Abortion Trauma: Application of a Conflict Model

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Full Text: Headnote ABSTRACT: This paper advances the proposition that in carrying out the decision to undergo elective abortion, a woman experiences a potentially traumatizing psychological event. Vignettes from clinical practice illumine the symptoms and development of post-traumatic stress disorder in the aftermath of abortion. A model of psychic trauma is presented to account for the nature of abortion as a traumatic Stressor. It is based on psychoanalytic considerations, with an emphasis on the role of aggressive energy in the reconfiguring of psychic activities following trauma. The concept of an intrapsychic conflict between the basic drives leads to an understanding of the post-traumatic state, and its persistence. INTRODUCTION In the polarized political atmosphere that clothes the societal debate over elective abortion, relatively little attention appears to be directed at the impact of the event on the central actor, the pregnant woman. On one hand, evidence has been presented (Dagg, 1991) suggesting that the negative impact of abortion is transitory, and may be overshadowed in the long run by positive effects. In contrast, Speckhard (1987) has documented deleterious long-term effects for a sample of post-abortion women, and Barnard (1991) has presented data on posttraumatic symptoms three to five years post abortion that rival those of Viet Nam veterans. Whatever the overall incidence of post-abortion trauma turns out to be, the clinical reality is that for many women, the event is a powerfully stressful one, requiring psychotherapeutic or spiritual intervention (see, for example, Selby and Bookman, 1990; Stanford, 1986). Networks of post-abortion support groups, such as Women Exploited By Abortion (WEBA) testify to the experience of victimization incurred when actions taken under tremendous stress have unanticipated effects (Reardon, 1987). Despite the availability of these data-oriented studies, accounts of treatment interventions, descriptions of indigenous support/self-help groups, and first-person testimonies, there continues to be resistance within the professional community to the acknowledgment that elective abortion can be traumatic. This resistance is exemplified by a recent commentary in the Journal of the American Medical Association (Stotland, 1992) which concludes flatly that: "There is no evidence of an abortion trauma syndrome (p.2079)" The purpose of this paper is to contribute to an understanding of the post-traumatic stress reaction that clearly occurs in a number of instances. The intention is to illuminate the clinical syndrome in the light of a generic approach to psychic trauma. Debates about incidence and prevalence await empirical answers; however, considering that some 1.6 million abortions are reported annually, in the United States alone, it will be seen that even very small percentages would reflect large numbers of individuals. THE NATURE OF PTSD Post-Traumatic Stress Disorder (PTSD) formally entered the psychiatric nosology in 1980 in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). It was retained in DSM-III-R (American Psychiatric Association, 1987) with only minor revision. Descriptively, PTSD is a unique diagnosis in that it requires, as a diagnostic criterion, identification of an external originating event. For an event to be considered "traumatic" it must be of such a nature that it falls "outside the range of normal human experiences" and "would be markedly distressing to almost anyone." While this criterion (A) might better be determined by anthropologists or sociologists than psychiatrists, the intent seems to be to identify an event that violates expectations or assumptions about one's place in the world (see, for example, Janoff-Bulman, 1985) and one's preparedness for such an event. Thus, to lose a loved one to illness, even suddenly, would be a cause for grief, but to lose a loved one to murder might well be considered traumatic. In each case the loss would be the same, but in the case of murder the intrusion of harmful human agency imposes a different meaning and evokes a more conflicted response in the survivor (Amick-McMullan et al., 1988). Following the descriptors of PTSD, a

