The following article is a summary of a paper entitled The Long Term Psychological Effects of Abortion presented by Catherine A. Barnard, PhD, a clinical psychologist currently in private practice in Santa Rosa, Cal. at the annual meeting of the Association for Interdisciplinary Research in Values and Social Change, Sacramento, Cal., June, 1990.

Since the legalization of abortion in 1973 there has been a significant amount of literature regarding both its positive and negative sequelae. The studies that have focused on the long term effects of abortion have described and identified high stress reactions. Research to date has not focused on psychometric measurement of identified high stress reactions but instead has relied almost entirely upon subjective reactions. No research has attempted to measure stress reactions as a type of post-traumatic stress syndrome (PTSD) and only limited research has been done to determine predictor variables which may indicate the likelihood of high stress reactions to the abortion experience. Clinical psychologist Catherine Barnard (1990) undertook a study in an attempt to address these shortcomings in post-abortion research.

Research to date has not focused on psychometric measurement but instead has relied almost entirely upon subjective reactions.

The subjects in the study were women who responded from a random sample of 984 women who had abortions during 1984-86 at a clinic in the Baltimore, Maryland metropolitan area. Of the 984 women who had abortions only 160 could be contacted 3-5 years later. The others had left bogus names or addresses at the abortion clinic or had moved. Some of them hung up on the research assistant. Of the 160 contacted 136 agreed to participate and were sent research packets to complete and return. Of the 136 women who agreed to participate, 80 completed and returned the questionnaire. The research packets included 48 questions to determine the extent of PTSD according to the DSM-III-R criteria of the American Psychiatric Association, the Impact of Events scale (IES) of 15 items to determine intrusion and avoidance items and the current amount of stress the person is experiencing within 7 days from an event that had occurred in the past, and the Millon Clinical Multiaxial Inventory (MCMI) as a diagnostic instrument in an attempt to determine variables that might predict a high stress reaction to the abortion experience.

Post-Traumatic Stress Disorder

DSM-III-R Criteria

PTSD criteria require that a person has gone through an experience that is out of the usual range of human experience and that would be markedly distressing to almost anyone. Although abortion clearly is more and more common it is frequently something that cannot be talked about so that it feels unordinary. The 80 women in the study experienced PTSD symptoms to the following degree 3-5 years following their abortion.
Persistent re-experience of the traumatic event in at least one of the following ways:
- intense psychological distress at exposure to events resembling an aspect of the event i.e. anniversary reactions, reaction to vacuum cleaner noise. 25%
- recurrent and distressing dreams of the event i.e nightmares 23%
- a sense of reliving the experience - flashbacks of the abortion experience 45%
- recurrent and intrusive recollections of the event - thoughts 29%

Persistent symptoms of increased arousal not present before the trauma as indicated by at least two of the following ways:
- difficulty falling or staying asleep 39%
- irritability or outbursts of anger 25%
- difficulty concentrating 29%
- hypervigilance 39%
- exaggerated startle response 31%
- physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event, i.e. cramps, sexual dysfunction 21%

Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness not present before the trauma in at least three of the following:
- efforts to avoid feelings associated with the trauma, numbing, unable to have loving feelings 23%
- markedly diminished interest in significant activities; i.e. loss of joy, pleasure 20%
- feeling of detachment or estrangement from others 23%
- a sense of a foreshortened future 14%
- efforts to avoid activities associated with the trauma i.e. avoiding baby showers or pregnant women 11%
- inability to remember an important aspect of the trauma i.e. can't remember going to clinic or abortion procedure 11%

Overall, 18.8% of the women had diagnosable PTSD according to each of the criteria set forth in DSM-III-R. However, considering that 39 - 45% of the women had sleep disorders, hypervigilance or flashbacks it seems clear that abortion is a frequent stressor event in women's lives even if all of the PTSD criteria are not present.

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The Impact of Events Scale
The Impact of Events Scale (IES) consists of 15 items that the subject rates on a scale of “none at all” to “very frequently” and attempts to assess the current degree of stress that the person has experienced in the past 7 days from an event that occurred in the past. The IES includes both intrusive and avoidance questions.

