Universal Responses to Abortion? Attachment, Trauma, and Grief Responses in Women Following Abortion

Author: Speckhard, Anne; Mufel, Natalia

Publication info: Journal of Prenatal & Perinatal Psychology & Health 18. 1 (Fall 2003): 3-37.

Abstract: None available.

Full Text: Headnote ABSTRACT: Twenty-six million legal abortions occur each year worldwide. Of these an unknown percentage of women have adverse psychological sequelae. This article reports on interviews with a nonrandom sample of fifty women regarding reproductive history, abortion experiences and emotional responses in the former Soviet Union country of Belarus, where abortions are often used as a primary form of birth control. Both positive and negative responses were queried but emphasis was on cross-cultural comparisons with western samples regarding posttraumatic sequelae, depression, grief and guilt, and using an objective measure of trauma symptoms, the Impact of Events Scale-Revised (IES-R). Comparisons with existing Western literature allowed the question of: Similar to the cross-cultural concept of posttraumatic stress disorder are their possibly universal responses to abortion as well? As in western samples, attachment and recognition of life during pregnancy were present for many women despite choosing abortion, and eightytwo percent of the sample reported posttraumatic sequelae, which is high. Grief, guilt, dissociation, depression, anxiety and psychosomatic responses were also in common across cultures. The authors conclude that despite disparate circumstances and abortion use, women who have adverse responses are very similar across these two divergent cultures. They call for more research using representative samples to learn what percentage of women are likely to have adverse responses and which variables predict negative responses. Headnote KEY WORDS: PTSD, abortion, attachment, avoidance, grief, guilt, pregnancy decision-making, physicians and abortion, cross-cultural aspects. INTRODUCTION Worldwide there are an estimated twenty six million legal abortions per year (Alan Guttmacher Institute, 1999). While most women fare well after abortion, there are some women for whom abortions involve health or psychosocial consequences. Studies of American women and more recently Russian women have shown that at least small minorities of women opting for abortion suffer psychological consequences. Their symptoms range from short-term mild distress to posttraumatic stress disorders (Bagarozzi, 1994; Barnard, 1990; Butterfield, 1988; Forst, J.G., 1992; Major, et al., 2000; Mufel, 2000b; Ney, 1982; Rue &Speckhard, 1996; Speckhard, 1987; Speckhard &Rue, 1992). Given the huge numbers of women involved, it is of interest to understand the dynamics of post-abortion distress and to untangle why some women do not cope well with abortion and are at times even traumatized by it. Likewise given that in every culture the choice for abortion and its psychosocial consequences are influenced by societal practices, it is of interest to learn if negative psychosocial responses to abortion are different or similar across divergent cultures. The main purpose of this study was to examine women in an Eastern European country (Belarus) in regard to contraceptive attitudes, behaviors and decision-making and psychosocial responses to abortion. Abortion practices in many regions of Eastern Europe and the former Soviet Union differ from the West. Modern contraceptives are less readily available, whereas abortion is widely available, meaning that abortion often becomes de facto the primary form of fertility control. Likewise, the grim economics and housing shortages create a situation in which women who are faced with an unplanned, ill-timed or unhealthy pregnancy find abortion a necessary fact of life. For the purposes of this study, an American and Belarusian psychologist collaborated in an exploratory study of abortion experiences to discover if there are significant differences across cultures or if women react similarly to their abortions even in such divergent social contexts. It was of interest to the researchers to learn if a minority of Belarusian women might experience posttraumatic responses to abortion, similar to that reported in Western clinical studies, or if they would evidence guilt or grief responses

as reported in western samples. Likewise, it was of interest if there would be significant differences in such responses, if they existed. For example, women in the west who are traumatized by their abortions frequently complain of strong religious guilt, whereas in Belarus state-imposed atheism over the seventy decades of Soviet control and the culture's high reliance on abortion as a primary form of fertility control might shape different responses. Likewise, it was of interest to learn if there would be differences in women in Belarus who have totally free access to abortion with very little social condemnation compared to women in the United States who are exposed to anti-abortion rhetoric and at times must walk past anti-abortion protestors to obtain their abortions. The researchers investigated not only posttraumatic responses, but depression, panic, anxiety and other sequelae evidencing distress as well. They wanted to find what factors appeared linked to these responses and if these would bear similarity to Western results. Thus, this study gave the possibility to explore, at a very preliminary and rudimentary level, the question "Are there potentially universal responses in women (which of course occur along a continuum of very broad possibilities), concerning post- abortion distress?" Interestingly with the advent of studying posttraumatic stress disorder, increasingly trauma researchers are finding that many of these concepts of traumatic stress, when they occur, do act as universals describing clinical phenomena across a broad range of cultures. Similarly in this paper we hoped to uncover some of the same, and if there are universal responses that cross cultures, it would give the opportunity to begin to name some of these universals for future large-scale cross-cultural research. In order to make cross-cultural comparisons from this small sample with clinical studies from Western countries, the research interview was constructed using vocabulary and concepts derived from the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders-IV-R (APA, 1994) regarding posttraumatic, depressive, and panic responses. Likewise questions incorporating the potential suffering of grief or guilt responses to the abortion based on western studies were included. The Impact of Events Scale, revised (IES-R), a research instrument commonly used in Western trauma studies, was utilized so that results would be comparable across cultures and even across traumatic events (Weiss &Marmar, 1995). The national abortion rate in Belarus is 40 per 1,000 women of fertility age. This compares to Belgium, the Netherlands, Germany and Switzerland, which have much lower abortion rates, below 10 per 1,000. All other countries of Western Europe and Canada have rates of 10-23 per 1,000, and to America where the abortion rate is 20 per 1,000 for women of fertility age (AGI, 1999; CDC, 2001). Contraceptives in Belarus are difficult to find and not well understood, with many myths in the general and medical population that interfere in their appropriate use. Hence abortion is often over utilized in comparison to contraceptives. EXPLORING POST ABORTION RESPONSES The sample for this study is small and nonrandom, chosen primarily for the purposes of exploring this topic. The sample included fifty women age fifteen to forty-three that had at least one abortion. All of them lived in Minsk, the capital of Belarus, except 2 persons who lived in a nearby small town (4%). The sample was gathered in two ways: (a) women came in response to advertisements in different gynecological clinics and universities, inviting women to be interviewed about their abortion experiences (64%); or (b) they were invited to participate by telephone, based on clinic records of a previous abortion (36%). In all cases the advertisements and invitation was simply to come in to talk about psychological responses following abortion: positive and negative. Of those women invited by telephone, threequarters declined to participate. Also fifty-two percent (n = 26) of women who at first agreed to an interview failed to present at the agreed upon time. When they were telephoned to reschedule appointments, the main reasons given for dropping out were a lack of time, unwillingness to return to the past, and anxiety talking about the experience. Those who refused to participate from the onset were not formally questioned as to why they refused. Those who initially declined may be better adjusted and feel no need to speak about their experiences or they may have similar reasons as those who dropped out. Thus, the study likely over-represents women who were more comfortable speaking about their abortion experience, were looking for someone to talk to about it, had more free time, or could handle their anxiety about returning to this experience. As with all clinical nonrandom samples on this delicate topic, it is impossible to know if they actually represent the larger

