said she could understand why a woman threw herself out of a window to her death in a mother and baby home, ‘It could destroy you’. While the participants note how this negatively affected their self-esteem, they also describe a defiant determination to make something of themselves and disprove the nun’s prophecies that they would never be loved or succeed in life.

4.2.2 Enforced Silence, Secrecy and Exile

One of the striking findings of this research was that the majority of the women (4 out of 5) had not spoken about their experiences in their homes to anyone, including their husbands or closest friends, for over forty years. The silencing of their experiences is described by all participants as deeply painful, ‘It is a heartache for 46 years to keep schtum’. (Ruth, Interview 5) It is not just their words that were silenced, but also their emotions and their bodies. They speak of their bound breasts leaking milk for their babies, and not being allowed talk about it, or in one case, being told to ‘walk normally’ when struggling to walk with post-partum stitches. Incidents where they were told that they could never speak about their child are remembered by all women with vivid clarity, indicating that the silence was strictly imposed with an air of threat. Secrecy was ordered, not recommended, and they were fearful of the consequences of speaking about their experiences. There are several references to how their parents never spoke about, or ever held their child. In the here-and-now of the interviews, they struggled to understand or resolve this experience.

4.2.3 Psychological Captivity and Exile

The theme of psychological and actual exile runs through the testimonies. There are several references to feeling alone, isolated, ostracised, rejected, and estranged from their families. Four of the five women I interviewed left Ireland after they lost their children. Those who left, returned later in life with the hope of reunion with their child. Ruth describes how this exile hindered the healing of the trauma she had experienced, because could not share the experience with anyone. Sarah was collected from Home A and brought straight to the Airport. Her mother said
‘You didn’t think you’d be coming home again did you, after what you’ve done?’. I noticed the look of bewilderment and fear on her face as she described how she didn’t know where she was going or what was happening. This sense of not knowing what was going on, and not having any say or power is evident in four of the interviews. Sarah went on to have a career as a nurse and social worker in the UK, and recounted how she met many exiled Irish women in the course of her work ‘on park benches’ in the UK who had been to the mother and baby homes, and were ‘telling that same story’.

The process of exiling began for these women from the moment of disclosure of their pregnancy. For many of the women, they never went home again, or their sense of home was lost forever.

4.2.4 Not Knowing/Innocence

The youth and innocence of these adolescent women at the time of their pregnancy comes across in the testimonies. They had little knowledge about pregnancy or childbirth, nor did they feel they were given adequate information. One woman stated that unlike other women, ‘At least I knew that the baby came out of the vagina.’ In most cases, the birth experiences are described as profoundly lonely and terrifying experiences. What stands out in many of the testimonies is the perceived absence of compassion or comfort as they were giving birth. Ruth’s description of giving birth captures the clusters of affect common among the testimonies, those of terror, isolation and vulnerability.

‘...the pain... the humiliation, being left alone, terrorised, terrified, crying out for my mother... begging them to ring my mother, “just get my Mam”... and one of them said, “it’s written on your file, no contact”. She didn’t want to know.’ (Ruth, Interview 5)

Many of the women recount how efforts were made in the homes to obstruct their attachment to the newborn child. Ruth was instructed not to cuddle her child while breast feeding, as this would interfere with the adoptive parent’s bonding with the baby. ‘Before the child was even born, he wasn’t yours, they made sure you knew that.’ In some accounts, the theme of defying what the nuns ordered them to do comes up again, as the description of enforced detachment is coupled
with a statements of how the enormous bond with their babies ‘was never broken’. (Sarah, Interview 1)

4.2.5 Rejection by family and society

The rejection and perceived disgust and disdain of society, family and church was internalised. Survival adaptations for the women I met included throwing themselves into work, and career, voluntary work and families. A number of the women acknowledged how they were lucky that they never went down the road of using negative coping mechanisms such as alcohol abuse and self harm, but, ‘There but for the Grace of God go I.’ (Participants 1,2 and 5)

4.3 An Alteration in Relationship to self and others

Participants related how these experiences affected relationships in three main areas: their relationships to their parents and siblings, and to their subsequent husbands and children. They also recount how they also viewed themselves differently, having partially ingested the shaming mantra they had heard from their families, priests and nuns.

4.3.1 Difficulties in subsequent relationships

The inability to trust in future romantic relationships is thematic in the interviews. Two women spoke of fear of ‘being let down again’, a statement of the enduring effects of their abandonment by the fathers of their children. They were either very cautious, or lacking in discernment about the men they would meet afterwards. There are many accounts of relationships with subsequent men which were unsatisfying or abusive; ‘Sleeping with the enemy… I’ve lived it.’ (Bernie) The women refer to evidence of physical, emotional and sexual violence in subsequent relationships. They women describe ‘performing’, ‘functioning’, being ‘like a robot’ in their marriages. All of the women make connections between their choice of life partner and their experiences of losing a child to adoption in the Mother and baby home system. Bernie ‘… felt I had to take my punishment, (cries) and unfortunately that lasted for a long time.’ There are echoes of this relational dynam-
ic throughout the transcripts. Their sense of self-worth in relation to others was impacted, ‘because I was told I would never marry, I would have tolerated assholes’. (Bernie, Interview 2)

Some of the women refer to how their subsequent children were affected as they were over protective, or unable to be fully present; ‘they didn’t get their whole mammy.’ Ruth stated that she felt children sensed the psychological damage of the primary care giver, and that this had a ripple effect on their lives.

4.3.2 Breakdown of relationships in family of origin, especially with their mothers.

One of the most prominent themes emerging from the interviews is the severance of the relationship between the woman and her own mother. It is repeatedly asserted that at the moment of disclosure of the pregnancy, the relationship with their mothers was lost. Leanne’s statement, ‘Oh, my mother rejected me straight away, I was a dirty bitch.’ is representative of many of the women’s accounts. This rupture was never repaired for four out of the five women. They describe how they never built bridges with their mother, and ‘I don’t feel anything for the woman’, (Sarah) and ‘If I could sue the bitch now, I would’. (Bernie) The women struggle to comprehend how mothers could have sent their daughters to a mother and baby home. They also question why they didn’t stand up for themselves, and assume some responsibility in wondering how they ‘allowed people to dictate to me,’ (Bernie) They report feeling guilt, self blame and confusion around this is.

4.3.3 Damaged self esteem

‘I never felt I deserved anything, I never felt I deserved love. I allowed myself to be abused in my marriage, ‘cause I ways felt I had to pay for what happ… for what I did.’ (Bernie, Interview 2)

This research finds that the experiences of residing in an Irish Mother and Baby home had an injurious effect on their self-esteem, with a legacy impact throughout the lifespan. While damaged self-esteem appears strongly as a theme, the counter indication of defiance, confidence, and awareness of their enormous personal and professional capacity is an equally strong oppositional force in the testimonies.
While I never asked a question directly seeking to ascertain the nature of the relationship each mother had with the father of their child, it was interesting how each participant made a point to inform me that the context of their pregnancy was the existence of a significant relationship with their partner. ‘It was not a one night stand’ (Gráinne, IV 4) These statements rejected any assumption that they were ‘fallen women’ or promiscuous. One of the women was pregnant as a result of a rape. She noted how there was neither language nor compassion at the time in Ireland (1950’s) for the extensive child sexual abuse and rape she had suffered. Instead, she was ‘a dirty bitch’. How they were viewed negatively by others directly influenced how they viewed themselves.

