Fragmentation of the Personality Associated with Post-Abortion Trauma
by Joel Osler Brende, M.D., FAPA

This article is a sequel to "Post-Trauma Sequelae Following Abortion And Other Traumatic Events", Joel Osler Brende, Association for Interdisciplinary Research Newsletter, Vol. 7, No. 1, July/August 1994.

Post-traumatic fragmentation of the personality following abortion has important personal as well as social implications. The author points out that victims of post-traumatic self-fragmentation intermittently become self-destructive, depressed and/or antisocial. Traumatized adolescents and young women are reported to be particularly vulnerable to the loss of innocence and idealism and meaning for their lives. This was confirmed in a study of women attending a post-abortion support group at the Medical College of Ohio published in 1989. This study found that anti-social disorders and paranoid delusions as well as drug abuse, were significantly higher in the group of women who had aborted as teenagers compared to women who had abortions after the age of 20. Women who reported multiple abortions had more often considered suicide and scored higher on borderline personality pathology and depression compared to women reporting only one abortion.

The author reports that post-traumatic fragmentation predisposes to a higher likelihood of unstable and destructive relationships. This was confirmed in a Louis Harris telephone survey conducted for the Commonwealth Fund on April 20, 1993 of randomly selected US women. In this survey, 28% of women who reported ever having an abortion said they had been physically abused by a spouse compared to only 12% of women in general.

People enduring extreme stress often suffer profound rupture in the very fabric of the self

The author also reports a high incidence of abuse or addiction to alcohol, prescribed drugs, and illicit drugs. In a 1993 survey of 700 women who responded to a random questionnaire survey conducted by the Elliot Institute, the rate of substance abuse was reported to be 14.6% among women who aborted their first pregnancy compared to only 3.8% among women who did not abort their first pregnancy.
Women who engaged in substance abuse prior to their first pregnancy were excluded from the study.

There are various psychiatric disorders that may result from trauma. The syndrome, Post-Traumatic Stress Disorder (1980, 1987, 1994), has come to be recognized by the presence of three groups of symptoms in approximately 20% to 35% of trauma survivors: 1) Denial/detachment/avoidance, 2) Intrusions/nightmare/flashbacks, and 3) Physiological symptoms, i.e. startle reactions, hypervigilance, and aggressive outbursts.

It has also been recognized that there is another group of survivors, although smaller in number, who experience “dissociation” to block out the emotional and physical pain, in addition to the symptoms described above. These survivors, when exposed to actual or threatened death or serious injury to themselves or their family members during major traumas or assaults may be given a diagnosis of Acute Stress Disorder (DSM-IV, 1994). At the moment of the horrific event, their minds separate from the physical pain and emotional terror. (Near Death Experiences have been reported by survivors of cardiac arrests who describe leaving their bodies during a dissociative experience.) 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 some cases “fragmentation of the self” during the formation of multiple personalities.

“People who have endured extreme stress [often] 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 it asunder and cutting through its biological and psychic integrity” (Parson, 1988).

Heinz Kohut (1971, 1977) a prominent psychoanalyst and one of the significant thinkers in the field of “self theory” has recognized the impact of traumatic stress on the “self”. Severely traumatized individuals can become overwhelmed by “disintegration anxiety” and suffer from fragmentation of the “self”, particularly when young or immature (1977). When this happens, certain pathological behaviors are mobilized to fill the “hole” in self. Stabilizing the self structure and preventing further fragmentation is essential if healing is to occur (Kohut, 1977).

The Dynamics of Post-Trauma Victimization

A victim experiences loss of innocence, physical well-being, and sense of ideals. They also lose trust in individuals such as parents, men, husbands, physicians as well as systems - medical, legal, etc.

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

A victim experiences violation of physical, emotional, and spiritual boundaries - causing physical and emotional wounds - fear, grief, and anger.

A victim experiences shame: When a victim feels betrayed by someone who should have been supportive, he or she feels ashamed and distrust - and erects a “wall” around his or her feelings:
Internal shame alters the victim’s self-concept and damages self-esteem, self-integrity, personality, and the quality of inter-personal relationships. It causes the victim to become depressed, unstable, emotionally fragile, distrustful, and to erect a “wall” to suppress normal emotions.

A victim feels fragmentation ("not together" “feeling empty inside”), has a sense of inner deadness, or deep internal shame, and develops a sense of omnipotence or invulnerability as a defense. He or she becomes overprotective or easily angered, causing further victimization behavior.