population, and are less or more distressed than the population in general. The research began in March and finished in July 2000. The methods of survey were anonymous in-depth interviews conducted by a psychologist including the use of the Impact of Event Scale (IES-R), as an objective measure of PTSD symptoms with additional questions making an assessment of PTSD possible. Translation into Russian was done by Nadegda Tarabrina in Moscow, where she previously used the IES-R in a study with Chernobyl liquidators (Tarabrina et al., 1993). Her version of the IES was translated and back translated and has been used in other prestigious research endeavors in the Russianspeaking world. Only one item (regarding emotional numbness) was found as somewhat problematic for our sample in translation. That was quickly discovered and the same extra explanation in Russian was given for all participants. The time required for the interview and for filling in the questionnaire varied between forty minutes and one and one half-hour. The interview began with a complete sexual history including attitudes, knowledge and behaviors concerning fertility control and dealt with social and psychological factors contributing to the pregnancy and the choice of abortion. The interview was loosely structured, allowing the women to state their experiences in the order they preferred but specific areas of inquiry were covered in each interview. The questions dealt with whether the pregnancy was planned, reactions to the pregnancy by self and significant others, decision-making, earlier pregnancy(ies), physical and emotional responses to the pregnancy and to the procedure, contraceptive behaviors before and after, psychological reactions both positive and negative (i.e., including relief, and increased contraceptive awareness, sadness, post-traumatic responses, grief, guilt, etc.) The IES-R covered posttraumatic stress reactions. Questions were also posed about thoughts before and after the abortion regarding fetal life and if the woman felt any significant sense of attachment during or after her pregnancy. The interviewers were very careful not to suggest responses but to probe gently covering each possibility. In some cases women denied responses in certain categories (for instance, grief) but displayed bodily reactions that contradicted their responses (i.e., began weeping) or displayed defensiveness. In these cases, the interviewers accepted and coded the verbal response at face value, respected the apparent defense and did not probe further, unless it came up again later and the woman was at that time willing to address it. Given that the most distressed women likely declined to participate in the interviews and that defenses were observed but respected in those who were interviewed; the stress evidenced in this sample is likely lower than what was actually present in the population, although without a random sample this is impossible to know. All of the variables other than those coded by the IES-R (e.g., guilt, grief, fetal attachment, etc.) were coded by the interviewers as either absent or present based upon the women's self report, and presence was only considered if the woman reported a significant reaction lasting longer than a month. SAMPLE CHARACTERISTICS General Data Age. The age of the women varied between fifteen to forty-three years with twelve percent in the fifteen to nineteen category (n = 6); twenty-six percent in the twenty to twenty-four category (n = 13); forty-two percent in between the ages of twenty-five to thirty (n = 21); and eighteen percent in between the ages of thirty to forty-three (n = 9). Marital status and children. Sixty percent of the women were married (n = 30) and forty percent were unmarried (n = 20). Forty-six percent were childless (n = 23) and the remaining fifty-four percent (n = 27) in both the unmarried and married status had children, nearly all having only one child, which is usual in Belarus. Religion. Twenty-two percent (n = 11) were non-religious or did not belong to organized religious groups. Some of these professed belief in a higher power. Eight percent (n = 4) were Catholics; seventy percent (n = 35) were Orthodox. The majority of those that professed a religious background were not regular church attendees, or involved in any type of church life but simply stated that their family background as ethnically Catholic or Orthodox. Hence it became apparent in this sample that despite their history of state-mandated atheism and the suppression of religion, many had maintained at least some religious identification. Level of education. Forty percent (n = 20) had university education; twenty six percent (n = 13) were university students; thirty-four percent (n = 17) had secondary education (22% finished secondary college and 1 person was still in secondary education). Number of abortions. Fifty-eight percent (n = 29) had one abortion, eighteen percent (n = 9) had two abortions, twenty-four percent (n = 12) had more than two

abortions (from three to eleven total). Forty percent of the sample had their abortions prior to four weeks gestation with the majority spread through out the first trimester and only a few occurring in the second trimester. We report purely descriptive statistics in this article. Statistical predictors of posttraumatic stress disorder (PTSD) following abortion in a larger sample of Belarusian women are reported elsewhere (Mufel, Speckhard &Sivuha, 2002). Psychological Responses Eighteen percent of the sample (n = 9) had no negative psychological sequel to their abortion experiences at the time of the interview, although five of these stated that they had difficulties earlier which were now resolved. Thirty-two percent of the sample (n = 16) had some problems, but did not meet the objective criteria indicating the possibility of PTSD measured by the IES-R (augmented with additional clinical questions making PTSD assessment possible). Fifty percent (n = 25) met the objective criteria of the IES-R and were also clinically assessed as indicating PTSD. Eleven of these women could even be said to have indicators of severe posttraumatic stress disorder, as their scores were highly elevated (exceeding the cutoffs indicative of PTSD on all axes of the measure). In total, eighty-two percent of the sample (n = 41) had some form of negative psychological sequel. More than sixty percent of the women stated that they would have liked psychological counseling to help them deal with the emotional aspects of their loss and twenty-four percent (n = 12) accepted the offer of psychological treatment following the interviews. Posttraumatic Responses The most frequent symptoms in our sample were of a posttraumatic nature: avoiding thoughts and feelings (96%); depression (78%); guilt reactions (80%); flashback episodes (76%) and distress at exposure to events that resemble some aspects of the abortion (92%). All other symptoms of PTSD occurred in the sample except inability to recall aspects of the abortion. The most rare symptoms were suicidal thoughts and attempts (8%) and self-destructive behavior (10%). The mean scores from the IES-R were 22 for the avoidance subscale (compared to the established cutoff 17 for PTSD); 14 for intrusion (compared to the PTSD cut-off of 16); and 10 for hyperarousal (no established cut-off exists for the hyperarousal scale, Weiss &Marmar, 1995). It can be seen that the scores are quite elevated as the mean participant nearly qualified for possible PTSD according to the IES-R established cutoffs. Table I shows the frequency of PTSD symptoms in the sample and mean scores for the IES-R. Contraceptive Use The women were asked about their reasons for getting pregnant: Forty-four percent (n = 22) reported not using any contraceptives or very inconsistent use of contraceptives when getting pregnant. Others cited failed contraceptive methods, although most of these were using faulty methods such as withdrawal or counting days without full understanding of their fertile times. Forty percent of the sample (n = 20) changed their attitude towards contraception (became more attentive) after their abortion experience.

Table 1
Frequency of PTSD Symptoms in the Sample

Re-experiencing trauma:

- Nightmares/recurrent dreams 32% (n = 16)
- Flashback episodes 76% (n = 38)
- Anniversary reactions 48% (n = 24)
- Distress at exposure to events that resemble some aspect of the abortion 92% (n = 46)

Avoidance/denial:

- Avoiding thoughts or feelings about the abortion 96% (n = 48)
- Avoiding situations/activities that cause thoughts of the abortion 64% (n = 32)
- Inability to recall aspects of the abortion 0% (n = 0, There were however three women who had severe anxiety recalling as well as claims by some that they don't recall, as they became more comfortable with the interviewer they had better recall, some also refused to discuss particularly painful aspects of their abortion experience.)
- Emotional numbing 28% (n = 14)

Increased arousal:

- Sleep difficulties 48% (n = 24)
- Irritability or outbursts of anger 46% (n = 23)
- Difficulty concentrating 34% (n = 17)
- Hypervigilance 38% (n = 19)
- Exaggerated startle response 58% (n = 29)

Associated symptoms:

- Depression, frequent crying, anxiety 78% (n = 39)
- Guilt/inability to forgive self 80% (n = 40)
- Self-destructive behavior 10% (n = 5)
- Suicidal thoughts and attempts 8% (n = 4)
- Sexual dysfunction 24% (n = 12)
- Relationship problems 54% (n = 27)

Impact of Events:

- Avoidance—mean score 22 (compared to PTSD cut-off of 17)
- Intrusion—mean score 14 (compared to PTSD cut-off of 16)
- Hyperarousal—mean score 10 (no established PTSD cut-off)

Decision-Making Eighteen percent of the sample (n = 9) reported coercion for the abortion by their relatives or partners; thirty-eight percent (n = 19) reported that their partners influenced the decision toward abortion, but left the ultimate choice to the women; twenty-four percent (n = 12) made the decision by themselves, sometimes with discussion with the partner, sometimes not; and twenty percent (n = 10) made a joint decision. Fourteen percent (n = 7) of the women reported that they had not wanted to have an abortion, but needed support from their partners to decide against abortion. Sixty percent (n = 30) of the women expressed ambivalence about the decision. Among women who were ambivalent about having the abortion, personal finances, housing conditions and pressure from the partner were significantly more common than among non-ambivalent women. Reasons for Abortion The main reason given for abortion was economics. Sixty-eight percent of the women (n = 34) cited the absence of money or an apartment, being a student, difficulties in life, fears of the future, etc. as their reason for abortion. Fourteen percent (n = 7) stated that they were not ready to be responsible for another life; six percent (n = 3) were married but pregnant by a lover and didn't want to leave their husbands; six percent (n = 3) worried about the effects of heavy drinking or smoking during the early stages of an unplanned pregnancy; four percent (n = 2) aborted what would have been a third child stating that it is impossible to have three children (this belief is due to shortages of housing for larger families and economic stress); and one woman cited dangerous work. (This woman worked long hours in a tattoo saloon with exposure to blood and toxic conditions). Attitude of the Physicians In Belarus, as in many parts of the former Soviet Union and Eastern Europe, abortions are more available and more economical than consistent use of many forms of birth control (such as oral contraceptives). This means that multiple abortions are common and that many women appear for abortions without having taken adequate precautions to prevent unwanted pregnancies, leading to frustration on the part of the medical staff. Thus, even though abortion is not socially condemned and widely available, hostile attitudes sometimes exist among overworked abortion providers. Twenty-six percent (n

