

The Physician's Responsibility In Adoption, Part I: Caring For The Birthmother

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Abstract: The unmarried pregnant woman considering adoption needs more than medical care from her family physician. She needs an advocate who can help her reach the right decision about her untimely pregnancy, advice about the options for adoptive placement of her child, and respect as the child's

mother during her hospital stay. After the birth and adoptive placement of the child, the physician can help the birthmother resolve her grief and may serve an ongoing role as an intermediary between the adoptive family and birthmother. (JABFP 1988; 1: 50-4.)

Prior to the mid-1970s, most unmarried women who became pregnant placed their children for adoption. Abortion was illegal, and teenagers and adults alike disapproved of sexual activity outside marriage. Typically, the pregnant teenager was sent away from her community to keep her pregnancy a secret from her friends and relatives. She was not permitted to see her infant after birth, was not allowed to participate in the choice of adoptive parents for her child, and was not given any information about the adoptive parents.

Today's single pregnant women have more options and more control of the decision-making process, resulting in some dramatic changes in statistics since the early 1970s. Nearly one million abortions are performed on unmarried women each year, and about 350,000 are performed annually on teenagers.¹ Experts estimate conservatively that 95 percent of children born to unmarried women are kept, and only five percent—or about 36,000 each year—are placed for adoption.

Care of the birthmother years ago was predicated on the belief that placing a child for adoption was an experience that could be permanently denied or forgotten. It is now acknowledged that placing a child for adoption is a difficult decision that a birthmother will live with for the rest of her life. It is essential that she be able to look back on her experience and know that she made a responsible decision with full knowledge of her other alternatives.

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The Decision to Place a Child for Adoption

Physicians with the expertise, time, and inclination to counsel the pregnant woman about her alternatives should do so, while in no way trying to influence her decision. Those who do not have the time or desire for such counseling—or whose personal values prevent them from presenting all options equally—should refer the woman to a responsible pregnancy counseling service, social worker, or therapist for the decision-making help she needs. She should be advised that by seeking counseling from an adoption agency she is in no way committing herself to adoption or to that agency.

The decision to place a child for adoption is an emotional one, and it is not unusual for the woman to change her mind several times during her pregnancy or after the birth of her child. Consequently, the physician caring for her should not assume that any "decision" she makes during her pregnancy is her final choice.

Recent studies indicate that teenagers who place their children for adoption are more likely to have involved their mothers in their decision-making process, while those who keep their babies are more likely to have been influenced by the mother's male partner² and more likely to have received emotional support during the pregnancy from the baby's father, their family, and their best friend.³ The inability of teenagers to project into the future, along with pressure from their peers and from society, influences pregnant adolescents to keep their babies rather than place them for adoption.⁴

Knowing that family, friends, and society strongly influence the teenager, the physician

should provide unbiased counseling or refer the pregnant woman for counseling to someone uninvolved in her decision.

Prenatal Care of the Birthmother

Aside from routine prenatal care, a complete medical, psychological, social, and sexual history should be taken of the birthmother and the birthfather. Obtaining information about the birthfather may be difficult, particularly if the birthmother is unwilling or unable to identify him. The physician should impress on the birthmother the importance of this information to the adoptee. If the birthmother is reluctant to identify the father or if she is an adolescent in her early teens, then incest should be suspected. If the physician discovers that the pregnancy resulted from incest, he should advise the adoption agency or adoptive parents of the necessity of genetic assessment for the child after birth (McGillivray B: personal communication).

The physician should try to determine whether the birthmother is at high risk for having a sexually transmitted disease. Appropriate diagnostic tests and examinations should be conducted so that proper treatment of the birthmother can be initiated and her infant can be evaluated and screened.

Determining who is at high risk for a sexually transmitted disease is a subjective decision and requires that the physician or a member of his staff be able to take a sexual history of the birthmother and birthfather in a sensitive way. Generally, women who have been sexually active with multiple sex partners, who have been sexually active with a person with a sexually transmitted disease, who have been sexually active with bisexual men, who have been intravenous drug abusers, and who have been sexually active with a partner in a high-risk group are considered at high risk for most sexually transmitted diseases.

The Centers for Disease Control (CDC) recommend that women at risk for syphilis be screened for the disease during the first and last trimesters of pregnancy.⁵

The CDC also recommend that in addition to those in the high-risk group for other sexually transmitted diseases, teenagers and unmarried women be screened for chlamydia at their first prenatal visit and again in the third trimester.⁵

Those traditionally considered at risk for hepatitis B include women from Southeast Asia, Alas-

kan Eskimos, Haitians, health care workers, patients on hemodialysis, those who regularly receive blood products, and those in sexual contact with hepatitis B carriers. But with some 16,500 pregnant women estimated to be carriers of hepatitis B, the Centers for Disease Control are giving serious consideration to recommending that the screening test for hepatitis B be included in the routine prenatal panel.⁶

Throughout the pregnancy, the physician should treat the pregnant woman as any other expectant mother, even though she may be young, immature, and seemingly dependent on her parents. It is critical that she take full responsibility for the decision she will make about the future of her child. She cannot take that responsibility unless she is given the opportunity to make decisions about her pregnancy, labor, and delivery.

