A DEPICTION OF A

BIRTHMOTHER'S EXPERIENCE

OF RELINQUISHMENT

-A HEURISTIC INQUIRY

Submitted by

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1.0 INTRODUCTION

○ *1.1 Background to the Study*

Inspiration to pursue this research was gained from a case study which I undertook between 1993-1994, in the self-as-therapist mode. My experience as a birthmother was indwelled in some depth via the creative arts of dance, visual art, music, poetry and metaphor. A heightened knowledge of self resulted from successive indwellings on a number of depictions of the recurring themes which had pervaded my thoughts during the intervening years since the relinquishment of my only child. After the story of this lived experience unfolded in a rich and varied reservoir of art work and text, it was evident from a literature search, that aspects of my birthmother's experience of post natal relinquishment bore close resemblance to case studies relating to post traumatic experience, maternal loss and morbid grief. (Brodzinsky 1990: Condon 1986: Rynearson 1981: Silverman 1981: Winkler and van Keppel 1984)

The major assumption underlying my own case study, adapted from Shainberg (1983) was that healing would be possible in creative arts therapy if, through a process of holistic change, a birthmother could discard her entrenched veil of pretence, enhance her self knowledge and awareness, and lessen her preocc-upations with compulsive thoughts and feelings pertaining to relinquishment. A further aim was to pursue a phenomenological approach to bereavement, to take the existential view that in times of crisis, heightened awareness can bring about a positive shift in the human condition. (Kessler 1987)

This current research has drawn on the intersubjective experiences of two women, the researcher, and the co-researcher, who will be referred to as Zena, who surrendered their first born sons ten years apart, in the 1960s and 1970s respectively, under conditions of closed adoption. The study examines in some depth the lived experience of the younger woman Zena, regarding the relinquishment of her surviving twin son, twenty one years before the commencement of the study, when she was fourteen years old. When I contacted Zena via an advertisement at the local neighbourhood house, an easy rapport developed between us as we exchanged stories about relinquishment while for the first time sharing memories with another relinquishing mother. This initial contact established a degree of trust and confidence which reassured us regarding the worthwhile nature and viability of the project.
Zena was made fully aware of the planned process which aimed to document her lived experience of relinquishment via creative arts therapies. She understood via informed

consent that she could withdraw from the project at any time. She was also made aware that the interviews and creative arts procedures would most likely evoke painful memories which may or may not lead to therapeutic outcomes, and felt prepared for the challenge with a positive determination. It was understood from the outset that the central purpose for meeting, sharing experiences, engaging in artistic expression and discussing meanings, was to focus attention on the birthmother's experience of relinquishment, and to arrive at a distillation of her experience via words and painted images.

○ *1.2 Definitions*

a) The term *relinquishment* has a finality about it which has haunted me without any diminishing intensity, for more than thirty years. Derived from the French *relinquir* and the Latin *relinquere*, its meaning "to leave behind" was fully understood by the relinquishing mother, who on deciding to give up her child, was then legally bound to surrender or renounce her parental rights. She was then expected to let go her maternal instincts and to release any bonds of motherhood that might tie her to the child already intended for adoption.

What I was not counselled about or could not control were the unforseen and over-whelming maternal instincts, which presented as longings to know about the welfare and whereabouts of my son, with the ever present dream of eventual reunion. I could not and would not let go and continued to harbour thoughts which relived the painful circumstances of my relinquishment.

b) The term *birthmother* is used throughout the literature in preference to "natural" mother or "real" mother and for the major part of this project, the term refers to the woman who relinquished her child in a legalised process of closed adoption. Some comparative reference will be made to birthmothers who have more recently surrendered children under open adoption procedures.

c) The term *indwelling* is referred to by Moustakas (1990a) as the heuristic process of turning inward to seek a deeper, more extended comprehension of a particular human experience.

d) The term *member checks* is used in relation to the phenomenological or heuristic interview, where as a form of validation, the researcher checks with the co-researcher regarding verification of data and meanings.