= 13) of this sample reported hostile or humiliating attitudes of the physicians toward them during abortion. For instance one woman recalled her physician refusing her anesthesia saying if she was so brave to have sex, she must also be brave for the pain of her having an abortion. (Occasional hostility of this type has been recounted in similar experiences told to the American author by American patients). Six percent (n = 3) said that the nursing assistants were kind, comforting them by holding their hands. Attitude Toward the Procedure Local and or general anesthesia is generally provided to women. Yet all of the women reported that the procedure was unpleasant and physically or emotionally painful for them. Six percent of the sample (n = 3) was so ambivalent at the point of the abortion that they wanted to leave prior to it (one woman actually stood up from the gynecological table, but was cajoled by her husband to return for the abortion). Attitude Toward the Pregnancy Forty percent of the sample aborted prior to four weeks and nearly all of the abortions were within the first trimester. Yet seventy-six percent (n = 38) of the women said that they felt a life was present in the aborted pregnancy, and seventy percent (n - 35) expressed having formed an attachment to this life; hence there was some element of human loss perceived by the women in their abortions. While most were able to distance themselves somewhat from this, sixteen percent (n = 8) of the women referred to the aborted pregnancy as the death of "my child" or "my baby". Relationship Difficulties Two women said that their partner decided to impregnate them against their will, by failing to use withdrawal as promised, but deciding instead to create a pregnancy in hopes of trapping the woman. For these women the abortion was a means of escaping a coercive partner and also a symbolic ridding themselves of their partner's coercive domination. IMPLICATIONS AND DISCUSSION In the present study it was found that when confronted with abortion, both positive and negative feelings occurred. But in this sample the negative emotions were predominant. The profile of responses including depression, anxiety, posttraumatic sequelae, and grief and guilt reactions, is similar to those presented in western studies, although the prevalence in this sample is much higher. Looking at the mean IES-R scores of 14 for intrusion and 22 for avoidance it can be seen that they exceed the diagnostic cutoffs potentially indicative for posttraumatic stress disorder for avoidance (of 17) and are quite near the cut-off (of 16) for intrusion. In an American sample, Pope, Adler, and Tschann (1999), also using the IES, reported in preliminary analysis on an investigation of young women experiencing abortion. Those in the age group of eighteen to twenty-eight, on average, exceeded or nearly exceeded the cutoffs on both avoidance and intrusion of the IES, hence evidencing posttraumatic stress responses as the mean response for that age group. Barnard (1990) used the IES on a follow-back sample of 80 American women three-to-five years after their abortions and found forty-six percent scored in the moderate or above range on the IES, and twenty percent more than exceeded the cutoffs for PTSD. Generally the literature on posttraumatic and negative emotional sequelae following abortion in American clinical samples hover between five and twenty percent but rarely exceed fifty percent as in this sample (Bagarozzi, 1994; Barnard, 1990; Butterfield, 1988; Forst, J.G., 1992; Major et al., 1990; Major et al., 2000; Ney, 1982; Speckhard &Rue, 1992). It could be that in this sample the subjects inadvertently self-selected as a group of highly traumatized women, or that given the lack of contraceptive choices and heavy reliance on abortion as contraceptive back-up, or the high incidence of negative attitudes of physicians and less than optimal clinic settings that Belarusian women are more highly traumatized by their abortion experiences. While comparison of clinically reported responses across cultures is possible as in this study, comparing the actual incidence of post-abortive symptoms is impossible without random representative sampling in both cultures, which at this time still does not exist. Meanings of Pregnancy, Recognition of Life and Attachment Related to PTSD As with all traumas, meaning is a central predictor of how the event will be experienced (Donovan, 1991). Similar to Western samples (Speckhard, 1996) it was found that the women who suffered the most trauma after abortion were those who at some point felt that the abortion involved a human life, often to which many had created some emotional bond. In these cases the abortion was much more traumatic in that it was experienced as a death event on the one hand, and in the second instance as the "death of my child". For those who were traumatized, these meanings were usually present at the time of the abortion,

but for some they came afterwards. When PTSD occurred it was always as a result of subjective meanings on the part of the women that caused the event to be experienced as the death of a human being. Of course those who were not traumatized did not view their abortions in this manner-for them it was a simple, necessary but perhaps unpleasant medical procedure. Some of the women who suffered PTSD went so far as to say they suffered because they had killed their unborn children. In some, but not most, of these cases social discourse and anti-abortion messages contributed to the formation of these internal meanings. In the group of women where the abortion was experienced as the loss of a life, some women suffered guilt as a result, while others stated that they did not feel guilty since they felt they had little choice, but it was nevertheless traumatic and caused them to grieve. Women who had abortions after having had children often stated that it was difficult because after having had a child, they felt an increased recognition of life early in pregnancy and they knew exactly how it feels to be pregnant and the attachment that occurs to the unborn child. This is similar to statements about attachment and loss in pregnancy, made by women in western samples (Bagarozzi, 1994; Barnard, 1990; Leifer, 1980; Speckhard, 1987; Speckhard &Rue, 1993). "The second abortion was most difficult after a child. I know what it is that I abort. Even that early in pregnancy, I began to feel the child in my body and I understood that I am pregnant." The attitude of the physicians can cause or increase negative psychological responses after abortion as well, especially guilt and fear reactions. One woman said her physician chastised her saying, "You must think earlier." This phrase haunted her afterward. Another said her physician warned her that she might lose her ability to bear children, which caused her to worry excessively afterwards. Posttraumatic Responses The following case of "Nica" demonstrates the full picture of a postabortion trauma situation: the decision-making process, the perceptions of pregnancy and the formation of internal meanings that influence psychological problems and the potential for post abortion trauma. Because it is a case of a failed early abortion (prior to four weeks) necessitating another abortion, it demonstrates post-abortion trauma and at the same moment the possibility of absence of any emotional consequences after abortion (i.e., before she discovered a repeat procedure was necessary). The case of Nica, 22-years-old, a university student, single, with no children. "It was an unplanned pregnancy. I was surprised. I have never used contraception. I thought I was infertile. I decided to have an early abortion without any doubt. I felt sad about it, but I didn't feel that there is someone in my body. I knew I had to do it. After my abortion I felt absolutely calm without any discomfort in my soul. But I didn't have menstruation and I had morning sickness. I didn't understand this. I visited the doctor after two months and we made an ultrasound. It was so difficult to get up from the examining table after she said it was a little baby with legs and arms. I can't remember how I returned from her office. I was very upset and I can't be alone in this situation, so I decided to tell my mother. It was awful. She didn't understand how I could sleep with my boyfriend before marriage. I called my boy friend. I told him I need help; but he didn't care. Next, I went to the diagnostic center to be sure that after the first failed abortion everything is okay with the baby, and it was. At that moment I was proud I had a baby. When I crossed the streets I thought, "People, you don't know I have a baby". But I didn't have a job. My mother was against my keeping the baby, because my partner won't help me. We won't be married. I couldn't decide what to do. The doctors gave me two appointments for the abortion. I returned two times from the clinic. The first time, I saw an ad against abortion. The second time when everything was prepared for the abortion, the doctor told me "You are so young, how can you live after this?" I couldn't do it when he said that. But after two weeks more, I lost my strength. I was so tired. I decided to abort. I thought if I do it, Fd be able to stop this situation and forget all. I was like a zombie. My mother went with me to clinic. I had the feeling that I am going to the execution chamber. I had panic, fear, and every moment I wanted to cry. Nobody can understand my emotions. The doctors were hostile to me. All of them were in a bad mood and they shouted at me. When I felt pain during the examination, I told the doctor. He said, "You can make a baby so you must be brave enough for the pain". But the nurse held my hand and was very supportive. I had to stay in the hospital for complications. I didn't think about this baby until I went home and in the atmosphere of home I began to understand everything. I cried in my room for three weeks. I was very

