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# Illegitimacy, Adoption, and Physicians

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This year in the United States approximately 265,000 illegitimate babies, 6 per cent of all live births, will be born. They will represent all social and economical levels and affect at least a million persons — the unmarried mother and her parents, the putative father and his parents, and the friends of one or both of them. In addition, they will involve countless social workers, physicians, lawyers, clergymen, and nurses. Illegitimate births are no measure of the number of illegitimate conceptions — those of married women during periods of separation from husbands, and those terminating in abortions and miscarriages. Illegitimate birth rates, even though the rate of births out-of-wedlock among adolescents has not increased in recent years, do not indicate in adolescents the annual prenuptial conceptions and the pregnancies ending in late fetal death. Nor do the data represent the innumerable covered-up and get - out - of - town cases.

Like most social problems a discussion of illegitimacy evokes an infinite variety of comments — from stern disapproval to moralistic sermons on the rot of welfare; and from nonconstructive pity to vigorous mandates for crash programs to provide anticonceptive measures to the unwed female teenagers and adults. In this respect no single cause, or set of factors, leads to illegitimacy. Nonetheless, as a social calamity, it challenges anyone sensitive to the influence and the effects of social, cultural, and economic phenomena on the social illnesses of a community. Responsible proposals for the prevention and management of social illnesses are seldom effective if they are ignored and denied, or surrounded with secrecy, moralistic generalizations, and taboo-like attitudes. In part, similar attitudes once prevailed toward communicable diseases, cancer, and nutritional disabilities. No person alone, or one group, can curb illnesses that require the knowledge and experience of innumerable professional persons. Hence, in order to understand illegitimacy and to decrease it (to help persons in trouble is not to be confused with condoning what has been done), it is essential to draw on the wisdom and ideas of persons not only in the social and behavorial sciences but also in medicine, religion, education, and law.

Most persons, including some physicians, tend to believe that

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neither illegitimacy nor its aftermath represents, or causes, any particular problem: most babies born out-of-wedlock simply are put up for adoption and innumerable infertile and childless couples are eagerly ready to adopt them. But this is not the case. Illegitimacy not only is associated with health, economical, psychological, and educational handicaps; it tends also to create and propagate mental and social distress. Suicidal thoughts and attempts, as well as attempts to cause or to procure abortion, are not uncommon. With regard to medical care, fewer unmarried women than married women receive regular prenatal care; it often is haphazard and late in pregnancy. The neonatal and infant death rates of illegitimate births are twice as great as legitimate births. The mental and physical development of babies born of very young mothers often is unfavorable. Adoption, generally regarded as the best practice for unmarried mothers, is available only to relatively few illegitimate babies. Indeed only 30 per cent are placed for adoption: approximately 70 per cent of the white babies are adopted; up to 95 per cent of non-white babies are *not* adopted.

One shudders about what finally happens to the '70-per cent' babies not put up for adoption (and perhaps even to some that are), for very little is known about the homes in which some of the children are reared. Some mothers eventually marry the putative father. Some are adopted by stepfathers after the mother's marriage. Some are reared by grandparents, who may still be relatively young, or [illegible]latives and friends. Some are [illegible]cted. Some are abandoned to [illegible]gers. Some are disabled by seri[illegible]hysical and mental handicaps. S[illegible] are known to the courts as del[illegible]nts. Some spend their life in [illegible]nstitutional existence. Some are [illegible]ed from one temporary foster ho[illegible] to another. Some are placed as [illegible]si-adoptives in long-term foster [illegible]nes without legal consummation [illegible]g effected.

The intangible cos[illegible]f illegitimacy are immeasurabl[illegible] Most babies and children are dep[illegible]d of a home and family life, and [illegible]the interest, affection, and the [illegible]achment of parents. The social [illegible]blems of babies and children n[illegible] individually faring well in emo[illegible]al, mental, and physical develop[illegible]nt often become the problems o[illegible]dults and in turn the problems c[illegible]ommunities. It is not possible t[illegible]stimate the actual cost finally p[illegible] Nevertheless, it should be po[illegible]ed out that such costs are not p[illegible]arily borne by Aid To Families W[illegible] Dependent Children (AFDC). I[illegible] most states, over 90 per cent of u[illegible]arried mothers with illegimate ch[illegible]dren are not recipients of AFDC. [illegible]erhaps more should be. The purp[illegible]se of AFDC is to help preserve an[illegible] maintain the family structure. At th[illegible] present time, it fails to meet even [illegible]he minimum physical needs for food, clothing, and housing of children and mothers qualified to receive it. Regardless, AFDC is the pet hate of avowed welfare critics. Yet, if AFDC were sufficiently adequate to help educate, guide, and train its young recipients in the educational and vocational employment fields, it would, over a



period of time, not only increase their chances for social and educational improvement but also decrease the number of persons on welfare. Obviously the problems are difficult, but there is no evidence that AFDC subsidizes and perpetuates career unmarried mothers, or that it increases out-of-wedlock babies. Nor is there any documentation for the obsessive notion that tries to link unmarried mothers and illegitimate babies, as well as immorality and lazy dependency, to AFDC.