An example of intrusive questions are “I thought about it when I didn’t mean to” or “I had waves of strong feeling about it”. 86.8% had at least a minimal intrusive stress response. Moderate and high intrusion combined was 45.5% and high intrusion alone was 16.9%.

An example of avoidance questions include “I tried not to think about it” or “I felt as if it hadn’t happened or it wasn’t real”. 80.3% had at least a minimal avoidance stress response. Moderate and high avoidance combined was 46.8% and high avoidance alone was 23.4%.

The high stress reactions in the IES averaged 20% which was nearly the same percentage of PTSD determined by DSM-III-R criteria. According to this study it is very possible that almost one-half of the women having an abortion are suffering as a result of it. This was considerably higher than what was initially expected. Clearly more research is needed in an attempt to replicate the results.

It is very possible that almost 1/2 of the women having an abortion are suffering as a result of it.

Million Clinical Multi-Axial Inventory
The MCMI is a diagnostic test which was used in an attempt to determine variables that would predict a high stress reaction to the abortion experience. The MCMI has a number of clinical scales and can provide a clinical diagnosis utilizing a computer print-out. It was found that in the clinical areas of hysteronic, anti-social and narcissistic scales that the post-abortion women had significantly higher scores than the sample on which the test had been normed (p > .01). The MCMI also found a significantly higher level of paranoid/personality dis-
order and greater anxiety in the post-abortion women but found a lower level of depression compared with the normed sample. And I asked the question, “What kind of women are getting abortions”? The clinical picture of personality disorders suggests that it is one of somebody who has been wounded early in life, has difficulty in relationships and has tremendous difficulty with intimacy.

In terms of variables that predicted high stress reactions to abortion, the most important was a woman’s relationship with her mother while growing up. The lack of a mother-daughter bond was very important. A past history of emotional problems at home was the second highest predictor of high stress reactions. A person who has had emotional problems in the past is likely to struggle again. A woman who had a conflicting relationship with the father of the aborted child and poor aftercare at the clinic were also predictors of high post abortion stress reactions.

It is very important to take results like these and look at what kind of women are getting abortions and what is happening to them before they ever go to get an abortion. The clinical implications need to be examined and additional research undertaken in order that answers to currently unanswered questions can be obtained.

Catherine A. Barnard, PhD

A full copy of her research report may be obtained from the Institute for Abortion Recovery and Research, 111 Bow Street, Portsmouth, New Hampshire 03801-3819, Cost $15.00

Comments:
The reported level of PTSD (18.8%) and the high stress levels of the IES (approx. 20%) 3-5 years post-abortion indicate that emotional or psychological reactions are not limited to a few days or months, nor are they rare or miniscule as reported by some pro-abortion researchers.

The stress response of the 80 women who participated in the study are probably lower than the original sample of 984 women. Various studies have shown that women for whom the abortion was more stressful are less likely to participate in a study. Sample Attrition in Studies of Psycho-social Sequelae of Abortion: How Great a Problem Adler, J. Applied Social Psychology 6(3):240 (1976).

Women who did not report high stress reactions are not necessarily well or healthy. There is evidence that the study group had a narcissistic personality disorder. Such persons may have a basic incapacity for experiencing genuine feelings of grief, sadness and depression. Narcissistically vulnerable individuals tend to respond to loss of control with either shame (flight) or rage (fight) which may have occurred with this sample. Narcissistic Personality Disorder. Clinical Features, V. Siomopoulos, Am. J. Psychotherapy, Vol. XLII, No. 2, April 1988 p. 240 - 253 and cited authorities.

General Stress Response Found At Time of Abortion

Researchers at Duke University measured intrusion, avoidance, depression and anxiety in 55 women prior to their abortion and also about 5 hours after their abortion and found a wide range of responses. A level of distress was found to be similar to other distressed populations according to the Impact of Events Scale. It was concluded that there was evidence of a generalized stress response syndrome. Four distinct coping styles were identified. Women tended to be either “approachers” or “avoiders” with respect to cognitive and emotional activity that was oriented either towards or away from a threat on a conscious and unconscious level. Avoiders experienced more distress than non-avoiders. Coping with Abortion, Cohen and Roth, Journal of Human Stress, Fall 1984 p. 140-145.