angry toward my mother. I told her to feel guilty that she had pushed me to abort. I wanted to have a baby and my family is the reason for this abortion. I understood between the first and second procedure that I'm a mother and I still couldn't comprehend afterward that I'm not a mother. I began to count the weeks. The birthday of my baby is in March. I was thinking how it would be if I'm pregnant, how when I get large how I would be in the bed, when I went to the public transport I think everyone must give me a place to sit. Now, when I meet with new acquaintances I tell them I have a son and I tell about him, if I don't think I'll meet them again. I choose a lot of things for him, clothes and food. I can't meet with babies. It's too painful. I broke the relationship with my girlfriend who asked me to baby-sit for a few hours with her daughter. I was rude to her. I hide my emotions from mother. I'm very afraid I won't be able to have a baby. Now the doctor tells me everything is okay. Now I talk with my son. I write him letters. I ask him to forgive me, but he doesn't forgive me because it was very painful for him. I have a frequent dream that he is in a pool of blood with broken arms and legs but alive. I also dreamed that I have an eight centimeters plastic doll, like at the ultrasound. Everybody has normal babies and I have such a little one. When will he be strong and big? I cry when I get this dream. I believe in God, but Fm afraid to go to church, everything in church is so clean and right and Fm so dirty and weak." Clearly between the first and second procedure Nica changed all her meanings about the pregnancy and consequently her responses to its loss. At first she is able to abort a "non-being" and have no upset over it. Then when she learns this procedure has failed and her pregnancy is much farther advanced in weeks she feels differently. During the ultrasound her doctor refers to a baby and says it already has arms and legs. She is proud and happy to be pregnant, but unable to find support for carrying to term. With grave reservations and grief she decides to pursue abortion. At this time another doctor questions if she can live with her choice and Nica views an anti-abortion poster that reinforces her doubts about her choice. All of this combines to create a situation in which the abortion is experienced as the death of her child and Nica consequently suffers deep trauma and grief that she likely would not have suffered if the earlier abortion had been successfully completed. It is an interesting depiction of how experience and social discourse create meanings and internal definitions of the abortion experience which in turn heavily influences the course of posttraumatic responses. Re-Experience The triggers to reexperiencing abortion trauma include situations or dates that are reminders of the abortion. In some cases they may even be phrases that were used in that significant situation: We discussed what to do. I cried. He only said everything will be okay. I took that to mean he would support me in this pregnancy, but it meant he would support me through an abortion. I was devastated. He said the same phrase in the clinic after my abortion, when he saw my condition as his responsibility. When I remember him saying that "everything will be okay" and that I thought it meant for my baby, but he thought only of abortion, it makes me hate him. I hate this phrase now and it upsets me every time he says it about anything, our finances, our life, anything. It reminds me that I cannot trust him for everything as I once believed. Re-experience in one case is even triggered by the dates of the journals in library: I work in a library. When I go there I think: during this year I was pregnant, this year the first child was born, this year was my abortion, this year he would have been two years old ... Avoidance Similar to western samples the women traumatized by their abortion experiences tried to avoid feelings and situations that remind them of their abortions. This was highly individualistically defined but for some women included: the clinic where they had the abortion, returning to gynecological exams, avoiding pregnant mothers or young babies, etc. Some women also reported being completely overwhelmed for a period of time and even trying to avoid their own lives. Life became too stressful and hard for them. In these cases they regressed from previous successes and needed a lot of support to gather energy for future life. I couldn't pass my exams, I took one year academic leave. Sometimes the avoidance mechanism was so strong that current symptoms of PTSD did not at first emerge in the interview, especially when the woman was given free reign to structure her story as she wished. These symptoms were only revealed with administration of the IES-R when the women began admitting there was much more to symptoms previously minimized. Also by that time in the interview, sufficient trust had been built and women who had been hiding strong emotional reactions began to open up, often with

tears. Dissociation and Avoidance of Responsibility It is interesting to note how some women avoided responsibility for abortions that later caused them guilt or trauma. Many women recounted that at the time prior to the abortion their pregnancy represented a life to which they had formed an attachment. However, they somehow felt incapable of protecting it, and opted for abortion. Then they were later traumatized by its loss. This appears to be a contradiction until one understands that many of these women used an emotionally dissociative mode in order to carry out the abortion. These women described feeling so frightened and emotionally overwhelmed by the realities of an untimely pregnancy (and often also the lack of social support) that they felt unable to take responsibility for the situation. Instead they went to the abortion as a means of trying to escape an intolerable situation, without fully acknowledging it. However afterwards, and in some cases even during the abortion, the dissociated reality returned and they were faced with the horror of having aborted what to them had been perceived as a living being, even in some cases defined as "my child". This caused deep emotional repercussions. Use of the dissociative defense during, or prior to, abortion has been noted in American samples as well. Elizabeth Karlin, an American abortion provider, reported witnessing women in her practice curl into the fetal position on the gynecological table or speaking in "baby talk" during an abortion (1997). She found this to be an extreme, though nevertheless real, response of women unduly distressed by abortion. Blaming Others When dissociated emotions return, as they generally do, the painfulness of having carried out an action that one regrets, feels guilty about, or which has been experienced as traumatic can be too much to bear. In some cases instead of being able to work through guilt and trauma, the woman lays the blame and responsibility for the abortion on the partner, family or gynecologist as a way of avoiding it altogether. One woman blamed us for her abortion, because we didn't persuade her enough against. Her gynecologists only explained the possible consequences and gave her time to make her decision. But according to her point of view they must stop her. It means to take responsibility for her decision. Yet women who use a dissociative defense to go forward to an abortion, are often troubled by the doctor's role: How can gynecologists take babies' lives? Others feel anger at those who did not offer support to help them follow their convictions or desire to protect the life that they recognized: I can't stand to see the daughter of my sister because we became pregnant at the same time, but my mother told me that I couldn't have two children without a husband. Yet my sister was without a husband also. A frequent scenario in both this and Western samples is that of the partner emotionally distancing himself from the situation, leaving the actual decision to the woman. She also fails to take full responsibility, and requests an abortion while in an emotionally dissociative mode, making a "rational" but cold decision only, which violates her inner convictions. Afterwards, these women are often angry with everyone who did not stop them, the partner and the whole world. It must be said in defense of women who abort under circumstances of extreme stress, and lacking social support, that partners and family members who are coercive or suddenly unsupportive, disappearing when a pregnancy appears, can play a key role in forcing a woman into a state of extreme distress, even into a dissociative state where she is less able to make a responsible decision. Likewise, many women in our sample were not well informed medically about contraceptives and about their abortions and some received hostile reactions from their physicians. While women such as these must face their own actions they also have the right to expect that the medical profession act responsibly toward them, aid them in proper use of contraceptives, aid their decision-making, recognize dissociative modes, and protect them as needed, even protecting their pregnancies in situations of extreme ambivalence or when it was clear a partner is being coercive. Hence, feelings of guilt and anger toward others over responsibility for the abortion is a thorny social issue as well as an issue of dissociative defenses which needs more attention. Compensatory Mechanisms and Repetition Compulsion Some women tried to avoid re-experience of the abortion situation by repetition of the situation with a positive end (from their point of view). These women became pregnant very soon again or all the time were imagining or preparing for this condition. In this case, a compensatory mechanism becomes a part of the avoidance reaction: to repeat the situation with another end to avoid the negative emotions and grief. This mechanism helped some of the women to cope with

