SENATE INQUIRY INTO COMMONWEALTH CONTRIBUTION TO FORCED ADOPTION POLICIES AND PRACTICES

ADOPTION ORIGINS VICTORIA SUPPORTING PEOPLE SEPARATED BY ADOPTION

PSYCHOLOGICAL IMPACTS BY

SUBMISSION BY DR G.A. RICKARBY MB BS FRANZCP MANZAP CONSULTANT PSYCHIATRIST

Preamble to Submission

On behalf of Origins Victoria members we are citizens of the Commonwealth of Australia and are mostly residents of the State Of Victoria

As citizens of the Commonwealth of Australia we have an inalienable right to protection under the Australian Constitution and Common law of this country

As Australian citizens the Commonwealth affords us protection from unlawful and harmful actions that threaten our rights to Life Liberty and Justice from those who would deny us these rights within and without the borders of Australia.

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

The author graduated in medicine from Melbourne University in 1956. After commencing training in Psychiatry in London, I arrived in New South Wales in late 1971 to take up a position as Senior Medical Officer at Rydalmere Psychiatric Hospital in the first week. Of 1972 and, while in this position, to complete my training in Psychiatry in New South Wales where I became a Psychiatrist in 1974.

In 1976 I returned to practice Child Psychiatry as NSW Health Department's Child Psychiatrist for Inner Western Suburbs of Sydney until I moved to Newcastle in 1978 for family reasons and took up the corresponding position there, still flying to Sydney one day a week to continue my Sydney responsibilities until I was able to be relieved in 1983.

I had a wider role in that I flew to Narooma monthly and later to Dubbo to conduct supervision and clinics. I was the first psychiatrist to be Consultant to The Adolescent Unit at Royal Alexandra Hospital for Children Camperdown.

In 1986 I became Child Psychiatrist for the Central Coast and was based at Gosford Hospital until 1989 when I went into semi retirement, still keeping Visiting Consultancies in Newcastle and Gosford. I am now in part-time Private Practice and sit on the Mental Health Review Tribunal where, because of an administrative change, I am again to be an employee of The New South Wales Health Department from 1st July this year.

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

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

In 1974 I was giving a lecture about preventable psychiatric morbidity to a large group of nurses about the possibility of using proven experienced parents as adoptive parents, when I received a hostile response. I was told that these babies were the "right" of those who could not have children of their own, and people who were not wholly behind this were a danger to the people who would never have another opportunity of having children.

From then on I took a much closer interest In the cultural prescriptions driving adoption practices in New South Wales, ironically at a stage when it was undergoing radical change due to the social renaissance that occurred after 1972.

Taking the Child Psychiatry role for the Inner Western Suburbs of Sydney Burwood, Strathfield, Drummoyne, Ashfield and Croydon in 1976, l was to find that adoptive families were a frequent source of referal. (I put the issue in here as it is pivotal to one illegal practice in the taking of consents of birth parents: that is to idealize adoptive families as necessary and desirable for babies, and to use such images repetitively in promoting adoption to the potential provider of the baby).

The long line of mentally ill, substance addicted, maritally divided couples (over both adoption and other issues), who hadn't grieved their own or their mates sterility whom I saw in trouble during child rearing crises when they didn't have the resources or will to see them through, disabused me of this notion very quickly. My colleagues and I wrote about this after waiting to take a future sample: Adoptive Families in Distress. (the heavily edited version).

I looked around at the adoptive families I knew socially, and there were similar themes occurring there too, partly because the adoptive family had no training in dealing with the inevitable identity disorder of the adoptive child, because, once the adoption was confirmed, they were left to do whatever they would, with no help or guidance about the special difficulties. The cultural myth was that it would be "just like having your own children".

Adoptive parents were given misinformation, in that there was a cultural expectation that the baby would match the family because of a skilled selection of babies, and that affluence and religion based upbringing would override other difficulties.

Adoptive parents were given no help with hard testing behaviours in primary school age, with temperamental issues that might have been expected in the biological family, or differences in style of thinking and problem solving that were inate. They were not helped with their own grief, or their deeper feelings about bringing up somebody else's child except for the myths around the "abandoning" mother implying to the child that he or she was was much better off with them.

Overall I have seen more adoptive parents for this variety of help than I have seen relinquishing mothers.

So not only were the young mothers subject to promotion of adoption, but the promotion was in a large number of instances an outright lie, and when there were capable people adopting, they had to deal with a child different in temperament and cognitive style from themselves through an intense identity crisis, not to mention the early damage to a baby who is born into a vacuum figuratively speaking, as there is no mother to hold and suckle, her noises have gone suddenly and there is no breast smell on which to imprint - many consider this separation as primarily damaging.

When, as well as the inherent misfit, the adoption was associated with frank psychiatric illness in the adoptive family at the time of adoption, or later sexual abuse, it was difficult for Child Health professionals not to become both distressed and angry. Once the Department of Community Services signed them off and The Department of Health was distracted from other duties caring for them.

The author wrote Family Psychiatry and the Selection of Adoptive Parents published in the

Australian Journal of Social Work and it was used widely, but it was closing the gate after the horses. The Dept of Community Services (about 198O) started using me when they thought that refusals of adoptive parents might be challenged in Court (they hadn't succeeded in stopping anybody determined before that). I was prepared to give evidence for them.

The people I met were mostly frankly mentally ill. (I heard the argument that the mentally ill, should not be discriminated against as far as adopting children was concerned)

It is important to discuss, at this stage another myth that was used cruelly against original mothers. In 1997 I was disgusted to hear it still promulgated on a television show by a social worker who had worked in Crown St Hospital during the single mother's holocaust from 1966 to about 1973.

What she said was that the young mother could not readily go to Court to seek support from the father because a man taken there would have half a dozen others to say it could be them just as easily, or words to that effect. This was the myth that the young woman was prematurely sexualised, promiscuous and irresponsible. This myth was widespread and a source of creating a bad role for the pregnant single girl, particularly the teenager.

Having seen a large number of relinquishing mothers by the nineties, there were many instances of first intercourse, (some of it rape), some of seminal spills in the vulva, but most numerous were those of the first boy friend and profound ignorance about sex and contraception.

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

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

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

Inability to have Children

As already indicated, there were particulars leading to a large number of couples who were unable to have children. Effects of early contraceptives and Chlamydia infections have been already mentioned. The public were not as ready to come forward to have any venereal infection treated, ectopic pregnancy was common, and there was an extraordinary rate of premature hysterectomy performed in Australia that astounded medical statisticians in other

countries.

There were some causes in males such as infective disease of the genital tract which caused male sterility, again the the public would shun treatment, however there was little that could be done about mumps orchitis in childhood or adolescence. There were many instances where nothing could be found or where there were low sperm counts of unknown cause.