Call For Papers

The Association is planning for the Fifth Annual paper session to be held at the annual meeting of the Association, Wednesday, June 5, 1991 at the Atlanta Hilton Hotel, 255 Courtland Street NE, Atlanta, Georgia from 8:00 PM to 10:30 PM The topic of the conference is:

Health and Social Effects of Abortion

We are soliciting papers on this topic from any appropriate academic discipline. Both members and non-members of the Association are invited to participate. Data-based research papers will be given priority but other academic papers will be included and are encouraged. In order to apply for consideration for presenting at the paper session, please mail an abstract (500 words max.) with authors professional affiliations postmarked by April 15, 1991 to:

Paper Session
Association for Interdisciplinary Research
419 7th Street NW, Suite 500
Washington, DC 20004
Attn: Marie Hagan, Executive Secretary
Dr. Stephen Edmundson has been in private psychiatric practice in Atlanta for 19 years. He attended Medical College of Georgia at Augusta and served his internship at Piedmont Hospital. His first year of residency was at University Hospital in Baltimore and his last two years at Emory University Hospital. He then served for two years as a U.S. Navy Medical Officer. In his years of private practice, Dr. Edmundson has treated many women who have had post abortion problems.

Q: What is post-abortion syndrome (PAS)?

DR: Post-Abortion Syndrome is a category of Post Traumatic Stress Disorder, either acute or delayed. With the acute form, symptoms appear within six months of trauma and are usually resolved within six months. With the delayed type, symptoms last longer and the onset is much later. Most of the PAS category that I have seen occurred long after the abortion was done, many months to several years later.

This disorder follows a specific “stressor” event which is outside the normal experience and often has elements of a threat to life at some level. Most of these cases involve one specific incident. The disorder seems to be more severe and last longer if the stressor is of human design, which is certainly the case in an abortion picture.

Q: Is PAS recognized within the medical community?

DR: It is being widely discussed and is being accepted now. If a physician sees someone in the aftermath of an abortion and diagnoses Post Traumatic Stress Disorder, with abortion as the stressor, it would not be questioned. Post Traumatic Stress Disorder only became a listing (in the Diagnostic and Statistical Manual of Mental Disorders) in 1981 or 1982 in response to the combat-related disorders (of Viet Nam veterans).

Q: Why does PAS tend to manifest itself long after the abortion takes place?

DR: With an abortion, which might have carried with it a good deal of uncertainty and pressure, the individual is swept along with-out sorting out and thinking through issues involved. In all major crisis situations, there is a kind of helplessness and people are very suggestive. Pressure can persuade the individual to go ahead and get the abortion done. After it is over, the interest is in going ahead with the person’s life and forgetting about it. Denial comes into play. The person doesn’t want to think or talk about it — wants to keep it secret. There is a sealing over of the whole experience. Denial and repression, or erasing from conscious awareness, can lead the individual to not thinking of the abortion for some time afterwards. But to do this requires a good bit of mental energy.

Q: What are some common symptoms signaling PAS?

DR: Denial is one of the aspects of PAS. When memories do begin to come back, there may be dreams of the baby, or recollections of the abortion clinic, and often guilt and grief might begin to appear. Depression is one of the first signs, along with anxiety and irritability. The woman may experience emotional numbing: a feeling of going through the motions without being emotionally connected. There may be withdrawal in a marriage (or boyfriend) relationship, acting out in the form of sexual activity, or sexual responsiveness may be blunted. Sometimes we see repeated pregnancies, as if the individual is trying to replace the aborted baby. There may be difficulty concentrating, inefficiency in work, and a blunting of memory.

Q: Is there a relation between PAS and child abuse?

DR: Depression, irritability and difficulty coping would make it hard to deal with children. With all cases of Post Traumatic Stress Disorder, frustration tolerance is down and the individual is likely to explode in anger at limited provocation, and might well hurt someone.

I read a journal article in which the writer made the point that people have a strong natural drive to recreate themselves by having children, but in our time, there has been a progressive devaluing of children. Once we begin to abort them, their value declines even further. This undercuts the desire to recreate ourselves. This devaluation of children can be tied to our national decrease in childbearing, increase in unwanted pregnancies and subsequent abortions, as well as the marked increase in child abuse.