Bernie describes how being ‘made feel dirty’ established a process of devaluing and neglecting herself, and ‘always putting other people first.’ Others refer to feeling like a burden on family and society, feeling disgusted and ashamed, and significantly, being made feel ‘evil or wrong’. (Leanne, Interview 3)

I noticed some self-deprecating remarks among the participants, ‘I’m not a blonde bombshell’, or ‘are you finished with me now?’. What is most notable thematically is the counter indications of low self esteem, the pride based assertions of success and achievement, particularly in their careers. Again, I did not ask directly about success in careers, but it was important for participants to show that they had been determined to return to education, how they had held very significant and demanding professional roles. These assertions appear in the interviews contextually as a binary opposite to what they were told about their potential and capacity in life the mother and baby homes. While damaged self esteem is evident as a psychological legacy, so too is the journey to repair that damage in these women’s lives.

4.4. ‘It never leaves you’, Emotional and Somatic legacy of experiences

Women describe having flashbacks of the smells, sounds, and shaming experiences in the mother and baby homes. Some of the experiences are described as memories which ‘will never leave’
them, or will ‘go to my grave’. Women stated that they could feel themselves vividly re-living certain experiences. Pointing to her head, Leanne said ‘It’s in there all the time, you just can’t get rid of it.’ Bernie told me that the psychological torment was such that she used to whack her head off walls. She explains that this was because she couldn’t verbally express the emotional experience. This experience of not being able to talk about it, not having the words to describe the experience was mentioned by a few of the women. Bernie describes how she both physically and psychologically lost her voice, how she found in later life she had to get people to speak for her. She also said she used to do ‘cow breathing’, an involuntary ‘ugghhh’ sound.

The women describe being triggered by reminders of their child and experiencing ‘unexplained emotion’. (Gráinne) They also recall emotional reminders on the birthdays of their children. They report strong anger based reactions in relation to nuns: ‘If I even see an image of a nun, I feel like going up and giving the television a belt.’ Another said: ‘what the nuns done to me… I want to go up and smash them.’ Distressing intrusive memories included memories of the child being taken away, remembering the screams of women when their children were being taken from them, and the last sighting of their child. Sarah describes experiences of panic, being afraid she was going to choke, and feeling like the ceiling in a supermarket was going to fall down on her, and having to run out.

4.4.1 Dissociative Experience:

The process of splitting off or exiling the painful memories is described by each participant. This process is consciously understood as a way of coping. The women describe it as ‘living two lives’. (Ruth, Interview 5) Grainne spoke of her ‘sublimation’ of the experiences, and many of the women said that they blocked it out to some extent, ‘obilterated’ or ‘internalised it’, ‘almost like it didn’t happen’. They describe feeling not fully present in their lives and relationships. Some describe a feeling of numbness, ‘like I was in a glass house, and every now and then I would come out’. There are several reports of having gaps in memory or blocking out the experience of being in the home. Ruth describes how she lived her life from then on ‘as if in a fog, hardly ever there’.
4.4.2 PsychoSomatic symptoms

There are a number of references to the emergence of somatic symptoms which are phenomenologically understood to relate directly to the experiences documented in this research. Sarah manifested painful physical symptoms in her pelvic area and leg ‘aches and pains for no reason, so acute that I couldn’t turn.’ Scans and X-rays showed nothing. She said that all her emotion was blocked in her hip ‘I physically felt that pain, but of course it wasn’t physical pain, it was emotional.’ It was only when she started talking about her experiences that the pain went away. She had further somatic symptoms including hearing loss called Minieres disease, a hearing loss associated with trauma. She was asked repeatedly by doctors whether she had suffered a trauma in her life, and she said she didn’t. She didn’t want to bring it all up and because she still carried the shame of ‘what I had done’. She concluded emphatically that the loss of her hearing was a direct result of the trauma she experienced in Home A.

Three of the five women had hysterectomies and gynaecological problems in later years, including massive ovarian cyst (Bernie, at age 37) and cervical cancer. One woman said that after her hysterectomy, she was ‘so blessed to have the bloody thing gone’. Two of the women had been in body shattering car accidents.

4.4.3 Distressing Intrusive Memories of Children taken away

By far the most traumatically encoded and vivid memories surround the experience of the children being taken away. Sarah used the present tense to describe the experience, as if it was happening in our interview: ‘they creep up behind you and they’ll snatch your child, and that’s it, gone! (starts to cry and wring hands) … that’s how they do it, there’s no pre-warning that it’s going to happen.’ Many women use the words ‘snatched’, ‘grabbed’, ‘kidnapped’ ‘stolen’, ‘taken’ to describe their separation from their children. For Ruth, Sarah and Bernie, their babies were taken away without any fore-warning, consultation, or understanding of informed consent. Ruth remembers finding the empty cot, with the baby clothes she had knitted folded up where her baby should have been. She said that this image haunts her. Another mother cried as she recounted how she
turned around to see a nurse walk out of the ward with her daughter. She was told her daughter was ‘just gone.’

The adoption process itself generated distressing memories. The absence of information or support to keep the child is remembered and reported, together with the sense of threat and powerlessness surrounding the destiny of the mother and child unit. ‘Nobody had said there was a choice… literally there was no choice… nobody said what services were available’. (Ruth, Interview 5)

Some of the women state that their babies were simply taken without permission. While two of the mothers agreed to the adoption, albeit feeling that there was ‘no choice’, they were not given information to support alternatives. Both of these women state that if their families were supportive of them keeping the child, or if the social attitudes were more favorable, including the attitudes of landlords and provision of social welfare for unmarried mothers, that they would have considered keeping their child. Both sought reunion with their child later in life, and continued to think about their sons for the years post separation.

4.4.4 Silenced sorrow - Unresolved or Disenfranchised Grief

The women interviewed for this research were clear that their grief was not limited to the loss of the child, it extended to losing their home and families, social and economic support, loss of faith and church, and loss of parts of self. The grief for the loss of their child ‘gets worse every day… there is no loss like it.’ (Ruth, IV 5) There was nobody to acknowledge the pregnancy or their child. They saw how other children’s births were celebrated in their families, and other losses were mourned in the family. All of this exacerbated the sense of lack of recognition or witness to their grief, which continues to be profoundly felt.

For women who have reunited with their children, there is still a statement of the loss of the life they should have had together. Ruth, who has not yet had a much longed for reunion, ‘If I ever get to meet the man he has become, the loss of the life journey we should have had together is forever gone.’ The women spoke of the trans-generational continuance of their losses, that there are now grandchildren, who ‘call someone else granny’ (Bernie IV 2). Another dimension of the grief de-
scribed by the participants was a legacy of wondering if their parents ever felt remorse, not only for the loss of the child, but for their role in placing them in a mother and baby home.

Participants refer to being scarred, damaged, and traumatised by their experiences of pregnancy and loss in Ireland’s mother and baby homes. The relational trauma, internalised shame, and ongoing silence in families and in Irish society continues to affect their lives.

4.5 Reflections on the research process

Prior to commencing the interviews, I had two lengthy phone conversations with organisers of support groups, who needed to get a sense of me, assess my motivations, and ensure that the process of interviewing would in no way exploit or harm women who could be vulnerable due to their experiences. I was aware that the process of seeking informed consent for this research was especially important, due to the process (or lack thereof) of informed consent around the adoption of their babies.

