Complicated Mourning: Dynamics of Impacted Post Abortion Grief

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Full Text: Headnote ABSTRACT: Current estimates are that one in every five women in the United States will have undergone at least one abortion, with 1.4 million abortions occurring annually. Increasingly, long-term stress reactions to abortion have been documented in the research literature. Post Abortion Syndrome (PAS), a variant of Post Traumatic Stress Disorder, occurs in women who experience their abortions as traumatic. When the emotional components of the abortion experience are repressed, as in PAS, impacted grief and complicated mourning result. Diagnosis and treatment strategies are discussed, as well as the societal dynamics that have slowed recognition of this disorder. Soon after my abortion, I began waking up at night hearing a baby crying. It seemed so real that I was sure there was a baby somewhere in the house. I would get up and begin switching on the lights, looking in closets, searching, trying to find that baby, so I could make it stop crying. My roommates thought I had lost my mind. They would tell me there was no baby crying but I was sure there was. I couldn't sleep. That's when I started taking the sleeping pills. INTRODUCTION There are circumstances in which a person experiences a sense of loss but does not have a socially recognized right, role, or capacity to grieve. When a loss cannot be openly acknowledged, publicly mourned or socially supported, grief is disenfranchised (Doka, 1989). Abortion is one of those losses. Ambivalent relationships and concurrent crises have each been identified in the literature as conditions that complicate grief (Worden, 1982; Raphael, 1972; Rando, 1984; Doka, 1989). Abortion often contains both of these elements. Attachment to the fetal child1 may occur despite the desire to rid oneself of it, to be freed of the crisis pregnancy. The trauma involved in being both attached to and responsible for the death of one's fetal child can be emotionally overwhelming, and cause a range of symptoms. Contrary to widely held assumptions, an undetermined but significant number of women are psychologically traumatized by their abortions. These women suffer immediate, chronic, long-term, delayed and/ or acute post abortion grief reactions. This range, as defined by Speckhard and Rue (1992 a &b), can vary from the experience of Post Abortion Distress (PAD), a type of adjustment disorder, to Post Abortion Syndrome (PAS), a specific type of Post Traumatic Stress Disorder caused by a traumatically experienced abortion, to Post Abortion Psychosis (PAP), which may include major thought and affective disorders. It is important to note that any of these range of symptoms would not be expected to appear if neither psychological attachment nor recognition of fetal death occurs either at the time of the abortion or at a later date. However, one would expect that for a large percentage of women having abortions, the abortion is recognized as a type of death experience, and that at least for some a bond of attachment to the fetal child has been experienced which is severed traumatically in the abortion. Women with such perceptions, particularly the latter one, are those most at risk for PAS and complicated mourning. When PAS occurs, complicated mourning and the dynamics of impacted post abortion grief ensue. Scope of the Problem At the time that abortion was legalized in the 1973 Roe v. Wade Supreme Court ruling, those in the health care sector generally assumed that with the stigma surrounding an illegal and clandestine procedure removed, any mental health risks from abortion would be marginal and minimized. In the early seventies there was little awareness of the potential psychological-health risks of the abortion procedure, and no expectation that induced abortion would be so extensively used, in some cases substituting as a form of birth control. The view of abortion as a psychologically benign procedure remains intact today. The prevailing opinion in the psychiatric-psychological literature as well as that espoused by nearly every professional health and mental health organization is that abortion has negligible mental health risks and that any negative psychological outcomes which do occur are short-term in duration (American

Psychological Association, 1987; Fox, 1990). Abortion has been viewed solely as a coping mechanism, with little to no consideration that it also could be experienced as a traumatic event. There is fierce political controversy surrounding the subject of abortion: "the heat of the conflict tends to melt the boundaries between demonstrated fact and personal belief (Stotland, 1992). Professional recognition of the existence of post abortion trauma is often held hostage by these heated emotions as well as by political philosophies, as illustrated by Stotland (ibid.) in her recent report in the Journal of the American Medical Association. In this report she states: "There is no evidence of an abortion trauma syndrome." Yet in her book she clearly contradicts herself in acknowledging that post traumatic stress disorder results from illegal abortions and a higher risk of adverse psychiatric sequelae occurs with later-term legal abortion, coerced abortion, and when there is a prior psychiatric illness. Likewise, she concedes that men can have profound negative feelings such as guilt, rage, helplessness and loss, about abortion, their own responsibility in it and exclusion from it (Stotland, 1989). There is no argument in the traumatology literature that the experience of trauma is shaped by one's interpretations of it, including one's political interpretations of it. However, our understanding of trauma, including abortion trauma, should not be shaped by politics. While abortion has become the most common surgical procedure performed in the United States today, very little is known about its psychological outcomes for the women, and even less is known about its impact on their family systems and significant others. To date, there has been no large-scale, national epidemiological study on the emotional health risks of abortion, nor one comparing postpartum stress reactions among the various pregnancy outcomes. This absence of available data on abortion's aftermath and how it compares to other pregnancy outcomes is striking in a consumer-oriented nation where approximately 1.5 million abortions occur each year. Nearly one out of every three pregnancies in the United States ends in abortion. Current estimates in the U.S. are that one in every five women will have undergone at least one abortion during her childbearing years (Forrest, 1987). REVIEW OF THE LITERATURE DOCUMENTING ABORTION AS TRAUMA The first international symposium on the psychological effects of induced abortion occurred in 1978 at Loyola University in Chicago (Mall &Watts, 1979). During this symposium, Liebman and Zimmer (1979) reported on their study of 70 post-abortive women; 58 (83 percent) of these women identified their abortion as causative of emotional problems in their lives. The authors described women's reactions to abortion, such as flashbacks, depression, guilt, sleep disturbance and lowered self-image. Though not explicitly identifying abortion as traumatic, the presenters at this symposium clearly documented psychological health risks of this procedure, including post-abortion psychotic reactions. In congressional testimony, Rue (1981) presented evidence identifying abortion as a stressor capable of causing Post-Traumatic Stress Disorder (PTSD). The Diagnostic and Statistical Manual of Mental Disorders (DSM III) first identified PTSD in 1980. At the first national symposium on post abortion healing held in 1986 at Notre Dame University, Post Abortion Syndrome (PAS) as a clinical entity was formally defined as Selby and Speckhard independently reported on post-traumatic responses to abortion experiences and as Rue defined and set forth the criteria for diagnosing PAS as a variant of PTSD. In the past five years increased attention has been directed at the potential of abortion to be experienced as trauma. In recent years the literature has included reports of long-term and high-stress reactions to abortion (Speckhard 1987a; Speckhard 1987b; Reardon 1987; DeVeber, Ajzenstat, &Chisholm 1991; Angelo, 1992; Rue &Speckhard 1992b; Speckhard &Rue 1992); traumatic responses, including the biphasic alternations described by Horowitz (1974) of avoidance/denial and intrusion/reexperience (Speckhard 1987a; Rue &Speckhard 1992b; Speckhard &Rue 1992); as well as studies using standard outcome measures of PTSD (Barnard, 1990; Hanley, Piersma, King, Larson &Foy, 1992). In their recent paper, Speckhard and Rue (1992) further defined and set forth criteria for diagnosing PAS. These diagnostic criteria are presented in Table 1. Through structured interviews with highly stressed post-abortive women, Speckhard (1987b) described the impacted grief, guilt and long-term reactions that typically follow a traumatic abortion experience. These include nightmares, anniversary reactions, projections of fears and anxieties onto subsequently conceived pregnancies and children, fears that others would learn of the abortion,