It is not unusual for the birthmother to request that the prospective adoptive parents share the birth experience with her, and the adoptive parents are often eager to be present at their child's birth and take active roles as childbirth coaches. In addition, there may be people the birthmother does not want in attendance, such as her parents. This is something that should be ascertained in advance. The physician should inform hospital personnel of the birthmother's plan and obtain any necessary permissions if her preferences are inconsistent with hospital protocol. It is also recommended that the birthmother sign a consent form giving permission for the adoptive parents to be present at the birth.

During this prenatal period, the physician should prepare the birthmother for the grief she will feel when she is separated from her child. She should be educated about the normal stages of denial, anger, bargaining, depression, and acceptance that people experience with a loss. The birthmother who is prepared for the intense emotional reaction she will experience with the adoptive placement of her child may be less likely to allow these normal feelings to influence her decision than one who is unaware of this grief reaction.

The physician should encourage the birthmother to see her child after the birth because it provides an opportunity to resolve the early grief stage of denial. Seeing the baby seldom causes a birthmother to change her mind about adoption plans. A birthmother who changes her mind probably was not totally committed to the plan and, consequently, should not have gone through

with it. Seeing the baby does, however, reassure her that her baby is all right and gives her the satisfaction that her efforts during her nine-month pregnancy were worthwhile. It also gives the birthmother an opportunity to say good-bye—an important part of the grief process.

The prenatal period is a good time to encourage the woman to develop a plan for resumption of normal activities after the baby's birth. The teenager especially needs to be committed to returning to school or to seeking employment soon after the birth. She may have difficulty motivating herself to resume these activities during the depression phase of grief unless she has developed a plan beforehand.

Care of the Birthmother during Labor and Delivery

During labor and delivery, the birthmother should be treated by the physician, nurses, and hospital personnel as they would treat any obstetrical patient. That is, they should provide her with information about the progress of her labor and her baby's condition, be sensitive to her preferences during labor and delivery, allow her to make necessary decisions, and give her a sense of achievement. Most importantly, the hospital staff should be aware that this is not an appropriate time for them to discuss her plans for the baby. Should she wish to express her feelings about placing the baby for adoption, the hospital staff should have access to her counselor or social worker and offer to call that individual, but they should not discuss her plans with her themselves.⁷

Postnatal Care of the Birthmother

After the baby's birth, the birthmother should continue to be treated as the infant's mother. Such actions as moving the birthmother into a hospital room off the obstetrical floor (unless she requests it) and denying her access to her baby may seem sensitive, but they in fact deny the reality of what has happened and, consequently, do not help her grieve. The birthmother should again be encouraged at this time to see her child, but her wishes should be respected if she prefers not to do so. The birthmother should also be encouraged to recount her labor and delivery experience and otherwise be supported during this period of grief.⁷

The physician should not ignore the needs of the birthfather or the biologic grandparents if they

are involved in the pregnancy and birth. They, too, may need to grieve for the loss of their child or grandchild.⁷

Ongoing Needs of the Birthmother

Just as a widow does not recover from her loss by the time the funeral is over, a birthmother does not finish grieving before she leaves the hospital. Success in adjusting to the decision to place a child for adoption is connected to the opportunities the birthmother has to discuss her feelings about adoption, receive support during her grief period, and resolve her feelings of loss.⁸ It is important for the birthmother to know that, as with any loss, she may always look back on her decision to place a child for adoption with some sadness. This is not inconsistent with resolution of grief or acceptance of her decision.

Some birthmothers who do not adequately resolve their losses may experience adverse psychological reactions, including fears about future fertility, sexual dysfunction, and distrust of men.⁹

Private Adoptions

An estimated 17,000 infants, or about half of those placed for adoption in the United States today, are placed for adoption independently of adoption agencies.¹⁰ For a birthmother, private or independent adoption is often desirable because she can stipulate the conditions under which she will place her child and select the adoptive parents. A surprising number of pregnant women, though, choose private adoption because they are unaware of the existence of social service agencies or do not know of a specific adoption agency.¹¹ Actively choosing private adoption instead of resorting to it out of ignorance can be therapeutic because of the sense of responsibility and control it can impart to the birthmother when she is feeling otherwise emotionally compromised.

The physician who is presented with a birthmother who prefers a private adoption should be aware that privately arranged adoptions are legal in all but a few states, but each sets its own restrictions, such as whether a baby can be placed with parents who live out-of-state and what kind of financial compensation can be made to the birthmother by the adoptive parents. The physician considering becoming involved in a private adoption should consult a lawyer to determine what is legal in the state. The birthmother also should be

encouraged to have an attorney who is different than the one representing the adoptive parents to insure that her interests are adequately protected.¹¹

The physician involved with a private adoption should be aware that private adoptions lack the same opportunities for readily available counseling that a birthmother has with an agency adoption. In one study of independent adoptions, the majority of birthmothers did not discuss alternatives to adoption with anyone. And only 26 of the 98 women who wanted to discuss their concerns discussed them with someone trained to counsel people under stress.¹¹ Most adoption agencies and public social service agencies provide counseling to a pregnant woman considering adoption without requiring her to place the child for adoption or to place the child through their agency.