○ *1.3 Need for the Study*

The literature reviewed here has revealed that significant numbers of birth-mothers were coming to the attention of social workers, medical practitioners, psychiatrists and psychotherapists with emotional disorders which could be traced back to the trauma of their relinquishment experience. Very little specialised help in the form of therapy has been available to birthmothers who have felt poorly understood by health and welfare personnel.

According to Stiffler (1991), their plight has been grossly under represented in the triad of adoption literature, with greater attention being paid to adoptees and adoptive parents. Stiffler estimates that only five per cent of adoption related materials have dealt with the birthmothers' lived experience of loss and grief. Since literature searches in 1994 and 1996 failed to uncover any study which linked creative arts therapies with relinquishing mothers, this study has been designed to open up new avenues of approach in understanding, and depicting the felt experience of relinquishment, via the creative arts.

○ *1.4 Limitations*

a) At the outset it was recognized that a single case study could not be used to generalize about the felt experience of all birthmothers who relinquished under closed adoption circumstances.

b) The possibility also existed that the single subject would not provide rich enough material to obtain a dense description of the subject's relinquishment experience.

c) It was also possible that the intense pain accompanying recall of events surrounding the relinquishment, might cause the subject to withdraw from the study, or distance herself from the material to allow for a period of recovery.

d) It was considered unlikely that strict timelines or tight program plans could be adhered to and therefore an emergent design was built into the methodology.

e) It would be necessary for the researcher to put to one side the clinically derived symptomatic material which pervaded the literature on birthmothers, in order to approach Zena's unique experience in an open manner.

● 2.0 LITERATURE REVIEW

Literature reviews during the period 1993-1994 did not reveal any post positivist studies having been undertaken with birthmothers about their experience of relinquishment. Nor were there any examples from the creative arts perspective with this sub group of women. Therefore I turned to the available literature on research with birthmothers which was in the positivist medical model, mainly undertaken in clinical conditions or via surveys.

○ *2.1 Theories about Grief and Mourning*

I have placed research about the birthmothers' sense of grief and loss in context, by firstly discussing literature about normal stages of grief and mourning, followed by pathological variants to grief. Although this material is often written from an instinctual and biological perspective, some attention has been paid to a phenomenological and existential analysis of the subjective feeling state of grief. (Smith 1975) I have selected much of this material for discussion on the basis of my journey towards self knowledge, while searching for meaning regarding my own lived experiences of grief and loss.

● 2.1.1 The Normal Mourning Process.

I had become aware that my profound experience of relinquishment was more prolonged than the normal mourning process as outlined by Bowlby (1982) and Parkes (1972). They had identified numerous stages in the long term mourning process which needed to be worked through before the experience of loss could be contemplated without pain. These stages were referred to as numbness involving a sense of loss, yearning involving a degree of anger, disorganization characterised by feelings of despair and reorganization ending in closure. The difference in my case was the lack of closure and a sense that these stages were still present for the relinquishment experience (see 2.2.3), long after closure had occurred following the more recent death of my parents.

According to Worden (1982), manifestations of normal grief can be categ-orised under the headings of feelings, cognitions and behaviours.

a) Feelings experienced during normal grief include sadness, anger and blame directed outwardly at significant others and inwardly at the self. This is often followed by a sense of guilt and agonizing self reproach, anxiety and panic attacks, loneliness, fatigue, helplessness, shock, numbness, which is thought to be a protective mechanism, and yearning during the search phase.

b) In regard to cognitions, it has been found that if the following selected thought patterns persist, they can lead to depression or anxiety. They include confused thought, difficulty in concentrating, pre-occupation, rumination and a sense of presence. Worden (1982) cited the findings of Dorpat (1973) who contended that depression could be regarded as a defence against mourning.

c) Behaviours involved in grief patterns include sleep and appetite disturbances, absent mindedness, social withdrawal, avoidance of reminders, searching and calling out, sighing and crying, restless overactivity, visiting special places and carrying or keeping remembrance objects.