preoccupation with the aborted child, discomfort around small children, frequent crying, flashbacks, sexual and relationship dysfunction, suicidal thoughts, and increased drug and alcohol usage. The majority of women studied reported being surprised at such intense reactions to their abortions. In the first study to apply standardized outcome measures for PTSD to abortion, Barnard (1990) reported that 45 percent of her sample of 80 women had symptoms of avoidance and intrusion, and that 19 percent met the full diagnostic criteria for PTSD. Speckhard and Rue (1992) provided additional clinical descriptions of abortion trauma and rationale supporting the diagnosis of PTSD. Symptoms of traumatization have also been documented in populations of women who are aborting for therapeutic reasons. This fact suggests that "wantedness" may not be the key issue determining whether or not a woman is traumatized by her abortion, as some have suggested. In a study of couples who elected to undergo prostaglandin induction abortion for genetic reasons, i.e., because of fetal anomalies, Magyari et al. (1987) reported negative psychological sequelae in their sample. Other researchers have corroborated that grief over a perinatal loss, including abortion, often occurs irrespective of wantedness (Peppers, 1987). ABORTION EXPERIENCED AS TRAUMA It is likely that post-abortion traumatization is underreported and occurs with more frequency than current estimates suggest (Adler et al., 1990). According to the DSM-III-R (American Psychiatric Association, 1987), PTSD traumata involve "an event which is outside the range of usual human experience . . . e.g. serious threat to one's life or physical integrity; serious threat or harm to one's children . . . or seeing another person who has been or is being, seriously injured or killed as a result of . . . physical violence." Recently, trauma experts have expanded that definition to include even learning or hearing of a traumatic event (Peterson et al., 1991).

Table 1

Post abortion syndrome: Diagnostic criteria.

A. *Stressor:* The abortion experience, i.e., the intentional destruction of one's unborn child, is sufficiently traumatic and beyond the range of usual human experience so as to cause significant symptoms of reexperience, avoidance and impacted grieving.

B. *Reexperience:* The abortion trauma is reexperienced in one of the following ways:
- recurrent and intrusive distressing recollections of the abortion experience;
- recurrent distressing dreams of the abortion or of the unborn child (e.g., baby dreams or fetal fantasies);
- sudden acting or feeling as if the abortion were recurring, including reliving the experience, illusions, hallucinations, and dissociative (flashback) episodes upon awakening, when intoxicated, or at other times;
- intense psychological distress upon exposure to events or objects that symbolize or resemble the abortion experience (e.g., medical clinics, pregnant mothers, subsequent pregnancies), including intense grieving and/or depression on anniversary dates of the abortion or on the projected due date of the aborted child.

C. *Avoidance:* Persistent avoidance of stimuli associated with the abortion trauma or numbing of general responsiveness (not present before the abortion) as indicated by at least three of the following:
- efforts to avoid or deny thoughts or feelings associated with the abortion;
- efforts to avoid activities, situations or information that might arouse recollections of the abortion;
- inability to recall the abortion experience or an important aspect of the abortion (psychogenic amnesia);
- markedly diminished interest in significant activities;
- feelings of detachment or estrangement from others, including withdrawal in relationships and/or reduced communication;
- restricted range of affect (e.g., unable to have loving or tender feelings);
- sense of foreshortened future (e.g., does not expect to have a career, marriage, children or a long life).

D. *Associated Features:* Persistent symptoms (not present before the abortion), as indicated by at least two of the following:
- difficulty falling or staying asleep;
- irritability or outbursts of anger;

- **difficulty concentrating;**
- **hypervigilance**
- **exaggerated startle response to intrusive recollections or reexperiencing the abortion trauma;**
- **physiologic reactivity upon exposure to events or situations that symbolize or resemble an aspect of the abortion (e.g., breaking out in a profuse sweat during a pelvic examination or hearing vacuum-pump sounds);**
- **depression and suicidal ideation;**
- **guilt about surviving when one's unborn child did not;**
- **self devaluation and/or an inability to forgive one's self;**
- **secondary substance abuse;**
- **eating disorders.**

E. *Course:* Duration of the disturbance (symptoms in B, C and D) of more than one month's duration; onset may be delayed (by more than six months after the abortion).

Note: Developed by Vincent M. Rue, from diagnostic criteria for "post traumatic stress disorder" in the *Diagnostic and Statistical Manual of Mental Disorders III-R* (DSM III-R), American Psychiatric Association (1989, p. 250–251). The American Psychiatric Association in no way supports the existence of "post abortion syndrome," nor does it find any clinical evidence for it. The *DSM III-R* does not make reference to it. However, the *DSM III-R* does list abortion as a "psychosocial stressor."