stress and guilt, and to forgive themselves. Unfortunately for others it ends in another pregnancy in unrealistic circumstances and yet another abortion. The case of Tanya. "Two months after my abortion I had a mania to become pregnant again. I used sex only for pregnancy, without any pleasure, for six months. I don't remember what I did during those six months. They are missing from my life. My husband was against it. He felt uncomfortable, but I confronted him with this fact. After the birth of another child I felt much better. These two babies are together in my mind." The case of Larissa. "After my abortion, I wanted again to be pregnant. Every month I hoped I would become pregnant. I lived in this condition. I tried not to use alcohol or drugs because maybe I'll be pregnant. I loved the condition of pregnancy. Fm happy when I see babies, even since my pregnancy (aborted). My partner became very careful with contraception because he does not want a pregnancy at this time. I know I can't be pregnant. I used pills and now we use condoms. Sometimes I dream I used the wrong pills. I was thinking about destroying his condoms. I know it's stupid. I count to the middle of my cycle, but he controls everything. He says we can't." Overprotection Compensatory mechanisms appear not only as the desire for a new pregnancy but also as overly strong love for another baby. This can cause a reaction of overprotection and overcompensation to the next baby. I gave my baby everything that I didn't give my unborn babies. Compensatory pregnancy and overprotection responses as reactions to a traumatic abortion have been reported in Western samples as well (Speckhard, 1996). Delayed PTSD Delayed reactions of PTSD were also reported in five women. These were generally triggered by additional losses that became connected to the abortion by feelings of guilt or the expectation of punishment. For instance subsequent gynecological problems, especially infertility or infections that might compromise fertility or problems with a subsequent pregnancy, problems with subsequently born or present babies (sickness, accidents and traumas) and even other life situations were potential triggers for the onset or return of upsetting emotions about the abortion. In some cases gynecological or other problems after an abortion, or losses, confirmed unconscious fears that one will be "punished" for the abortion. Depression and delayed PTSD occurring in conjunction with pregnancy loss or fertility problems following an abortion have been reported in Western samples as well (Klock et al., 1997; Speckhard &Rue, 1992). Abortions Among Medical Professionals Abortion is a difficult situation not only for patients but also for physicians and nurses who are involved in gynecological care. If they agree to provide abortions, they are surrounded by this situation their entire professional lives: the gynecological table, instruments, and the process of abortion. It can weigh heavily, especially if they find themselves in the position of using abortion themselves. In our sample there are five subjects who were either gynecologists or midwives. They showed very strong reactions following their abortions, including posttraumatic responses of guilt and avoidance. Some refused afterwards to do abortions, even to help people to find a doctor for an abortion. When my friends and other women ask me to help with abortion it's a very difficult situation for me, very disturbing and I begin to refuse. It feels like a sin comes to me, to be asked to help find a good doctor. I want to avoid assisting in any abortion but it is connected to my work. I try to block it out. Others became hostile and upset when encountering other women who made decisions that contradicted their own. After my first two abortions I was disturbed and very hostile to women who had many children in a difficult economic state, how could they! Also the physicians worried about medical consequences more than other people did. They see complications after abortions in their hospitals and less often see cases without any troubles, so it creates a connection in their minds that there are increased risks. For physicians it is really strange even to be in an abortion situation: I know everything about it (contraception), how could it happen with me? Similarly, Gianelli (1993) reports on adverse psychological responses to abortion in American doctors. Surprise at the Depth of Responses All of the medical persons and most of the women in the sample didn't expect and could not imagine that they would have psychological problems after abortion. I couldn't imagine that this could occur with me. While we had no control group in order to make comparisons on this variable, it may be that women who cannot anticipate any psychological consequences after abortion are less in touch with their feelings and as a consequence less able to foresee and prevent the problems they might encounter. Positive and Negative Changes in Self Identity Just

as in Western samples we found that for some women the experience of abortion created a change in self-identity (Major, et al., 1990). Some met the abortion crisis afterwards becoming more competent and responsible, especially in regard to contraception. Even though contraceptives are often feared and difficult to obtain, women from this sample said that they could never allow themselves to repeat this experience and hence they suddenly became increasingly self-reliant in taking more responsible in seeking out contraceptives and reliably using them. For others deeply negative changes occurred in their perception of their ideal self. Mufel (2000a) studied self-image after abortion with Belarusian women and found that for some it took up to a year for this existential crisis to be resolved. Relationship Issues Abortion both reflected the state of relationships and influenced them afterwards. In some cases the failure to support the pregnancy was a cause of conflicts or separation. When the partner was supportive and the decision was made mutually there was generally a better outcome for the relationship. Most of the women in our sample agreed jointly with their partners for abortion. Of those who did not make a joint decision, this was usually due to the fact that they did not have a stable or good relationship. Sometimes the partners became very coercive with the women: My husband told me that he will divorce me if I don't have an abortion. Abortion trauma caused sexual problems for some of the participants as has been also reported in Western samples (Bagarozzi, 1994). In some cases the pain and emotions related to the abortion interfered in the sex life. Other times, the women became so afraid of repeating another abortion that they no longer trusted contraceptives and lost their enjoyment of sex: It was very painful when they dilated the cervix. I lost my libido after. I wasn't interested in sexual relations. I tried to do everything not to be in this situation again. This occurred for 6 months. Sometimes painful emotions after the abortion can unconsciously form the behavior of the pair. For instance one couple separated on the anniversary of the abortion without ever realizing that their increased conflicts during that month may have been related to anniversary reactions to the abortion. Only during the interview did the woman realize the timing of her partner's abandoning her for another woman and how similar it was to how he had emotionally abandoned her when she was faced with pregnancy. Guilt Reactions Along with PTSD responses, guilt reactions are one of the most frequent symptoms (eighty percent) but at the same moment one of the more complicated to resolve. Many of the women who expressed guilt over their abortion said that they can forgive themselves, or God will forgive them, only if they make up for the abortion by bearing another child. This was found in western samples as well. For instance one woman despaired of forgiveness because she had opted for sterilization. Instead of viewing herself as responsible for having prevented herself from having repeated pregnancies and abortions in an untenable financial situation she said: God could forgive me if only I give life for another baby but that can't happen because I became sterilized. Others expressed the fear that God will never forgive them: I know that everything I do is not enough to redeem the guilt. I cannot go to church because I am too dirty. When God gives us something we must take it. In conducting this study the researchers debated about asking questions regarding guilt. From clinical work and cultural knowledge, they expected to find some posttraumatic responses (although not to the high extent found). However, the Belarusian partner on the team flatly expected there to be little guilt and certainly no religious guilt, given that there is little anti-abortion rhetoric and most young people are only loosely affiliated to churches, if at all. Despite this it was decided to probe gently toward the end of the interview to learn if women experienced guilty reactions to their abortions and if so if they had any spiritual beliefs concerning their actions or the experience of abortion. The results were very surprising. Despite their history of state mandated atheism, religious beliefs appeared to be highly present. Eighty percent of the sample expressed guilty reactions following their abortions, many stating that they feared judgment from God or that they were unable to forgive themselves. Fourteen percent (n = 7) of women were sure that bad consequences in their own lives and those of their close relatives following the abortion were a direct result of it, (i.e., punishment of some sort). This was extremely interesting given that at the same time they stated that they had no relationship with God and never or only rarely had been in a church. Seventy-eight percent of the sample professed religious affiliation despite infrequent or rare contact with the church. Indeed most stated their

affiliation as though listing an ethnicity versus a belief system, stating that their grandmothers had been religious, but they themselves were not. Hence the majority of the sample claimed only loose, if any, religious connections, yet they still experienced guilt and many expressed it in a religious manner, invoking God's punishment for their actions. One woman recounted the following as all attributed to her abortion decision: We were robbed, and I had a divorce and I lost my driver's license. All of this because of my abortion. The two main religious groups represented in Belarus and in the sample (i.e., Catholic and Orthodox) condemn abortion, although there is little public forum for their views as compared to the strong Catholic presence in nearby Poland, or in Ireland. Likewise there is very little anti-abortion rhetoric and no clinic protesters, as in America. Nevertheless religious prohibition for abortion is felt by women who ethnically consider themselves Catholic or Orthodox, despite their very loose affiliations with the church and the widespread acceptance of abortion within society. Even more interesting was the fact that when those who stated that they suffered guilt were questioned about how they must resolve their guilt, nearly all stated the need to visit a church to reconcile over the abortion. This was often stated despite the fact that many had never stepped foot inside a church. Catholics generally said they must visit confession, although most were terrified to confront their priests. Orthodox women stated that they must light a candle in church and pray for forgiveness, although they too were terrified to enter their church or speak to their priests. Despite their claims of a need to reconcile spiritually, only fourteen percent (n = 7) of the sample did so following the abortion, despite many stating the importance for them of this action. With strong emotional responses they cited fear of further condemnation, humiliation and shame, and feared God would not forgive them if they did so. Yet they deeply professed the need for forgiveness. Hence they suffered guilt that they did not know how to reconcile. Most seemed unaware of Christian teachings that offer them the possibility of reconciliation or if they were aware did not believe this could be extended to them. This level of guilt, but not the double bind of feeling the need to return to a church to which they are strangers has been reported in Western samples as well (Rue &Speckhard, 1992b). It should also be noted that twelve percent of the sample (n = 6) reported that they had been exposed to American films about abortion or read anti-abortion literature provided by American missionaries working in Belarus (in clinics or university), which made them feel guilty. For example one woman read a poem that was written from the point of view of the aborted fetus and she was haunted by it and felt tremendous guilt for three months afterward. Hence it was learned that even in divergent cultures the world is not so small, and that influences from one culture cross to yet another. Attachment and Recognition of Life Attachment and recognition of life are the best predictors of guilt, grief and trauma reactions as is described in another article regarding a larger statistical sample (Mufel, et al., 2002). If the woman recognizes fetal life during her pregnancy and especially if she makes any type of attachment to "her baby" she is more likely to have post-abortion trauma. If the decision was made in doubt or in an emotionally cold manner as described previously, using dissociative defenses, these feelings of recognition of life and attachment easily return after the abortion is accomplished. One woman explained her feelings: I know I took a life but if you think about this you could become sick. Many triggers can resurface the doubt or actual perceptions of fetal life and attachment and these then trigger feelings of guilt, depression and posttraumatic sequelae. Three women said, "I killed my baby." The perception that one has destroyed one's own fetal child in abortion often destroys the healthy self-image, replacing it with one of self-hatred. One of the ways women unconsciously tried to resolve their guilt over breaking their attachment to the fetal child was in dreams: to conclude the pregnancy by delivery or to ask for forgiveness. At the same moment we can say that it is a part of a compensatory mechanism. The main topics of dreams were: a tiny 'disappeared' baby, the birth process, and dreams about the gender and the life of the baby had it lived. Likewise, waking fantasies accomplished a similar task of working through grief, trauma and guilt. The main topics of the fantasies were fantasies about the gender, appearance of the baby, her/his future profession, and relations between mother and child. One woman recounts: I feel he is close to me. I was on the street and suddenly had an impression that he is here. It was after ovulation. I have a feeling that air moves around me. It feels to me that it was the baby's soul. I think that