Q: Is there usually an event or situation that triggers PAS?

DR: There are some particular things that tend to bring back an awareness of the abortion, such as the woman’s admission to a hospital or going into an operating room, her child being taken in for surgery, the birth of her child or seeing a friend’s newborn, and the death of a child or a close relative or friend.

Q: Is every woman who has had an abortion likely to develop PAS?

DR: Some women may work through the aftermath of abortion with the aid of a support group, their church or family and friends. But I believe the only person who would not be affected by an abortion would be someone with severe character disorder. Such an individual can form no real attachment to other human beings and therefore has no feeling for how their actions affect others.

The better a woman’s capacity to repress, the longer the disorder will be put off, but the greater the eventual stress. Some women can talk quite glibly about the issue. They build support groups and are not consciousness bothered by their abortions, but they spend a great deal of time and energy justifying them.

Q: How is PAS treated and resolved?

DR: I review symptoms carefully, with no prejudices. I take the person back through a life review and interview close relatives. I see the patient frequently, but it is important not to overwhelm them by bringing too much to the surface at once. In the process of resolving feelings about the abortion, the individual must understand how and why it happened. The patient must look at how she handles her life.

Q: Is grieving for the aborted child an important aspect of therapy?

DR: Yes, but one aspect of denial is the idea that the aborted baby was not a person. For a person in crisis, it is easy to buy into the idea that the fetus is just a piece of tissue. But this tissue in the woman’s uterus is not in any sense her tissue. The fetus is a unique individual: there has never been one like it, there will never be another. In order to resolve grief, the woman must admit that a child was aborted.

Q: How would you advise a woman suffering from PAS?

DR: She should turn to those who are pro-life, support groups and counselors who take a clear stand on abortion and can help restore the woman’s sense of the meaning of life. Abortion delivers a body blow to the meaning of life.

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Post-Abortion Syndrome as a Variant of Post Traumatic Stress Syndrome

The following article is a modified version of a paper presented at the annual meeting of the Association for Interdisciplinary Research in Values and Social Change, Sacramento, Calif., June, 1990. It develops a theoretical model of the woman who aborts both as a victim and as an aggressor using the principles of trauma psychology. The author, Robert C. Erikson, PhD is a clinical psychologist residing in Hinckley, Ohio, who has had considerable experience with Post Traumatic Stress Syndrome particularly in war veterans. He has also presented his work at professional meetings of the Society of Traumatic Stress Studies.

Introduction

The purposes of this paper are to present a generic model of psychic trauma, to locate within this model the abortion experience as a traumatic event, and to locate Post Abortion Syndrome (PAS) within the family of post traumatic states, and demonstrate its identity as a post-traumatic stress disorder (PTSD). The particular point of view to be advanced, termed “trauma psychology” (Emery and Emery, 1989), emphasizes intrapsychic conflict rather than interactional or contextual variables.

Activities dominated by aggression will tend to initiate a train of thoughts, feelings and behavior characterized by repetition and maintenance of preparedness rather than gratification.

In the case of abortion leading to PTSD, the struggle is between the incompatible goals of libido and aggression. The aggressive drive is understood to represent a destructive force operating internally to destabilize psychic structures, and externally to act on the environment without regard to object choice. The achievement and maintenance of a correspondence between internal and external realities through these operations is the process of adaptation, serving the narcissistic (libidinal) aim of survival. Aggression operates on the regulatory principle of repetition-compulsion, rather than pleasure-unpleasure, which regulates libidinal activity. Activities dominated by aggression will thus tend to initiate a train of activities (thoughts, feelings, perceptions and behavior) characterized by repetition and maintenance of preparedness rather than gratification (tension reduction). This implies in the post-traumatic state an alteration of pre-existing structures due to the disruptive effect of aggression on attachments, both in the internal and external milieu.