Many women who are traumatized by their abortions refer to unanticipated pain and fears of bodily injury. A fear that parts of the reproductive organs may have been removed or damaged is commonly expressed among women who have undergone a traumatic suction abortion. Among women with PAS there is usually a perception of fetal death, at times including sights or contact with parts or the whole of the fetal child (Selby, 1990; Speckhard, 1987b). Indeed, when bodily injury (such as a perforated uterus) or an incomplete abortion occurs, psychological traumatization is exacerbated. Complications, the need for further procedures, and the experience of any sensory contact with the aborted fetal child generally increases psychological traumatization, because the abortion is likely to become defined as a human death event as well as one that involves the potential for physical harm to the self. Likewise, others often become aware of, and involved in, what was expected to be a simple, and secret answer to a problem pregnancy. If following an incomplete abortion, the whole, or parts of the fetal body are discharged the woman is confronted with the shocking reality that the death of a recognizable human being has occurred. Likewise, increased psychological trauma occurs if the fetal child survives the abortion and the pregnancy continues. In these cases the woman must face an unsuccessful death attempt; reconcile her participation in that process; as well as make a decision as to whether or not to repeat the procedure; which if not repeated may result in the birth of a severely damaged child. The confrontation of abortion involving a human death experience is taken to the extreme in the rare cases when the surviving fetal child of a late term abortion is delivered alive. In these cases the woman may become the custodial parent to a child whose life she attempted to end, and whose health may be severely compromised by the abortion attempt. Cases involving complications of these types have led to medical malpractice suits in which psychological injury has been established as a result of biased counseling, lack of informed consent procedures, negligence and/or malpractice. Unlike many other types of traumas, the abortion trauma is an experience which is purposefully undertaken. Some have argued that PAS is not a type of PTSD because it is volitional in character (Wilmoth et al., 1991). However, any trauma that occurs as part of the abortion event is often made worse by the perception that it was self-inflicted. With the advent of self-administered abortifacients this issue becomes even more salient. Preliminary evidence suggests that the guilt of being solely responsible for performing the abortion is intensified with self-administered abortifacients such as RU-486. In one clinical trial several women described their experiences with RU-486 as follows: "It's real easy on your body. The hard part is the emotional part."

(Krier, 1990.) The DSM-III-R (American Psychiatric Association, 1987) does not preclude volitional Stressors in the criteria for PTSD (e.g., divorce and accidental homicide). In fact, it clearly indicates that PTSD is more severe and longer lasting when the stressor is of human design, as in the case of abortion (ibid). Case Illustration A 21-year-old single female patient presented for therapy over an eating disorder of three years' duration, beginning shortly after an abortion occurring at age 19. Upon exploration of the abortion, the patient remarked, "It was just one of those things. I wish it wouldn't have happened that way, but I don't see how that could have any bearing on what I'm dealing with now. I had to get that abortion, I didn't have any other choice. I was in college and I would have had to drop out otherwise." The patient was invited to consider discussing any thoughts or feelings about the abortion that may have been related to the near onset of her eating disorder. At first she was reticent, but in a matter of weeks she began remembering and sharing more of her feelings about her abortion. The patient alternated between remembering intense feelings of attachment to the fetal child while denying any long-term impact, stating that she knew the abortion was the right thing to do. She continued to deny until asked about her thoughts and feelings during the abortion. In tears she recounted, "When I was up on the table I felt this terrible panic inside, and I wanted to scream and say 'Stop, don't do this,' but I knew it was too late. It was like I could feel my baby panicking inside, trying to get away. It was horrible, too horrible for words. Then I just felt an emptiness and I knew my baby was dead, that it was over. I felt so alone and I wished I could be dead too. Now I feel like my uterus is a tomb and I wonder if I'll ever be able to have children." As the patient dealt with her feelings of loss over the abortion and her guilt and anger, at herself and others, for not protecting the fetal child, her eating disorder was no longer utilized to manage the intrusive recall. She began to openly mourn her loss. In addition, other researchers have noted the link between recurrent abortions and eating disorders, both functioning as an internal calming mechanism for dealing with consciously unacceptable emotions (El-Mallakh &Tasman, 1991). In the case reported herein, the bulimia served as a means of dealing with the negative reexperiencing of abortion traumata. DIFFICULTIES IN RECOGNIZING IMPACTED GRIEF REACTIONS TO ABORTION Not unlike other types of post traumatic stress disorders, traumatic responses to abortion often go unrecognized and unlinked to the traumatic event. This is particularly true of abortion since expectations are of bringing relief from an untimely or undesired pregnancy. Societal denial of traumatic abortion experiences and post abortion grief results in few practitioners routinely including pregnancy histories in clinical intake interviews (Donovan &McIntyre, 1990). Likewise, the reproductive status of women seen in psychiatric outpatient and inpatient settings is often overlooked or not reported. Recent abortion or delivery may be buried in a woman's history rather than highlighted as a possible factor in her illness and decision to seek psychiatric care. (Stotland, 1989, pg.9). Researchers at the National Institute of Health Statistics have found the denial on the part of women who have had abortions as problematic; more than one out of two post-abortive women in federal reproductive surveys deny ever experiencing an abortion (Koop, 1989), when statistical estimates make that an unlikely truth. Women who are not traumatized by their abortion often feel stigmatized about having had one, viewing it as a socially deviant act (Zimmerman, 1977). Highly stressed post-abortive women are doubly stigmatized-first by their reluctance to share their abortion experiences for fear of being viewed as deviant, and secondly by feeling that their reactions are a sign of maladjustment to what appears to be a relatively simple, common and benign procedure (Speckhard, 1987a, 1987b). PAS women often tend to view themselves as defective for experiencing their abortions as traumatic, because the trauma that occurs in abortion is neither societally recognized nor anticipated. Like other domains of post traumatic stress responses, post-abortion research and treatment is complex and fraught with pitfalls. This is particularly true with respect to denial on the part of the subject, and the tendency to overlook the traumatic event by those making the inquiry. The tendency to overlook or even discourage disclosure of traumatic material in general has been noted by other trauma researchers (McCann &Perlman, 1990). Case Illustration A thirty-seven-year-old childless, married woman was referred for treatment for PAS after being hospitalized three times and undergoing outpatient psychiatric care for over one year. There was no indication of preabortion psychological morbidity. The patient

