Treating the Trauma of Abortion

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Full Text: Headnote ABSTRACT The author describes a technique to ease the trauma of abortion to the mother by attempting to communicate with the fetus using hypnotic visualization. As a result, women who employed the technique experienced little or no guilt following abortion, with some having spontaneous miscarriages. Each one reported the experience as positive, and appeared to have opened the grieving process prior to the loss of the fetus, leading to an increased sense of continuity and completeness in the experience. Also discussed is a case of attempted but uncompleted abortion. The trauma to the fetus is seen in the adult through techniques of age regression. The theory of ego states, their formation and development, has significant implications in the treatment of early trauma. These include the trauma to a fetus of an attempted abortion as well as the trauma to a mother who has a completed abortion. I have employed hypnoanalytic ego-state therapy effectively in both types of traumas in a number of cases. If thoughts and feelings can have a negative effect upon the body, they can also have a positive one, since influence is not unilateral. The way therapists have tried to effect a positive change within the body of the patient is by the changing of thoughts and feelings and through the process of visualization. Libraries are replete with books describing the use of visualization to help the individual in various ways. Examples promoting the use of imagery in psychotherapy include Focusing by Gendlin1, Go see the Movie in Your Head by Shorr2, Getting Well Again by Simonton, Mathews-Simonton and Creighton3, and the Journal of Mental Imagery. In Getting Well Again the authors describe a visualization technique they developed with cancer patients. Its purpose is to help the body reduce the growth of malignant tumors. A clinic in Los Angeles (The Newton Center for Hypnotherapy) specializes in using hypnotic visualization with cancer patients. Their results are impressive. The difference between visualization and hypnotic visualization probably lies in the depth of relaxation achieved and the natural capacity of the patient to enter into an altered state of consciousness, called hypnosis. As a hypnotherapist I use hypnosis and visualization when working with newly pregnant women who are trying to decide whether or not to abort. My position is a neutral one, since I believe the client must make this decision for herself. During the first session we discuss the pros and cons, the facts, data and the consequences of whatever action is possible for the client. We explore her feelings, attitudes and beliefs. During the second session we explore her feelings and attitudes about abortion at a more unconscious level with the use of hypnosis. The ability to reach unconscious processes depends upon the client's hynotizability. Hynotizability is not dependent upon personality characteristics but upon the client's natural ability to dissociate, i.e., to enter this altered state of consciousness. More sessions may be necessary before she makes a decision about her pregnancy. During these sessions I begin the process of visualization and communication as follows: After a hypnotic induction I have the client visualize the fetus in any way that comes naturally to her in her mind's eye. She then speaks to the fetus silently expressing her conflict about the pregnancy. I then have her wait for any response-whether through feeling, hearing or seeing. The client repeats this process at home, usually by just closing her eyes, breathing to enter a relaxed state, focusing on her abdomen, and stroking her abdomen gently. Sometimes the client receives a response, positive or negative, sometimes not. If the client decides to have an abortion and a medical appointment has been scheduled, I have her speak to the fetus silently, first in my office, and then at home, explaining why she cannot give it birth and expressing her feelings to the fetus. If the woman senses a response of agreement from the fetus, then I have her begin the process of visualizing the fetus leaving her body in any way that comes to her. If the client receives no response, then she makes the decision as to when the visualization of the abortion is appropriate.