My experiences supported the work of Bowlby (1982) and Parkes (1972) who indicated that a number of stages in the normal grieving process need to be traversed before mourning is complete. These include:

i) acceptance of the reality of the loss
ii) experiencing pain and grief
iii) adjustment to changed status
iv) detachment, withdrawal, reinvestment in new beginnings and closure.

My experience of closed adoption had in fact prepared me for all these stages except closure.

- **2.1.2 Pathological Variants to Grief**

Since intense grief still accompanied my experience of relinquishment, I turned to various authors for insights into reasons why closure had not occurred. According to Schultz (1978), morbid grief reactions differ only in intensity and duration from normal grief responses, but because these reactions tend to be internalized, the individuals concerned are susceptible to psycho-somatic disorders with resultant long term physiological harm. Millen and Roll (1985) used Parkes' (1972) study to identify factors which might delay or suppress grief. They found that these determinants have particular relevance for the sub group of relinquishing mothers who may experience this entire syndrome due to the following cluster of circumstances:

a) the loss was socially stigmatized and therefore accompanied by shame, guilt and loss of self esteem
b) external events prevented the expression of feelings of loss
c) there was uncertainty about the reality of the loss
d) normal expected mourning was absent and unacknowledged
e) mourning rituals were lacking (p.417).

Worden (1982) discussed the condition of prolonged grief as "a separation conflict leading to the incompletion of one of the tasks of grieving". He also identified grief that was "masked as somatic or behavioural symptoms", where the person is "unaware that unresolved grief is the reason behind their symptoms"(p.65). These points affected me very profoundly, setting me on a path of discovery to resolve my prolonged grief via creative arts therapies.

○ *2.2 Relinquishment within the Adoption Process*

This section examines a number of studies which suggest that closed adoption practices, which have led to intense suffering amongst relinquishing mothers, need to be modified to allow a process of open access to occur. However there continues to be controversy, as more recent studies (Blanton and Deschner 1990: Lancette and McLure 1990) seem to suggest that the intensity of grief may be heightened rather than lessened by open access conditions.

The study by Blanton and Deschner (1990), involved a questionnaire sent to a large group of teenage birthmothers only six months after relinquishment under open access conditions. Results from the Grief Experience Inventory, were compared to two other groups of mothers, the recently bereaved and birth-mothers who surrendered under closed adoption legislation. The findings unexpectedly revealed that relinquishing mothers display more grief symptoms than bereaved parents particularly under open access conditions. Birthmothers using open adoption experienced more social isolation, physical symptoms, despair, dependency and difficulty with daily physical functioning than women who relinquished under closed conditions (p. 532). Blanton and Deschner (1990) concluded that there was more interference in the grieving process thereby delaying the onset of closure (p.535).

A smaller qualitative study, by Lancette and McLure (1990), found that birthmothers who surrendered under open legislation still suffered extreme grief reactions, they still missed the recognition provided by mourning rituals, and an additional factor emerged concerning their perception of lost dreams and fantasies surrounding motherhood.

- **2.2.1 Social pressures to relinquish**

Although our relinquishments occurred ten years apart, Zena and I shared many similar circumstances and lived experiences as birthmothers and were aware that with de facto marriages, single parenthood and lesbian relationships being more commonplace in the 1990s, it would be difficult for today's youth to envisage a time when raising a child alone was considered to be both socially unconventional and morally undesirable. Winkler and Van Keppel (1984) put our experience into perspective by painting a vivid picture of Melbourne middle class society prior to the mid 1970's where "the social climate which was hostile toward sexual activity outside of marriage", reserved a heavy censure of shame and guilt against unmarried mothers who "had transgressed society's norms about sexual behaviour" (p.9).

According to Rynearson (1982) the most common response was therefore to deny the pregnancy, and this "conspiracy of silence" was bolstered by the persuasive opinions of social workers, adoption agencies and families who wanted the matter cleanly settled, tidily put aside and forgotten. Young women, therefore, did not seek medical confirmation of their condition until relatively late in their pregnancy, when they had "started to show". They then left home or were hidden away in back rooms living isolated lives for fear that detection would bring shame to their families and loss of career and marital prospects to themselves.