he would have been a good musician. In this case the woman fantasized about her unborn child and gave him attributes of her that were unfulfilled, as many parents do. She wanted to be a musician. She felt that her unrealized dreams died with the abortion. Grief and Spiritual Responses Seventy-four percent (n = 37) of the sample reported grief over the loss of the aborted pregnancy, and thirty-two percent (n = 17) cried or grieved for a significant time period after the abortion. Some of these said that they counted the months until the due date, a sorrowful time for them. Another said: I built a small cemetery, where I go to cry and ask for forgiveness. When gently questioned if they had any spiritual beliefs concerning life during the pregnancy or after abortion, ten percent of the women (n = 5) were sure that the soul of their unborn child transferred to another human being (i.e., to their next child or to someone else's next child). For instance one woman said that she had an abortion after the death of her uncle and by this action she felt guilty that she had not permitted the soul of her uncle to return to earth. Another said of her sister's daughter, "I dreamed she is my daughter." These spiritual beliefs were also interesting given that the majority of the sample did not adhere strongly to any faith. Yet when faced with perceived death, loss and grief, they "spiritualized" the aborted pregnancy and wrestled with issues of whether there is a spiritual essence in the human being and with issues of life after death. These same issues have also been reported in American samples (Speckhard &Rue, 1993). Ten percent of the sample (n = 5) wanted to have another baby immediately after abortion. It was clear that this was a wish to undo the loss. Likewise when women were asked whether or not they wanted to have children in the future, despite current life situations not suitable for having a child, fifty-six percent (n = 28) expressed the wish for a future child. Anxiety and Panic Forty-eight percent (n = 24) of the sample had symptoms of anxiety and panic (including panic attacks) related to their post abortion distress. These appeared to be linked to unresolved and repetitive intrusive posttraumatic recall. Psychosomatic and Self Destructive Responses Twenty-eight percent of the women in our sample reported emotional numbing. Repression or dissociation of traumatic feelings often engenders psychosomatic disorders, which we observed in this sample as well. In some women there were psychosomatic reactions to the pregnancy or abortion. For instance one woman reported that she became very ill with "morning sickness" only upon learning of her pregnancy. Her extreme response might be simply coincidental or have appeared by unconscious motives as a means of providing her with an excuse to abort it: When I understood that I'm pregnant the awful toxicosis started. Before, I didn't have it. My physical condition was so awful; I couldn't even stand up for a week. I lost a lot of kilograms so much so that I had to have an abortion to avoid this very difficult, for me, physical state. Also many of women had physical consequences after abortion (inflammation, pelvic infections, and so on). It was not the aim of our study to examine physical symptoms so it was impossible to know if these were psychosomatic, the result of multiple partners, or of the abortion practices themselves. Nevertheless some women attributed their physical responses as evidence of punishment and it appeared that for some women their unresolved emotional pain may have been finding outlets on the somatic level. One woman told us that all her problems with her health appeared because of abortion: headaches, back pain and inflammation. Another variant of self-destructive behavior is an eating disorder. This was also present with some women gaining weight after the abortion up to their delivery date, in a sense denying that the pregnancy no longer existed, while others lost weight rapidly as they struggled with depression and PTSD. One woman recounts: I lost a lot of weight after the abortion, more than 10 kilograms. Eight percent of the women reported suicidal thoughts or attempts. Most of them were desperate attempts to communicate their grief and despair with significant others. One woman recounts her suicidal urges: I have thought about cutting my wrists, and that my partner will find me and save me. Then he will understand how much pain I have. I don't want to die, but I want to show him my feelings. Other frequent feelings after abortion are of emptiness, that a type of violence has occurred upon her body and soul, feelings of having lost control, retiring into oneself, grief, anger, and avoidance of all pain. Suicidal urges, somatization and eating disorders following traumatic abortions have also been reported in Western samples. This research and its comparisons to other studies highlight the importance for psychological practice of understanding the often hidden nature of

post abortion trauma. As with other traumas, the women coming for psychological help following a traumatic abortion experience may present in therapy with other problems because of guilt or avoidance, but more often because they are confused and overwhelmed by upsetting emotions. For example, one woman came to therapy because of drug addiction and only in therapy realized that her addiction had begun as a way to forget about post-abortion feelings and dreams, to avoid what to her was an unacceptable reality. Hence it is always wise to take at least a brief sexual history to learn about previous pregnancies and possible abortions, and in the case of abortions, to at least probe lightly as to how it was settled: favorably or with some distress. In many cases this will open the door to further discussion, perhaps not immediately but in later sessions when the therapeutic bond and safety is established. In either case it signals to the woman that it is not totally bizarre to have an adverse reaction to abortion and that the psychologist is open to pursuing the topic if need be. Unfortunately some women have found in previous therapy that this is sometimes not the case. The following is a list of the main related psychological problems that were recounted to us and which may present during the first counseling session when post-abortion trauma is the central issue: 1) Posttraumatic stress including guilt. 2) Depression. 3) Crisis of identity or existential crisis. This may be manifested as a loss of sense, self-hatred, or anger towards people who don't agree with her position, or in an interest in irrational and mystical ways to find the Truth. 4) Self-destructive tendencies. These may include suicidal attempts, addictive behavior, eating disorders, and are connected both with attempts to escape intolerable emotions and the feeling of having destroyed one's ideal-self and lowered self-esteem after abortion. 5) Psychosomatic disorders. 6) Family conflicts. During pregnancy, even those of short duration, women can begin to develop and realize their role as a mother and begin to see their partner as a father. When this suddenly stops with abortion, but the attachment relationship to the pregnancy has been strong and not yet resolved, these role transitions don't suddenly revert back to their original states with the fact of stopping pregnancy. This creates a difficult situation for the couple: objective and subjective family roles are different and the family must solve this problem to survive and to not get caught in the position of blaming or hating each other. 7) Overprotection. Fears of punishment or the desire to compensate for an abortion leads some women to be overprotective or overindulgent for other children. 8) Sexual problems. Unresolved conflicts and emotions with the partner and about the abortion trauma often interfere with sexual pleasure. Anger, grief and guilt can all translate into the sexual relationship. If the abortion was very physically painful, upsetting "body memories" of the abortion can be triggered when the cervix is touched roughly as in lovemaking. 9) Problems with sleeping. Nightmares, sleep disorder etc. may be traced back to posttraumatic responses to the abortion. 10) Panic disorder. Anxiety states over abortion trauma, similar to those caused by PTSD can drive panic disorder. 11) Unresolved grief. 12) Pre-abortion counseling. The fact that some women facing abortion do experience posttraumatic responses afterwards indicates that pre-abortion counseling of women and couples is very important both to women finding it hard to make the decision and to women who are at risk of post-abortion problems. These "at risk" groups have been identified earlier in several studies with coercion, young age, prior pregnancies, depression prior to the abortion, attachment in pregnancy, recognition of life, etc. identified as risk variables in western samples (Major, et al., 2000; Rue &Speckhard; 1992a) and attachment and recognition of life also being indicators of risk in a Belarusian sample (Mufel, et al., 2002). Women who have these "at risk" features should be carefully screened and helped to make the best decision for their circumstances and directed to additional resources both before and after their abortions. Counseling needs to address the decision-making process to ensure that the abortion decision has not been arrived at under coercion or in despair. In the former instance, the coercing partner must be stopped or the woman protected as in any other cases of battery, as a forced abortion is essentially a type of battery. In the latter instance of despair, if resources are available, the woman can be directed to them and her range of choices increased. Abortions made when no choice is available are tragic and can be expected to end with some grief or trauma. Likewise as mentioned earlier those who refuse to take responsibility for their decision are in a risk group for emotional problems after abortion. In this case psychological counseling is crucial at the