In the interview process, I noticed how I have been somehow desensitised to abuse in Irish institutions due to extensive media exposure around the Magdalen laundries, and the publication of the Ryan Report (2009) which documents the abuse of children in Irish institutions. I needed to challenge this lens of awareness, and focus on the experiences of the individual women I was meeting and their phenomenological experiences.

I recognised the emotional impact on myself as a researcher as I entered the lives and homes of the participants. There was a feeling of weighty unresolved grief in the interviews. At times, I felt a heavy sadness after the meetings. I imagined what it would be like to have one of my children taken and not being able to mourn, get support, or mention it again. The image of being torn or ripped reflects the felt sense of this experience and of hearing these testimonies. I was struck by the sound of tears of these women falling on their kitchen tables. I felt emotionally impacted myself at times, while with the women, driving home, and transcribing the recordings.
I was born in the early 1970’s, around the same time as these women gave birth to their children. I noticed my realisation ‘I could have been that baby’, that these experiences came about in the Ireland I grew up in, although social attitudes to the unmarried mother have changed enormously. As I developed a rapport and connection with the participants, I felt a sadness that their children had missed out on a life with them as their mother. I noticed the emergence of my counter-transferential grief for my own mother and for a child I lost through miscarriage. I was struck by their warmth towards me, and the welcome they extended to me. I also felt a sense of responsibility as a researcher to respectfully and accurately present and interpret their phenomenological experience.
5. Discussion

5.1 Introduction

In this section I will address my findings in the context of research on the signs, symptoms and best practice in the treatment of trauma and shame based trauma. I will relate my findings to existing literature on the life psychological impact of adoption on birthmothers, and unresolved or disenfranchised grief. I will make suggestions around the implications for practice. I will explain how my results relate to the literature, stating why they are acceptable and how they are consistent, deviate from, or supplement previously published knowledge on the topic.

5.2 Overview of the Psychological Legacy


Other studies indicate that educational failure, poor employment status and being deterred from future relationships are a common legacy for birthmothers. (Cole, 2011, Verrier, 1993, Rickarby, 2010) In contrast to this, my findings showed a powerful determination among the women to get married, have further children and succeed in employment and training in their lives. I would argue that the context of the mother and baby homes is an important factor contributing to this variance. The women were told in the mother
and baby homes that they would never marry, that they would never achieve anything in life. Several of the participants said that the strong desire to defy and disprove these suggestions was a key motivating factor in getting married or pursuing a career. My findings therefore indicate that the environment within which they lost children to adoption had a specific impact on the psychological legacy for this group of women. While these women showed psychological legacies common to birthmothers represented widely in the literature, they also had additional traumatic experience to contend with; incarceration and the wholly disapproving and damning social attitude to unmarried mothers in Ireland, 1950 - 1980. ([Earnar Byrne, Goulding 1998, Kelly, 2005, Graham 2012] Participants in this study were affected by the ‘predominant scripts of shame’ Kaufman (1989) in Irish culture.

A key contextual variance between my findings and existing literature on the experience of the birthmother, is the dominance of the Irish Catholic code of morality ([Earnar Byrne, 2007, Ferriter, 2012]. This dimension was enormously significant as context for this study. My findings show that this environment wielded a sense of damnation as well as shame for what was culturally considered a despicable crime. By being sent to the mother and baby home, the women felt they were being condemned to ‘hell on earth’. Many women referred to the homes as ‘hell’ where they were told they had ‘done the devil’s work,’ they were ‘Sin-Full’. They felt they would never be forgiven, and needed to take their penance and punishment. The ideology of the church, and the priests and nuns who embodied that ideology, are central players in the experiences of the women in this study. Participants’ accounts highlight a process of rejection of the church, nuns, and the ideologies and practices which were instrumental in shaming these women. This is significant, because an alteration of systems of meaning is a clinical criterion for complex trauma ([Ford and Courtois, 2009]).

Leeming (2004) asserts that if experiences of shame are socially determined, that repair and healing must also have an interpersonal dimension. This research finds that the interpersonal dimension of healing was non-existent. In its place was a denial, dissociation, and exiling of interpersonal and intra-personal experience. The culture of secrecy and shame directly impeded access to support for healing shame, trauma and unresolved grief for Irish birthmothers. Instead, participants’ accounts indicate that it contributed
to interpersonal retraumatisation and revictimization (a diagnostic criterion for DESNOS). This process has been observed by Stromsten (2011, p. 36), who argues that there is an increased risk of retraumatisation and avoidance for shame prone individuals.

5.3 Discussion of Key Findings:

This study shows that the core clinical markers of PTSD, namely dissociation, withdrawal, emotional and physiological distress, nightmares and intrusive memories and distress when reminded of the event, (DSM V, 2013, Herman, 2012, Ford and Courtois, 2009), are represented across participants’ accounts. Diagnostic criterion for Complex Trauma include evidence of alterations in the following: regulation of affect and impulses (unexplained emotion, panic attacks); attention or consciousness (dissociative experience); self-perception (including shame and guilt); relations with others (including revictimisation); somatization (including examples of gynaecological issues and unexplained somatic symptoms); and systems of meaning (such as loss of faith in church). (Ford and Courtois, 2009) My findings provide evidence for all of these criterion.

While this study did not involve a clinical assessment for DESNOS such as the SIDES³ self report questionnaire, (Van der Kolk, 2002) or the Dissociative Experiences Scale (DES⁴ Bernstein and Putnam 1986), the interviews strongly suggest phenomenological evidence of the core criterion. One of the key main factors of dissociation is depersonalisation, characterized by ‘the recurrent experience of feeling detached from one’s self and mental processes or a sense of unreality of the self… feeling that you are standing next to yourself or watching yourself do something’ (Bernstein and Putnam, 1986). Using the very same language in their references to detachment and unreality, participants’ accounts reflect this experience of ‘watching yourself live’ (Bernie, IV 2).

Dissociation is generally defined in terms of disconnection, separation, severance and splitting. I would argue that this research shows that there was also a phenomenon of culturally reinforced dissociation, represented in the psychological exile of unmarried mothers (Cole 2011) and the separation from wider society, by the very act of placing

³ Structured Interview for Disorders of Extreme Stress

⁴ Dissociative Experiences Scale
them in Mother and Baby Homes. Dissociation was encouraged by a society which demanded that these women live their lives as if these experiences never happened. The process of separating and hiding women in these homes and stripping them of their own names and identities also suggests a culturally sanctioned dissociative process.

David Spiegel (1994) makes a case for embracing the role of culture in dissociation. He argues for the expansion of the definition of dissociation in the DSM to include an awareness that ‘the neurobiology and the psychology of dissociation may vary according to the cultural context in which they occur’ (Spiegel, 1994, p. 159). He asserts that the phenomenology of a dissociative syndrome can ‘be attributed to the patterned effect of culture on suffering’ (Spiegel, 1994, p. 159). Among the participants, there was a clear belief that society and church expected them to suffer, atone and take punishment. Participants’ accounts indicate that the dissociative experiences were interwoven with the theme of exile, both psychological and actual (Cole 2011). Lucey (2014) has commented that a dissociated traumatic injury ‘just persists in a different place but without an address’. He contends that there may be an Irish cultural disposition towards splitting and disconnection, indicated in civil war politics, the division of country, and denial of truth.