In the front line in managing adoptive families however, child psychiatry clinicians were aware of many couples who had marital and sexual difficulties, who led oppositional and divergent lives where the intercourse frequency was very low or absent. This type of ailing marriage where the couple were bound together in a hostile insecure situation is not to be confused with the unconsummated marriage which was also encountered. Here the couple often had a strong loving bond, but had difficulties related to having intercourse so well described in Michael Balint's book Virgin Wives.

The Difference in Social Power

The group of people who wanted babies (other women's) contained a large proportion from the middle class, as a result of both being employed, having property and other assets, as well as social affiliations and status.

In this culture respectability was highly valued. In dealing with adoption agencies after 1965, these couples often related to the agency with a strong public display of praise and gratitude, and the agencies would have photographs of happy adoptive families with cards, and a sense that they had personal ties with many adoptive families as a result.

Many agencies such as the Catholic hostel for unmarried mothers at Waitara had specially selected adoptive parents come to talk to the mothers about the benefits of adoption. Many such families adopted two to four children.

The relationship had a personal element to them and there was a sense of reciprocity experienced by the workers in agencies, antenatal hostels and maternity hospitals. The overall myth promulgated was "Isn't it wonderful we can find such loving homes for the unwanted babies". For those with an angry adolescent adoptee in psychotherapy, this was black humor indeed.

The Cultural Underrating of the Destructive and Often Irresolvable Effect of Grief.

The next cultural issue to be considered is important because unlike many of the others discussed, it is still a major issue in the 199O's. That is the cultural underrating of the destructive and often irresolvable effects of grief.

The cultural byte then was "They will soon get over it and be glad they are able to start their life over again afresh". This was before the research of Madison and Raphael that showed tenfold morbidity for the bereaved, and before the comprehensive study by Singh et al of the effects of the Granville disaster and the contribution of Ms Buttrose to disseminate some of this

knowledge to the general community.

The grief at loss of the baby has been compound, lifelong, full of sadness, anger and searching, and has involved much decompensation into depression and preoccupied distancing from relationships, or the person becomes an inured defence against such grief.

Nearly fifty percent were never to have another baby.

The practices of some of the hospitals around the birth were to aggravate the grief profoundly. The cultural myth was. "We have to stop her seeing the baby and give her sedative drugs - that will make it easier for her."

Even superficial study shows these factors to be sticking points of aggravated grief. The only ones it was "made easier for" were those taking the baby.

Certainly a process like this was a response to the intuitive knowledge that the extant bond with the baby would be developing further and the resistance to signing the consent would be great indeed, despite the difference in power. This was all done before consent was taken, and in Crown St the young mother was subjected to large doses of barbiturate drugs until after the signing of consent.

Consent

One issue which could be easily obscured was the common law issues of informed consent. But at the time there was much focus on the signing of the consent. The thirty day period to revoke this was of such small moment to those administering adoption practices, that it was virtually ignored as a threat to adoption as it was easily deflected by such strategies with adult professional power as; "You don't want to do that to your baby dear"; "You wouldn't be able to cope dear", and the variation of this, "We would have to take you to court because you are incompetent to care for your baby", (Crown St used this before taking consents), "It's too late the baby is gone", or the variation of this is that the adoptive parents would be highly distressed.

Young mothers heavily brain-washed (and I use this term in full consideration of those practices which lead to the term becoming part of living english) hardly ever sought legal help, were readily bluffed into thinking these professionals were acting legally, and would have great difficulty in getting the correct papers to the Supreme Court as required.

It is salient that no mother went to the professionals office to say that she was ready to give consent. The professional went to her bedside and indicated it was time for the routine signing of the papers. This was described to me scores of times as being put in a manner that there was only one inevitable answer "Yes".

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

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

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

Associated Practices:

Isolation, Incarceration, Suggestion, Forced Labour, Repetitive Indoctrination, Humiliation, and Moral Coercion, including Social Role Subjugation.

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

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

Superficially the living in a hostel, convent or other prenatal institution, was said to be preferred by the girls to 'hide their shame'. However the practice allowed for the breaking of their usual first order social support, particularly their family and peer support. Here they had a new peer group in the same predicament. And their parents were replaced by a new group of 'parents' who would repetitively feed them bytes of the myths and use guilt and shame keys to bring them to a state of low self esteem.

Where this was superficially kind or warm, regression was promoted, and, as the Chinese and the North Koreans found in the fifties, this was the most effective form of mind changing possible. Where they were harsh there were attempts to please them in the only way possible - be ready to sign the consent, and it is the long term effects of those imprinted suggestions that are marring their lives twenty or thirty years later - particularly those who never had subsequent children, an outcome associated with going through this treatment.

You will hear that some were restricted to the building without street clothes, some who worked in laundries and toilets, some were literally locked in during various phases of their pregnancy, and some had suggestions repeated in such a manner that that they doubted they would ever be a good mother for a child, or they would harm any other child they had or destroy the life of their partner.

These elements of damage were over and above the damage they were to suffer from the loss of their baby. Over forty per cent had no further children, and those of us seeing the children they did have later were aware that these associated practices were often the principal cause of family disfunction, even considering the mothers post traumatic fear of losing another child and crippling pathological grief decompensating to depression.

It was as if these factors were post-hypnotic suggestions of the most compulsive kind. Some were consciously mediated, but others acted through the unconscious, creating compulsive attitudes and behaviours only accessible to significant psychotherapy.

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

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

Unethical and Unlawful Practices.

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

However I must draw attention to some issues that may be over looked.

First - Crown Street.

One issue is the role of the medical staff, as without their prescription of scheduled drugs the whole pattern of abuse would be entirely different.

The commonly used offending drugs were Sodium Pentobarbital, Amytal, and Stilboestrol.

I studied a number of Crown St files and I also had the occasion to study Chelmsford files. The similarity was striking, the barbiturate drugs the same and in similar dosage (although not the same frequency to produce deep-sleep over a period of weeks). The senior Psychiatrists at Chelmsford and Crown St were the same. I was aware of the collusion between the two when I uncovered a letter by Dr Harry Bailey from microfiche kept at Paddington, ordering the abortion of twin foetuses (close to viability) of a Chelmsford patient by hystorotomy. This was duly carried out without the womans consent and she was wondering twenty years later whether her babies were still alive and with somebody else.

In this manner the Crown St files of relinquishing mother had more in common with Chelmsford files than they do with the files of other relinquishing mothers.

At Crown St drugs were also used for control in the ante-natal period, for many days usually, but sometimes drug control went on for many weeks. Chloral Hydrate, Sodium Pentobarbitone, Amatyl were all used. A 200mgrm dose of Sodium Pentobarbitone was given intramuscularly within some hours of the birth, this was often repeated during the first five days, but often backed up by oral doses of Pentobarbital or Amytal.