decision-making moment to assist the woman not to dissociate her emotions and to make a conscious decision for which she takes full responsibility. Those engaged in pre-abortion counseling must also be trained to recognize and address dissociative defenses. A woman who goes through with an abortion divorced from her emotions, as an automaton, is likely to have trouble keeping her emotions at bay afterward. It is a delicate balance to offer free choice while at the same time being responsible to query about emotions and to delay providing an abortion until a woman is truly at peace about her decision, and not simply dissociating her emotional responses. Likewise women should be directed to clinics where the physicians and staff are supportive and the woman will not encounter abusive attitudes. 13) Follow-up care. It's important also to inform physicians and psychologists about psychological follow-up after abortion and to help them understand how they may contribute to, or lessen psychological trauma. Avoidance being one of the main symptoms of PTSD, it is important to note that even absence of any reactions after abortion can mean that the woman is doing well or it can also be the activation of strong avoidance. In this case the important follow-up task is to facilitate the process of expressing feelings, being open to both positive and negative responses to abortion. Another central feature of psychological trauma is that victims feel alienated from others, overwhelmed by negative emotions and unable to restore themselves to health. Many women told us that they had not talked to anyone else about their abortions in any great depth. They stated that the research interview, although initially feared, gave them relief by means of making a connection and the possibility to speak on this topic. Women after traumatic abortion experiences often feel a strong need for support and find that self-help groups are a good outlet for grieving, support and understanding. Learning that one is not alone and that it is normal to grieve and to have strong emotions after abortion can be very healing. Selection of these self-help groups is crucial in that some may be espousing strong anti-abortion beliefs and can be very judgmental and proscriptive in their approach, which can create further problems for some. Coping with trauma, grief and guilt are the most important parts of counseling for traumatic responses to abortion. Sometimes women find their own paths for healing in one area, but get stuck in another. For example, one woman told us that for dealing with emotions after abortion she made a small cemetery where she goes to cry and ask for forgiveness, yet she struggled with intrusive recall. Another woman told us about using a compensatory mechanism, which eased her guilt and grief but did not address the buried traumatic emotions. Dreams often suggest aspects of the abortion that need resolution and point to some solutions. CONCLUSIONS It was considered of interest for this research that there might be indication of universal responses to abortion that would cross cultures. Of course it was also possible that abortion responses are culturally based and experience-dependent, hence divergent experiences lead to divergent responses. Studying women in a former Soviet Union country (Belarus) where abortions are provided in a very different social context than in the west was informative. The investigators were able to learn by using variables and methods that cross cultures that there do appear to be universal responses to abortion, just as there are universal responses to trauma in general (as identified in the rubric of PTSD) which cross over very different cultures. Based on this study and its comparisons to existing research, the researchers conclude that women who are traumatized by abortion are not so different. In fact even those women who use abortion de facto as birth control, or face "choice less choices" seem to have similar dynamics in how abortion affects them when it inadvertently turns from being used as a coping mechanism into a traumatic stressor. Of the universals that appear to emerge from this study, which yet need confirmation in larger, representative comparison samples are the following: 1) Relief is a primary outcome of abortion. Despite posttraumatic responses, the majority of women reported that they also felt relief by ending their pregnancies. Upon realizing the degree of traumatization their choice caused, some desperately wished they could undo their abortions, while others said despite the trauma they had no choice or would choose the same again. Hence ending a pregnancy by abortion, even when it ends for some (not all women) in posttraumatic stress does often bring at least short-term relief from an immediate and pressing crisis. 2) Abortion does not always end in the traumatization. Despite the high incidence of posttraumatic sequelae in this sample, women in Belarus as well as in the

Western samples do successfully use abortion as a coping mechanism for unwanted and ill-timed pregnancies avoiding deep psychological responses. A group of these women however do find that the coping mechanism they have chosen results in posttraumatic responses. To estimate the incidence of these negative responses in either culture and make comparisons across cultures requires large randomized studies. 3) Traumatic responses. Results of this study demonstrate that even despite wide cultural differences when PTSD occurs after abortion, which is not in all cases, it follows a predictable course with symptoms of: re-experience, avoidance, arousal, survival guilt, and losses in significant areas of life functioning. Posttraumatic responses of intrusion, avoidance and hyperarousal occur in both cultures. In this sample the posttraumatic responses were highly represented. It is unknown what percentage of a representative sample of women in either culture would evidence posttraumatic responses to abortion, but given the large numbers of women involved it is an important research question to pursue. Likewise peritraumatic dissociation, particularly during the abortion decision-making phase appears to be related to laterterm maladjustments and PTSD. This study while not using a representative sample does suggest that there may be higher rates of posttraumatic stress among women using abortion in Eastern European and former Soviet block countries than in Western countries. This is certainly an important area to explore further with quantitative and representative research. One hypothesis about the higher rates may be that women who do not have adequate access to contraceptives and face severe economic hardships with easy abortion access may feel themselves in a situation similar to the term, which was coined during the Holocaust of facing "choice less choices". While their dilemma is certainly less dramatic than those faced in the Holocaust, these women may have similar feelings of having no morally acceptable option available from which to choose and hence the feeling that they must choose one that violates their inner convictions and suffer afterwards. 4) Guilt. Abortion can lead to strong guilt responses in women despite widely divergent cultural milieu. Guilt responses were present even in women from a culture that had seventy years of state-imposed atheism. This indicates that even when religion is not officially a big part of life many pregnant women, though not all sense that fetal/embryonic life and that its loss, especially by their own decision, brings up spiritual issues for them which many may need help in resolving. 5) Grief and spiritual responses. When abortion is experienced as a death event grief and spiritual issues are raised despite cultural differences. Research in the West on the moral development of young girls (Gilligan, 1993) and clinical work with women evidence the strong relational nature of women's moral development. This appears true in other cultures as well. This is borne out by how many perceived their abortion experiences as the death of their unborn child and how even very early in pregnancy they had bonded to the fetus/embryo. Indeed many women expressed guilt and grief over having aborted "my baby". Likewise, many of the women in this sample expressed their thoughts and feelings about their abortions in spiritual and relational terms demonstrating that women may have attachment issues that surface in pregnancy and that are difficult to resolve when a pregnancy is terminated. 6) Recognition of life and attachment. Attachment to the fetus/ embryo occurs very early during pregnancy for some women, as does recognition of the fetal life as human and valuable. These phenomena occur even to women who are sure that they will use abortion to end their pregnancies. These two variables are likely related to individual factors of personality, may also include responses to specifics of the pregnancy, and/or be under the influence of culture factors that support such views. In any case it appears that recognition of life and attachment to the pregnancy are central variables to understanding and predicting posttraumatic responses to abortion, as well as responses of guilt and grief. This study demonstrated that cultural factors certainly do play a part in defining if a life is recognized and in, how taking that life by abortion is defined. In this sample the background of Orthodox and Catholic condemnation played a large part in creating guilt over this decision, even for women only loosely tied to the church. Likewise, statements by physicians, viewing ultrasounds, the previous experience of motherhood (i.e., a pregnancy carried to term) also influenced how likely recognition of life and attachment would be. Nevertheless, despite social influences, it is interesting to see how early and active during pregnancy recognition of life and even attachment is, even in a sample where forty percent of the