I would argue that these birthmothers have been living with significant psychological distress for many years, and that shame and secrecy have functioned to impede access to healing. Participants’ accounts repeatedly indicate experiences of intense fear and helplessness, as well as emotionally encoded trauma memories which they continued to experience after the events were over. These phenomena are also diagnostic criteria for DESNOS6 or Complex Trauma (Ford and Courtois 2009). Reminders of the experiences were avoided by not speaking about them for decades. Conscious and unconscious burying of experiences is also consistent with descriptions of dissociative experience (Van der Kolk, 2001,p.374). This research argues that these women were threatened by the banishment from family and society (Bloch Jones, 1993) with the resultant experience of a social death (Budden 2009). My findings contend that shame is an inextricable affective dimension of trauma in these accounts. It is also a powerful aspect of the social and cultural context for these women’s experiences. This finding supports the argument that a

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6 Disorders of Extreme Stress Not Otherwise Specified
definition of trauma and PTSD which does not take account of shaming experience, is incomplete (Lee and Scrapp, 2001, Matos and Pinto 2009, Budden, 2009, Dorahy, 2012).

5.3.1 The Affect of Shame as a psychological legacy.

Shame, by its very nature is self-critical, self-conscious and involves self-censure. Participants’ accounts indicate that they have lived with psychological dynamics consistent with shame; secrecy, constriction and withdrawal (Middleton Moz, 1990, Kaufman, Gilbert, 1998). As Dorahy et al (2012, p.72) notes, these also affect states central to the alterations in self-perception in complex PTSD. Deborah Lee (2012) encourages us to take account of the fact that shame based or prone individuals have therefore a greater struggle in their attempts to overcome the effects of trauma, tending to turn responsibility upon the already embattled self. Participants’ accounts show that the code of secrecy imposed on these women was highly effective. The entrenched secrecy, which has become a survival strategy, is an important variable to consider when working with this population therapeutically. The challenge is that while it has aided survival, it has also hindered the healing of trauma. For Herman:

‘The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma… but far too often the secrecy prevails, and the story of the traumatic event surfaces not as a verbal narrative, but as a symptom.’

(Judith Herman, 2012, p. 92)

Literature on the experiences of birthmothers indicates that many mothers who lost children to adoption condemn themselves, wondering why they were not strong enough to keep their child (Soll, 2000). This literature illuminates the experiences of women in this study, many of whom struggle to reconcile with how they failed to challenge or defy the decisions being made about them and their children. While they were all adolescents at the time of their pregnancy, we must remember that the age of majority in Ireland was 21 years until 1985. This contributed to their disempowerment in relation to their parent’s decisions to place them in a Mother and Baby Home. Participants exposure to traumatic stress in adolescence is significant. Due to brain development at that time, trauma experienced at this life stage is associated with ‘enduring sequelae that not
only incorporate, but extend beyond PTSD’ (Cook et al, 2003, p. 5). It also increases the likelihood of vulnerability to complex trauma.

5.3.2 The loss of a child to adoption was experienced a traumatic event with life-long consequences.

Adoption is commonly perceived as voluntary, as a decision or choice, (Bloch Jones 1993, Kelly, 2009). Wiley (2005) advises against making an over-simplified dichotomy between adoption as a choice or coerced, and notes that we must take a view of the wide continuum in relinquishments. (Wiley, 2005, p. 21) The coercion, may be perceived rather than actual, by loved ones, spouses and cultural norms. Wiley notes that the issue of coercion as a continuum has not been adequately addressed by the literature. (Wiley, 2005, p. 21) This is reflected in my findings. While some of the women are emphatic that their babies were brutally taken from them without consent, others state that their hands were tied, the environment and social context essentially excluded them from other choices. For Soll (2000) a ‘Gun to the head choice’ is not a real choice (Soll, 2000, p.60).

5.3.3 The Associated Practices within the Mother and Baby Homes of incarceration, coercion and isolation contributed significantly to the traumatic psychological legacy.

In the context of forced adoption in Australia, psychiatrist G. Rickarby makes the point that ‘associated practices’ of coercion and isolation contributed hugely to the traumatic legacy, and that they functioned to ensure the process of adoption. He states that without these practices, many women would have kept their babies. The Chart of Coercion by Amnesty International referred to by Herman (2012) describes coercion as an environment within which there is strict regulation of diet and dress, isolation from support and information, petty rules, organised techniques of disempowerment and disconnection, installation of helplessness and terror, and repetitive psychological domination through the infliction of psychological trauma. (Herman, 2012, p. 76) Most significantly, Herman notes that the final step of psychological domination involves forcing a person to ‘violate her own moral principles and betray her own basic human attachments.’ (Herman, 2012, p.83) Many of these dynamics are described by participants of this study. Experiences of practices within Ireland’s Mother and Baby Homes are broadly reminiscent of those accounted for in the Chart of Coercion. Goulding does not hesitate to refer to the
mother’s stay at the baby homes as incarceration: ‘I’ve seen farmers kinder to their animals’ (Goulding, 1998, p.67). While incarceration describes the over-arching experience of women in this study, there is some ambiguity, as two participants found that the home was in fact a ‘cocoon’ from a fearful home environment, others stating that they found the dormitory style company of other girls to be familiar and somewhat comforting. One participant found the nuns to be supportive and kind to her. However she was older at the time of her pregnancy than the other participants, and her stay was shorter — three weeks prior to giving birth.

5.3.4 Disenfranchised and Unresolved Grief

Disenfranchised or unresolved grief is generally assumed across the literature to be part of the story of a woman who has lost a child through adoption. It is a grief which gets worse over time. (Winkler and Van Keppel, 1984, Condon, 1986) Writers such as Verrier (1993, p. 126) emphasise that it is important that counsellors working with these women are aware of this. This research finds evidence to support her assertion that many birthmothers may be unaware or ambivalent about their grief. One participant stated ‘I didn’t know I had that grief’ (Bernie IV 2). As therapists, it is important to heed Soll’s suggestion (2000) that birthmothers may be so accustomed to the keeping the secret from themselves and others, that they may deny that it is an issue altogether. He warns that counsellors may need to be prepared for this denial of experience as an initial presentation, or survival strategy. ‘Keep in mind that she may well feel that her life depends on not talking about her loss at all and certainly not feeling the feelings associated with her experience.’ (Soll, 2000, p. 107) This process is reflected in this research. When asked about their grief, many women started by saying they ‘just got on with it’ or buried it, however the dynamics of grief and loss were clearly evident in their testimonies.

5.4 Unexpected Findings

While this research focussed on women who had been in the Mother and Baby Homes, the findings indicate that a very significant aspect of the traumatic psychological legacy was in fact centred on the experience of ostracism from the woman’s own family and society. The relational trauma (De Young, 2009) indicated in the betrayal and exiling from their own flesh and blood was a prominent theme. The actions of parents and siblings, priests, doctors and social workers outside of the homes were equally significant in the
shaming and relational injuries perpetrated on these women. The severance of the relationship with participants’ own mothers upon disclosure of their pregnancy was an unexpected finding, repeatedly asserted across four of the interviews.

While I expected to find that secrecy within Irish society had a role to play in the shaming and psychological legacy to the women, I did not expect to find that the secrecy and shame presents an immense ongoing struggle, and that it continues to hinder women in talking openly about their experiences or in healing the trauma.

5.5 Unanswered questions:
Data from the interviews bring up a number of unanswered or unresolved questions for the interviewees. While this study does not have scope to fully explore the issues raised, I will summarise the issues as follows:

5.5.1 Child Protection issues: The interviewees made several references to girls as young as twelve being in the Mother and Baby Homes with them, and there are a few references to pregnant women in the homes who were living with an intellectual or physical disability. Concern was expressed as to why it would appear no course of action was being taken around the apparent sexual abuse of these girls and women.