Structure of Psychic Trauma

A psychic trauma occurs when 1.) active intention to do harm (aggression) is stirred; 2.) the individual executes such intention; and 3.) a conflict exists due to the achievement of the destructive goal and the perception that the achievement is incompatible with the goal of maintaining relationships. Conflict between the incompatible goals of attachment and destruction leads to the experience of stress. Stress in this model is the internal expression of problem-solving activities aimed at resolving the conflict. These stress responses, together with the activities at the time of the trauma constitute through re-enactment the symptomatology of post-traumatic states.

Conflict between incompatible goals of attachment and destruction leads to the experience of stress.

In the case of abortion, the act of undergoing abortion constitutes the execution of harm. The decision to abort, however, implies already that the intention to do harm is present. Such an intention will be in conflict with the pre-existing tendency toward attachment with the unborn child. The conscious awareness of pregnancy implies, indeed requires, that the formation of an ego-structure representing the child in psychic reality has begun. Considering the intimate physical interaction between mother and child in pregnancy, the psychic structuralization of the pregnant state may well begin prior to conscious awareness. The internal conflict over whether or not to continue the pregnancy begins when the mother perceives herself not as an aggressor but as a potential victim. That a mother can perceive herself as a potential victim of the unborn child is demonstrated in the reasons given for not carrying the child to term; economic hardship, frustration of other goals, ties to the father against whom there may be aggression present; physical well-being; social pressure, or emotional well-being. (Torres and Forrest, 1988) In such circumstances the child is perceived as a threat, (aggressor) to the mother (victim). The decision to abort thus implies that aggression is already dominating the mothers’ mental activities, for the libidinized ego structures of self and child have been already transformed into aggression dominated structures of victim and aggressor. At the point when the decision to abort is made, the internal
representation of the self as aggressor has begun to impact on relationships, including detachment from and de-humanization (objectification) of the infant.

Due to the co-existence of incompatible identifications, a pathological identity structure is created under the impact of the aggressive drive.

During and after the abortion the victims identity becomes associated with the object represented by the unborn child. The psychic bond between self and object, transformed by aggression, becomes an identification with the victim. The psychic structure representing the mothers’ self in the event becomes an identification with the aggressor. Both structures are necessary to represent within the internal milieu (psychic reality) and the actors and activities in the external world. Due to the co-existence of these incompatible identifications in the abortion event, a pathological identity structure (fusion of victim and aggressor) is created under the impact of the aggressive drive. The external conflict is internalized and serves as an organizing element. (Erikson 1989)

Re-Enactment

Following the regulatory principle of repetition-compulsion, the aggressive drive directs behavior into re-enactment, organizing activities around and through the trauma identity structure. Re-enactment is predictably expressed through the three conventional response channels. The cognitive channel is dominated by intrusive thoughts and recollections of the event, unless active distraction or avoidance measures are taken. Where such measures are taken in the course of the abortion experience, one would expect to find them recurring as part of the re-enactment process. Two simple examples of such stress responses (avoidance behaviors) are substance abuse and compulsive work. The cognitive channel includes nightmares of the event, repetitive and relatively undistorted by dream work, such that they actually are not dreams so much as nocturnal recollections.

Re-enactment in the affective channel will include re-production of emotional experience at the time of the abortion. One would expect primarily three affective responses: anger or rage, as the affective expression of the aggressor identity; tenderness and fear, as expressions of identification with the victim; and affective numbing, representing a fusion of the two, and an avoidance of any feeling at all. Numbing is a characteristic stress response in that it solves the problem of intense emotional conflict, but at the expense of pleasurable or positive affective states as well.

Re-enactment through the physical or sensory-motor channel has two notable components. In sensory re-enactment, distortions and hallucinations are encountered in the senses i.e. visual, auditory or olfactory as well as somatic representations depending upon the selection of perceptual elements at the time of the abortion. Sensory distortions and hallucinations in such circumstances may be produced in dissociated states, and are not to be misunderstood as indicators of psychosis. Somatic reenactment will take the form, typically, of a repetition of pain or other bodily sensation at the time of the abortion or its aftermath. The correspondence will be very specific as to body location and experience. It may include whatever the experience of the abortion included: pain, cramping, nausea, etc., as re-enactment of the experience of victimization in the abortion. The aggressor counterpart of pain is analgesia. (absence of sense of pain) Somatic numbing (distinguished from psychic numbing) is reported in terms of parts of the body feeling ‘dead’ or anesthetized. It may be that the common report of sexual inhibition (69% in Speckhards sample) includes loss of capacity to experience sexual arousal due to somatic numbing.