Those barbiturates were relatively quick acting, caused extreme sedation, stuperous states and delirium was frequent, sometimes due to withdrawal as much as intoxication.

Clearing

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

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

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

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

Second: Taboos

The Parliamentary Inquiry will hear of many senior professionals associated with the the above practices. Few of them will have been leaders and many will have gained employment with an institution where they had to quickly conform to institutional culture and practice.

It will be important to see past these these people to those who exerted leadership in full knowledge of the unethical and unlawful practices of the time, where the end: the provision of babies for adoption: justified the process necessary.

It will be important that their destructive role by such leadership be looked at whatever their affiliations. The senior Josephite nun who controlled the adoption of thousands of babies is one

example, and another group who would generally be seen as untouchable in this respect is the Salvation Army.

Non-adoption Alternatives

Women who know I am interested in adoption have told me their experience when they nearly had their baby adopted out.

The outstanding theme of their stories is not that of professional advice about adoption alternatives, but one of being rescued by a senior relative or partner giving them support, or stubborn refusal to sign documents and of calling the bluff of those who tried to separate them from their baby.

I am not impressed for this reason either of the statistics of single women who kept their baby or the sophistry around the issue of alternatives for the single mother.

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

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

However this changed attitude and practice certainly contributed to the number dropping like a stone in this period, although changed mores and the Supporting Mothers Allowance were significant issues but so also was the drop in pressure as the invitro fertilisation program was succeeding.

The legal difficulties for mothers gaining recompense.

The vast majority of mothers who lost a child to adoption are not seeking recompense, but recognition of what was done to them and the recognition of the extent of their suffering. As their children have been brought up on myths of their mothers inadequacy, immorality and rejection of their babies, they need a firm clear statement to undo some of these attitudes.

However there are some who lost babies despite their determination to keep them. Those to whom such flagrant abuse has occurred require recompense as part of the process outlined in the previous sentence.

Their legal difficulties come about through failure to set aside The Statute of Limitations no matter how extensive the damage or blatant the abuse.

It would appear that their legal advisers have great difficulty in predicting legal outcomes,

establishing negligent practice in a culture of abuse, or looking to common law failures of duty including the issue of informed consent and the abrogation of the right to use the thirty day period to revoke consent.

The failure of one case over issues of the adversary not being able to bring witnesses to balance their testimony over what should have been part of their case, left them with a sense of dismay, injustice and betrayal.

Recompense will be discussed further in the section on distress assistance.

Measures to assist persons experiencing distress due to adoption practices.
General Issues.

Distress is associated with the mothers grief, specific issues of damage, and problems about continuing their life despite this, and then in relating to their child as an adult and the complex feelings and stress which occur as they come to reunion (which many times is delayed or never happens) and then to relate to a young adult with very complex feelings about them often based on destructive misinformation, frequent identity damage with secondary self destructive behaviours, and learned testing behaviours then to be practiced on the mother who lost them.

Many mothers are very frightened of the child they will meet; so are the children, but those who have made it to being autonomous can handle it better and often constructively take the lead in the reunion situation.

Straightening the record.

In general mothers say they want help particularly in straightening the record, a full and compassionate account of their plight and the treatment to which they were subjected which is not fully communicated to their child. They want competent counselling from people who are not identified with the perpetrators.

Many are desperate for this and will travel hundreds of kilometres or even interstate for this. Special training for such counsellors would be required, although there are some among their number who have professional qualifications who may work through their own effects of loss to be able to help their peers.

Generally peer groups are very supportive but it is difficult for them to be organised, as in my experience, most groups are funded by individual savings from social security payments.

Those who have exposed themselves are aware of the high level of distress among the great majority who are frightened of rejection or social stigma and who are unable to come forward.

Damage.

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

1. Pathological Grief.
2. Personality damage associated with the defences used against grief, against post traumatic stress phenomena and against depressive decompensation.
3. Personality damage associated with the isolation of the birth experience and the loss of the baby, where this is a secret and there is no significant other to share the feelings and unresolved issues associated with the loss.
4. Axis 1 Psychiatric Disorder
    1. Post Traumatic Stress Disorder.
    2. Major Depression
    3. Dissociative Disorder
    4. Panic Disorder (and other anxiety disorders)
    5. Dysthymia
    6. Situational Stress Disorder (often associated with reunion)
    7. Alcohol Dependent Disorder
    8. Prescription Drug Dependent Disorder
    9. There are other drug dependent disorders which are uncommon among these mothers.

(please note that 4.7, 4.8, & 4.9 will be dealt with under section 7 below)
(These will be added later, Ed)

5. Personality damage associated with psychiatric illness as a sequel to loss of a baby to adoption.
6. Personality damage associated with long term Pathological Grief.
7. Aggravation and precipitation of a wide variety of physical illness which are related to stress.
8. Disorder and incapacity in human relationships.
9. Educational failure and poor employment status.
10. Failure of bonding to other babies.

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

1. Pathological Grief.

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

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

Pathological grief refers to distinct and major failure of this process. After loss of the baby, the first stage of shock, numbness and disbelief may persist because the mother cannot face the finality of loss of her baby and the feelings of rage, guilt, depression that might overwhelm her. The numbness and disbelief are protective against this emotional second stage of grief. This may persist for a long time and may be associated with naive beliefs that the baby will be returned or some `nice' social worker will appear to help the return.

Many find the next stage, which they enter after they accept finality of the loss, produces such anger and despair they revert to the first stage, and I have seen this see-saw between the two occur over two or three decades, and associated with decompensation in Major Depression.

Others stay in the second stage of major feelings: they cannot accept the implications of their loss and thus cannot mourn. This arrest is not understood and people readily become irritated with them as they return to the issues of their arrested grief. At The Inquiry there will be many with this type of damage and their presentations will represent for them the first attempts to look at implications of their loss in the social world. Such damage is to be seen in the context that when a mother loses a child from babyhood to middle age, and the loss is untimely and has other bad outcome features, the most stable and mentally healthy person becomes similarly afflicted.

Others are stuck in the stage of mourning, going back again and again to the same issues where they cannot get satisfactory answers.

There are supra-pathological variations of pathological grief, particularly where grief is totally inhibited and denied, and the grief goes underground coming out in unconscious release, such as in over-protection of other children, binding and intrusive behaviours, irritability, and unexplained depression. The mechanisms of defence become part of the personality. In particular a large proportion go over some elements of blocked grief again and again; sadly the repetitive nature of their talking about the blocked area of their grief is a measure of their damage, but to the listener who has long ago understood the issue from the first telling, it can be tedious or irritating. It is most productive for the listener to ask themselves internal questions as to why the block is there, what alternative is untenable, and how the mother otherwise might develop.