5.5.2 Medical Practices: One interviewee’s allegation that she was ‘sewn up’ or sterilised without consent after childbirth raises a question as to whether there was a practice of eugenics or sterilisation in the Mother and Baby Homes. This study also finds that practices around medicating women during childbirth, and also as an agent of securing compliance by sedating emotions, (Ruth, Interview 5) begs further investigation.

5.6 Implications and Recommendations for Clinical Practice
In this section I will offer suggestions informed by my findings and existing literature towards best practice for working with trauma and shame based process among birthmothers, the issues pertaining to adoption and loss, and disenfranchised grief. From a practical perspective, the findings suggest that therapists can work with the issues represented in the study by embracing the following:
5.6.1 Working with Shame as an affect among birthmothers:

1. It is recommended that therapists are prepared to psycho-educate around shame, guilt and humiliation and how they manifest. This is seen by Lee and Sccragg (2001) as an important step towards the healing of shame based trauma. This research finds that the absence of compassion from self or others was a notable and painful omission.

2. Birthmothers can be helped by updating memories to include and apply feelings of self compassion (Lee, 2012, Matos and Pinto 2014). This may involve challenging the internalised critic.

3. As self blame is frequently symptomatic (Bloch Jones, 1993, p. 275), birthmothers may benefit from support in forgiving themselves and curbing the instinct to self attack —

4. Birthmothers may need support to reject the secrecy. Participants in this study found their recent ‘coming out’ and sharing of their experience to be empowering.

5.6.2 Counselling women who have lost children to adoption: specific strategies

Soll (2000) says that many birthmothers cannot see their helplessness and powerlessness. He suggests that an important part of healing involves correcting this false belief system.

‘The first step for healing the fracture is for the mother to understand that she had no way to keep her baby. She must fully understand this fact - then learn to believe this fact on an emotional level’ (Soll, 2000, p. 152)

This study recommends that therapists become acquainted with the language birthmothers use to describe their experience, (Kelly 1999, p. 41). Begin by asking women to describe the social context, the environment, the era they grew up in, and the era their parents grew up in. This will help trace the values in the family and society which may have been part of the story of relinquishment. (Robinson, 2001, p. vii) Place the adoption in its wider social, familial and environmental context. This could include an exploration of choice as a continuum. Explore responsibility — to what extent were the mothers responsible for their loss? To what extent were others responsible? (Robinson 2000-2003, p. 143)

It is therefore pertinent that therapists are prepared to psycho-educate around the legacy of traumatic experience and PTSD. Knowing what is wrong helps a birthmother know what to expect, and gives framework for dealing with experiences. (Bloch Jones, 93, p.
Many mothers were traumatised signing adoption papers, so much so that they were amnesiac of it. (Rynearson, 1092)

5.6.3 Implications and Recommendations for Practice: Disenfranchised Grief
1. It is important that therapists are cognisant of the need to consider grieving styles, spirituality, the meaning of a loss and cultural background. (Doka 2012, p. 344)
2. It is recommended that therapists avoid invalidating birthmother’s grief, for example by telling them they did the right thing to give the child up for adoption (Robinson, 2000, p. 144).
3. It may be harder to deal with a psychological death than a real one. (Soll, 2000, p. 108, Rynearson, 1982) It is important for therapists to be aware that women who lost children to adoption had a worse grief reaction than someone whose child had died. (Rynearson, 1982, p. 338-340)
4. For Leeming (2004), the interpersonal dimension of healing and mourning is critical to the healing process, therefore he recommends involving others in the therapeutic process.

5.7 Recommendations for Further Research
The trans-generational psychological impact of these experiences deserves further research. We must also ask what was the impact of the trauma on subsequent children, spouses, and the adopted child? Another area worthy of further research is the impact on the fathers of the lost children. For the women I interviewed, the fathers ceased to have a role in the child or mother’s life after the disclosure of pregnancy. Their voice is almost entirely absent from the stories of the unmarried mother and her experiences in Ireland.

5.8 Potential Limitations and Weaknesses
One limitation of this study is the ambivalence around the source of the traumatic symptomatology. Clearly, pre-existing developmental trauma needs to be acknowledged within the overall understanding of the symptoms presenting. Pre-existing developmental trauma and Adverse Childhood Experiences (Felitti and Anda, 1997), is indicated among the research participants, including experiences of child sexual abuse and rape, violence
in the family of origin, alcohol abuse, poverty, and other markers of dysfunction within family systems. However, this is an acknowledged phenomenon in trauma treatment in general. The AIP (Adaptive Information Processing) model for treating trauma with EMDR (Shapiro, 1995) understands that single incident trauma may well be part of a memory network connecting with a myriad of other traumatic life experiences.

The sample selected for this study represents those who have been adequately resourced to be able to discuss the experiences with a researcher. The women themselves were clear that there is a greater majority of women, who are highly distressed and have not yet spoken to anybody, including their husbands and subsequent children. If PTSD is indicated amongst the women who have strong survival adaptations, it suggests that the potential for undiagnosed trauma among the wider population of women is significant. Fear of rejection and social stigma continues to hinder these women from accessing support.

A strength of this study is the event of finally bringing a focus, through the voices of the women themselves, to the often harrowing psychological reality of what they went through when they had their babies, and what they continue to endure. By informing the therapeutic community on the psychological impact, and educating around best practice in this area, this study also contributes to discussions around appropriate redress and psychological rehabilitation, which should include the provision of empirically validated trauma treatment therapy for these women where required.
6. Conclusions

In conclusion, this study finds that the symptom clusters of trauma, shame and unresolved grief create a complex interweave in the psychological legacy of the participants. The contextual factors of imposed secrecy, incarceration, exile and dominant social moral ideologies, further exacerbated the symptoms, and greatly hindered healing. When working with survivors of mother and baby homes, we need to work in awareness of the significant environmental factors contributing to the psychological legacy. The particular targets of shame in Irish society, must be taken into consideration as a therapist endeavours to fully understand their phenomenological experience. How these targets have changed over the lifespan of these women must also be understood as context for their experiences; ‘Yesterdays unmarried mother is todays single parent, and hardly an eyebrow is raised’ (Cooper in Doka et al 2012 p. 266). Therapists will need to adopt specific practices to work with healing debilitating shame. The findings highlight that the sense of a defective self, and the affect of shame was a prominent psychological legacy for participants.