further criterion (B) is the occurrence of reexperiencing phenomena related to the event. The traumatized individual will have recurrent nightmares, intrusive thoughts about the event, resurgence of the emotional response at the time of the event, or behave as if the event were recurring. Only one phenomenon is necessary for the criterion to be met. Criterion C is met by the occurrence of "avoidance" symptoms: withdrawal, avoidance of external reminders, emotional numbing, loss of interest, anhedonia, or efforts to avoid thoughts, feelings or behaviors associated with the trauma. Finally, criterion D requires two symptoms of hyperarousal: that is, two of hypervigilance, sleep disturbance, irritability, decreased concentration, or exaggerated startle response. In Barnard's sample, 18.8 percent of women met these criteria with respect to an abortion. From my own case material, the following vignette illustrates these symptoms: A 22-year-old woman who underwent an abortion at age 17 reported a five-year history of repetitive nightmares. The nightmares were vivid, veridical repetitions of the actual event. After five years, they still occur once or twice a week, and result in her awakening and screaming. This is a reenactment of her emotional response at the time of the event. Since then she has felt emotionally estranged, distrustful, and has entered no new relationships. She gave up previously enjoyable hobbies, and experiences her job and her life to be without meaning. She is wary and irritable, alienated from family and coworkers, and without close friends. She contemplates relocating out of state in order to "put everything behind" and "make a new start". In the above example, we find that the traumatized person has essentially reorganized her life around the reenactment of the activities from the time of the abortion. The nightmares and emotional outcry reflect the actual event. The alienation and distrust are reenactments of her social milieu at the time: she felt so alarmed and shamed at discovering that she was pregnant that she trusted no one, including parents, with the information. She broke off her relationship with her sexual partner shortly after the abortion and has continued in a socially isolated state. The attempt to avoid dealing constructively with thoughts and feelings is expressed externally through the intention to relocate, and an unwillingness to explore the issues in therapy. The conflict present at the time of the abortion is reflected in her dual intentions: she approached both a female counsellor and myself, then withdrew from treatment. She felt unable to trust either of us, as she felt unable to trust her mother and father. A CONFLICT MODEL OF TRAUMA The approach to understanding PTSD as an expression of intrapsychic conflict was first outlined by Emery (1987) and has come to be termed "trauma psychology" (Emery &Emery, 1989). Trauma psychology is an elaboration of the understanding of the operation of the intrapsychic aggressive drive derived from general psychoanalytic theory. Although analysts differ on the question of the primacy of aggression (see, for example, Brenner, 1986), the trauma psychology model accords it the status of a primary drive, along with the libidinal drive, consistent with the final position of Freud. In his unfinished Outline, he was clear in his thinking regarding the operation of two instincts and their derivatives: that "this interaction of the two basic instincts with and against each other gives rise to the whole variegation of the phenomena of life." (1920, p.21; emphasis added) It is suggested that in the event that these basic aggressive and libidinal drives are both active and in conflict as to goals, the experience will be one of stress, and the potential for trauma will be present. The goals of the libidinal drive are creation and nurturance of life, maintenance of relationship with others through the formation of internal objects of attachment, and investment of energy in those attachments. The goals of the aggressive drive are to secure a state of adaptation with respect to the external world, altering both the external milieu and the internal milieu in the interest of a correspondence or congruence between these levels of psychic reality. When there is a perception of threat in the external world, aggressive energy is involved in the response to that threat, and disregards to a degree the investment of libidinal energy in specific objects (cathexes). When the perceived threat coincides with the identification of an object of attachment, the psychic conflict is aroused, and its solution will require a dominance of one drive or another. In the event that aggression dominates the resulting activities, at the expense of attachment, then an intrapsychic injury or trauma is said to occur. Under ordinary conditions, persons are commonly presented with such scenarios. In the vicissitudes of everyday life, we experience conflict with others, and may respond aggressively as in an argument with a loved one. Some level of distress