Society condoned this deception with false hospital records, conniving hospital almoners, altered birth certificates, closed adoption records, and an official attitude from the medical and social work community that it was best for the birthmother to forget the incident as quickly as possible and make a new start in life. It was assumed that since the young mother had proven herself to be fertile, sometimes after the one experience, she would go on to marry, have more children, and forget the birth of her first born child. Brodzinsky (1990) showed conclusively that this was a fallacious assumption that needed to be corrected in future clinical practice in order to achieve better post surrender adjustment via full acknowledgement of the birthmother's loss.

The overriding assumption in favour of closed adoption continued to be the strongly held altruistic belief that it was best for the child if the unwed natural mother relinquished her baby to a worthy, married, but childless couple who were deemed better able to raise the child (Rynearson 1982: 339). The young woman was then expected to close her mind on the incident forever or be deemed to have made a "poor adjustment".

Field's (1992) study concerning psychological adjustment of relinquishing mothers recorded the New Zealand respondents as "feeling little or no choice about giving up their children for adoption" (p.235). He concluded that the women in his study, who had relinquished twenty to forty years ago, were overwhelmed "by feelings of lack of control and lack of social support at a time of great personal distress" (p.241).

Condon (1986) found that although the decision to relinquish was construed by society as "voluntary", the women in his small Australian study felt that relinquishment was their only option, citing reasons of financial hardship, family pressure, social stigma and lack of emotional support (p.117). Millen and Roll (1985) undertook a study with women who were presenting for psychotherapy. They also concluded that because of the stigma associated with illegitimacy and the prevailing attitudes and opinions which pointed to the undesirability of a single woman raising a child alone, these relinquishing mothers chose adoption "for the sake of their child's well-being" (p.412).

These clinical studies gave me a number of avenues to pursue in the process of self knowing regarding the complex issue of understanding my own decision to relinquish.

● 2.2.2 Birthmothers' Post Traumatic Stress

Literature within a positivist medical model, reviewed for this paper has confirmed that the experience of relinquishing a child in young adulthood, in a process of confidential adoption, when the woman is often at her most fertile prime time, has left a high proportion of birth mothers with a complex "general chronic psychological disability", manifesting itself via psychosomatic symptoms (Condon 1986). These may include feelings of low self esteem (Field 1992); dependent personality disorder and a "discordant dilemma of separation and loss" (Rynearson 1982); selective memory loss, "depression, alienation, physical complaints with no biological basis, sexual difficulties and difficulty in making commitments" (Millen and Roll 1985: 411).

Rynearson (1982) claimed that relinquishment was such a "fundamentally disjunctive event" that it could lead to abiding feelings of sadness, leaving the birth mother with a condition referred to by Condon (1986) as long term or morbid, unresolved grief, presenting as psychological trauma or "pathological grief reactions which have failed to resolve" since the pregnancy (p.117).

These overwhelming clinical findings confirmed to me that I was not alone in my prolonged grief and that another birthmother might also gain insights from experiencing creative arts therapies in a heuristic framework.

● 2.2.3 Grief Patterns of Relinquishing Mothers

The ensuing discussion follows the general stages in the grieving process as delineated by Parkes (1972) and Bowlby (1982), and applies them to birth-mothers as they are depicted in the literature. This account may well have been subtitled - the author's experience, especially in regard to what Stiffler (1991) terms the ongoing, non linear nature of the grieving process which may be initially slight but take several decades to surface.

a) Realization

The realization stage is characterised by shock and numbness. Both Rynearson (1982) and Field (1992) reported that the last trimester of pregnancy for relinquishing mothers was characteristically a time of intense loneliness, with no help being available of an emotional kind. Winkler and Van Keppel (1984) revealed that at the delivery, the mother was actively discouraged from forming a relationship with the child as a separate person from herself, and that the majority of mothers were not permitted to see or touch the baby at any stage. Furthermore, Rynearson (1982) postulated that the:

> feelings of numbness and dissociation during hospitalization and a virtual absence of mourning were directly associated with the administration of general anaesthesia and deliberate policy of post-partem isolation of the mother from her child. (p.339)