Sometimes the upcoming surgical procedure presses her for time; sometimes she simply senses the appropriate time. It is surprising to me how often a response is elicited. How this process occurs is a moot point. I think of the response as coming from the client's own unconscious rather than from another energy system. In any event, I let the client arrive at her own interpretation. No matter what happens physically, the client finds emotional release in this procedure, and with the emotional release comes a reduction of guilt. Clearly guilt is not a desirable therapeutic response, and any action leading to guilt feelings in the client should be avoided. Every therapist has seen the neurotic circle of patient-perceived 'bad' behavior producing guilt, which is inexorably tied to self-punishment, leading back to repetition of the same 'bad' behavior. In these cases, therefore, that self-defeating behavior may cause another unwanted pregnancy. In two cases I recall in the past few years, spontaneous miscarriages occurred after applying the above procedure. Mary aborted spontaneously two days before the scheduled surgical appointment and Jane the morning of the same day. Both were convinced they had communicated with the fetus and felt relieved of guilt. They experienced several 'dialogues' with the fetus and felt the fetus understood and agreed. They reacted to these communications with a sense of awe, respect of another energy system, and a sense of love by the fetus in agreeing to end its existence. Their experiences were profound. Recently I worked with a woman in her thirties who had a different response. When she first expressed her feelings and need for an abortion to the fetus, she 'heard' words such as "You don't mean that!" She continued the process of weeping and talking to the fetus at home until there was only silence in response. She concluded the fetus accepted her intended surgical abortion. She began the abortion visualization, but no miscarriage occurred. The surgical intervention was accomplished without complication; healing was rapid; and the client felt little or no remorse. She knew at all levels she had made the appropriate decision for herself. Perhaps these women experienced the grief syndrome before the loss of the fetus, so that when the abortion is done, the whole experience is complete. I have seen very little regret or remorse. Many find in this process a deeper sense of self, even a deeper respect for life, looking forward to pregnancy in the future when the time is more appropriate. I believe the most positive aspect of the therapy is the feeling of love they perceive as coming from the fetus when they feel agreement. It is as if a force beyond their own comprehension somehow understands their grief, their sorrow, their desperation. Instead of a potential tragedy, this process becomes a healing experience in the lives of these women. Up to now I have been speaking of helping the mother with the intended surgical abortion to lessen the psychological trauma of that experience. But what about an attempted abortion. Could an attempted abortion that was unsuccessful damage the fetus psychologically? If the fetus can experience bliss from the soft, warm environment of the natural womb, then it follows that it could also experience and react to a womb wherein a threat to its life is introduced, whether chemical or mechanical. It would seem probable that a life-threatening fetal experience would create a biological anxiety that is imprinted in such a way as to come out later in dreams, drawings, or hypnosis as well as feelings and behavior. Once experiences are neurologically recorded, they can be communicated later after words are learned. Through stimulus generalization, words which are attached to similar events can be extended to cover the original somatic impressions. If, for example, a 4-year-old child is burned and hears the word in connection with the experience, the child will be able to use the word in describing a similar burn experience which occurred to him prior to the development of language. The earlier burn experience was recorded in the brain and under hypnotic regression the memory of it can be evoked with a reasonably good hypnotic subject. This memory is then reported by the subject in words learned subsequent to the experience. Accordingly, it should be quite possible to explore memories of the first year of life or even pre-birth under hypnotic regression. I recognize, of couse, that distortions in remembering and re-experiencing, which operate in all recollections, may falsify data even more at these early levels. In the clinical experience of my husband and myself, we find that the divisions of personality we call ego states either developed as part of the individual's natural differentiation of function for reasons of psychic economy, or were split off as a defense during moments of trauma. We have many examples of each. We are quite aware of the studies on demand

characteristics4, and while we cannot guarantee to have been fully successful in eliminating this operator contamination of the data, we have tried in our therapy and research to avoid suggesting responses and content to the patient. In the case being presented here the evidence seems to point to the dissociation of personality structure within a developing fetus into two separate ego states as a reaction to the the trauma of the chemical onslaught by an attempted but unsuccessful abortion, followed by another life-threatening experience at 8 months in utero. As a result one part of the psychological structure was born and developed with the physical body; another was psychologically unborn and conceptually remained behind in the uterus. The case of Susan This female college student came to see me complaining of a constant feeling of apprehension, muscle tension and stomach pain. She never seemed to be free of these, although the exterior she presented to the world was that of calmness and proficiency. In her studies she felt like a machine-reading, digesting and regurgitating academic material without a sense of selfness being involved in the process. She was always surprised when she continually earned A's on her papers and exams. She never felt "I did this" but rather "It happened." Her body build typified the Bioenergetics model of the schizoid character5 i.e., a tight, compact, muscular frame. In order to discover what was going on inside of her, I worked with her body and with her ego states, both in and out of hypnosis. Of the several ego states that were delineated, one which she called "Survival" became of major importance in the therapy. Survival said, "Achievement is survival. It's not a matter of choice-it's like eating; you do it to live." Its influence in the personality was overwhelming and strong. It operated not only in the area of academic achievement, but also whenever she perceived any expectation coming from her world, especially from an authority figure. Under hypnosis, Survival reported her function was to protect a helpless, fearful child state with whom no other ego state had direct contact. She guarded it against harm by pushing the personality to meet the demands of the world. Survival provided the drive that made the personality work like a machine, a schizoid shell that operated without feeling. Through hypnosis we uncovered some early life traumas, but there was insufficient evidence to account for the severity of her symptomsthe schizoid split. The pervasive, underlying feeling was that of always having been rejected, and a constant fear throughout childhood that if she did not obey her parents some horrible consequence would occur. Her parents, however, were not mean or abusive. Accordingly, in an attempt to find out where the rejection came from, I used an Affect Bridge. The Affect Bridge6 is a hypnotic technique in which a common feeling is used as a bridge to move an individual experientially from a present or recent experience to one in the past during which the same affect was felt. I induced a deep hypnosis and suggested she go back to the very first time she felt rejection. She described that she was alone, could not see anything, but felt her hands pushing on something soft. Her feeling was one of dread-dread of existing and of being born because she would be alone. I asked her how she came to that thought and she said, "It is obvious; I can feel it throughout my whole body; it's the pressure choking me and all around me." I asked her what she could do about it, and she described how she fought it by pushing it away and finally by being born. As we went through the birth process she had a feeling of repulsiveness because she was inside her mother and a feeling of self-revulsion at birth because she had come from mother. However, she went on to say, "There is a part of me that is good. It didn't come from her. It came from me. It will help me live." I then asked to talk to that part directly. A similar but more assured voice answered. It said, "I'm the strong part; I came before she was born so she would survive; I keep her going." It continued by explaining it was born so the fetus could survive physically, but the feeling, psychological self was gone. To quote, "She had killed the self inside of her already. I couldn't bring that back, but I could keep her alive physically." And with further questioning it explained that the only way to bring her back was for her to feel wanted. This ego state apparently was the same one uncovered early in the therapy, which she named Survival, and which the patient described as pushing her to meet the demands of the world, the one who said, "Achievement is survival." Her own achievement, and only her own achievement, made her feel wanted. My feeling at this point of the therapy was that we had dealt with the earliest possible life experience. We discussed what she knew of her birth. She stated that her mother told her that at eight months in utero, the doctor was concerned because the fetus no