will follow until one or the other actor takes steps to restore the relationship, thereby restoring the attachment. Failing this, the psychological distance created by the conflict will endure, and subsequent events may reflect further conflicts as representations of self and other continue to be aggressively determined. In the developmental process, this state of affairs may be the source of underlying "borderline organization," (see Kernberg, 1984, p.112 ff). In later stages of maturity, it may be the substrate of the experience of alienation, a hallmark of post-traumatic states (Erikson, 1950). When the aggressive actions are such that the relationship is irreparable (as with lethal acts), the potential for restoration of the previous libidinized internal state is lost; the psychic structures representing the identities of self and other in the event come to be dominated by the aggressive drive, and regulated by the psyche according to the principle of repetition-compulsion rather than pleasure-unpleasure (Freud, 1920). This perspective suggests the conditions that render an event or situation traumatic. There is the perception of at least two actors, the agent of harm (designated aggressor) and the recipient of harm (designated victim). Others may be present, including witnesses, enablers, co-victims, and co-aggressors; in addition, one might add the observing ego or internal witness, which records the experience. The challenge to adaptation resides in the requirement to represent internally the harmful transaction. Through the process of constructing the internal representation, the identity structures of each actor are organized, giving rise to a pathological structure of victim/aggressor fusion (Emery &Emery, 1989). The traumatic event is internalized, informed by aggression at the expense of attachment. It becomes an organizing element of subsequent psychic life, regulated by the principle of repetition and characterized by reenactment (Erikson, 1990). A 34-year-old married woman came for therapy, complaining of feeling "worn out, aimless, a failure". She wondered aloud why she had come, stating she felt worthless and "I don't know why I'm here". She had become pregnant thirteen years previously with a man she had known only a month, and had gone for an abortion, about which she expressed no feeling. One year after this she had become pregnant again, with the same man, and had a second abortion within a day or two of the anniversary of the first. She subsequently married her partner, but felt it was a bad choice. She believed "he married me because I was insecure ... he trapped me," and expressed the thought that "if he would only die, it would solve my problems-I don't need him". She also described having dreams about her two live children being killed. Her descriptions of her relationship with her husband alternated between remorse that she betrayed him and failed him with anger at him for "pushing her into" the second abortion, and self-reproach for going ahead with it. The woman described above has felt angry and alienated from her husband throughout their marriage. She has two sons, aged two and five, with whom she is aggressive and punitive, and at the same time fearful of abusing. The impact of having carried out a destructive option can be seen in the repetitious pattern of aggression toward objects, and the conflict is consciously expressed through feelings of depression and guilt. In viewing the decision to undergo elective abortion as an act of aggression, it is most instructive to think of the woman's selfperception as a person caught in an insoluble dilemma, with the option of carrying the baby to term being equated with victimization. In each of the first two vignettes the woman believed that there was a realistic expectation of shame, disgrace, and indeed punishment from others in her social and family matrices. They each perceived the prospect of curtailed autonomy and lost opportunity as results of bearing a child. In addition, each was totally unprepared for the emotional consequences. Subsequent to abortion, the woman is subject to continuing conflict rather than the expected resolution. The structuring of the conflicted state through formation of an identity structure representing the aborted baby (identification with the victim) can be seen in the feelings of self-depreciation. A patient said: "I feel worthless-less than human-a piece of garbage. Since I killed my baby I don't deserve to live". As the woman in the second vignette said: "I don't know why I'm here", revealing the unconscious thought that she should be dead, like her aborted offspring. The shifting enactments of victim and aggressor are amply illustrated in the following case: A 26-year-old married woman became pregnant within months of the birth of her second child. Her husband became angry and threatening, emotionally coercing her through threats of abandoning her if she did not abort this third pregnancy. The husband's doctor likewise advised her that the