There is suppressed grief where the person keeps their grief in secrecy, but fully conscious, distraught, and has their weeping times when alone, and their breakdowns on anniversaries or special days.

Pathological grief is related to other forms of damage because it frequently decompensates as defences are inadequate and the psychiatric disorders such as Major Depression, Dysthymia and Panic supervene. Pathological Grief is almost universal among these mothers and underlies the other issues of damage discussed below.

2. Personality damage associated with defences.

The defensive style: whether it is alert avoidance of anybody who might take one of their

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

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

This is quite a different condition from 2/ above. Here the issues are guilt, shame and secrecy. These elements become fixed as part of the personality which arrested in development. This is also the original mother who puts a veto on her lost child contacting her. In many cases nobody knows her secret, but in many cases her husband knows, but not her children. She is highly frightened and vulnerable about this and in many cases the children's cousins told them a decade ago, but they know they must not say they know. She is left with the cultural bytes she received twenty years ago and the social attitudes of the time.

Some of these mothers long for a reunion and when it is approaching go into a highly disturbed crisis state and sometimes seek help. Others have made up their mind to live their secret right through, and, when contacted by their lost child, give a frightened `go away' message that is devastating and permanently damaging for the adoptee.

Generally I help them tell their husband and children, and the improvement in their general personality and expression of feelings, their relationship with both adoptee and their own children are enhanced. A woman with residual damage from `shame and guilt culture' is in dire need of help, and has a much better outcome than those people described in 2/ above. However the two states are not mutually exclusive and The Inquiry will hear about some people who show features of both types of damage, This type however respond much better to therapy, encouragement and support, particularly when their family is fairly well functioning. Those with and understanding partner tend to have a very good outcome indeed.

4. Axis 1 Psychiatric Disorder.

General.

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

4.1 Post-traumatic Stress Disorder.

In this disorder the trauma of separation or fearful experience of being emotionally isolated during obstetric trauma is so severe that this experience is imprinted and intrudes into dreams and waking experience in an uncontrollable manner. The experience is so aversive and so reinforced by the repeated intrusion that the young woman becomes hyperalert and vigilant to

anything where a repetition of the circumstance is possible or is threatened. Elaborate avoidance behaviours develop and some may by symbolic or associative. Some of these avoidance behaviours can become secondary psychiatric conditions such as a phobic avoidance of hospitals as an aspect of their PTSD, or very deep seated fears of becoming pregnant again.

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

4.2 Major Depression.

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

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

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

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

4.3 Dissociative Disorder.

This serious disorder takes a number of forms. In essence it occurs when consciousness is so overwhelmed by shock and unbearable feeling that there are splits or discontinuity of consciousness. It is sometimes confused with the serious biological illness - Schizophrenia, but it is distinct and quiet unrelated. It is more related to Multiple Personality Disorder, although the split aspects of consciousness do not have their own identity as in MPD.

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

lost a child suddenly as a result of accident.

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

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

4.4 Panic Disorder.

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

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

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

4.5 Dysthymia

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

4.6 Situational Stress Disorder.

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

5. Personality damage associated with Psychiatric Illness as a sequel to loss of a baby to Adoption.

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

6. Personality Damage associated with long-term Pathological Grief.

This occurs when grief is arrested at one phase, denied, or is characterised by another salient defensive mechanism or, oscillates between two phases depending on how much grief is tolerable according to circumstances and support. These grief behaviours and repeated experiences of feeling become so regular and fixed that they supervene the previous personality to the degree that they become permanent personality characteristics.

Some of these are not adaptive such as irritable preoccupation with particular people who were instrumental in their baby's loss, and others are compulsive, such as vicarious care of those similarly affected. If this is done with some insight it is more adaptive, but often it is persued by projecting their own pain onto the others and having a personal set of solutions which are not necessarily adapted to the needs of others.

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

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

The common theme is that severe and protracted grief has been consistently shown in research to be associated with major poor health outcome. Many thought this was marginal and would be difficult to demonstrate. Maddison, when he was working in Boston, showed it to be of the order of 1000% increase as measured by the General Health Questionnaire; this was repeated by Raphael in New South Wales in the early seventies with similar results.

Depression has also been shown to be similarly correlated and there is a death rate among the depressed that is of a similar order to that from heart disease.

There have been numerous confirmations both of the order and quality of health deterioration after bereavement and the range of disorders involved is wide. Cancer has been one that has been documented, and one principal explanation of that is changes in the immune system. Illnesses such as asthma, peptic ulcer and colitis have all been part of public awareness on being aggravated by stress. This is mediated through stress and the response of the neurones in the hypothalamus that release Corticotrophin Releasing Factor to stimulate the pituitary gland.

There are more obvious links between unresolvable grief via the cigarettes, alcohol, benzodiazepines that are used to modify unbearable feelings and bad health outcomes that are the sequel of these. Eating disorders and dietary problems are common. Similarly both the

depressed and pathologically grieving are vulnerable to risk taking behaviours. This includes driving on the highways and the relationships they will accept. There are other direct connections such as inappropriate avoidance of health management and those responsible for it. Again, research funds are required to study the health of this group.

8. Disorder and Incapacity in Human Relationships.

It is important here to consider the direct links between loss of a baby to adoption and the disorders and incapacity's in relationships.

The first issue to consider is the significant and often abrupt change in self-esteem. Many were shocked when they realised they were to be seen as immoral, unreliable and promiscuous. Some never saw themselves as a mother even well into pregnancy only to acquire a new view of themselves and enjoying it after the baby moved intimately inside them.

But as the adoption promotion rolled over them, the integral part of this was their own unfitness to be a mother and their not deserving to be a mother because of their conceiving outside of social mores. This process was repetitious, many faceted and continually reinforced. In the hospital where they gave birth they were given many messages of being inferior, worthy of contempt and were readily discounted. In this respect the nursing profession were major contributors to their damage in self-esteem.

Many of these young women were not self-assertive; any self-assertiveness remaining was targeted as part of the `focus on consent' campaign. Gone were all the elements of self assertiveness, they were on their own, dependent, made to feel immoral, and also given the false view they were in the wrong, with no rights and legally helpless.

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

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

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

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

It is important to say here that those who have high quality partners who are supportive and

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

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

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

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

I have discussed above the recrudescence of grief during a subsequent pregnancy and confinement and the subsequent bonding failure with the baby. After a while when we found family dysfunction with a mother being depressed and preoccupied, or overprotective with anxiety about losing a child, we knew to gently search for this as a likely antecedent, only to back off if we read acute distress that it might come out.