The findings agree with Higgins (2014) and others, that therapists are recommended to approach their work with this client group aware that they may be trauma survivors. (Higgins 2014, Rickarby, 2000, Cole; 2011, Soll, 2000). The findings also suggest that the loss of a child in an Irish mother and baby homes may have contributed to the psychological legacy in a number of specific ways. In particular, a mother may have experienced systematic and repetitive shaming ‘mantra’, imbued with a damning Catholic code of morality with life long consequences. The shunning, silencing and shaming of the participants was experienced as highly traumatic, with psychological consequences such as complex PTSD and dissociation. The event of being sent to a mother and baby home may be historical, but the experience of rejection and silencing was found to continue to this day. The findings also highlight that rejection and abandonment by families, in particular mothers, has created an enduring and traumatic psychological legacy.
7. References


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**Other resources**


**Sample invitation letter**: Invitation Letter vs. Signed Consent Form: Documenting the Consent Process [http://orc.research.sc.edu/PDF/](http://orc.research.sc.edu/PDF/)


Appendices

Appendix A  Invitation to participate & Information Sheet

Letter of Invite:

Study Title:

*An exploration of the experiences of women who lost children to Adoption in Ireland’s Mother and Baby Homes, and the psychological legacy of those experiences.*

Dear Kathy,

My name is Sinéad Kavanagh. I am a student in the MA in Integrative Psychotherapy Programme at Cork Institute of Technology. I am also a trained and accredited Counsellor Therapist, and I work full time in this area. I am conducting a research study as part of the requirements of my MA in Psychotherapy, and I would like to invite you to participate. I will be supervised at all times by Dr Geraldine Sheedy, MIACP, PsSI. The results of this study will be written up as a Masters thesis.

I am studying the experiences of women who lost children to adoption in Ireland’s Mother and Baby Homes. If you decide to participate, you will be asked to meet me for an interview about your experiences, from the discovery of your pregnancy to the present day. In particular, you will be asked questions about how these experiences affected you throughout your life. The meeting will take place in Dublin Centre or a mutually agreed upon time and place, and should last about one hour. The interview will be audio taped so that I can accurately reflect on what is discussed. The tapes will only be reviewed by myself, and I will transcribe and analyse them. They will then be destroyed. You may feel uncomfortable answering some of the questions. You do not have to answer any questions that you do not wish to. It is my hope that you will benefit by talking
about these experiences, and also make a contribution to others in doing so. I sincerely hope that others in the community/society in general will benefit by the findings.

Participation is confidential. The results of the study may be published or presented at professional meetings, but your identity will not be revealed.

Taking part in the study is your decision. You do not have to be in this study if you do not want to. You may also quit being in the study at any time or decide not to answer any question you are not comfortable answering.

I will happy to answer any questions you have about the study. You may contact me at 087 8275084 or email kavanagh_sinead@hotmail.com, or my faculty advisor and supervisor of this research, (Geraldine Sheedy) if you have study related questions or problems.

Thank you for your consideration. If you wish to take part in this study I am enclosing an information sheet and a reply sheet which you can return to me in the SAE enclosed. If you would like to find out further information, I would be delighted to hear from you. You can contact me at 087 8275084 or by email at kavanagh_sinead@hotmail.com. I look forward to hearing from you. If you would like to participate, please contact me to discuss participating.

Yours sincerely,

________________________________________
Sinead Kavanagh
Glin North,
Dingle,
County Kerry
087 8275084
kavanagh_sinead@hotmail.com
INFORMATION SHEET

Study Title:
An exploration of the experiences of women who lost children to Adoption in Ireland’s Mother and Baby Homes, and the psychological legacy of those experiences.

Researcher: Sinéad Kavanagh

Participation
If you decide to take part you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What happens if I take part?
If you agree to take part, the researcher Sinead Kavanagh will contact you to arrange a convenient time/venue for an interview. The interview will take place at an agreed place and time convenient to you. The researcher will ask you a series of questions relating to your experiences loss of a child to Adoption in Ireland’s Mother and Baby Homes.

What are the possible disadvantages and risks of taking part?
There are no potential hazards in taking part. However, if you become distressed when discussing your experiences of loss of a child to Adoption in Ireland’s Mother and Baby Homes 1950 - 1980, and you feel that you would like to discuss this further, I can offer you the name of individuals or services that will be able to help you.

What are the possible benefits of taking part?
The study will give you the opportunity to express your opinions about your experiences in the Mother and Baby home. Benefits may arise from gaining insight into your experience, contributing to research in this area or enable you to better understand your experience.

What happens to the information I give?
The interview will be audio-taped so that it can be transcribed at a later date. It will be transcribed by the researcher Sinead Kavanagh. Following transcription the recording will be destroyed. Whatever you say will be treated as anonymous and confidential. Confidentiality is very important and all transcripts of interviews will be made anonymous and only distinguishable by number.

Following transcription of your interview I will forward the transcript to you. At this point you can check for any errors and/or ask to delete any information which you do not wish to have included in the research.

I will be supervised at all times by Dr Geraldine Sheedy, MIACP, PsSI.

What happens to the results of the study?
The results of this study will be written up as a Masters thesis. No participant will be identified in this thesis. Following completion of the study I will forward the findings to you if you indicate that you wish to receive same.

How can I find out more about the research?
If you have any further questions about the research, then please get in touch with me. You can contact me at 087 8275084, by email at kavanagh_sinead@hotmail.com or by post to Sinead Kavanagh, Glin North, Dingle, County Kerry. If you wish to take part I would be grateful if you could fill in the reply slip attached and return in the SAE provided. I will then contact you to arrange a meeting.
INFORMED CONSENT FORM
Information Sheet

This Informed Consent Form is for participants/interviewees in research titled An exploration of the experiences of women who lost children to Adoption in Ireland’s Mother and Baby Homes, and the psychological legacy of those experiences.’

Name of Principle Researcher: Sinead Kavanagh
Student in the MA in Integrative Psychotherapy Cork Institute of Technology

Part I: Information Sheet

Introduction
I am Sinéad Kavanagh, a Student in the MA in Integrative Psychotherapy at CIT. I am a trained, qualified and accredited Counsellor/Therapist and I work full time in this profession in a number of different settings. I am doing research on the experiences of women who lost children to adoption in Ireland’s Mother and Baby Homes, and the psychological legacy of those experiences. I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or of another researcher.

Purpose of the research
The research aims to explore the experiences of women, from the time they discovered and told people about their pregnancy, their experiences in the Mother and Baby Homes, and also the impact these experiences had on them afterwards. The purpose of the research is to find out whether there are specific elements of these experiences were traumatic and what effects that had on the mother before, during and after the birth and loss of her child. I also hope to find out whether the silencing and shaming of pregnancy outside of wedlock in Ireland had a significant impact on women who went, or were sent to Mother and Baby Homes in these years. Finally, I hope to draw conclusions from the interviews about what therapists and counsellors need to be aware of to adequately support women who lost children through adoption in this setting in Ireland.

Type of Research Intervention
This research will involve an interview with me as the researcher. It will take about one hour to complete the interview.

Participant Selection
I have chosen you to participate in this research based on the fact that you are a member of the Coalition for Survivors of Mother and Baby Homes, and as such you have support within that environment around these issues. I feel that your experience can contribute much to our understanding and knowledge of the experiences of women who lost children through adoption in Irish Mother and Baby Homes.
Voluntary Participation
Your participation in this research is entirely voluntary. It is your choice whether to participate or not. You may change your mind later and stop participating even if you agreed earlier.

Procedures
A. Brief introduction to the format of the research study.

I am asking you to help us learn more about the experiences of women who lost children through adoption in Ireland’s Mother and Baby Homes. I am inviting you to take part in this research project. If you accept, you will be asked to participate in an interview with myself. During the interview, I will sit down with you in a comfortable place agreeable to you. If it is better for you, the interview can take place in your home or a friend's home. If you do not wish to answer any of the questions during the interview, you may say so and I, as the interviewer will move on to the next question. No one else but myself as the interviewer will be present unless you would like someone else to be there. The information recorded is confidential, and no one else except myself will access to the information documented during your interview. The entire interview will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept on a digital recording device which will be locked away securely. The information recorded is confidential, and no one else except [name of person(s)] will have access to the tapes. The tapes will be destroyed after two weeks.