women had abortions prior to four weeks gestation. It may be that some women just naturally recognize pregnancy as containing life and naturally create attachments to this life as they consider what to do about their pregnancies, even when they ultimately choose abortion. It is also interesting to note that a related statistical study by the same authors with a larger sample found that these two variables predicted posttraumatic responses. This was born out in this study as well and only makes sense as all traumas revolve around a stressor event which is individualistically perceived and to which meanings are attributed. These in turn define how the event is experienced: as horrific, involving threat and death; as a situation in which one is powerless or not; or as simply an unpleasant, perhaps painful but on the whole, rather benign event. This brings up the need in every culture to help women to explore their feelings prior to an abortion decision to be sure they do not make, without careful reflection, a decision that violates their inner convictions and perceptions and that will likely lead for them to posttraumatic responses. Likewise if there is depression, PTSD, psychosomatic or other issues following an abortion, recognition of life and attachment issues are often profitable to explore to help a woman resolve feelings of guilt, grief or trauma. 7) Abortion trauma often goes underground. It appears from our sample, and certainly has been noted in western samples that women often hide their abortion experiences and are reticent to talk about them (Bagarozzi, 1994). In our sample we found this to be true as well. It was extremely important to establish rapport and a sense of safety for the women to be able to open up to speak about their experiences. Many arrived at the interview, burst into tears or went "emotionally numb" and said they could not talk about it, or expressed concern during the interview that they could not talk about particularly painful aspects of their experiences. Only by taking time, being patient and being calming influences for them, were they able to speak. While many had diagnosable PTSD following their abortions, few had sought professional advice. Instead they had experienced deep shame, confusion and retreated inside of themselves. For those working with women in any culture it is important to understand that there may be many presenting issues masking post-abortion trauma. Some of these include depression, eating disorders, panic and anxiety disorders, etc. as previously listed. Likewise, many women may so strongly experience guilt, grief and trauma or have so deeply buried their feelings about their traumatic abortions that they may not make the connections with their current suffering to their past experience without gentle questioning. Overtime, many of the women in our sample had resolved aspects of their PTSD, but often extremely painful areas remained, most notably guilt, trauma, and grief. There appears to be a need for programs to address women's unique needs following abortions. In conclusion, the concept of searching out universals in how women experience pregnancy and abortion is important. If they are distressed by pregnancies ending in abortion, then identifying predictors of trauma (such as if they recognize life or attach to their unborn fetus/embryo), will help women around the world who are facing problematic pregnancies and contemplating abortion. Likewise, given the huge numbers of women utilizing abortion each year it is critical to begin representative and prospective studies of these women to learn what percentage do well with abortions and what proportion suffer negative psychological responses, including posttraumatic responses. Of these it is also important to know how long they last and what variables are important in predicting such responses. These are areas for which there is a great need for further research. References REFERENCES Alan Guttmacher Institute (1999). Sharing responsibility: Women, society and abortion worldwide, (pp 25-27). New York: AGI. American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, D.C.: Author. Bagarozzi, D. (1994). Identification, assessment and treatment of women suffering from posttraumatic stress after abortion. Journal of Family Psychotherapy, 5(3), 25-55. Barnard, C. (1990). The long-term psychosocial effects of abortion. Dissertation Abstracts International 51/08-B: 4038. Butterfield, L (1988). Incidence of complicated grief and posttraumatic stress in a Postabortion population. Dissertation Abstracts International 49/08-B: 3431. Centers for Disease Control (2001). Morbidity and Mortality Weekly Report, January 07, 2000/48(51);1171-1174, 1191. Donovan, D. M (1991). Traumatology: A field whose time has come. Journal of Traumatic Stress, (4)3:433-436. Forst, J. G. (1992). The psychosocial aftermath of abortion. M.S.W. thesis; Masters Abstracts 31/01: 151. Gilligan, C.

(1993). In a different voice: Psychological theory and women's development. Harvard University Press: Cambridge, MA. Karlin, E. (1997). Affidavit of Elizabeth Karlin in Karlin, et al. v. Foust et al. (Case Number 96-C-0374-C) in the United States District Court for the Western District of Wisconsin. Leifer, M (1980). Psychological effects of motherhood: A study of first pregnancy. New York: Praeger Special Studies. Major, B. N.; Cozzarelli, C.; Sciacchitano, A. M.; Cooper, M. L.; Testa, M.; &Mueller, P. M. (1990). Perceived social support, self-efficacy, and adjustment to abortion. Journal of Personality and Social Psychology (ISSN: 0022-3514), v. 59, no. 3, pp. 452-463. Major, B. N.; Cozzarelli, C.; Cooper, M. L.; Zubek, J. Richards, C; Wilhite, M.; &Gramzow, R. H. (2000). Psychological responses of women after first-trimester abortion. Archives of General Psychiatry (ISSN: 0003-990X), v. 57, no. 8, pp. 777-784. Mufel, N. (2000a). Changes in self-image after abortion, Health and Living Scientific Journal #4. Mufel, N. (2000b). Decision-making about abortion in adolescents, Health and Living Scientific Journal #3. Mufel, N. Speckhard, A. C. &Sivuha, S. (2002). Predictors of posttraumatic stress disorder following abortion in a former Soviet Union country. Journal of Prenatal &Perinatal Psychology &Health, 17(1), pp. 41-61. Ney, P. G. (1982). A consideration of abortion survivors. Child Psychiatry in Human Development, 13, pp. 168-179. Pope, L., Adler, N. &Tschann, J. (1999). "Post-abortion psychological adjustment: Are minors at increased risk?" Unpublished paper. Exhibit 2, Affidavit of Nancy E. Adler, Ph.D. in North Florida Women's Health et al. v. Florida, et al. Romans-Clarkson, S. E. (1989). Psychological sequelae of induced abortion Australian and New Zealand Journal of Psychiatry (ISSN: 0004-8674), v. 23, no. 4, 555-565. Rue, V. &Speckhard, A. (1996). Getting Beyond Traumatic Pregnancy Loss: Research Findings and Clinical Applications. Master Class presentation at the Georgetown University Medical Center's Trauma, Loss &Dissociation: Foundations of 21st Century Traumatology 2nd Annual Conference, Alexandria, VA. Rue, V. &Speckhard, A. C. (1992a). Informed consent &abortion: Issues in medicine and counseling, Medicine &Mind, (invited article), 7, 75-94. Rue, V. &Speckhard, A.C. (1992b). Post abortion trauma: Incidence and diagnostic considerations, Medicine &Mind, (invited article) 6(1-2), 57-73. Speckhard, A. C. (1987). Psycho-social stress following abortion. Sheed &Ward Publishers, Kansas City, MO. Speckhard, A. &Rue, V. (1992). Post abortion syndrome: An emerging public health concern, Journal of Social Issues 48(3), pp. 95-119. Speckhard, A &Rue, V. (1993). Complicated mourning: Dynamics of impacted post abortion grief, Journal of Pre- and Peri-Natal Psychology, 8(1), 5-32. Speckhard, A. (1996). Traumatic death in pregnancy: The significance of meaning &attachment. In Death &Trauma: The Traumatology of Surviving, Charles Figley, Brian Bride, &Nicholas Mazza (Eds.), Taylor &Francis. Tarabrina, N. V., Lazebnaya, E. O., Zelonova, M. E., Lasko, N. B., Orr, S. P. &Pitman, R.K. (1993). Psychophysiological responses of Chernobyl liquidators during script-driven imagery. International Society for Traumatic Stress Studies Annual Meeting, San Antonio, Texas. Weiss, D. S. &Marmar, C.R. (1995). "The impact of event scale-revised." In Assessing psychological trauma and PTSD: A practitioner's handbook, J.P. Wilson &T. M. Keane (Eds.), New York: Guilford. AuthorAffiliation Anne Speckhard, Ph.D. and Natalia Mufel AuthorAffiliation Anne Speckhard, Ph.D. is Adjunct Associate Professor of Psychiatry, Georgetown University Medical School, Washington, D.C. and Psychological Consultant for Advances in Health, Mclean VA. She is also Professor of Psychology, Vesalius College, Free University of Brussels. She lived in Belarus with her husband the U.S. Ambassador to Belarus, from 1997 to 2000 during which time this research was conducted at the Belarusian/American Women's Center. Likewise, Dr. Speckhard has conducted research interviews with women regarding their psychological responses to abortion in Romania, Netherlands, Belgium, Belarus, Russia and the United States. Belgian address: 3 Avenue des Fleurs, 1150 Brussels, Belgium. U.S. address: PSC 81, Box 135, APO AE 09724. E-mail: Aspeckhard@brutele.be or Speckhardl@aol.com Natalia Mufel is Assistant Programme Officer for Early Childhood Development, UNICEF, in Minsk, Belarus. She is a Ph.D. aspirant in Belarusian State University, lectured gender-oriented courses in European Humanities University and wrote the chapter "Women's Health" for the United Nations' report about the state of women in Belarus (2003). She served as psychologist for the Women's Wellness Center, Minsk, Belarus during the time of research. E-mail: mufel@it.org.by Editor's Note:

Collaboration and travel between the researchers was supported by a grant from the NATO Science Programme, Collaborative Linkage Grant No 978603.

Publication title: Journal of Prenatal&Perinatal Psychology&Health

Volume: 18

Issue: 1

Pages: 3-37

Number of pages: 35

Publication year: 2003

Publication date: Fall 2003

Year: 2003

Publisher: Association for Pre&Perinatal Psychology and Health

Place of publication: Forestville

Country of publication: United States

Journal subject: Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

ISSN: 10978003

Source type: Scholarly Journals

Language of publication: English

Document type: General Information

ProQuest document ID: 198724800

Document URL: http://search.proquest.com/docview/198724800?accountid=36557

Last updated: 2010-06-06

Database: ProQuest Public Health