There are some mothers who themselves had pre-existing mental illness, sometimes constitutional and sometimes as a result of child abuse. The experience of loss of a child always exacerbated their condition and the subsequent relationships they formed. Many of these people were highly confused during the experience and their behaviour became disorganised to being chaotic.

All the relating difficulties as a result of their loss add up to special difficulties when these people come to reunion eighteen to thirty-five years later. I find that their understanding of young men in the eighteenth to thirty-five year age group is clouded by their own experiences, their difficulty in imagining the stages of development their son has gone through and their own fantasy life in which he is still a young child.

They seem to have a much easier time with their daughters if the latter are mature. However daughters who are immature in matters of autonomy, sexuality and dependence create almost insurmountable problems vis a vis becoming empathic with their mother and also her reciprocating. It is warming to find the girl friends and young wives of the young adoptees, sometimes creating a special understanding and accepting of the mother who lost their partner as a baby.

9. Educational Failure and poor Employment Status.

While the Inquiry will hear from some mothers who went back to their school after their confinement only to be turned away and rejected, more usual were those who went back to their studies, but were preoccupied, lacked concentration, could not find meaning in their studies or have motivation to organise them to an educational goal. We know they were grieving unsuccessfully and often depressed. Examinations are difficult under such circumstances. Single minded study is even more difficult.

Fortunately there were many more jobs around twenty-five years ago. Most of them were unskilled, but provided a regular income. There were thoughts of going back to study and achieve some of the goals they had before, but this was easier considered then achieved. It is interesting that in their forties some of them are able to go back to late secondary and early tertiary education.

The cultural myth was, "Having a young baby would destroy their life and education. Adoption will leave them free to continue it. " I know a few who got back to their education usually after some years, but only a tiny minority whose studies were not set back significantly if not totally.

Some of the mothers you will hear from are highly intelligent. Among those who come to the Inquiry they will probably be over represented. Research conducted on their occupations and income, and then compared with women of the same age would answer clearly whether their education and employment prospects were damaged. If a random sample of relinquishing mothers' were taken for such research an even greater disadvantage might be demonstrated.

10. Failure of Bonding with Subsequent Babies.

This subject has been introduced earlier in the submission.

In summary the subsequent pregnancy rekindles the grief and distress around the loss of the first baby. Post-traumatic stress phenomena, and the anguish of pining regret and anger often retroflexed against the self for not being able to fight harder becomes a major theme. Thoughts and feelings are intrusive and preoccupation is compulsive.

It is difficult to see the new baby through all this. It is difficult to remain with feelings about now, whether it be distress at feeding problems or joyful pride in the new born

Later there is anguish at every milestone of the next child as the sense of missing the lost baby is hard to suppress and conjecture, often idealised, is continually in mind.

There is often intolerance of normal development difficulties in the new baby, sensitivity to others wanting to take him over. I have on numerous occasions heard of major anxiety in mothers that their mother or mother-in-law wants their new baby or even their sister wants them after some brief help while they are sick. They are not able to use family day care mothers and often opt for more impersonal and less satisfactory creches for child minding. If they must use a carer, they are highly anxious about any attachment of the baby to the carer, and will suddenly change to the detriment of the baby.

Without being paranoid in the psychotic sense, they are highly alert to any complaint that might be made about them to D.O.C.S or any other authority, and are highly anxious if any Family

Law Court issue might threaten their continuing care. They have conscious fears and many dreams about losing their child in various manners.

On the other hand their blocked feelings of grief come out on their child who is usually imperfect compared with the child lost to adoption. Sometimes they are harsh and use emotionally incontinent checking measurers. Then they become shamed and guilt ridden at what they have done. It is during these times they seek help from Child Health services or private doctors, but in many cases just present the surface of the problem without telling of the real issues.

Definitive Action.

Public Declaration of Significant Findings.

This needs to be a public account of major and common effects of past adoption practices, specifically addressing the power and coercion applied and the helplessness of those who lost their baby.

A special version of this should be published and focused at adoptees, particularly to disabuse them of the myths that the public have held about their mothers, and indicating the abuse, coercion and damage their mothers had to bear.

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

Public Education about the difficulties faced by adoptive parents and how little preparation there was for this role or how little the help available. This should also include issues of grieving sterility, ongoing and hidden low self-esteem, and the protracted effects of the insecurity created by raising another woman's child. There were recurrent problems in dealing with special difficulties of the adoptive relationship at each stage of development and subsequent testing behaviour by the adoptee.

Many wouldn't recognise that over compliance with adult wishes was a sign of false self development and personality damage. But the type of help they were getting was platitudes, untested cultural myths and did not address their real difficulties. However, some did well to become a secure family; all the more congratulations to them to have done this despite the difficulties.

Any help to insecure adoptive families to come to terms with these factors will help a mother with reunion.

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

Remedial Therapy for Personality Damage and Psychiatric Illness.

There are a wide range of requirements. Some need to be involved in groups run by their peers or receive counselling from the peers who have some professional counselling training. Others need counselling from professionals who are not associated with adoption apologists. The

financing of this will need support.

At present the Victim's counselling service keeps proper control of counselling requirements for victims including a report to assess the need for counselling and agreement to finance a counselling contract. While there is some intrusion into privacy by this method, it is a responsible way to channel public money to provide essential help for those to whom it is overdue.

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

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

Help with Reunion.

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

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

Problems Contingent on the Adoptive Family.

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

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

Such secure adoptive families are far outweighed in numbers by each of the other two groups.

Both may contain adoptive parents with personality disorder or psychiatric illness.

In one of these the adoption has been such a negative experience or the adoptive family so disintegrated, that the adoptee has long separated and gone his or her own way in life, sometimes in trouble, sometimes dead from suicide or drug overdose, sometimes married early, sometimes working in a far off place.

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

Those who do not tell the adoptee at all are a sub-group of the above, but I have only struck four over the last fifteen years. People like to talk about this one because it is one small aspect of adoption information which is well known and many have previously thought about it. It creates its own special problems, but in my experience this situation makes up less than 1% of adoptive families and seems to gather a huge amount of attention that distracts from the pressing problems of the other 99 point something percent of people in distress.

But I will say that the culture has long known this to be a dangerous situation, and the disaster comes as the cousins or others tell the adoptee in primary school years and the whole secret is carried on in a disintegrating charade. I know of one case where the adoptive parents were successful in hiding the information for 25 years or so, with highly distressing consequences for the `relinquishing mother' and giving the adoptee a totally false facade to her life. I am aware the the Inquiry might hear about this instance directly.

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

It is `a very hard ask'.

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

To train counsellors for this role, needs a group of special people who can be moderately objective, aware of the anguish entailed and able to negotiate with highly insecure adoptive families. In the interim time before open adoption/fostering arrangements become universal, it is important to introduce adoptive children to their biological parents at a younger age and not

wait until all the myths and prejudices are formed into hard defences.