recalled, "The first abortion was in December '78 or '79 (twelve years earlier). It cost $235.00.1 remember going there. It was kind of like a dream. I can't remember the second one except that I know I did have one ... Afterward, the nurse came to get me and asked me how I was. I was crying. They took me back to this little observation room. Everyone was so cold. I think Steve came to pick me up. The second time he didn't show up. All I remember is going home on the bus, cramping severely, Steve coming home with a toy, a model airplane." Although the couple remained childless following the two abortions, the patient described a room filled with boy toys, mostly furnished by her husband, who refused to discuss the abortions. The patient described a history of intrusive reexperiencing that corresponded to her menstrual cycle, of becoming euphoric when she ovulated, followed by increasingly manic behaviors as she wrestled internally with ambivalent feelings of hoping that perhaps she was pregnant while fearing the same. As menses occurred, profound depression over not being pregnant ensued. The patient referred to becoming psychotic just prior to her menses on three separate occasions, each resulting in a psychiatric hospitalization. "They always focused on the trauma of getting my period. Each time I would insist on getting a pregnancy test. The last time my husband hospitalized me he came home and found me with a baby doll. I was washing it and dressing it. In the hospital I was hallucinating, seeing these atom bombs, the end of the world, and that we needed to be sending babies off in eggs to protect them, and of a lot of funeral scenes. One of the times I thought I was going to the hospital to have my baby." The psychosocial history included an inability of the patient to be with infants following her abortions, stating that they make her cry. She recalls feeling that her own aborted children were "nowhere". "I always wondered where they were, and about my internal organs-that they were diseased and dead." Speaking of her religious beliefs she said "I know I'm forgiven, but I don't feel it. It still feels wrong. It haunts me." The patient described 10 years of bingeing and purging that functioned as a means of regulating the unwanted reexperiencing. As the patient progressed in therapy her memories of the abortions returned more completely. In regard to the second abortion for which she had been largely amnesic, she recalls, 1 remember getting off the table and the nurse asking me, 'How are you?' I felt like saying, How do you think I am? I just killed my kids, I'm fine.' " In her journal she wrote, "Screaming, screaming, that's all I hear when I listen inside. It's over. The silence begins. You are gone. I killed you. I am all alone. What have I done?" Sharing this, the patient stated, "I was always blaming my husband for the abortions, but when I wrote in here, I took responsibility. When it came down to it, I did it. I miss them so much. I hope I can finally have a baby. I never thought I did this before. I always thought it was Steve and I hated Steve. I wrote, ? didn't want you', and I know it's true because if I did they would be here, it was my choice in the end. That really hurts. All the anger and hostility and the hating probably explains a lot of my depression." As the patient began recognizing and coming to terms with her responsibility for the fetal deaths of her children, she worked through the anger at herself, her husband, and others. She was also encouraged and freed to mourn her losses and to increasingly turn her attention to the present state of her marriage and attach herself to the hope of having another child and a healthy family life after all these years. Her mania and depression linked to the menstrual cycle diminished greatly as she worked through her grief, returning only when additional issues of guilt and fitness for parenthood arose as she continually found herself physically unable to conceive another child. DISENFRANCHISED GRIEF AND COMPLICATED MOURNING Attachment to the Fetal Child In our society, feelings of attachment to the fetal child and loss over the severing of those attachments are not generally recognized in any type of voluntary or involuntary pregnancy termination. Likewise, abortion is not generally recognized as a death event. There is little or no social recognition of the sense of loss that has been incurred nor of the need to mourn this loss. Because the loss by abortion is not a socially recognized one, or because when it is recognized, the action by which it occurs is condemned, support for grief work is neither readily available nor forthcoming. When abortion is experienced as trauma, many of the feelings surrounding the event are repressed. When coupled with feelings of isolation and alienation, grieving becomes particularly difficult. High-stress post-abortive women and men are often reluctant to avail themselves of social support for fear of condemnation by others. Because abortion continues to carry a social stigma, those

who grieve over an abortion perceive limited to no support from friends and family for their feelings of loss. Likewise, they feel equally unable to express their desire to grieve to those who support their choice, due to a fear (or actual experience) of being told that there is nothing to grieve. Not uncommonly from these sources come reprisals for having chosen a course that led them to grieve, or expressions of defensiveness by those who may feel implicated in supporting a decision that has caused distress. Because of the highly polarized feelings most people harbor over abortion, the post-abortive person often finds herself or himself unable to express grief to either party in the abortion debate. Such a person experiences disenfranchised grief (Doka, 1989). Ambivalence-Guilt Ambivalent relationships and concurrent crises have each been identified in the literature as conditions that complicate grief (Worden, 1982; Raphael, 1972; Rando, 1984; Doka, 1989). The abortion event often contains both of these elements. Attachment to the fetal child may occur despite the desire to rid oneself of it-to be freed of a crisis pregnancy. Rando (1986) has identified the significance of this attachment: "Parental loss of a child is unlike any other loss. The grief of parents is particularly severe, complicated, and long lasting, with major and unparalleled symptom fluctuation over time" (pg. xi). That the abortion involved a purposeful decision on the part of the woman who now wishes to grieve her fetal child makes it more difficult to grieve than for other parents whose children have died. Ambivalence related to attachment in abortion decision-making is not easy to resolve. Women who grieve the loss incurred in abortion are rarely clear as to what their relationship is to the deceased. To deny that a traumatic death experience has occurred is to deny any sense of awareness of attachment to her fetal child that the woman may have experienced. Such denial can result in impacted grief. To come to terms with the loss of attachment to the fetal child, an affirmation of the parent-child relationship must first be acknowledged. This, however, is contradictory to having allowed the child's death. Preoccupation-Continuing Attachment After the Abortion In the manner common to biphasic reliving of the trauma (Horowitz, 1974), PAS women generally express two levels of thought processes in regard to the abortion. Consciously they express regrets and concerns about the abortion, but do not acknowledge or grieve the loss of the fetal child. On the unconscious level, however, severe impacted grief over the traumatic death of the fetal child is present and influences subsequent behaviors and personality organization. Intrusive thoughts and reexperiences typically reflect an ongoing preoccupation with the aborted child at the unconscious level. Until the perceived traumatic death of the fetal child is acknowledged consciously, the woman's survivor guilt and grief reactions cannot be processed. Rando states that the mourner's protest of loss is often expressed as a preoccupation with the lost object. This preoccupation manifests in dreams and a desire to deny and reverse the loss, and in over 50 percent of mourners is expressed in visual or auditory hallucinations of the person who died (Rando, 1991). The hallucinations function as a means of psychically undoing the death, momentarily, in order to accomplish a purpose. With the post-abortive woman, these types of hallucinations often accompany the grieving process once the abortion loss is more openly acknowledged. They tend to be benign or positive in nature (Speckhard, 1987a), although occasionally the hallucination of a "haunting" by an angry fetus has been reported (Rue, 1987). Typically a positive experience is described in this way, as one woman recounted: "You're going to think I've really lost it, but the other day I had the most wonderful experience. I was thinking about the abortion and hoping that my baby forgives me, and suddenly I felt this presence. I didn't actually hear words aloud, but I felt he was telling me that he forgave me and that I could get on with my life. It was really powerful. I knew that was him and that he's ok now." Grief Work-Severing the Bonds of Attachment The complicated mourning that typifies post-abortion grief involves an unacknowledged preoccupation with the aborted fetal child. Lindemann (1944, p. 143) defined grief resolution as achieving "emancipation from the bondage to the deceased," readjustment to the environment, and the ability to form new relationships. One of the tasks of the mental-health clinician is to assist in "sharing" the grief work by helping the bereaved extricate himself or herself from overattachment to the deceased person. This, however, becomes problematic for the post-abortive griever, because significant problems exist with recognition, identification, and diagnosis of the distorted presentation of this type of grief.

