POST-TRAUMA SEQUELAE FOLLOWING ABORTION AND OTHER TRAUMATIC EVENTS

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The legalization of abortion in the United States two decades ago has opened the floodgates to what has become the highest abortion rate in the world. Abortion has now become the most commonly performed surgical procedure in the country. Approximately one out of four pregnancies is terminated by abortion.

Within the current “pro-choice” climate, the scientific community perpetuates a pro-abortion attitude by holding to the politically correct position that abortion poses no physical or psychiatric danger and may even provide emotional relief for women who choose it (Adler et al., 1990, David, 1985; Major, Mueller, & Hildebrandt, 1985). In fact, some authors have suggested that professional groups are in danger of denying any negative effects from abortion (Mester, 1978). For example, it is common for pro-abortion researchers and authors to believe that abortion performed in adolescents is more likely to be positive than negative, suggesting that they have the capacity to make responsible decisions, are at no higher risk for negative consequences (Foster and Sprinthall, 1992) and may even experience elevated self-esteem and academic achievement (Zabin & Sedivy, 1992). The prevailing position of the American Psychological Association is characteristic of that held by many national and international mental health associations i.e. that abortion, particularly in the first trimester, does not create psychological hazards for most women undergoing the procedure (Fox, 1990).

According to Speckhard and Rue, this is an unwarranted overgeneralization which cannot be logically supported because it is based on a body of research that is methodologically flawed and typical of the tendency of medical and mental health professionals to avoid describing negative consequences fol-
lowing abortions, particularly adverse psychological and emotional symptoms, for fear of providing support to anti-abortion groups and risk stigmatization (Speckhard and Rue, 1990).

This is the prevailing attitude in spite of much evidence demonstrating that abortion often causes psychological stress, including Post-Traumatic Stress Disorder (Barnard, 1990; Rue, 1985, 1986, 1987; Selby, 1990; Speckhard, 1987a, 1987b; Vaughan, 1991), psychotic reactions, and delayed psychiatric illness requiring psychiatric hospitalization (David, Rasmussen & Holst, 1981).

In 1989, after reviewing more than 250 articles pertaining to the health risks of abortion, Surgeon General Koop concluded that "...the data do not support the premise that abortion does or does not cause or contribute to psychological problems." Later he testified in the House of Representatives "there is no doubt about the fact that there are those people who do have severe psychological problems after abortion" (Koop, 1989).

What are the facts? They are emerging slowly but most certainly there are many women, both young and old, who can be expected to suffer psychological side-effects - sometimes very serious ones - after having an abortion. Much unreported symptomatology seems to be related to women's massive denial about negative experiences, particularly pertaining to guilt and grief (Milstein & Milstein, 1983). On the other hand, it has seemed more acceptable to report extensive negative emotional experiences when abortions were for medical reasons, i.e. genetic factors (Bumberg, et al, 1975).

Denial appears to be a frequent psychological defense used in coping with abortion in order to minimize emotional consequences. Cohen and Roth (1984) found that state anxiety levels are elevated prior to abortion and that women who used denial before the abortion were more anxious and depressed than those who did not use denial (Adler, 1975; Cohen & Roth, 1984; Wells, 1991).

While the facts are emerging slowly about psychological side effects following abortion, researchers should take note that many victims of traumatic events eventually have delayed symptoms - sometimes quite serious ones. But, how often is still unclear. Similar to the eventual but delayed discovery of the nature and gravity of post-traumatic symptoms in veterans of the Vietnam war, there may come to be an ever increasing awareness that delayed post-traumatic symptoms may also take place in 'survivors' of abortion.

For example, in 1985, more than 20 years from the onset of the war, 800,000 of the nearly 3 million who went to Vietnam were found to be suffering from Post-traumatic Stress Disorder (PTSD) - an incidence of nearly 27% (Brende and Parson, 1985). These men and women were also found to be suffering high rates of depression, suicide, difficulties with the law, broken marriages, drug and alcohol abuse and dependency. Perhaps if a similar research project were undertaken to elicit the psychological problems of women who have had abortions, there may be similar findings.