Repeat abortion will, to a degree, reflect a re-creation of the social, emotional and relational circumstances present before the initial abortion.

Behavior re-enactment of the abortion is a matter of particular concern, as reports of repeat abortions indicate that over 40% of all abortions in the U.S are repeat abortions. (Henshaw and Silverman, 1988) Repetition of traumatic events have similarly been reported with respect to other trauma populations, including rape victims (Neumann et al, 1989) and combat veterans (Vander Kolk, and Greenberg, 1987). While the concept of re-enactment is simple its ramifications are potentially complex. Research into the particular circumstances of repeat abortion is needed, as one would hypothesize that, to a degree, it will reflect a re-creation of the social, emotional and relational circumstances present before the initial abortion. If one hypothesizes that abortion reflects a relationship conflicted by the presence of aggression and alienation in the first instance, subsequent abortions would be expected to follow re-enact-
ment of sexual-aggressive activities in which the woman engages, i.e. sex without commitment, without contraception or with lackadaisical use of contraception. Promiscuity leading to repeat abortion would be expected when the initial abortion included elements of aggression against the father as when the sexual relationship was manipulative or exploitative of the male. In that instance, the male partner is objectified and dehumanized by the woman enabling her to carry out aggression against him through the abortion of 'his' child. When the perception exists that the male is victimized, subsequent identification with him as victim may lead to sexual tenderness and engagement in relatively casual sexual behavior. A repetition of mutually self-defeating affairs may ensue, or such a pattern with the same partner may evolve.

Re-enactment is clearly maladaptive because its aim is to re-create a past event rather than to respond to present reality.

Such re-enactment has a quality of drivenness as aggression acts imperatively through the trauma identity. From an external perspective such behavior is clearly seen as maladaptive because its aim is to re-create a past event rather than to respond to present reality. It maintains the victim-aggressor character and enlists other actors in collusion as the aggressive social matrix is re-created and the scenario of trauma is played out. The experience of the aggressive drive operating in the person is usually one of helplessness in re-enactment, as in the original trauma and is part of the victim identity. It is coded cognitively as "the elimination of the victims choice, and the obliteration of her agency" (Roth and Liebowitz, 1988). It is understood now that this loss of choice and agency is a subjective experience of the conflict over ones' aggression and a perceived inability to adapt to present requirements of external reality.

From this point of view it can be seen that repeat abortions frequently are re-enactments of conflict between drives, and have little to do with ego functions such as learning. Because the re-enactment involves a host of volitional behaviors, from the finding and engaging in a sexual partner, to the planning and carrying out of the abortion, the intentional quality of the activity is clear. Its domination by aggression elicits parallel aggression in the observer, leading to such stress responses as blame and judgementalism and feelings of anger. This point of view also predicts that post-abortion counseling which focuses on contraceptive use will likely prove futile. From Speckhards sample of aborted women experiencing stress, the conflicted nature of their behavior is clear. Sixty-four percent used no birth control and only 8% of the remainder used effective means such as the pill or the IUD. It was observed that "many of the women commented that its (contraceptive methods) use when they were used was not regular or conscientious". Yet "all of the pregnancies in the sample were classified by the subjects as unintended". (emphasis added) (Speckhard, 1987 p. 36) Thus, despite the subjective report of intention or lack of it, the subjects behaviors tell a different story. The need to maintain a credible self-image requires a disavowal of intentionality experienced as victimization and representing a degree of self-deception. For such women, to forego the cycle of re-enactment the acknowledgment of intent will always be a necessary step.