Bargaining-Attempts to Recoup the Loss Women with PAS often undergo contradictory attempts to avoid knowledge of the loss with simultaneous attempts to recoup it. Such women often enter into compensatory relationships with pregnant women and/or children, and attempt mastery over the survival guilt through compulsions to help while at the same time avoiding recall of their own terminated pregnancy experience. Women who are stuck in this stage of denial of their loss are likely to make comments in therapy such as, "I often think about how Fd like to adopt a couple of older children some day." The ages typically coincide exactly with how old the aborted children would be had they been carried to term, although any connection is often denied. Reenactment-Attempts at Mastery Mastery of the traumatic material is sometimes attempted through reenactment compulsion. Like other reenactment compulsions, the PAS woman returns to the traumatic material by repeating a version of it, usually by becoming pregnant again only to abort yet another pregnancy. This may occur many times before the trauma is recognized, with a great deal of additional traumatic material being added with each additional abortion. While the majority of the 1.5 million abortions performed annually are first abortions, 44 percent are repeat abortions. Delayed Reactions Complicated grieving does not always proceed in a linear fashion. Even normal bereavement can involve alternating periods of intensification and subsiding symptoms, and these may return years after the loss. When abortion is experienced as trauma the emotional reactions to it are often impacted only to resurface when the woman is again faced with childbearing issues. Often, subsequent childbearing events trigger reexperience of the abortion trauma, causing fears during pregnancy (sometimes contributing to a repeat abortion experience) and significant problems with birthing and bonding subsequent to birth. These reactions are typically accompanied by a sense of confusion, as considerable time may have passed since the abortion. Further, because of repression on the part of the individual and societal denial, the woman has no context in which to view her abortion as a potential causative agent in these delayed grief and trauma responses. Nearly one in three abortions in the U.S. are performed on adolescents. The risks of delayed reactions are likely to be greater for this subgroup than others because so many are ill-informed about reproductive facts. For those who were ill-informed it is often only years later, during a subsequent pregnancy that is carried to term, that they may come to perceive and experience traumatically their previous abortion as a human death event. In older women, menopause, hysterectomy, and other reproductive losses can be the trigger for equally confusing delayed episodes of reexperience and grief reactions. Impact on the Family System Family systems dynamics often bear the legacy of a traumatic abortion. Ney (1982) identified three possible reactions of children to a previous abortion in the family: the reaction of (1) the "haunted child," who survives to live in distrust of what may be in store for him while parents conspire not to burden him with the facts; (2) the "bound child," who is overprotected; and (3) the "substitute child" or replacement child, who carries a heavy burden of expectation that he may not be able to fulfill. Speckhard documented that the perceived and wished-for characteristics of the aborted fetal child are often projected onto existing or subsequently conceived children. Such projection creates resentments and an inability to recognize individual differences in the present child. Likewise, overprotection may be an expression of inward guilt over not having protected the aborted sibling. Fearful fantasies of hurting the child during pregnancy, at birth or as a small infant, also often disrupt bonding and can create a very negative maternal self-concept. These fantasies may take on an obsessive nature that reflects guilt over how the aborted fetal child's life was ended (Speckhard, 1987a). Case Example I can't stand to be around Heather. I really love her, but whenever I'm with her I keep thinking about knives. It's like this inner voice keeps telling me to go and get a knife. When I'm in the kitchen I can hardly stand to handle the knives anymore. I get so scared that I might do something to her. And I know if I keep up like this I'll end up in the hospital and then they will take her away from me. I'll be judged an unfit mother and I'll never see my daughter again. I wish I could end these thoughts. Am I crazy or what? If the abortion is held as a family secret, but siblings learn of it, it can create fears and guilt in children who may be too young to deal with information that contradicts their construct of a nurturing parent. According to Weiner and Weiner: "There is increasing evidence that even very young children may be aware of maternal abortions