Latter Day Apologist Organizations.

I see women who have been to contact organisations who offer to assist in reunion where original mothers are trained to approach the adoptive family and say they just want to be their child's friend, or "like a sister", that they can never replace their child's `true parents' in the child's life, and generally behave in a self-effacing obsequious manner, and only relate to their adult child in a manner that meets the adoptive family's approval.

These organisations often use the term `birth mother' which some say, "Well, at least they are saying we are some sort of mother. " But others are humiliated and wounded by this term as it is a contradistinction implying that they are mother by virtue of giving birth only. These original mothers say it is an imposed name and is inherently untruthful--there are no other terms like this such as `birth brother' or `birth family'. It is a reminder, they say, of their humiliation and is there to maintain their diminished status.

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

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

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

Anglo-Saxon Culture and Heredity.

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

In such a culture it is important to know what is `good blood' and `bad blood'. How temperament in dogs is a pivotal issue above colour or face, which animals are resistant to disease, which ones to weakness or stunting of growth. In whatever manner such a culture sees the same issues in humans, and however regrettable some of the ethical issues that arise from such deeper cultural fantasy, it is still a major issue because, while horses race at Randwick,

footballer's sons repeat their father's glory, and brothers play in the New South Wales eleven, it does not leave the centre of the cultural stage.

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

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

Accountability.

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

Those with Pathological Grief arrested around irresolvable anger at humiliation, repugnant neglect of their needs and even smug abuse: they need to have some idea of how it happened and know the faces of those who organised the taking of their children. In 1997 I gave the paper: Adoption Grief: Irresolvable Aspects. The grief is irresolvable for a number of reasons, but certainly one of them pivots on this issue of accountability.

Without such identification and while public ignorance then and now about the abuse committed on them still exists, these woman live in an Orwellian world where `doublethink' is everyday. How can they resolve their grief while the public is taken in by the apologists' myths, rationalisations and excuses.

Sophistry.

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

and help me keep my baby."

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

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

Recompense.

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

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

They also want as satisfactory reunion as they can manage.

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

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

These are:

To provide widespread knowledge of why The Statute of Limitations was virtually impossible for these women to comply with. Many were so damaged with Pathological Grief, Dissociative Disorder and Depression that it was the last thing they could think of. Many others were developing hard shelled defences against their feelings, and others were retreating under a shell of secrecy driven by shame and guilt. Few had any sophistication about the law.

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

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

Consideration should be given for an Act to be introduced to Parliament to clarify the set of circumstances in which these women were abused, and to take account of the wide variety of offences that were committed against them in such a way that the legal process would be seen to be fair by them and the general public.

Such an Act could by-pass a lot of lengthy and costly legal process which hardly any of these women can afford, and even specify, like the Acts for Workmen's recompense, or motor vehicle accident recompense, a scale of damages they might receive depending upon the degree of damage, thereby making the whole process relatively uncomplicated.

Other Funds Required.

Legal aid damage cases with merit.

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

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

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

Because of the extensive evidence required in the sections A, B & C of Questions 6 and the difficulty in knowing which areas of this question will be required in 45 minutes: the answers to the other questions have been put in writing over the weekend.

By Dr. G.A. Rickarby MB BS FRANZCP Member of The Faculty of Child Psychiatry RANZCP MANZAP: Consultant Psychiatrist.

Opening Statement.

When I first heard of the distress and illness in the lives of women who had lost a child to adoption, I thought the problems were unusual. Throughout the decades following I found I continually underestimated the severity of their distress and the widespread gravity of their disrupted and blighted lives. There are tens of thousands so damaged, and I consider the cruel and unnatural treatment of these women by their fellows to be of such extent and seriousness that it has only been surpassed by the treatment received by our indigenous people.

I would also say that while practices associated with drugging, threats of police and physical separation catch the attention and imagination, that the great bulk of damage was due to the `mind-bending' techniques by those in power that shaped the mother's view of herself, her

entitlements and ability to fight for her own and her child's obvious rights.

Questions.

1. *What is your current occupation and experience?*

   My Current Occupation is twofold. I am a Consultant Psychiatrist in Private Practice at Lake Macquarie, and I am a Part-time Psychiatrist Member of The Mental Health Tribunal which is under the administration of the NSW Department of Health.

   I am involved in the latter on Tuesdays and Wednesdays mostly. In my private practice I confine my paediatric psychiatry to autistic disorders and assessment and consultation for children who are potentially taking action in Court as a result of abuse, assault or bereavement.

   I also practice as a psychotherapist. It is in this context that I see mothers who have lost a child to adoption, although I have done assessments in preparation for litigation for these women also; three of which have been completed. (One was for action in another State).

2. *What was the experience in counselling mothers who have experienced distress as a result of past adoption practices?*

   This began in general practice in Victoria where I had counselled five women and one man in the early to mid sixties.

   In psychiatry practice in Victoria, London and at Rydalmere Hospital NSW, including the Fairfield community, between 1968 and 1976, I saw women who had previously lost a baby to adoption, and I realised in the mid-seventies that I had probably missed this information about many of them, as I was mostly only to obtain this information as I inquired about it. Many of these were out-patients and not In-patients, and commonly they had Pathological Grief which decompensated into Major Depression, or their life and family relationships were disturbed by their long term grief.

   When I returned to Child Psychiatry in1976, while most of my work was with adoptees and adoptive families, I saw a steady number of original mothers whose distress was affecting their families. Much of this was due to the spreading effects of their depression, or post-traumatic phenomena related to their fear of losing another child.

   A child Psychiatrist covering a wide area consults with numerous other professionals with problems and management dilemmas. Covering the Inner Western Suburbs of Sydney, The Hunter Region, Orange and the Far West, I was frequently consulting with other professionals who carried these cases without ever seeing the patient.

   This led to me consulting with the Association of Relinquishing Mothers (A.R.M.S.), Offering supportive opinion, and some consultation: also assisting with submissions. This continued until this was stopped by a Gosford C.E.C..

   On my retirement in 1989, I was able to see original mothers at my practice, however

because of my other duties I was unable to see a large number; however, many write to me or telephone me from other states (except Northern Territory) and I was able to meet many at The Sixth Australian Conference on Adoption at Brisbane in 1997.

Particularly in legal cases, but also in others, I have studied in detail Photostats of their records from hospitals including the conduct of their labours and medication given to them. I have read at least a dozen of these, and have copies of at least five. I also know women from other contexts who are original mothers. In all I have seen some hundreds of original mothers over thirty-five years, and have consulted about or been contacted by as many more.

Unfortunately I have had to refuse to see many in the last two or three years for reasons of time and health. I have eight in long term psychotherapy, two of them on a weekly basis.