In addition, both Condon (1986) and Winkler and Van Keppel (1984) drew attention to the negative moralistic attitudes displayed by some medical and nursing staff towards single mothers at a stressful time when they were without any supportive emotional network. Millen and Roll (1985) pointed to the irony of these denial strategies which at the time of delivery and surrender were intended to convey the reassuring message "that the experience was then over". However the woman, whose

motherhood continued long after the papers were signed, carried the pain and anguish of this experience for the rest of her life. She invariably remained unaware that her psychosomatic symptoms, stress related illnesses and deep seated pain and tension were related to the sense of loss and unresolved grief experienced at the time of her first pregnancy.

b) Denial

The denial stage begins with the initial experience of loss at delivery and relinquishment. It is characterized by a lack of overt reaction and a degree of disbelief, which is manifested in the birth mother as a state of denial. According to Parkes (1972), the progress from denial of loss to acceptance may be permanently blocked through fantasy. This notion has been researched by Lacette and McLure (1992), who found that the birthmothers' unfinished grieving was blocked by an overwhelming sense of lost dreams and fantasies related to the potential roles of mother and grandmother.

According to Rynearson (1982), in his study of psychiatric patients who had relinquished a child, the adoption solution for unwanted pregnancy had the aim of returning the prodigal daughters to their families where they would quickly restablish "their former, non maternal identities." However, what Rynearson (1982) called "persistent internal signals of their repressed maternity", kept surfacing in an environment which was totally hostile to any processing of the experience. He reported that all the women felt "involuntary curiosity when seeing a stranger with a small baby" (p.339). Both Rynearson (1982) and Condon (1986) referred to the fact that the relinquishing mother was quite likely to develop immature defences of denial, fantasy and repression, and to withold open expression of feelings. Winkler et al (1988) suggested that all counselling intake interviews should include a question relating to adoption experience in order to rapidly identify a possible underlying cause of stress.

c) Mourning

The mourning stage after loss as defined by Bowlby (1982), will normally last from 6-12 months, and may contain symptoms such as anger, disbelief and a tendency to search for the lost person in hope of reunion (p.672). Rynearson (1982) referred to the mourning of the relinquishing mother being complicated by the continued existence of the child, who was growing and developing "while remaining inaccessible" to her (Condon 1986). The child is "lost to the mother but still lives" (Winkler and Van Keppel 1984). Condon (1986) likened the situation to that of the missing war dead

where relatives are never able to say goodbye with any sense of closure, while there is a possibility that they will return.

d) Yearning and searching

This is undertaken either consciously or unconsciously to locate or envisage the surrendered child. Millen and Roll (1985) maintained that these "impulses are not irrational and further may not be futile", as the mothers "know that their child is alive and that the possibility of future contact may be more than a fantasy" (p.414). As previously observed, these fantasies may intrude to interfere with the realization process in grief. According to Kirkley-Best and Kellner (1982) in regard to neo-natal death, parents who do not see or hold their baby may have particular difficulty in the phase of yearning and searching, since there is no clear picture of the baby's presence (p.422). They further reported the "almost unanimous agreement" in the literature "that seeing and holding the infant is helpful in successful grief resolution."

These observations had particular relevance for me since, like other birthmothers of the period who were surrendering under confidential closed adoption procedures, I was anaesthetized at the moment of birth to prevent me from seeing the child or forming a potential bond through touch. When I awoke, all evidence of the birth and after birth had been whisked away and I was left to nurse my stitches in lonely isolation.

The matter of reunion has particular relevance for the birthmother. Both Shawyer (1979) and Rynearson (1982) discussed the recurring vision of reunion, which Rynearson termed a "persistent fantasy of restitution", (p.339) but which in some remarkable cases, including Zena's and my own, has come to fruition as imagined. Deykin (1984) reported that the greater the elapsed time since surrender, the more likelihood that the birthmother would be obsessed by a desire to search, especially if external pressures had been placed on her at the time of relinquishment (p.275).