despite family attempts to maintain secrecy. For those children experiencing other powerfully unresolved conflicts, the abortion of a sibling may trigger a severe reaction ... an abortion can be, for the preschooler, a proof of the parent's capacity to be dangerous. In middle-class homes, where the hostility may be more heavily veiled, an abortion and its surrounding mystery can be experienced as a concrete violent act." (1984: 209, 215) Young children who have some awareness of the abortion may develop fears about being harmed by their parents, due to their perception of their parents having been capable of harming the aborted sibling. As younger children typically do, they may deal with this fear by introjecting the negative attribute of the parent onto themselves, seeing themselves as "bad" or "tainted" rather than recognizing the parent as potentially dangerous. Older children may resent knowing about an event that they feel unable to integrate into their parental concept. This is not to say that parent-child sharing about an abortion in the family is always detrimental. It is, however, recommended that such sharing occur only at an appropriate time in the family history and at the appropriate developmental stage-when the child is strong enough to incorporate such information, when it can be comprehended without threatening the development of healthy cognitive structures, and when it can be potentially beneficial (i.e., mid-late adolescence or later). Likewise, hurt and anger harbored toward men may cause distrust and irritability in the marital dyad. Anger that accompanies intrusive thoughts is often directed at the male partner, whether he was involved in the abortion or not. Traumatic flashbacks of pain during dilation may occur during intercourse, painfully disrupting the conjugal relationship. Grief and ambivalence over the use of one's reproductive abilities also often contributes to a strong desire to avoid sexual intimacy and/or pregnancy. For others, anger itself becomes self-punitive, acted out in selfdenigrating sexual relationships. Clinical evidence of the impact of abortion on relationships can include: (1) decreased self-disclosure; (2) decreased communication because of increased defensiveness; (3) increased apprehension when communicating; and (4) a rupture of the trust relationship between the partners. In relationships, then, abortion may provide "pseudo-homeostasis"; that is, a stability through nonadjustment rather than through readjustment, which can promote even more serious relational disequilibrium (Rue, 1985). Men who have been involved in an abortion often struggle with their internal self-concept of masculinity, feeling that they failed to protect and nurture. These feelings of failure and guilt are often generalized into many areas of the marital and familial relationships. PMS Cyclical reexperiencing of the abortion trauma and intrusions of grief reactions often correlate with the menstrual cycle, greatly exacerbating and/or mimicking hormonally caused symptoms of PMS. Ovulation may coincide with a sense of hopefulness coupled with anxiety about conceiving. Menses may bring ambivalent feelings of relief coupled with depression over not having conceived. The menstrual flow often causes flashbacks of the experience. TREATMENT MODEL As in the treatment of any Post Traumatic Stress Disorder, Post Abortion Syndrome must be recognized and normalized in order for the trauma victim to begin dealing with the traumatic material. Detection of impacted emotions by the health-care provider and education about trauma responses are primary to effective interventions. Because abortion grief and traumatization are so pervasively denied on a societal level, it is paramount in post-abortion grief for the health-care provider to take the initiative in exploring the patient's perceptions and reactions to an induced abortion (Harris, 1986). Normalizing Grief and Trauma Reactions Planned Parenthood, an organization that has historically denied the legitimacy of post-abortion traumatization and that abortion involves a human death experience, affirmed in their Complete Guide to Pregnancy Testing and Counseling, that "women can have a variety of emotions following an abortion (grief, depression, anger, guilt, relief, etc.). It is important to give her the opportunity to air these feelings and be reassured that her feelings are normal. The counselor can also help by letting the woman know that a sense of loss or depression following an abortion is common . .." (Saltzman and Policar 1985, pg. 94). PAS women are usually greatly relieved to learn that their reactions are not atypical. As they find that their symptoms are common to any trauma disorder and that others have experienced abortion as trauma, then· social isolation and self-doubt begin to disintegrate. While they may protest that their abortion was a benign experience, they are often glad to begin to have a framework for understanding the trauma reactions they have

had during the years subsequent to the abortion (i.e., fears of intercourse, pregnancy, childbirth, physician's offices, etc.). They also can begin to see how they have coped through the use of strategies of avoidance as well as their compelling need to repeat and attempt to redo aspects of the abortion trauma(s). Diagnostic Protocol As with other trauma disorders, diagnosis and treatment often overlap considerably due to the necessity to break through levels of denial and repression when identifying traumatic material. An examination of the abortion experience is always warranted when a woman admits to having an abortion and presents a profile of depression, psychosomatic symptoms, compulsive behaviors, preoccupation with the aborted fetal child, troubled family relationships, and/or troubled pregnancy and birth experiences, (Speckhard, 1987a, pg. 20-21). A helpful comment to employ when beginning such an inquiry might be: "Many women have strong emotional reactions to an abortion experience and they often find these reactions so difficult to resolve that they attempt to hold them inside for years and years. Because of what you've told me about your current situation and how it seems to be linked in some areas to your earlier abortion(s), I'd like to at some point go back over your abortion(s) in detail. It's important to see if there's anything left unresolved that perhaps relates to how you're feeling and behaving now." At this point the woman typically protests that her abortion was "no big deal" or that she cried a lot at the time but got over it eventually, or that "Yeah, at the time I had to just numb it out, but it doesn't bother me now." It is generally best to respect such protests as resistance and pace one's inquiries with the trust that is building in the therapeutic alliance. Moving too quickly into the traumatic material and drawing connections between the abortion and obvious avoidance or reenactment behaviors before the woman's own curiosity, ability, and willingness to process these connections occurs is likely to result in the following: 1) a therapeutic impasse; 2) decompensation in the patient who is pushed beyond her tolerance for traumatic recall; or 3) the patient abruptly terminating treatment. Generally, when the current presenting problem is a result of a past trauma, it generates enough information and linkages back to the traumatic event that, for the astute observer, it is simple to keep drawing attention to the possible need to address the abortion as generative of some of the current dysfunction. For example, one patient was told, "you keep telling me about your fear of doctors, and your unwillingness to take care of yourself after your abortion if it involved going to see a doctor. Would you be willing to tell me what happened between you and the doctor during your abortion?" This woman related in tears that she felt her doctor had betrayed her by not realizing how fearful and without resources she had been and how much she had wanted support to continue the pregnancy, instead of the advice he had given her-to abort her pregnancy given the circumstances. "What kind of doctor is that? Couldn't he see how scared I was?" she asked tearfully. When a woman admits that there might be some merit to discussing her abortion(s) it is useful to ask her to relate how she became pregnant, when she first sensed her pregnancy (as opposed to having it medically verified), what her thoughts were about the developing embryo, if she personified it and referred to it with any referents of attachment (e.g., as "my baby"), and how she came to decide to have the abortion. This line of questioning typically begins to uncover the dual thought process of attachment and denial of attachment to the fetal child. To follow this a step further it is helpful to ask something like, "It sounds like you were already attaching to and defining your pregnancy as a baby. Can you describe how you dealt with those thoughts and feelings?" She typically will answer these questions in remarks similar to the following: "I just shut down," "I went dead inside," "I tried not to think about it," "I had to go numb," or "I cried and cried until I realized it was useless and I had to be hard and shut it out." It is helpful to then respond, "It must have been really hard to shut that down when you realized you couldn't go through with the pregnancy. Do you have any idea how you did this-the shutting down process?" This line of questioning helps the woman to see how she has attempted to emotionally numb her feelings of attachment and to see her grief and trauma responses over how that attachment was severed. Beginning to realize that an attachment process did occur and that it was never really grieved helps the woman to see how she has continually numbed out her feelings since the abortion as they continued to resurface. When they begin thinking in these terms, many women will describe how they were unable to keep their feelings of attachment and protection shut down during the