POST-TRAUMATIC RESPONSES: NORMAL AND ABNORMAL

In order to clarify the nature of post-trauma symptoms, it can be helpful to know about the reactions of survivors to serious traumas. There are predictable responses to a variety of stressful and traumatic events including vehicular accidents, assaults, natural disasters, war, robberies, rapes, or major surgeries. Symptoms can also occur after witnessing a crime, violent act, mutilation, death, body parts, or a dead body. Those who have lost family members (particularly children) or friends from a sudden or painful death, accident, suicide, or homicide, are also vulnerable (DSM-III, DSM-III-R, DSM-IV, American Psychiatric Association, 1980, 1987, 1994). The following are predictable post-traumatic responses:
Outcry:
It is definitely not an abnormal occurrence for individuals to respond to terrifying events with an audible cry for help. The body always reacts immediately via the “fight”, “flight”, or “freeze” response. Circulation is diverted to activate the key survival organs, glands, and hormones: heart, lungs, muscles, adrenal glands, and pancreas. Blood-clotting mechanisms are activated, insulin is produced, and blood sugar is mobilized. Senses become sharper, pupils dilate, muscle strength may increase. The capacity to think clearly is often enhanced, and sometimes there may be a review of past memories. In the event that the survivor suffers from a traumatic loss, the initial outcry response is likely to be manifested by crying and sobbing with tears.

Dissociation:
The victim of violence, injury, or sudden cardiac arrest, sometimes experiences a moment when his or her mind becomes separated or ‘dissociated’ from the body. For example, some individuals have reported near-death-experiences (NDE’s) during which times he or she was without detectable pulse or respirations but later revived with full recovery. Sometimes a survivor has ‘dissociated’ from the physical pain and emotional terror of a major trauma, assault, or rape to escape ‘feeling’ emotional and physical pain. Those who have been repeatedly abused, particularly children, rely on ‘dissociation’ as an unconscious but predominant psychological defense, eventually causing serious problems with memory, ‘seizures’, detachment, blackouts, and in some cases the formation of multiple personalities.

Disbelief/numbing:
Typically, a survivor experiences a temporary period of mental disbelief and emotional & physical numbing immediately following the outcry response (and sometimes during a prolonged emergency). He or she commonly has little or no awareness of pain in spite of severe injury, may deny the significance of the event, ‘feel nothing’, have no fear, and shed no tears. In the event that the survivor continues to experience continued emotional disturbance - grief, guilt, fear, or anger, this period of disbelief/numbing may be prolonged. In some cases trauma survivors persist in their disbelief/numbing/response, even to the point of amnesia. This explains why some trauma survivors often remember nothing and even maintain complete denial that they were ever abused or victimized.

Other psychological defenses may also be activated to enhance the disbelief/numbing response, including blocking, selective focus of attention, suppression of painful memories, and creation of a sense of omnipotence (the belief that one is indestructible).

Intrusions:
Eventually survivors may suffer from uncontrollable painful memories in the form of distracting recollections, feelings of guilt and grief, flashbacks, intrusive thoughts, and vivid images which disturb mental concentration. Nightmares and bad dreams may awaken survivors and provoke night-time panic attacks. In addition, survivors may have undesirable physiological symptoms in the form of startle reactions, angry outbursts, rapid heart rate, shortness of breath, physical pain, and autonomic nervous system abnormalities. They commonly attempt to avoid provocative sensations - smells, sounds, or sights - or other reminders of the traumatic event, including stimulating television programs and discussions of the experience. Anniversary times may also be very difficult.

Normal Recovery:
The emotional and physical responses just described are normal for everyone and hopefully, time-limited. Recovery, although not an easy process, eventually takes place over a period of time - often within six months. Survivors who permit free expression of their emotions and memories in the presence of persons who can listen empathically are likely to recover with few, if any, serious aftereffects. Caring friends, loved ones, skilled counselors, meaningful religious beliefs, and
prayer can facilitate the resolution of post-traumatic responses so that symptoms will eventually disappear. If not, these normal responses become the symptoms of Post-Traumatic Stress Disorder.

VICTIMIZATION AND POST-TRAUMA SYNDROMES
Numbing and Detachment:
Persistent post-traumatic symptoms commonly take the form of alternating episodes of intrusions and emotional numbing. In many cases survivors suffer from persistent numbing and detachment, which precludes their capacity for normal emotional expression. Psychoanalyst Henry Krystal has observed that victims develop a thickened stimulus barrier which “protects the person against the return of the previously experienced.. psychic trauma by blocking future ability for fantasy elaboration. Similarly, one’s capacity for pleasure, joy, and happiness may be sacrificed... This is the price of simultaneously (but less successfully) blocking off the excessive intensity of pain and distress.” (Krystal, 1988).