B. The type of questions you will be asked include an invitation to describe the reaction among friends or family to the disclosure of your pregnancy, and the events that lead to you entering a Mother and Baby Home. I will ask how you felt about your time there. I will ask you about the loss of your child to adoption, and how that has affected you throughout your life. I will ask if you found these experiences to be traumatic, and whether you have suffered symptoms such as depression, anxiety or flashbacks in the aftermath of this experience. I will also ask you about the supports, if any, you were offered.

Duration
The research takes place over 10 months in total. The interviews will take a minimum of one hour.

Risks
I am asking you to share with me some very personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion/interview/survey if you don't wish to do so, and that is also fine. You do not have to give me any reason for not responding to any question, or for refusing to take part in the interview. As this research explores sensitive and potentially traumatic memories, I wish to explain to you that it is possible that speaking about these experiences with me may be upsetting, and you may need the support of friends, or a counsellor who is experienced in dealing with this issues in the aftermath of our interview. I will inform you prior to our interview of accessible services that are available to you to support you should you need it after our meeting.

Benefits
It is my hope that you will benefit by talking about these experiences and that your participation is likely to help me find our more about how to best support women who have been through similar experiences. This research may benefit society as a whole as it can raise awareness as to the experiences of women, and the impact of their experiences throughout their lives. It may benefit other women who read this research to know that they were not alone in their own experience. It is my hope to submit a copy of this research to the Commission of Inquiry into the Mother and Baby Homes in Ireland, with a view to informing the commission of the psychological impact of practices within the home on the individuals participating in this study.

Reimbursements
You will not be provided any incentive to take part in the research.
Confidentiality
I will not be sharing information about you to anyone. The information that I collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the I as researcher will know what your number is. I will not write that information anywhere. It will not be shared with or given to anyone. I will adhere to Children First Child Protection Guidelines as I carry out this research.

Sharing the Results
Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that I get from this research will be shared with you and your before it is made widely available to the public. Each participant will receive a summary of the results. My findings may be published in the future in the form of an article, or part of a book. I will ensure that no identifying information will be contained in the written results. Names, places of birth, name of Mother and Baby home and dates will all be changed to protect the anonymity of the participants.

Right to Refuse or Withdraw
You do not have to take part in this research if you do not wish to do so. You may stop participating in the interview at any time that you wish. I will give you an opportunity at the end of the interview/discussion to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

Who to Contact
If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following: [name, address/telephone number/e-mail]
This proposal has been reviewed and approved by Dr. Geraldine Sheedy, Lecturer, Department of Applied Social Sciences, Cork Institute of Technology, whose task it is to make sure that research participants are protected from harm. You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Certificate of Consent
I have been invited to participate in research about the experiences of women who lost children to adoption in Ireland’s mother and baby homes and the psychological impact of those experiences.

(This section is mandatory)
I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____________________________

Signature of Participant _____________________Date ___________________________
Day/month/year

If illiterate
I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____________________________________

A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.
Signature of witness .................................................................

Date _______________________________  Day/month/year

Statement by the researcher/person taking consent:
I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:
1. An Interview concerning the issues outlined in the Informed Consent Document.
2. Confidentiality and Anonymity of all participants is absolutely guaranteed
3. Participants can withdraw from the research at any time in the process, and do not need to give a reason for doing so.
I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent  SINEAD KAVANAGH

Signature of Researcher /person taking the consent ______________________________

Date _______________________________  Day/month/year
Appendix C: Interview Schedule:

A. Background, Cultural and Social context.
1. In your own words can you describe the situation surrounding your pregnancy and how it came about that you went to a Mother and Baby home?

2. How was the news of the pregnancy disclosed, and what were the reactions to the disclosure?

3. How did you feel about the decision to have your child adopted?
   Prompts: Did you feel you had power/choice in the situation?
   Were you fully informed of your rights, given options etc?

B. Experiences within Mother and Baby Home
4. What are the most prominent memories you have of the Mother and Baby home?

5. What is your memory of the separation with your child?

6. Were you offered any support? (from family and friends, counsellors, social workers, church people, medical practitioners)
   If you did get support - what helped?
   If you didn’t - what hindered you in getting support?
   Did you receive any counselling or support at the time of relinquishment or since?

C. Shame and Secrecy
7. Did you tell people about your experience?
   If not, how did the keeping of the secret affect you and the living of your life?
   Was secrecy imposed on you about your pregnancy? If so, how did that affect you?
8. How did you feel about yourself after this experience? How did you see yourself?

D. (Trauma, PTSD and Complex PTSD)

9. How were you in the days and years after losing your child?

(Prompts: did you have any flashbacks, intrusive memories? Did you withdraw from others?
Were you self critical? Did you have anxiety? Did you suffer from depression, insomnia, nightmares. Did you avoid reminders of your experience?)

10. Did this experience impact on future relationships?

11. How would you describe the experience of losing your child through adoption?
   Possible prompt: did you find it traumatic?
   What, if anything, does relinquishment trauma mean to you?

E. Unresolved or disenfranchised Grief
   (If participants speak about Grief as part of their experience)

12. How did living with this grief affect your life

13. Did you feel your grief was validated and recognised?

14. How did you cope with reminders throughout your life... birthdays, things like that?

15. Did you use any coping strategies that were helpful/harmful
### Appendix D.

Sample of Codes and quotations, showing frequency of occurrence

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Frequency</th>
<th>IV No.</th>
<th>Sample Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame</td>
<td>108</td>
<td>3</td>
<td>“…the old Canon… he just hit the roof when my mother told him, and he shoved at me, lifted my skirt up to see if I was wearing a knickers… was she wearing a knickers… he shushed us out like that… and told my mother ‘Get her out of the town, get her out of the town’… oh it was a disgrace, that was, like you know.”</td>
</tr>
<tr>
<td>secrecy</td>
<td>77</td>
<td>1</td>
<td>“because, on admission to Home A when she left me at the door ‘you’ll never speak about this again to the family or any member of the family’, and 46 years down the line, I’ve only spoken about it to two members of my family in the last 6 months. And they haven’t spoken to me since… and thats fine, I can live with that.”</td>
</tr>
<tr>
<td>Enduring/life long impact</td>
<td>68</td>
<td>3</td>
<td>“They killed everything I have. (crying) Like, my feelings for anything or anybody… Its all dead (crying), and that resentment, terrible resentment towards everybody…”</td>
</tr>
<tr>
<td>Trauma/traumatic memory</td>
<td>55</td>
<td>1</td>
<td>“And I was that distraught and the head presenting, I couldn't get up, I couldn't lift my leg high enough to get up on the table, and I actually threw myself half way across the table, and thats how I gave birth, she actually lifted one leg, and I gave birth with one leg on the ground…”</td>
</tr>
<tr>
<td>relationship with mother</td>
<td>49</td>
<td>2</td>
<td>“My parents came in to visit me once in the hospital. My dad held my baby, my mother wouldn’t look at her. My father tried to get my mum to look. My mother wouldn’t look. Hard, hard woman. And still is to this day, I've nothing to do with her now. Cut all contact.”</td>
</tr>
<tr>
<td>Hatred of Nuns</td>
<td>47</td>
<td>3</td>
<td>“As you say, but like you know… what the nuns done to me, thats what I… I hate them, I mean I see them on the street… I'd love to go up and smash them… ooooh…”</td>
</tr>
<tr>
<td>Alone/Isolation</td>
<td>44</td>
<td>2</td>
<td>“…and ah, basically left on your own in the labour ward or cubicle… and you didn’t know what was happening, you know, the pain… excruciating… ahm, and hearing other people around you screaming… you didn’t know what was going to happen.”</td>
</tr>
<tr>
<td>effect on other relationships</td>
<td>42</td>
<td>1</td>
<td>“Having my son taken away from me so cruelly and that heartache, I thought, the same thing could happen… if I loved… right… I loved immensely the father of my child… and he relinquished all responsibility of being with me and supporting me. So if I found another man and got married, and did the same thing… Id’ have to go through all that again… and its almost like a protection for myself.”</td>
</tr>
<tr>
<td>Coping/Survival Strategy</td>
<td>40</td>
<td>1</td>
<td>“The conscious side of me was numbed, and numbed to the point of… I almost denied as a coping strategy to think it didn’t happen… but the reality of it was it did happen. But in order to keep myself from going down the road of… which I witnessed in Home A, suicide and other related mental health issues… even then I recognised them, I thought, I can’t allow myself… life owes me. There is a life out there to be lived. I can make something of myself. And if I fall now, I’m not going to be any good to my son.”</td>
</tr>
</tbody>
</table>
"attachment/bonding with child" 39 5  "Oh it was beautiful, ah, he’s, he hated being down, on your lap down here (on lap) … and they would tell you, you had to feed him down there, because you weren’t to bond with the child, because his new mammy would get upset if he bonded with somebody else. So I mean, before the child was even born, he wasn’t yours, they made sure you knew that. But am, I didn’t… the minute the nurse, or the nun would go out, I was up here (gesture to holding him up in her arms), and I used to sing to him, and everything. And he loved being up here… he used to cuddle in to me here… you know;"