It is critical that the physician communicate to the birthmother that the medical care she is receiving is in no way tied to the decision she makes.¹¹ A birthmother who is relying on prospective adoptive parents to pay for medical expenses may feel pressured to follow through in placing her child for adoption because she may be unable to pay the physician's fees herself. She may fear being without medical care at a most vulnerable time if she decides not to place the baby for adoption.

The birthmother in a private adoption is likely to want to select the adoptive parents and may want to stipulate the degree of openness in the adoption. It is often reassuring for the birthmother to have personal knowledge that the people who are caring for her baby are suitable parents.

The legal agreement that must be developed between the adoptive parents and the birthmother will outline the extent to which anonymity will be maintained. Private adoptions, like agency adoptions, vary in the degree of "openness" between the birthparents and the adoptive parents. They may choose to have no information about each other, to exchange nonidentifying information only, to meet each other without identifying themselves, or to meet with full disclosure of their identities. The birthmother should receive objective counseling about the advantages and disadvantages of each option.

Because open adoption is relatively new, there are no long-term studies on its effect on birthmothers or adoptive families. Those who favor some degree of contact between the birthparents and adoptive parents point out that birthmothers find it easier to place their child for adoption hav-

ing met the adoptive parents and found them satisfactory, and adoptive parents feel reassured that the birthmother is committed to her decision to place the child for adoption after meeting and talking to her.

In addition, after meeting the birthparents, adoptive parents may find themselves more understanding of the situation the birthmother was in and be better able to speak empathetically about the birthmother to the adoptee.

The obvious advantage of exchanging identifying information is the facility with which medical information can be exchanged in the future and the ease with which the adoptee can obtain information about his or her social and genetic background. The risk is that there may be unwanted contact in the future.

If those involved do not intend to exchange identifying information, the physician should encourage the birthmother to examine her feelings about her child knowing her identity when the child becomes an adult. If she wants this, she should reach an agreement with the adoptive parents about the release of identifying information to the adoptee at that time. In the absence of such an agreement, the physician may be faced someday with a request from the adoptee for identifying information about his birthparents but be restrained from giving the adoptee that information because of physician-patient confidentiality.

The birthmother and the adoptive parents may request that the physician serve an ongoing role as an intermediary, particularly if they want to have contact with each other without exchanging identifying information. The physician would then pass letters, gifts, or updated medical information from one party to the other throughout the life of the adoptee.

Caring for the Birthmother Who Places an Older Child for Adoption

Not all children are placed for adoption at the time of birth. Some children become available for adoption at an older age because their birthmother's parental rights have been terminated against her will owing to child abuse or neglect. And some birthmothers agree voluntarily to terminate their parental rights after extensive work with a social service agency convinces them that placing the child for adoption is in the child's best interests. In these situations, the child probably has been separated from birthparents and has

been in foster care or has been moved back-and-forth from the foster family to the birth family while social workers have attempted to help the birth family deal with whatever problems have resulted in neglect or abuse of the child.

The physician whose patient is a birthmother with a child in foster care should act as an advocate for the patient in the social service system to see that she is receiving the services she needs to overcome her problems. The physician should also work closely with the birthmother's social worker to provide whatever medical assistance or counseling is necessary. If it appears that reunification of the family is unlikely, the physician should work with the social workers to prepare the birthmother for termination of her parental rights.

The effects on birthmothers of having parental rights involuntarily terminated or of placing an older child for adoption have not been investigated. But even a mother who does not have the skills to raise a child properly or who has drug or alcohol problems that prevent her from exercising the skills she has probably feels an attachment to the child, particularly if they have lived together for any length of time. Even if she has been separated from the child because of his placement in foster care, the birthmother is likely to feel the same kind of grief that results from any loss when final action is taken terminating her parental rights, particularly if the action also prohibits her from further contact with the child. The physician should help the birthmother in this situation identify her feelings and help her deal with her emotional reactions.

Counseling in this situation should focus on helping the birthmother move through the stages of grief to acceptance, restoring her self-image if she feels guilty or inadequate at not being able to provide a nurturing environment for her child, and ultimately helping her accept responsibility for whatever problem resulted in the loss of her child.

The birthmother should be helped to identify the major problem that resulted in the termination of parental rights and should be helped to see that ongoing efforts to rectify this problem, while not resulting in the return of the child, may im-

prove her ability someday to rear another child. It is important to empower an individual to assume or at least believe she can assume a parental role in the future.

If a problem exists that will permanently prevent an individual from functioning as an adequate parent, this should be confronted and some alternatives found to fill the void that may exist for such an individual. For instance, mental retardation will permanently impair an individual from functioning effectively as a parent, but that individual may be able to satisfy her nurturing needs as an aunt or by participating in a community program for the disabled that involves children.

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