Repetitive Self-Destructive Behaviors:
Unfortunately, many survivors have been ‘shattered’ by their traumatic experiences and become victims of repetitive self-destructive behaviors and interactions with others, particularly those within their immediate families: As Parson states: “In my clinical experience with... survivors of traumatic experiences, I have been struck by the utter pervasiveness of survivors’ tendency to repeat dimensions of original traumatic experiences in virtually all spheres of their lives. Much of the clinical literature on PTSD... tends to focus on dramatic repetitive or reliving tendencies, as in the mental phenomena such as ‘flashback’ (dissociative states), traumatic dreaming, night terror, and other ideational, affective, and physiological reenactments. What is neither discussed nor appreciated to any extent it seems is the multiplicity of nondramatic ways repetitive phenomena are replayed. Thus, the detailed information gleaned on the traumatic history is imperative in understanding the survivors’ ‘reenactment probabilities’ in human relationships with the wife or partner” (Parson, 1988).

Fragmentation:
The most serious post-traumatic syndromes result in self-fragmentation disorders, often related to violent and repetitive events perpetrated on younger, more innocent and idealistic individuals, who have felt abandoned and betrayed by persons they expected to be supportive. Among the various groups of fragmented victims were found to be some Vietnam war veterans with evidence of ‘splitting’ and fragmentation (Brende, 1983, 1987). Psychoanalyst Erwin Parson, author of a number of articles on the subject of post-traumatic self-fragmentation states: “People who have endured extreme stress suffer profound rupture in the very fabric of the self. The manifestations of this rupture go far beyond mere symptomatic expressions; they go deep to the core of the self, tearing asunder and cutting through its biological and psychic integrity” (Parson, 1988).

In tandem with the rupture of the ‘self’ is the shattering of the survivor’s object world (members of family and society who were previously idealized), which Terrence DesPres (1976) observed in survivors of the Holocaust. Similarly, Lifton described the severed connectivity between self and others or ‘broken connection’ experienced by survivors of war and nuclear devastation (Lifton, 1973, 1980). This shattering experience has caused many survivors, particularly of war, to lose their faith in the capacity of human beings for goodness (Parson, 1988) and to lose faith in God (Mahedy, 1986; Brende & McDonald, 1989; Brende, 1990, 1991, 1993).

A number of analytic thinkers have wondered why ‘splitting’ or identity fragmentation occurs in response to traumatic events. Heinz Kohut (1971, 1977) a prominent psychoanalyst and one of the significant thinkers in the field of ‘self’ theory believes that a major trauma can impact on an individual causing
overwhelming ‘disintegration anxiety’ resulting in a fragmentation of the ‘self’, particularly when young or emotionally immature. When this happens, certain pathological behaviors are mobilized to fill the ‘hole’ in the self.

Parson believes that when trauma devastates the basic core of one’s identity, a split develops between what the survivor believes to be an ‘acceptable’ part of his experiential memory bank and what he cannot accept. “The pervasive power of the dual traumatic matrix has been referred to as the ruinous experience of the self” (Parson, 1984).

Ulman and Brothers (1988) have studied the fragmenting effect of traumatic experiences from an analytic perspective and found several kinds of trauma to be most shattering, particularly incest, rape, and combat. They have described several variables which influence the severity of the fragmentation, including the following:

1) Violation: When the trauma intrudes violently into the victim’s psychic space, the victim is not only deprived of autonomy and control, experiencing manipulation and often injury to the envelope of self, but also intrusion of inner space, the most sacred and private repository of the self. Rape, as a primary example of violent trauma, can disrupt the individual’s defenses, rendering them incapable of protecting the self. The resulting violation, particularly that of a sudden ‘blitz rape’ by a stranger, leads to victimization and extreme powerlessness.

2) Rejection, self-blame, and shame: Rejection leads to shame, very commonly found in survivors of the Vietnam war and rape victims. Their self-blame is enhanced by members of family or society who blame them for causing their own traumas (Notman & Nadelson, 1976).

3) Meaninglessness and the shattering of normal narcissism (self-esteem associated with innocence and idealism): Rape trauma perpetrated by unknown strangers has been believed by some authors to cause the most severe reactions because “the survivors are particularly likely to experience overwhelming feelings of bewilderment, helplessness, and utter terror because the unconscious traumatic meaning of the rape shatters archaic narcissistic fantasies that cannot be adequately restored” (Ulman & Brothers, 1988, p.115). Traumatic events inflicted on innocent young people during the normal age of idealism, is the most shattering and difficult to understand and assimilate. Among the long-term consequences may be pathological narcissistic traits characterized by self-centeredness, blaming others, needs to control the environment, and inability to establish empathic relationships.