"hiding" 36 2  "… you were made to feel like you’ve had a baby, all those hormones are going through you, all those emotions… even if you kept your baby. But you end up… you’ve gone through the experience and you’ve no baby. You’re told you’re not to talk about… you. You’re to walk normal. I remember bending down at my parents fridge and milk seeping out of my breasts…”

"Social status/stigma" 35 2  "You know, I wouldn’t have expected my parents to talk about that because this was about their status. It was nothing to do with their religion, cause they weren’t overly religious… It was about what the neighbours would think, what the relations would think…”

"Fear" 31 5  "And I knew, I just knew, Sinead… my whole gut was telling me this was not a nice place. I could smell it even when I walked in, the smell of fears smell of whatever. It was a hell hole.”

"Grief" 31 1  "…oh stop, birthdays were a nightmare… I would get up very early, he was born at half six in the morning, and I used to try and get up before any of the house would be awake. I’d always put a little candle in the cake and sing him happy birthday, and at Christmas I’d always buy an extra gift for a boy his age, so that he was always there, every family gathering, every party, anything to do with the family… I’d look at my sisters with their families complete. One of my sisters had a still born baby, and it was spoken about, and it was ok to grieve and stuff like that"

"Anger" 29 1  "I get an enraged feeling inside, of me wanting to burst out and say… you cruel person… but I know in reality, that person might be the nicest person ever. I feel enraged when one of the nuns who is still in Home A could come on public radio and be extremely verbal in her denial of any abuses that went on."

"criminal" 29 1  "… and embedded in my head was this secret, this terrible crime that I had committed, and it must never be spoken about.”

"Rejected/ Ostracised/ Abandoned" 28 1  "Well she said, I had to be got rid of, and within 24 hours… I didn’t know where I was going, I’d never heard of Home A, I was brought to Home A… didn’t know anything about it… thats how I ended up there. Bit of a culture shock.”

"Abuse" 26 1  "… in those days in Home A, you were told you have disgraced your family, society, you are a fallen women that nobody would want you, you had done the devils work, you’re evil… and it was like a continuous mantra… even during mealtime, which was always conducted in silence. You ate the so called food in silence, and the nuns sat on the podium reading from scripture on evilness and sinfulness and doing the devil’s work.”
Appendix D.

Sample of Codes and quotations, showing frequency of occurrence

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Frequency</th>
<th>IV No.</th>
<th>Sample Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PsychoSomatic Symptoms</td>
<td>26</td>
<td>1</td>
<td>“I had all my emotion blocked here (signals her right side - hip area)… and I left that clinic as if there was… pulled out. I still, I've never to this day told my doctor about my son, or my journey… I’m too embarrassed.”</td>
</tr>
<tr>
<td>Pre existing developmental trauma</td>
<td>24</td>
<td>3</td>
<td>“But I was raped at the age of 10 by this old farmer that used to give us milk. And we were depending on the milk you know… because of the big family we had. So I was raped by him at 10 years of age. He used to take me upstairs and have sex with me, and give me half a crown or six shillings, the most he ever given me was a pound. And I'd take it home and give it to my mother. I’m sure my mother knew, but she was depending on the money, and depending on the milk.”</td>
</tr>
<tr>
<td>lack of information, consultation and support</td>
<td>22</td>
<td>1</td>
<td>“…and the one thing that those nuns were great at was disempowering people, and taking away any decision making or involving in any decision making. There was no discussion at any point ever entered about options as to what I wanted.”</td>
</tr>
<tr>
<td>change in social attitudes/different times</td>
<td>21</td>
<td>3</td>
<td>“I don’t know if I…. but at that time there was nothing, there was no rape… we never even heard of a rape, we never heard of sexual abuse… nothing like that… the only thing they would say, that you were attacked… you were attacked, and that was all that it was. You were, you were the wrong one, the woman was the wrong one… you were wrong… it’s her fault.”</td>
</tr>
<tr>
<td>Defiance</td>
<td>21</td>
<td>1</td>
<td>“…but then I look at the other side, and the women who are suffering today, and you see, Sinead, it all boils down to our coping mechanisms and the choices we make. I chose to be bolshie about as to yes, I’ll qualify, and yes I will get married, and yes, I will have children, and nobody will tell me not to do anything ever again… or I could have gone that path and said, they've totally destroyed my life. I chose not to.”</td>
</tr>
<tr>
<td>Exile</td>
<td>18</td>
<td>1</td>
<td>“…within 24 hours I was exiled to the UK… and embedded in my head was this secret, this terrible crime that I had committed, and it must never be spoken about. To anybody.”</td>
</tr>
<tr>
<td>human rights</td>
<td>13</td>
<td>5</td>
<td>“I only found out this year Sinead, this year, nearly 42 years later, that the adoption act 1952… According to law, I had seven years to decide my child's fate. I had the right to ask for short term fostering, long term fostering, till I got on my feet. When I saw the law… that the Catholic law, could do what they liked… but the law of the land is something I didn’t even know about.”</td>
</tr>
</tbody>
</table>
Appendix E

Sample of Interview Transcript with line by line coding.

Identifying information is blacked out.

S: Sinéad (Researcher)

R: Ruth

Ruth, Interview 4
## Appendix F

Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE</td>
<td>Adverse Childhood Experiences</td>
</tr>
<tr>
<td>DES</td>
<td>Dissociative Experiences Scale</td>
</tr>
<tr>
<td>DESNOS</td>
<td>Disorders of Extreme Stress not Otherwise Specified</td>
</tr>
<tr>
<td>SIDES</td>
<td>Self Report Interview for Disorders of Extreme Stress</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
</tbody>
</table>