stress of having a third child could exacerbate her husband's heart disease, possibly killing him. Either way, she faced a possible life of poverty, alone with three young children and no marketable vocational skills. She sought out a friend who was a nurse, who told her she would be "crazy" to have another child, that she herself had had an abortion a few years before and "it was the best move I ever made". The woman in question protested, as a devout Roman Catholic, on religious and moral grounds. Abortion violated her internalized values, but the maintenance of an intact family was also a strong value at stake. Arrangements were made by the people around her, and essentially all she had to do was acquiesce, which she did. She clung to the justification that she was acting in the interests of her husband's health and her family's social and economic viability. During this time she was aware of being internally opposed, yet participated by going through with the procedure under anesthesia in a hospital setting. She therefore had no conscious experience of the abortion itself, but as she awoke the thoughts on her mind were remorseful: "What have I done?". She experienced subsequent symptoms of post-traumatic stress but kept them to herself. Attempts to talk about the abortion with her husband, after it was over, were met with silence. She came to treatment after her husband left her for another woman, and the rationalization of being able to keep the family together fell apart. It was seventeen years later. DISCUSSION In addressing issues of pregnancy and abortion from a psychoanalytic perspective, Pines (1982) has clarified the significance, particularly of the first pregnancy, to the woman's identity: "For a woman whose experience with her own mother has been 'good enough', first pregnancy is a pleasurable developmental phase characterized by identification with the omnipotent, fertile, life-giving mother" (p.311). "Nevertheless, it is a time of stress when conflicts belonging to past developmental stages are revived and the young woman has to achieve a new adaptive position within her internal and external worlds" (Pines, 1990, p.301). Among these past developmental conflicts appear to be problems with the mother-daughter relationship. Barnard (1991) found that among women reporting traumatic-stress reactions to abortion, lack of a mother-daughter bond was the most important predictor. Other predictors were prior emotional conflicts and conflicted relationships with the father of the aborted child. In each of the first two vignettes above, the patient aborted a first pregnancy, and each reported a poor maternal relationship. Indeed, neither had consulted her mother or told her mother about the abortion. In the third vignette, the situation was somewhat different. The patient had had two children prior to the abortion. With her third pregnancy, she sought a variety of opinions, but avoided discussing it with her mother. As she stated, "There was only one person who could have talked me out of it-and I didn't tell her what I was facing-that was my own mother". In order to carry out the abortion she distanced herself from the relationship. It would be misleading to imply that such potential risk factors for abortion trauma are in themselves aspects of post-traumatic pathology. Such conflicts could be pathologized only at the risk of missing the essential feature of PTSD, i.e., the reenactment of symptoms reflecting the event itself. The existence of the developing object in utero requires an adaptation in the mother's internal psychological world, involving the construction of a representation of an attachment object. Destruction of the fetal child assaults the stability of the corresponding internal structure. The conflict between life and death is then played out internally, with all the accompanying anguish of PTSD symptoms. The proposition that this conflict is at the center of the traumatic experience is supported with the words used by women in the circumstance. Almost universally, they speak of the "baby" rather than "fetus" or other terms. Commonly, there is an intuitive sense, even a conviction, of the gender. Frequently there is, or can be readily elicited, a name for the fetal child, and with that a sense that it had this name independent of the parents' intention to name it. These are indicators of the presence of a well-developed psychic structure representing the fetal child as an object of attachment. They reveal the humanity of the object, an attribute in conflict with the need of the aggressor to dehumanize the victim. The conflict can persist for years as illustrated in the case material, and the often-reported pattern of thoughts dwelling on the aborted child, what (s)he would have been like at different ages, and anniversary reactions, not only at the time of the abortion, but also at the time of the projected live birth, which aborted women frequently figure out for themselves. These perceptions of the humanity of the victim are sources of extreme distress. One option in response, as an