**THE VICTIMS EXPERIENCE:**

A victim experiences loss: of innocence, physical well-being, sense of ideals, and blind trust in individuals - including parents, men, husbands, physicians; and systems - family, religious, medical, legal, and political. As a result, the victim withdraws or isolates herself. The subsequent life style may perpetuate itself through repeated short-term jobs, brief short-term relationships, and frequent moves.

A victim feels violated, abandoned, betrayed, ashamed, and fragmented:

A victim experiences disrupted and invaded physical, emotional, and spiritual boundaries: The victim’s physical and emotional wounds result in persistent fear (panic, anxiety, hypervigilance, and startle reactions), persistent unresolved grief (numbing, depression, mood swings), and anger (irritability, aggressive outbursts, and bitterness).

A victim experiences shame: When a victim feels betrayed by someone who should have been supportive, he or she feels shame and distrust - and erects a ‘wall’ around his or her feelings:
Internal Shame

The Wall

Internal shame alters the victim's self-concept and damages self-esteem, self-integrity, personality, and the quality of interpersonal relationships. It causes the victim to become depressed, unstable, emotionally fragile, distrustful, and to erect a 'wall' to suppress normal emotions.

A victim experiences fragmentation:
A victim feels fragmented - 'not together', 'feeling empty inside', has a sense of inner deadness, or deep internal shame. He or she becomes over-protective or easily angered, causing further victimization behavior.

OMNIPOTENCE

The FRAGMENTED SELF

A victim repeats traumatization as if 'addicted' to a cycle of victimization:
Fragmented victims often become depressed, repetitively self-destructive, isolated, or provoke conflicts during their interactions with others, particularly those within their immediate families (Parson, 1988). To avoid numbing and depression, they often seek excitement, risky solutions, and destructive danger. Not infrequently they become 'hooked' on repeating stressful situations and risk taking.

The following case studies are indicative of post-traumatic symptoms of fragmentation and repetitive victimization:

Case 1

In an attempt to contend with her inner post-traumatic emotional turmoil, Margery, a victim of multiple traumas in her life including sexual assault, began drinking alcohol excessively as a means of attempting to control her distress. Within a few years her marriage ended. As an attempt to cope with loneliness she had a number of brief relationships. Then she moved in with a man who promised to take care of and protect her but eventually began to abuse her. When she became pregnant, he abandoned her and she had an abortion. Severely depressed, she began to rely heavily on sleeping pills and alcohol to sleep because of nightmares and a repetitive dream about reaching for an infant that floated beyond her reach.

One night, she overdosed on her pills but telephoned a friend who called for help. Fortunately, her suicide was prevented and she was admitted to a psychiatric hospital for treatment. It was during this hospitalization that she received help, the first step toward breaking her victimization cycle.

Case 2

Carol, a 21 year old college student, had been a victim of childhood sexual abuse and had also survived an abortion at age 18. She sought treatment for anxiety, mood swings, and depressive episodes which worsened after using substances to 'numb' herself. To help her feel more 'alive', she began riding a motorcycle, dangerously dodging in and around automobiles in heavy traffic to activate the 'adrenaline rush'. She frequently found reasons to become enraged at her boyfriend because anger induced a temporary sense of power and control over her anxiety. But this backfired when he would walk out of the house and leave her with a profound sense of abandonment, shame, and guilt. At those times she would gash her forearms, sometimes deeply. This behavior became a habitual response to threatened abandonment. After her wounds were sutured, she would reassure the doctor that she did not want to kill herself, explaining, "When Bob and I have a fight and he leaves, I feel 'dead inside'. I cut myself because that is the only way I can feel like I'm still alive."

Addictive Behavior: How can Carol's behavior be explained? First, she became 'addicted' - to substances, to repeated stress and victimization, and to her own internal chemicals. Adrenaline is an internal stimulant at times when she takes dangerous risks, which makes her feel alive. Fighting with her boyfriend activates her endorphins (brain chemicals) and she feels not only powerful, but also calm. Abandonment triggers a devastating combination of intolerable terror, grief, and anger which provokes emotional 'numbing' and the activation on internal opioids.

Vulnerable to Abandonment: She is vulnerable to abandonment, which she repeatedly provokes. Each time it happens, she feels unbearable 'numbing' - which
feels like 'death'. To assure herself she's alive, she cuts her wrists, even though there may be little or no physical pain.