Unfortunately, some of the more severely affected do not readily come forward, because this requires some core mental health and strong motivation.

3. *What was the psychological state of a woman considering the option of adoption, particularly in the period 0-7 days after giving birth?*

   Without drugs, this is an extraordinary crisis time in a woman's life. Frequently it is a time of multiple crisis with concomitant factors such as Caesarean Section, breast and bladder distress, and worry about babies condition. It is a time of crises in relationships: the woman's mother and male partner being essential people to meet her needs has been shown vividly in outcome research. It is a time of rapid change in the body with profound hormonal charges as the body switches from support of the placental circulation to lactation. These changes are associated with emotional liability and vulnerability. The community as a whole is and has been aware of the acute sensitivity of this time in a woman's development.

   Add to this the woman's helplessness, separation from significant others, being subject to repeated coercive suggestion, indoctrination and humiliation, and then to have the baby she knows so well inside her, taken from her by team work that is frankly conspiratorial, she would be in no state to rationally oppose or resist what `respected' and powerful older woman were wanting her to do. The notion of `informed consent' under such circumstances is unfit. The features of informed consent: `capacity', `volition' and `information' were at their lowest point.

   Add to this, the use of the drugs as outlined in 4. Below, the mother's state was one without will, confused and helpless: and this should have been obvious even to the omnipotent and ignorant. The intent of those who brought young women to this state and sought consent from them to give up their guardianship of their own child is one object of this inquiry. Considering the mothers were meant to be cared for by these people, their conduct can only be described as treachery.

   Certainly The Act and its intentions were treated in such a manner that `contempt' is too weak a term to express their attitude to it.

4. *What was the impact of any of these drugs on a person's capacity to make decisions*

regarding consent?

This is essentially a continuation of 3. above.

I am aware from the records I hold that a series of potent mind-altering drugs were given to many of these women. The worst abuses of drug administration I know of were at Crown Street.

The commonly used drugs:

- Pentobarbital Sodium
- Pentobarbitone
- Sodium Amytal
- Amylobarbitone
- Chloral Hydrate
- Valium (diazepam)
- Largactil (chlorpromazine)
- Stilboestrol

The first four drugs were barbiturates. They are depressant hypnotic drugs with a general effect on the brain, causing sedation, clouding of consciousness, a stuporose state and forced unconsciousness in higher dosage.

The Sodium version of each was to render the drug soluble to enable injection with rapid onset of effect. They were well known to have been used elsewhere in the world in political circumstances for interrogation or other uses. I have also reviewed Chelmsford files and Dr. Harry Bailey used all four to achieve so called `Deep Sleep' in that hospital.

Some of my patients also had them given antenatally - one patient extensively during weeks before the baby's birth. They cross the placenta to the foetus and are known to be highly dangerous to the baby, causing respiratory depression and hypothermia in the new-born.

In the 1990s they are virtually obsolete, but still valued by a small minority of drug addicts.

Pentobarbitone and Sodium Pentobarbitone were routinely used on selected mothers during the first week after the baby's birth in Crown Street.

Chloral Hydrate. This drug is a small inorganic molecule with an effect very similar to alcohol but is highly sedative and can induce unconsciousness. It is well known when mixed with alcohol: this combination is the legendary "Mickey Finn".

Valium (diazepam). This benzodiazepine drug is an anxiolytic and muscle relaxant. It particularly works on the part of the brain subject to emotional modification of behaviours and has an effect breaking the connection between feeling and cognitive states. It was often given on the morning of expected consent taking.

Largactil (Chlorpromazine). This wide acting tranquillising drug had many effects

including the potentiation of other drugs and general inhibition of emotional responses.

Stilboestrol. This synthetic oestrogen compound was injected intramuscularly and given orally to selected original mothers from 1965 until well into the seventies. The first injection was usually given in the Labour Ward or shortly thereafter and continued in vigorous doses throughout the first week. Its intent was to dry up milk.

Because of its association with causing cancer in later life and for other reasons it is obsolete. There was already serious doubts about its safety at the time it was being used.

Ethinyl Oestradiol, the naturally occurring hormone was available in the Sixties but was more expensive. The administration of this drug was given without any knowledge by the mother of what it was for or what it might do - there was never a hint of consent. It is prima facie evidence that conspiracy to abduct the baby was well underway many days before consent was sought.

I am able to advise you that the use of all of these drugs other than Stilboestrol: in the case of barbiturates, even forty-eight hours before consent taking: would compromise the capacity of any person to make decisions regarding consent.

5. *What was the psychological impact of women being given advice to "start life afresh" and that "they would soon get over " the loss of their baby and the experience of the loss?*

The experience of the mothers who lost a child to adoption is so polarised towards *the inability to continue with their life* and to *almost universal Pathological Grief* that simplistic advice of this ilk is fatuous. Remembering such advice makes them angry, but worse, they have feelings of hopelessness that what they went through at the time and their present plight will not be recognised by society and that their life as broken by the loss will not be validated.

It is a provocation that makes their depression more likely, their personality defences more rigid and their life more isolated, many of them believing they are the only ones who are grieving and who didn't start life "afresh".

One salient issue in this respect is the continued control of adoption resources centres, reunion organisations, and other public services for original mothers by `professionals' who push views of this type, indeed the views that were current in the Sixties and Seventies, and are sometimes staffed by the same people who colluded in taking their babies.

In hearing the experiences of mothers and particularly in studying the literature of these agencies, there is a continuation of patronisation, invalidation and also a wide-ranging insensitivity to mothers' grief and psychiatric morbidity due to adoption, and the distress and despair in their life situation.

Issues and practices carried on by them in 1998 which are untenable to mothers are:

a. The inability of these `professionals' to take any responsibility for the plight of the mothers, to show by any word, empathic gesture or sympathy that their

actions as a group caused any distress or damage to mother, baby or adoptive family, or that they were doing anything illegal or unethical.

b. Taking mothers into situations as part of a group without any assessment of their grief status, distress, personality or psychiatric disorders.
c. In group situations, requiring mothers to conform to attitudes, transactions with others, and styles of thinking about adoption, without any sensitivity to the mothers' position or to crises in their feelings brought up by the professionals, adoptees, and adoptive parents, let alone the aggravation of post-traumatic stress phenomena and depression as a result of these group contacts. These organisations have `a party line' which is against the interests of original mothers becoming validated or healed.
d. The use of suggestion to control them which is a thinly veiled repetition of what was done to them originally.
e. Crass paternalism from woman to woman - and only the mothers notice. The less damaged laugh.
f. An underlying ignorance about the damage these woman experience. It is not just that social-workers are not able to assess the psychiatric syndromes or are ignorant in this area, but that they are dabbling in an area of illness for which they are totally untrained. They ignore research about the nature of grief and the connection of Pathological Grief to breakdown in Mental Health which has been known for decades. Their unawareness of their own ignorance when dealing with the severely damaged is like taking lighted tapers into a gunpowder storage. Their use of groups when a distressed person requires extensive individual assessment and debriefing is destructive.