avoidance of the distress, is the embracing of the aggressor identity, which includes in its enactment the dehumanization of the intended victim. In such cases, the woman persists in or commonly returns to a mental state dominated by aggression, and which in fact predominated at the time of the abortion. One post-abortion woman reported, with a facial expression of intense distaste: "You can't imagine what it's like to have this . .. this thing growing inside you and feeding off you" (emphasis hers). This simple declaration illustrates the woman's perception of the child as an alien and inhuman threat; the dehumanization of the fetal child that this represents is in turn an aspect of the woman's aggressor identity, which she enacted by aborting the child and thus eliminating the "thing" that threatened. The extent of organization of activities around the trauma is illustrated more broadly by the example of a woman who had an abortion early in adulthood, experienced all the avoidance symptoms of PTSD, and expressed her trauma identity by becoming an entrepreneurial owner and operator of several abortion clinics. After a number of years promoting as well as providing abortions, she began to experience extreme guilt and depression. She subsequently left the abortion industry and became an anti-abortion advocate. We see the split between the aggressor and victim identities played out in sequence in this woman's life. Further, it is enlightening to consider this dynamic as it is manifested in the public polarization around the issue: women with past abortion histories lead both sides of the argument, often with vehement emotion and furious intensity. SUMMARY The proposition is presented that elective abortion can be a traumatic event leading to development of a post-traumatic state. A supporting theoretical model derived from analytic principles is offered in explaining the traumatic nature of the event. Clinical case material is presented to illustrate the reality of post-abortion trauma, and allusions to the societal issue of abortion are made. References REFERENCES American Psychiatric Association (1987). Diagnostic and statistical manual of mental disorders. (3rd ed., rev.). Washington DC: APA. Amick-McMullan, A., Kilpatrick, D., Veronen, L., and Smith, S. (1988). Family survivors of homicide victims: Theoretical perspectives and an exploratory study. Journal of Traumatic Stress 2(1), 21-35. Barnard, C. (1991). Stress reactions in women related to induced abortion. Newsletter, Association for Interdisciplinary Research in Values and Social Change 3(4), 2-3. Brenner, C. (1986). Discussion. In A. Rothstein (Ed.) The reconstruction of trauma, 195-203. Connecticut: International University Press, Inc. Dagg, P. (1991). The psychological sequelae of therapeutic abortion-denied and completed. American Journal of Psychiatry 148(5), 578-585. Emery, P. (1987). The dynamics of PTSD based on ten propositions. PTSD Quarterly Newsletter 4(4), 1-3. Emery, P. and Emery, O. (1989). Psychoanalytic consideration on PTSD. Journal of Contemporary Psychotherapy 19(1), 39-53. Erikson, E. (1950). Childhood and society. New York: Norton. Erikson, R. (1990). Dissociation, aggression, and re-enactment: the structure of psychic trauma. Paper presented at the 7th International Conference on Multiple Personality and Dissociative States. Chicago, Illinois. Freud, S. (1920). Beyond the pleasure principle. In J. Strachey (Ed.) The standard edition of the complete psychological works of Sigmund Freud, Vol. 18,7-64. London: Hogarth Press. Janoff-Bulman, R. (1985). The aftermath of victimization: Rebuilding shattered assumptions. In Figley, C. (Ed.) Trauma and its wake. New York: Brenner Mazel. Kernberg, O. (1984). Severe personality disorders. New Haven: Yale University Press. Pines, D. (1982). The relevance of early psychic development to pregnancy and abortion. International Journal of Psycho-Analysis 63,311-319. _____ (1990). Pregnancy, miscarriage and abortion: A psycho-analytic perspective. International Journal of Psycho-Analysis 71, 301-307. Reardon, David C. (1987). Aborted women: Silent no more. Westchester, IL: Crossway Books. Selby, T. with Bockman, M. (1990). The mourning after. Grand Rapids: Baker House. Speckhard, A. (1987). Psycho-social aspects of stress following abortion. Kansas City: Sheed and Ward. Stanford, S. (1986). Will I cry tomorrow? Healing post-abortion trauma. Old Tappan, N.J.: Fleming Revell. Stotland, N. (1992). The myth of the abortion trauma syndrome. Journal of the American Medical Association 268(15), 2078-79. AuthorAffiliation Robert C. Erikson, Ph.D. AuthorAffiliation Robert Erikson, Ph.D., is a clinical psychologist in Brecksville, Ohio, where he has recently completed four years as Director of the Center for Stress Recovery, the posttraumatic-stress-disorder (PTSD) treatment program at the Cleveland VA Medical Center. He is in private practice and is

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