longer moved; he could not find a heartbeat; and he anticipated the possibility of a stillbirth. When she was born, it was a breach birth. We speculated that the pressure and choking feeling might have been the umbilical cord strangling her. Therapy continued which included repetition of the pressure and birth experiences bringing bits of new data, but the feeling of "I'm not supposed to live" continued. I decided to use the Affect Bridge technique again to find the etiology of that feeling. In deep hypnosis I had her return to wherever that feeling first originated. She began to feel a churning "like on a real stormy ocean ... in a violent storm . . . being tossed and turned . . . feeling seasickness ... I'm very little." When I asked what she was thinking, she answered, "Nothing; my mind couldn't think yet." But she could feel in her body a fear of dying along with the tossing and churning and nausea. Suddenly all feeling shut off. To my inquiry she responded, "If I would have felt it any more my body would have died." For the rest of the session and subsequent ones, I obtained the following data: Long before the 8th month pressure experience, there was apparently a chemical onslaught that produced the violent storm which shut off feeling so that the fetus would survive. When the pressure came at 8 months in utero, other needed body chemicals started turning off, representing another threat to life. (Apparently this turning-off process was going on at the time the doctor was worried that the fetus might the because of its stillness and imperceptible heartbeat.) At this point a "life force," or "energy force," or "ego state," which the patient called Survival came to exist. Survival stopped these chemical life forces from ebbing away so that the fetus would not die. How Survival managed this process I really don't know. The patient, in hpnosis, explained, "The part that shut off was everything that wasn't physical ... all the emotional part and the part that made her a person turned off, first in the storm and then again at 8 months, because it was too afraid to die." Thus there was a splitting during the storm experience and a reactivation of that splitting at the 8-month experience. By the time the baby was born the schizoid character make-up already existed. After these sessions the patient contacted her mother. She found out that early in her pregnancy, the mother ingested an ergot preparation in an abortion attempt. The mother experienced severe contractions of the uterus, but nothing more happened so she made no other attempts. We concluded that the storm she felt must have been the effect of the ergot. It was clear to us that the sense of "I am supposed to die" came originally from the attempted abortion and was reinforced by the unusual pressure during the 8-month experience. Where the unusual pressure came from I don't know. But the pressure renewed the message of death, to which the body chemicals began to respond by shutting down, and in addition brought the message of rejection from the womb, which she pereceived as mother. Perhaps that message of rejection might not have occurred without the previous abortion experience. The sense of a malevolent environment was already there, resulting in feeling repulsed that she came from her mother and a feeling of self-revulsion at existing, since nothing good could come from that negative source. I am presenting the case of Susan because it was the most complex and unusual case of attempted abortion I ever treated, but I have had other cases, two of which I will mention. Both cases were young women who, after years of therapy prior to my seeing them, still felt they were not supposed to exist, or were afraid to exist. With one of these patients I became suspicious of the etiology of her problem when I saw the doodling she produced while listening to a class lecture just prior to our session. I asked her if she knew anything about her birth. She related that her unwed mother had tried to abort her, was unsuccessful, and then released her for adoption at birth. Looking at her doodles, I said, "I assume your mother attempted the abortion with a coat hanger," to which she replied with a very surprised, "Why, yes; in fact, it caused damage to my shoulder; the doctor noticed it at birth." The unconscious doodles told the story. In the other case, the patient explained that her father beat up her mother with the intent of inducing an abortion, because the mother refused to submit to an abortion. In reviving this memory under hypnosis, the patient re-experienced the fear of living she had always felt so strongly. I believe there must be many such cases in therapy where the patient's underlying conflict was caused by an attempted abortion, but it does not occur to the therapist or to the patient to reach back that far. In the interests of therapeutic economy, such probing is not always appropriate or necessary. However, in the hope of undoing such early damage, we should look more often for evidence at birth or prior to birth for psychopathy. Sidebar

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