**Inner Shame:** Her inner shame provokes repeated self-destructive behaviors which serve as self-punishment and repeated victimization. This entire sequence of victimization is, in many respects, a re-enactment of her 'shameful' traumatic past - the physical and sexual abuse she suffered as a child and the traumatic loss of her unborn child when she had an abortion.

**Case 3**

Susan, a 21-year-old white female, visited an abortion clinic where an incomplete abortion was performed with residual persistent bleeding and contractions. 48 hours later she was admitted to a hospital with bleeding, cramping, and fever of 102 degrees. An intact fetus was observed on ultrasound and an abortion was performed. Products of conception and fetal parts were removed. Her statements reveal a number of symptoms, many of which fit Post-traumatic Stress Disorder criteria. Predisposing factors included her impulsive decision to have the abortion and her sense of abandonment and betrayal by the doctor.

"He [the abortion doctor] didn't talk to me or ask how I felt about it. We didn't have any conversation. He told me how far along he thought I was and he did it. It almost felt like rape. It was hard enough for me to go the first time. I had mixed emotions about doing it. I just made a quick decision and jumped into it. I was so upset. I was crying and upset through the whole thing. He didn't respond - no talk about feelings. No questions. Nothing."

Susan sought counseling 3 1/2 months later, six months later, and again 9 1/2 months after the abortion when her depression worsened and she overdosed on medications. She then had six counseling sessions and was given a diagnosis of Post-Traumatic Stress Disorder. After 2 1/2 years Susan had the following symptoms:

**Intrusive images, flashbacks, and reliving experiences:**

"I picture what I went through again and again. It goes through my head. I picture the abortion all over again, every time I think about it deeply. That's why I don't want to think about it. I don't like to talk about it. I get upset and mad. When I'm alone and if I'm thinking about it I get upset."

**Triggers:**

"I turn off the TV whenever there is anything related to abortion. I used to turn it off whenever there was anything related to babies, period. Now it's just the subject of abortion. I don't want to use the word abortion."

**Anger or aggression:**

"The reason I get angry is the fact that I went through what I did. I have a lot of anger towards the doctor. I get angry at my best friend. I raise my voice. I make smart remarks. Sarcastic. I didn't used to do that. But most of my anger is toward the doctor."

**Guilt & Shame:**

"I wish I wouldn't have had the abortion. At the time I didn't have any choice. But I don't believe in it and I don't like to tell people. They might think I'm a bad person."

**Grief:**

"It still bothers me. I still cry once or twice a week."

**Distractibility:**

"I used to read a lot. Now I have difficulty focusing my thoughts. I forget a lot of what I was going to do."

**Selective concentration:**

"I'm pretty good at shutting things out around me. When I'm supposed to be listening to someone my mind goes everywhere except on what they're saying."

**Memory:**

"Her memory of the abortion is very vivid and as real now as when it happened."

**Numbing & Detachment:**

"I don't want to use the word abortion."

**Startle reactions:**

"I jump out of my skin if somebody sneaks up on me. I wasn't as jumpy before the abortion."

**Relationships:**

"I stay far from men. I'm scared of them. I don't want to have anything to do with sex. I just have a fear of having sex and getting pregnant."

"I worry about the children all the time. They never go anywhere without me. They've asked to stay over night. I always say no."

**Physical symptoms:**

"I have abdominal pains and had exploratory surgery last year (for pelvic pain). I get real tense when I get examined by a doctor... I've wondered if my female problems are because of this. Sometimes my stomach bothers me when I get upset. Until I calm down I don't eat at all."

**SUMMARY**

Abortion, the most frequently performed surgical procedure in this country, may often be experienced by the woman as a traumatic event causing post-abortion symptoms, particularly when there are pre-disposing factors. Symptoms often meet the criteria of Post-traumatic Stress Disorder, which is a recognized psychiatric disorder.

When a woman feels abandoned or be-
trayed by family members, including the father of the unborn child, symptoms are more likely to remain unresolved. Women who have been victims of prior traumatic events in their earlier years, are more likely to suffer difficulties following abortions, including repetitive traumatic experiences associated with post-traumatic fragmentation and "addiction". In the event that a woman feels betrayed by the abortionist and abortion clinic staff - often associated with emotional or physical complications - "helpers" may come to be perceived as perpetrators.

Women who feel that they are have been abused, abandoned, and betrayed become angry, distrustful, fragmented, and are unlikely to experience resolution of their symptoms without significant help.

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