It is for these reasons that I called for these organisations to be disbanded or unfunded in my written submission. In my view they should be replaced by services organised by a committee of original mothers with advisers from The Dept. Of Health in both the fiscal and health management areas.

What is The Nature of Post Traumatic Stress Syndrome? (In DSMIV it is Post Traumatic Stress Disorder: and frequently abbreviated thus: PTSD)

A. There are a series of elements: A major trauma (death, threat of death, disaster, loss, horror); the compulsive intrusion of the trauma into both waking consciousness and dreams, with fixation of memory onto specific elements of the trauma; major avoidance of situations, circumstances or people associated with the original trauma; major dysfunction and disability as a result.

   It is a central issue for mothers who have lost a child to adoption because it is related to some of the other diagnoses and damage I have listed in my written submission.

If elements of the experience are overwhelming, untenable or unbearable, breakdown to Major Depression occurs.

Or, If the trauma is totally overwhelming, dissociative defences, can occur leading to the

far more serious Dissociative Disorder.

The defensive mechanisms against the Disorder can leave the personality damaged by detachment, thick skinned defences, or those that are distrusting, withdrawn, agoraphobic, anxious or obsessive.

In the mother's case it is to be noted that PTSD is hardly ever existing on its own but in association with Severe Pathological Grief in one form or another. Pathological Grief is a condition that is also overwhelming, untenable and unbearable, and itself causes breakdown into Major Depression and the other conditions listed above. *Pathological Grief may cause more psychopathology in the long run because it may become worse in later years because of its renewal with the stage of development of the lost child or at changes in the life stages of the mother.*

However PTSD may also take a chronic form in the mother's life and this was particularly noted among those women who presented to Child Psychiatry Services.

There would be a hyperalertness to separation from a later child (among those eleven out of twenty who were to have another child) sometimes precipitated by a strong sense of the child being in danger, a Family Law crisis, a grandmother or even the mother of a school friend alienating the child's affections, even minor illness.

Another form would be a fear and hyperalertness about hospitals described in my main written submission.

This could create a major crisis when another fear was about losing the child because of sickness or accident.

Reading the newspaper or seeing other media coverage about adoption issues or loss of children can easily set off post-traumatic images of the original loss and the circumstances.

Being alone in a vulnerable situation (even a supermarket) can produce a return of overwhelming helplessness of the original experience in the maternity hospital. Anniversaries of admission and birth, can cause intrusion of painful and traumatic images. Frightening dreams of a post-traumatic nature can occur decades later, sometimes precipitated by an event such as described, but often occurring during a fever or brought back by a drug effect from preparations bought over the pharmacy counter.

B. The other disorders described in my main written submission all occur, some of them much more commonly than PTSD. Many women have gross disorders without having any PTSD. In order of frequency:

- Pathological Grief.
- Personality damage of the four types discussed in my written submission.

- Major Depression.
- Dysthymia
- Post-Traumatic stress disorder.
- Dissociative Disorder.
- Panic Disorder.

c. *How common are Post Traumatic Stress Syndrome and other disorders as a result of past adoption practices?*

Research is needed on these topics.

Among the group that go to peer support groups, Pathological Grief, and recurrent Major Depression are almost universal, Dissociative Disorder and PTSD also occur.

Of the more severe group who do not come forward but are sometimes `found', there are a mixture of three or four diagnoses with major personal failure.

Of the group who use Child Psychiatric Services, PTSD is most common.

Of the group who have difficulty accepting contact with adoptee's, personality damage associated with shame, guilt and secrecy is most common, and there is evidence from the networks of mothers that this group is very common, but many accept help to have reunion. From this source also is the indication that the group with major defences damaging to personality (often associated with Dysthymia) is also common.

What are the measures that might assist people experiencing distress as a result of past adoption practices?

Many of these mothers are `just hanging on'. they see the Inquiry as the one chance that their position, their circumstances and their broken lives and feelings can be understood by the community at large and particularly by their children. There is a strong feeling that if this is not achieved in this Inquiry there will be no other opportunity. They also require their powerlessness and their sense of betrayal by other women understood.

In many instances The Inquiries' findings per se will assist them significantly.

Some mothers want justice. The identification of illegal unethical and damaging practices will serve much of this. The identification of those responsible for flaunting The Act from a leadership position will also serve this and be a guideline for Civil action in unequivocal instances.

However, with one class of exception, I do not think criminal proceedings or other recriminating action is necessary or desirable provided the other issues above are addressed, as I think there will be a widespread beneficial change in the whole group when many of the facts and their implications are public. The class of exception: a large number of mothers are aware of histories of people who took part in taking their babies

who themselves benefited by receiving a baby to adopt. This question needs to be looked at carefully because the mothers specifically need answers in this matter. If there are found to be those who took a leadership position in the illegal taking of babies, with damage to the mother, and also benefited themselves by receiving a baby or babies from this system to adopt, it will be important for the mothers to see such a person prosecuted criminally as the law provides.

In my main written submission I consider the nature of public education about The Inquiry's findings; I go on to consider the needs of mothers for individual counselling or therapy. I consider the type of counselling to assist with reunion to be of a specialised quality and sometimes of a different nature than remedial counselling, although in some instances much remedial work is needed before reunion is tenable.

I would emphasise the requirement for all counsellors to be approved by a committee largely consisting of original mothers. Wherever an original mother could train for this role or train others; it would by highly desirable.

Within the Department of Community Services much incompetence has arisen from the Department's policy of demanding officers carry out generalist duties; whenever they have picked the trained and sensitive for these duties their service has improved; however, consent takers of the sixties and seventies often ignored the Act, the lack of capability of giving consent, distress, or even blatant expressions in the negative, let alone ambivalence about decisions. Because most of the remedial issues are Health issues and outside the Department of Community Services range of expertise, it would be better administered by the Dept. Of Health with some input from Psychiatry.

In general, people with qualifications in clinical psychology or psychiatric nursing should also be considered when staff working in adoption are being recruited.

Please see my main written submission for further issues.

Because of the reasons given at the beginning of 7, I consider that an apology from Government Departments of today would be a drop in the bucket and on its own would have a negative effect. It would be seen as blatant tokenism. I would not advise it.

However from those who conducted Adoption Agencies and institutions for the pregnant single woman I think a comprehensive, humble and sensitive apology, particularly from the two religious organisations most commonly identified for their inhumane treatment of thousands of young women would have a significant beneficial effect.

Dr. G.A. Rickarby