The literature supported my experience that symptoms of mourning were still being experienced three decades later by those birthmothers who did not work through the grieving process at the time of birth, and that search activity may not only be an attempt to resolve a significant loss, but also a means of achieving restitution of self. (Deykin 1984)

e) Disorganization

The disorganization stage emerges when intense grief gives way to feelings of depression, devaluing of self and apathy. Unresolved grief often presents as anger,

resentfulness and blame directed at an impersonal bureacracy. Feelings of sadness and guilt are directed towards the self (Winkler and Van Keppel 1984: Condon 1986: Rynearson 1982). Feelings commonly accompanying this phase are anger, reproach, guilt, despair, depression and somatic stress, commonly grouped together as a state of disorganization.

At this time, the relinquishing mother should have been receiving intensive counselling to assist her in developing appropriate coping skills. Millen and Roll (1985) reported the expressed feelings of respondents as "pieces of a person", "a haunting shadow of sadness", "gnawing feeling in my abdomen", being "broken or damaged in some undefinable way," and the definitive statement that "I sometimes feel I will never be complete!" (p.416).

f) Reorientation

The reorientation phase may be permanently delayed in cases where societal support for the grief process is lacking, the loss remains unacknowledged, and where severe problems which prevent reorganization may instead lead to "pathologic variants of grief" (Kirkley-Best and Kellner 1982: 422). Silverman (1981) demonstrates that the birthmother who gives the appearance of functioning well may without warning succumb to feelings of intense sadness or be overwhelmed by painful abiding memories. This is also consistent with normal mourning among recently bereaved persons, as I too had experienced after parental loss.

- **2.2.4 Summary of Pathological Grief Variants for Birthmothers**

Millen and Roll (1985) drew attention to the birthmother's situation, via parallels with the grief literature, defining it as a distorted and delayed grief process. Winkler and Van Keppel (1984) identified numerous stressors which were present in the single woman's life during the period before and after the birth of her child. Those factors consistent with my experience included:

a) the circumstances surrounding the pregnancy
b) the persuasive pressures to relinquish the child
c) relocation away from home
d) reduced income and exploitation through menial labour
e) family embarassment, ostracism, pressures to marry and legitimise the child
f) loneliness, isolation from friends and confidantes
g) lack of a support system network (p.26).

Given the above, it is not surprising that Raphael (1975), in Winkler and Van Keppel (1984), found that the relinquishment process was characterised by multiple stressors for the mother including inhibited, suppressed or absent grief, grief distorted by extreme anger or guilt and a state of chronic ill health. Antonovsky (1979) in Winkler and Van Keppel (1984) concluded that such a stressful life event had upset the woman's homeostasis and would need extensive restoration work to assist with coping behaviours (p.11). Condon's study (1986), found a pattern of unresolved grief, characterised by chronic emotional disability, severe and disabling grief reactions, including depression, psychosomatic illness and retention. In some cases there was intensification over time, of feelings of sadness, anger and guilt. Deykin et al (1984) spoke also for myself when they concluded that grief over a surrendered child appears to remain undimmed with time and that the relinquishment process was generally perceived as having a protracted negative influence on the respondents' self esteem and life functioning.

- **2.2.5 Post Relinquishment Grief Therapy**

Strategies described by Kirkley-Best and Kellner (1982) for early intervention with parents of stillborn babies, would appear to be equally suited to relinquishing mothers. Preventative grief therapy would ensure that the mother would be:
a) encouraged to fully express her sense of loss
b) permitted to see, touch, hold, and breastfeed her baby
c) allowed to leave hospital with a photo of her child and other momentos to confirm her motherhood status i.e. that the event took place.

Condon's (1986) findings led to the view that the intense grief experienced by relinquishing mothers could have been arrested in the early stages if the women had been permitted to acquire non identifying information, enabling them to establish a living image of their child and to resolve some of the ruminating associated with their grief.