Discussion

Not all aborted women have repeat abortions, as the adaptive resources available to the person can mitigate the re-enactment to a varying degree. What can be predicted, with confidence, however, is that any abortion will exact a psychic cost as a the woman involved follows one of three paths. Mardi Horowitz, (1986) a pioneer in trauma research, has concluded that trauma can have one of three outcomes. Resolution, when inner resources and external social supports are sufficient to counteract the alienation and retreat from a libidinalized social matrix. Pathology, characterized by alienation, re-enactment and post traumatic decline; or a "stable defensive distortion", which is a state characterized by an outward return to apparently normal functioning but with an impoverished but tolerable inner experience. It is the last which some women report as an experience of "maturation", but it falls in the poignant twilight of being "sadder but wiser". Horowitz (1989) acknowledged later that resolution of trauma may present an opportunity for change and perhaps growth, but he was quick to add, that such an opportunity should not be sought out - it's never worth it.

Conclusion

The proposition is advanced that abortion is a traumatic event; that its traumatic quality lies in its constituting an intentional act of aggression in conflict with the activities of libidinal energy; and that post-abortion syn-
drome is a post traumatic state characterized by victim-aggressor identifications over-riding object relations, re-enacted to a degree through the three response channels under the impetus of the aggressive drive and regulated by the principle of repetition-compulsion.

Robert C. Erikson, PhD

References


Erikson, R., Understanding PTSD from the trauma psychology perspective, presented at Fifth Annual meeting of Society of Traumatic Stress Studies, San Francisco, (1989)


Comments:

If intrapsychic or internal conflict is the origin of stress, PAS would occur regardless of whether abortion was legal or illegal. Various studies have found that postabortion guilt, depression, substance abuse, is similar whether or not the abortion was legal or illegal. Jewish theologian Martin Buber has pointed that guilt is not simply acquired from transgressing ancient taboos or social customs or law or parental values. He states, “Each person stands in an objective relationship to others... it is that persons share in the human order of being, the share for which that person bears responsibility”.

There is evidence of attachment toward the unborn child in women undergoing elective abortion. A study of grief reactions in women found that the response to elective abortions was symptomatically similar to miscarriage, stillbirth or neo-natal death. An intense response was present prior to the abortion suggesting that the decision to terminate the pregnancy may initiate the grief reaction. Grief and Elective Abortion: Breaking the Emotional Bond, Peppers, Omega, 18(1):1 (1987-88)

Intense aggression and anger can be measured prior to abortion. A British study tested 57 women who applied for abortion for mental health reasons and found a high level of hostility of about 2 standard deviations above the mean. Women predominantly evidenced guilt and self-criticism. Scores were similar to those of psychiatric populations. The Effects of termination of pregnancy: A Follow-up Study. Schmid & Priest, Br. J. Medical Psychology, 54:267-276 (1981)

Institute For Abortion Recovery and Research Founded

The Institute for Abortion Recovery & Research has been founded by Dr. Vincent Rue and Dr. Susan Stanford-Rue as a non-profit educational and research organization. It is dedicated to providing accurate scientific information on the psychological effects of abortion and to assisting those individuals seeking recovery by providing a clearinghouse for information, referral and treatment. The Institute purposes are essentially preventative and rehabilitative, and it is organized to provide a central, compassionate and professional center dedicated to the study and treatment of post-abortion trauma. The Institute is currently seeking financial support for its activities and has currently available the following list of publications.

Post Abortion Syndrome (Paper presented at U. of Notre Dame, 1987), Rue, Cost $10.00
Post Abortion Syndrome: Diagnostic Criteria, Rue, $1.00
Will I Cry Tomorrow? Healing Post Abortion Trauma (paperback 1987), Stanford - Rue, $10.00
The Psychological Aftermath of Abortion: A White Paper (research presented to Surgeon General Koop, 1987), Rue, Speckhard, Rogers & Franz, $15.00
Post Abortion Counseling: A Manual for Counselors (1988), Speckhard, $15.00

The Long-Term Psychological Effects of Abortion (research monograph, 1990), Catherine Barnard, $15.00
Spiritual Dimensions of Abuse and Abortion (paper presented at Marquette University, “Healing Visions”, 1990), $5.00
Forgotten Fathers (pamphlet), Rue, $1.00
Abortion Decision Making: A Crisis to be Shared (chapter reprint from To Rescue the Future), Rue, $5.00
Abortion in Relationship Context (journal article reprint), Rue, $5.00

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