abortion itself. As one woman recalled, "I tried to be so cool up on the table, but when they inserted the tube and turned on the suction machine I felt total panic. I knew they were killing my baby and I couldn't make it stop. It was too late. When it was over, I felt so empty and alone, like why should I even bother to go on living. I got off the table totally numb and dead inside." Some PAS women can tell their whole conception and abortion story without evidencing any emotional reactions. Generally, however, the emotion can be accessed if therapeutic inquiry goes beyond the woman's "emotionally sterilized" version of the story. Asking for details concerning what sort of day it was, what the staff were like, what was worn that day, what were the attachments and thoughts about the fetus, and, especially, what was thought and felt while up on the abortion table usually yields heretofore suppressed emotional data. Many women express surprise to find that they still harbor such intense emotional reactions even years post event (Speckhard 1987a, 1987b). They are also relieved to hear that repression, denial, suppression, and dissociation are normal defenses for dealing with overwhelmingly traumatic material. Many women will state that they cannot remember the abortion, or crucial aspects of it. If it appears that the abortion was experienced as a trauma, these lapses of memory should be interpreted as possible psychogenic amnesias. It is helpful to state, "Sometimes people have amnesia when it comes to troubling and painful events in their lives. To avoid remembering can mean you have some unfinished business with that event. Your memories and feelings are important. Whatever you remember can be safely dealt with here." Yet many women will continue to emphasize the reasons why the abortion was necessary and the immediate relief that they experienced after the abortion. It is best to acknowledge both sides of the story and to state that life's most difficult issues are those that we have ambivalent feelings about; and that while she perceives positive benefits from the abortion, our focus is now to deal with the negative ramifications. Defining the Steps of Treatment As the woman's level of denial diminishes and a treatment contract evolves regarding the necessity of facilitating integration of the traumatic experiences, it is helpful to define the steps of therapy. Tobecome free of the inner preoccupation with the aborted fetus, the woman will need to do the following: 1. She must recognize and define her attachment both at the time of the pregnancy and after the abortion. This work will entail admitting to whatever fantasies she harbors about the sex, age, state, current residence of, etc. of the fetal child, her feelings toward it and her fantasies of its feelings toward her. 2. As she admits to an attachment, she will need to recognize that a significant loss has occurred. She will need to be honest about the traumatic nature of the loss, admitting that in her mind a human death experience has occurred. 3. She will have to deal with her guilt over how that loss occurred and the psycho-spiritual concept of forgiveness. 4. She must be given permission and encouragement to begin to grieve over the loss. In grieving, she must end denial and bargaining efforts to undo the loss, work through anger and sadness over the loss, and move to acceptance. Finally, the woman will be able to redirect energy invested in an inner preoccupation with the aborted fetal child to other relationships in the here and now. 5. She will need to hear a realistic appraisal of the lifelong nature of parental grief. Anniversary reactions are common, even years after grief work begins, and a desire to replace the loss will exist until the grief is worked through entirely and new attachments are made that are not simply attempts to replace the child without grieving the loss. In sum, the goal of treatment for a woman with PAS is to recognize her traumatic loss and in so doing extricate herself from the relationship with her aborted fetal child. Rando (1991) states that the task of mourning begins with an undoing of the psychosocial ties to the deceased and the facilitating of new ties. Because of the traumatic nature of death by abortion, three steps often need to be taken before successful post-abortion mourning can occur: the woman needs to 1) revisit the dissociated memories and emotions of the trauma; 2) acknowledge and reframe the dissociated nature of the abortion experience; and 3) reaffirm the dissociated parental attachment to the fetal child prior to the abortion. This process might involve changing one's sense of identity or self and giving up or taking on roles that allow one to live happily without the deceased. As with any death experience, one cannot continue to persist as if the world has remained unchanged. Spiritual Aspects of Post-Abortion Grief Resolution Because abortion involves a death experience, the healing process necessarily involves some degree of spiritual resolution regarding what happens to those