Not long ago unmarried mothers were made to keep their babies as a daily reminder of their wrong-doing and sense of guilt. In another time both were put to death. Harsh penalties for pregnancy out-of-wedlock tend to bring not social and moral reform but the kind of miserable friendless l i v i n g that often is passed in a community to the next generation, and to the next. Physicians can help immeasurably in improving attitudes toward unmarried mothers and illegitimate babies: they are in key positions to impart to them a course towards useful, long-range goals.

Complex pressures surround illegitimacy. Indeed, they also surround adoption. Each situation poses questions about the physician's role — where it begins and where it stops. The physician is not an adoption agent. He has the conventional role of providing obstetrical care for the mother and medical and preventive health care for the baby, as well as deciding if the baby is suitable for adoption. He is held responsible also for a mother's physical and mental health care. Thus there often is need for close cooperation between the physician and a skilled social worker, and the early utilization and support of an accredited adoption agency. It is easy for a physician to assume the authoritative role of an intermediary who places babies. It is easy to bow to the temptation and the forcible urgings of friends, lawyers, relatives, and clergymen to be drawn into privately arranged adoptions. It is tempting to want to locate an adopting home for a baby, or to find a baby for an adopting couple. Each case must be acted upon individually because one tries to respect the feelings of persons who desire to deal confidentially with a physician rather than an agency. One also respects the desirability for the early placement of babies. Yet, these are not sufficient reasons to disregard the very purpose of adoption, which is to protect the legal and natural rights, indeed the basic needs, of a baby or child, and to enhance so far as possible an attachment of love and fidelity, and of psychological identity between it and the adopting parents.

Approximately half the adoption placements in the United States are made by independent unlicensed intermediaries, and half by licensed agencies. Most private intermediaries — physicians, lawyers, and clergymen — mean well, but, due either to inexperience or to bias towards agencies, (as well as to failure to understand that successful adoption requires careful planning and special knowledge) are associated with more unhappy and unsuccessful adoptions than agencies. A

licensed adoption does not imply an attempt to make the perfect anthropological match; it does mean 1) accepting full responsibility for a baby; 2) coordinating and centralizing the study and test data; and 3) providing clearcut advantages not only to the baby but also to the natural mother and the adopting couple. For the baby it means medical and hospital care, as needed, and the advice of experts in genetics, human development, and social anthropology. It means temporary foster care. It means a social casework evaluation of the natural mother and the adopting couple. It means being responsible for a baby not later adoptable. Agency adoption is far less risky for a prospective adopting couple in case the natural mother changes her mind about having her baby adopted. In order to surrender a baby to an adoption agency for placement, the mother must legally and completely separate herself from her baby. Empowered by law, the agency effectively blocks the natural mother regaining custody of her child, thereby preventing for adopting couples the chance of heartbreak and the ever-present risk of blackmail. Agency policies also protect children from being reared in legal and non-entity limboes with no right to their own names nor to guardianships and inheritances.

Heretofore, strong feelings about adoption agencies have often caused adopting couples, as well as physicians, lawyers, and others to resort to independent adoptions. Adopting couples unhappy at extraordinary delays in agency evalutions and adoption procedures, or disturbed at being rejected by one or more agencies, have even resorted to purchasing "boot-leg" babies. By and large most agencies have not had enough babies to equal the number of adoptive applications. The ratio of adopting couples to every adoptable baby has been approximately ten to one, but in recent years the number of couples applying for adoption through agencies has greatly decreased. Thus in most adoption agencies the "waiting time" has been greatly decreased; it even now is approximately six months. Adopting practices vary from community to community, and from state to state, in accordance with state laws. Therefore, in order to advise and guide adopting couples correctly and to reorganize and respect the best interests of the baby and the unmarried mother, as well as the rights and limitations of a minor, and the putative father, it is well to consult a key agency in the community, or the welfare department of the state.

Fortunately the *aggiornamento* in agencies is towards more and more placement not just of one baby or child with a couple, but often of two or more. Indeed, the size of an adopting family is being determined more and more not by rigid agency policy but by the ability of adopting parents to care for children. The often arbitrary rule regarding the maximal age of adopting couples in many instances is being lowered. Fewer agencies adhere to the outmoded requirement of requiring adopting couples to prove their infertility. Agencies, limiting applications to a restricted geographic area because of statutory differences between states and countries, are now able in some instances to extend their boundaries and cooperate with agencies out of state.

With fewer roadblocks to licensed adoption, physicians consulted by childless couples can confidentially foster and support adoptions through agencies. This depends on the availability of community and area agencies and of the adequacy of a community's medical facilities. It also depends on the physician's own attitudes toward unmarried mothers and on his understanding of the kind of phenomena that have altered her social and psychological life. It depends greatly on whether he thinks his role is to help and guide, or to admonish, censor, and disapprove. Finally one must distinguish between one's own personal feelings and what may be best for an unmarried mother and the putative father and their baby.