Studies undertaken in the 1990s (Blanton and Deschner 1990: Cushman et al 1993: Lancette and McLure 1990: Stiffler 1991) confirm that these measures have now been widely accepted in the process of open adoption. However it is also clear that the birthmother's hopes and expectations about access information regarding her child's progress, are frequently under realized due to changes initiated by the adoptive parents. This is clearly a stressful matter which is perceived by the birthmother as a betrayal of trust (Cushman et al 1993).

- **2.2.6 Reunion as therapy**

Field's (1992) study reported that despite "feelings of uncertainty, unworthiness and guilt about renewing contact", the birthmothers' innate striving to obtain non identifying information ensured that they gained higher scores on self esteem and wellbeing. Reunion itself considerably enhanced the mothers' psychological adjustment with the sharing of biological and familial information which had previously been denied to both parties. Shawyer (1979) argued, that the relinquishing mother's grief would be unresolvable until she achieved a reunion with her child. However Silverman's (1988) study of hundreds of reunited adoptees and their birthmothers recognised reunion as a healing process but as just one resolution to the potential problem that birthmothers would continue to grieve and may in fact take their grief to the grave.

- **2.2.7 Preparation for self disclosure**

As women prepare for reunion, they are faced with the potential dilemmas of disclosure. Kempler (1987) cautioned regarding "the risks and potential negative consequences of uncritical self-disclosure". He referred to the balancing effect of the relief felt on revealing a "closely guarded secret", with subsequent feelings of regret and "anxiety over too much exposure". He noted a considered opinion that the "clear feeling of consciously choosing to disclose or not to disclose" heightened the person's sense of "mature separateness, independence, and personal responsibility" (p.111).

○ *2.3 Post traumatic experience and creative arts therapies*

This section will discuss literature which mostly moves away from the positivist medical stance and discussions of relinquishment, into creative arts studies which deal with the experience of unlocking long held psychological trauma. The literature has been drawn from the disciplines of Psychotherapy and Arts in Therapy. Studies in these two disciplines have been scanned for their content and methodology relating to therapeutic intervention in cases of women being treated for chronic or morbid grief syndromes and long held psychological trauma, because no studies were found in literature searches from 1993-1996 linking any of the creative arts therapies with the target group of relinquishing mothers.

Johnson (1987) advocates the creative arts to gain access to traumatic memories which are often recalled photographically as dramatic flashbacks with highly visual and strong sensorimotor qualities (p.9). He discusses the place of creative arts therapies in alleviating the effects of psychological trauma, and identifies a syndrome, familiar to that described above for relinquishing mothers, in which "profound denial alternates with uncontrollable intrusion of the traumatic events". This occurs through "nightmares, flashbacks, hallucinations, and unconscious reenactments of the trauma" (p.7).

Johnson (1987) maintains that an individual copes with psychological trauma by "a basic splitting or dissociation of self" from anxiety provoking thoughts, leading to "an overall reduction in the person's ability to attach words to feelings, symbolize, and fantasize" (p.7). He presents a convincing case to support the use of the creative arts therapies "as diagnostic and psychotherapeutic tools for victims of psychological trauma", whereby access can be gained to painful memories through non verbal means, allowing the individual to work at "integrating the split off parts of the self" (p.12). His paper supports a number of "cognitive, developmental and psychodynamic reasons" for employing art therapy to tap into long held psychological trauma (p.13). Johnson's (1987) description of treatment of psychological trauma victims is divided into three distinct phases:

a) Gain safe and controlled access to traumatic memories, which neuro-psychologists maintain have been recorded as wholes, like photographs, and are recalled exactly the same each time from the more primitive visually based memory. Overcome denial or amnesia re the events.

b) Utilize the strong sensorimotor qualities of the trauma, to work through it in depth, in order to acknowledge, examine, conceptualize and transform the experience into one which rarely intrudes and can be recalled without debilitating intensity. Emphasis should be placed on visual and kinaesthetic aspects in preference to verbal and discursive forms of processing, which may lead to rapid closure.

c) Gain access to other similar victims of trauma for mutual support in order to alleviate feelings of isolation and alienation and to encourage a sense of forgiveness (p.9).

These three points provided an important backdrop to the emergent design for the project with Zena.

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