who die. Likewise, the volitional nature of the death and resulting guilt often require spiritual resolution. The type of resolution will differ according to the spiritual beliefs of those treated. Asking for, receiving, and giving forgiveness are actions often essential to restoring a positive identity or sense of self to the woman who feels she has "taken" the life of her child. An essential component of PAS is impacted anger and guilt that continues to poison other relationships. The woman who forgives herself and others and who feels forgiven is often freed to no longer feel she has to compensate for her actions, nor fear or punish others for theirs. She becomes freed to invest that energy in healthy relationships in the present, as she divests herself from her inner preoccupation with the abortion experience. Many women find it helpful to end their inner preoccupation with the fetal child by committing their child to a new life with their concept of God and heaven. As with any death, the woman may continue to hold a memory, but she must free herself to move on from the traumatic death of her fetal child. The women who do best are often those who can learn from past mistakes and extract something positive from the grieving experience, perhaps feeling that they have understood themselves better, or that they have a closer relationship with God as their "child" now resides in heaven. Psychic healing is often reflected when the traumatic abortion memory somehow takes on a more positive image. As one woman stated, "I used to only be able to picture my child dismembered and bloody, like what I saw in that receptacle. But now I know she is put back together and at peace with God." However, claims of greater maturity and/or that the unborn child is at peace may act as a defense for some, and thwart the necessary grief work of recognizing and accepting the death of their unborn child. Spiritual reconciliation can greatly aid in facilitating the grief work and can, on its own, produce profound positive changes (McCall &Wilson, 1987). However, spiritual resolution and healing should not be considered to be psychological short-cuts to the very human, very real, and very painful process of grief work. Likewise, as in any other aspect of psychotherapy, spiritual resolutions should never be imposed, but may be helpfully suggested in light of the patient's existing belief system. IMPLICATIONS FOR RESEARCH Risk Factors for Complicated Mourning Research evidence is clear that certain women are predisposed to negative post-abortion adjustment, and that their maternal health is at risk with existing abortion counseling. They are in need of more counseling, more information, exploration and deliberative time, and more assistance. Abortion traumatization may in many cases be prevented or remedied if women with documented risk factors receive adequate counsel to make a decision that fits their unique psychological and social needs. Empirical and clinical evidence suggests emotional harm from abortion is more likely when one or more of the following risk factors are present: * prior history of mental illness; * immature interpersonal relationships; * unstable, conflicted relationship with one's partner; * history of a negative relationship with one's mother; * ambivalence regarding abortion; * religious or cultural background hostile to abortion; * single status, especially if one has not borne children; * age, particularly adolescents versus adult women; * second-trimester versus first-trimester abortions; * abortion for genetic reasons, i.e., fetal anomaly; * pressure or coercion to abort; * prior abortion; * prior children; * maternal orientation; * biased pre-abortion counseling (Rue &Speckhard, 1992). Societal Costs of an Undiagnosed Depression Researchers have found that depression (of any origin) goes undiagnosed by the primary physician in one out of four cases, whereas postpartum depressions go undiagnosed in only one out of two cases. The difference likely stems from the fact that the precipitant of a postpartum depression, a recent birth, is obvious. Post-abortion depressions have no such obvious link, since the abortion experience is frequently hidden and because delayed onset so frequently occurs. Moreover, if it is politically incorrect to assume that abortion might be linked to a depression, a post-abortion depression becomes even less likely to be recognized. The estimated cost to society per year of an undiagnosed case of depression is $50,000. Treated, the cost of depression drops to only $3,000 (Mesaros, Larson, &Lyons, 1992). Post-abortive men and women whose impacted grief and trauma reactions go undiagnosed and untreated are thus likely to pose a high long-term cost to society. Need for Screening After studying men who accompanied their partners to abortion clinics, researchers Shostak and Mclouth (1984) recommended that these men were distressed enough to warrant receiving some sort of intervention. While the bodily impact of abortion and the psychic severing of ties

of attachment are perhaps more greatly and differentially experienced by women, it is true that men, the "forgotten fathers," can also grieve and suffer greatly. Certainly, early screening and intervention by those in the health-care system who treat men and women following an abortion would considerably lessen the long-term individual, family and societal costs. However, for such an intervention to be effective, the caregiver would need to be well acquainted with and understand impacted postabortion grief and trauma responses as they relate to that particular person's psychosocial history. Likewise, anyone connected with the abortion provider is likely to be regarded with suspicion or resentment by a woman who feels she has been harmed by her abortion. Need for Further Research Postpartum-stress reactions in general have been minimized and understudied. Women who miscarry and experience stillbirth and those who relinquish for adoption also experience disenfranchised grief. Research that would begin to assess the incidence of these types of postpartum-stress reactions and make comparisons among outcomes would be invaluable to health-care providers who serve women before, during and after pregnancy, as well as to the women themselves. Women and men who experience disenfranchised loss and whose grief and trauma reactions to abortion are impacted can hardly be expected to work through their loss with a professional community that is blind to their loss. Caregivers who serve these individuals can either be a help to them or a part of their problem. Hopefully as more recognition of the problem occurs, the former will be the more likely outcome. SUMMARY Contrary to widely held assumptions, an undetermined but no less important number of women are psychologically traumatized by their abortions. These women suffer immediate, chronic, long-term, delayed and/or acute post-abortion grief reactions due to their immediate or delayed perception of the abortion having involved the traumatic death of their fetal child. While this perception and resultant traumatization occurs for a significant proportion of women, others may be seemingly unaffected. When immediate traumatization occurs it may be openly and successfully dealt with, or it may be only partially resolved and result in chronic post-traumatic decline, with the delayed or chronic onset of symptoms unfolding into the classic dynamics of post traumatic stress disorder. An acute psychotic reaction triggered by a reexperiencing of the traumatic material may ensue when the traumatic experience is only partially resolved. Delayed onset of psychological traumatization occurs either from a lack of current resolution of traumatic material or when maturation and life events cause a réévaluation of the abortion experience that results in a traumatic perception of the experience. This chronic and/or delayed type of abortion-induced disorder has been labeled Post Abortion Syndrome (PAS) (Speckhard &Rue, 1992). In cases of PAS the trauma of how the fetal child died is reexperienced in flashbacks, nightmares, panic reactions and intrusive thoughts. The traumatic fetal death is not acknowledged and grief over the loss becomes impacted. Complicated mourning results as defined throughout this paper. Societal denial of abortion traumatization coupled with the defenses used to deal with the trauma make diagnosis of PAS and complicated mourning difficult. When the defenses of dissociation, repression, avoidance, denial, etc. are mobilized to deal with abortion traumatization, there is frequently an appearance of a minimal psychological reaction to the abortion. However, with careful evaluation, symptoms of intrusive reexperiencing and avoidance may be detected as well as many manifestations of impacted grief reactions. Treatment for PAS follows a standard post traumatic stress model. Recognition should be paid to the unique expressions of the trauma, guilt and grief reactions within the areas of sexuality, the psycho-spiritual and the familysystems dynamics. PAS is not solely experienced by women: children, men, extended family members and health-care providers may exhibit PAS. Complicated grief and trauma reactions resolve with thorough diagnosis and treatment. However, grief over the fetal child may, as in other death experiences of children, be revisited many times over the course of the parents' lifetime. Footnote 1 The term "fetal child" is used throughout this paper to indicate the differing stages of development, embryo through to fetus, in which abortion occurs. This term is used in deference to the perceptions of the woman distressed by the loss of her psychological attachment to what she generally refers to as "my baby" when she is allowed to grieve openly. Clinical experience suggests that she must be allowed to openly grieve her perceived loss no matter how others may refer to the fetal/embryonic stage of development or the length of gestation. The

feminine pronoun is used here and elsewhere throughout this article. However, the text may also apply to men, since men can also be negatively impacted by traumatic abortion experiences. References REFERENCES

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