Adoption practices may be different from those 25 years ago but the purpose of adoption remains unchanged — to provide a baby, or a child, a home in which to belong. Indeed the whole future of the child, as well as of the natural mother and putative father, may depend on how well this philosophy is effected. In this connection, unwed parents often need constructive understanding and assistance. Although it is assumed that adoption is the best practice, it should not be assumed that every unmarried mother should surrender her baby for adoption. Nor should it be assumed that she and the putative father no longer have natural rights and privileges. No unmarried mother should be arbitrarily coerced into signing a release, that she *must* give up her baby in adoption. Nor, on the other hand, should she be pressured to keep her baby. The decision to adopt, or to keep, must always remain the prerogative and the choice of the mother, and whenever possible, of the father. On her own, or on their own, with guidance and counsel, she needs time to consider a solution and to make a choice.

Even though an unmarried mother places her baby for adoption, should she not have the right (which is one of the fundamental rights of motherhood) to see her baby, and to hold and nurse it? Should the putative father also have the right to see his baby, and to visit its mother? The rigid denial of these rights has no logical basis. Yet, it is not uncommon for physicians, or for hospitals, not to allow a mother planning to surrender her baby for adoption, to see it and to hold it. Failure to respect a mother's wishes, or even to insist against her wishes that she must see her baby, is cruel. Any practice that is coercive and degrading, or that denies her right to legal counsel and confidentiality, is the very kind of practice that will require legal measures to protect an individual's personal and civil rights and, perhaps, forbid all unlicensed adoptions. Such practices, whether by lawyers, hospital administrators, social workers, physicians and nursing supervisors, are punitive by those whose role is to help. Motherhood, however brief in these instances, is the natural result of pregnancy, labor, and delivery. The viewpoint forbidding mothers to

see their babies, or forcing them to do so, or forbidding fathers to see their babies, is untenable. In this connection the young father of an out-of-wedlock baby has distinct problems not unlike those of the young mother. That he may later deny ever having been the father of a baby and live in nagging guilt and self-retribution, and not succeed as a human being either in marriage and parenthood, or outside it, often depends on our attitudes toward him. How unmarried parents are handled can make the difference between a miserable inadequate adjustment and a healthy positive one whether in their family, in school, on a job, or in later normal parenthood and marriage.

Most married couples do not anticipate being childless. Nor do they anticipate having to share parenthood with another couple and relying on an intermediary to acquire their child. Although childlessness creates problems that challenge the best professional persons in adoption work, it is well to realize that not all childless couples want children nor do all want to adopt. Some adults are not suited to parenthood. But many succumb to the pressures of friends and relatives to acquire children through adoption. Others are moved to adopt by misguided sentimentality, or out of the grief of the death of one of their own, or by neurotic and selfish motives. Adoption is not a therapeutic measure. It is not a solution to the emotional problems of couples faced with sterility; nor is it the solution to the loss of a child; nor to psychiatric problems and precarious marital states. Therefore, although neither adoption agencies nor physicians are infallible, the motives for adoption should be studied carefully.

In the evaluation of the prospective adopting couple the determination of factors of stability and maturity is not easy. Good neighborhood reputation and community standing, along with good health and average economical prospects, are positive attributes. Yet, these may not reveal the quality of a couple's marital life and adjustment, nor their capacities as individual persons. Thus, any assessment of attitudes and feelings requires the consideration and understanding of professional persons whose primary interest is to provide what is optimum for individual children and adopting couples.

In this regard physicians supporting the high standards essential in adoption practices have an obligation to support the need in agencies for more professional workers, and adequate agency resources. It does not mean mere social service and guidance, nor mere sentiment and charity. It means a long hard look at indifference, ignorance, and poverty — things inimical to healthy family and community life — and focusing on vocation, jobs, education, health services, and family life programs.

It is not likely that society will ever be without illegitimacy, or some of the insoluble problems associated with adoption. It also is unlikely that it will discard the fundamental concepts of the family and home. Physicians dedicated to the long-range well-being of children can render significant service to individual agencies, and indeed to community efforts, by helping to increase the adoption and foster-home care of children generally "hard-to-place": the older children, the non-white children, and the physically and mentally handicapped. Although the adoption of children with mental and physical disabilities is still likely to be regarded by some as repulsive, an increasing number of couples with support and guidance from physicians and social workers are willing to take these children. Such couples must truthfully know the facts of a child's disability. The home should be advantageous and beneficial to the child even when it is not likely that he will improve, or recover from his handicap.

This is the kind of humanity that dictates a deep interest in some of the problems related to illegitimacy and adoption. It reaffirms a concern for human beings who have struggles and hardships in a society of which all of us are a part. The course of a community, however, is inextricably bound up with the philosophy of concern we professional people have for the ills of the community and how they are acknowledged and faced.

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