Factors Influencing the Severity of Fragmentation

Ulman and Brothers (1988), whose studies revealed that combat, rape, and incest are the most shattering traumas, described several variables which influence the severity of the fragmentation: 1) the degree to which the trauma is experienced as a violation, 2) the presence or absence of support, 3) the presence of shame or self-blame, and 4) the capacity of the survivor to understand and find meaning.

The significance of these four variables is described as follows:

1) **Violation**: The violent intrusion of an offensive, repugnant, or abusive entity into a victim’s physical and 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.” (Bard & Ellison, 1974) Rape, as a primary example of a violent intrusion, 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 an experience of victimization and extreme powerlessness (Burgess & Holstrom, 1974).

Can a woman who receives an abortion be violated? Betty, a young married woman, described her dehumanizing ordeal as follows. After going through the formalities of requesting an abortion, she was whisked through a superficial counseling process, asked to enter the procedure room, told to undress, given a hospital gown, instructed to lie on her back, advised to lift both feet into the stirrups. She was required to wait apprehensively until the abortionist eventually entered the room, inserted a cold metal speculum into her most vulnerable body orifice, suctioned the remains of an unborn child from her womb, and left. That was not all. After two days of pain and bleeding, she was admitted to another hospital where a mutilated dead baby was found hanging partially from her vagina.

2) **The absence of support**: Most of us have had the experience of a supportive parent. For example, six year old Nancy came home crying one Thursday noon and told her mother she was struck on the head by the neighborhood bully. Her empathic parent looked at the superficial wound on her head, picked her up, asked her to talk about what happened, held, comforted her, and brought her daughter to their family physician for treatment. Because of the support Nancy received, the outcome
was positive. She regained her sense of well-being and gained additional courage to help her through future adversities.

A survivor who experiences the loss of emotional support is apt to feel the shame of victimization. Mary was a teenager who became pregnant, but kept the information secret from the 19 year old father. Her mother, upon discovering this information, became angry and, in opposition to Mary's wishes, vindictively insisted she have an abortion. Thus, she felt the loss of her mother's support. However, she hoped to have a doctor who would provide her with the empathy she needed. Expecting a compassionate physician, she was attended to by an impersonal technician who coldly carried out the procedure while ignoring her cries of pain and fear. Finally, when she informed the father of the child, his disappointment caused him to pull away and leave her isolated and fragmented with an overwhelming sense of guilt and shame.

3) Rejection, self-blame, and shame are the emotional precursors to victimization. Survivors become victims when their family members or those individuals in society who should have supported them, blame them instead for causing their own traumas (Notman & Nadelson, 1976).

For example, Mary felt ignored and betrayed by a cold and impersonal abortionist, and she was left with her own thoughts: "I must have done something bad. Maybe I am bad. Why else am I being treated like this?"

After the unborn baby was suctioned from her womb, she felt alone and abandoned by the abortion staff and later, by the father, whose anger was severe when he found out what she had done. The traumatic events contributed to the ending of their fragile relationship. Her residual shame and emotional detachment continues to interfere with dating or establishing serious relationships with men.

4) Meaninglessness and the shattering of normal narcissism (the self-esteem of innocence and idealism.) When a trauma is inflicted on an innocent and idealistic young person, he or she can feel shattered and depressed. The most severe reactions to normal self-esteem occur following rape trauma, which is "likely to [cause] overwhelming feelings of bewilderment, helplessness, and utter terror because the unconscious... meaning of the rape shatters archaic narcissistic fantasies that cannot be adequately restored." (Ullman & Brothers, p115)

Traumatized children, adolescents, and young adults are particularly vulnerable to losing their innocence and idealism, causing them to experience a shattering of self identity, a confused sense of meaning and purpose, difficulties making commitments, and problems with sustaining relationships. Such long term post-traumatic consequences have been found in survivors of the Holocaust (DesPres, 1976), the bombing of Hiroshima to end World War II, the war in Vietnam (Brende & Parson, 1984), adult survivors of child abuse, and victims of unwanted or botched abortions (Brende, 1994).

Innocence and idealism may be shattered by traumatic self-fragmentation

Researchers have also described the severed connection between victims and others (Lifton, 1980), the loss of faith in the capacity of human beings for goodness (Parson, 1988), and a loss of faith in God (Brende, 1991). In such cases, the traumatic events seem to devastate the basic core of identity, causing a split between what remains "acceptable" and what becomes denied as unacceptable. Parson has called this "traumatic matrix ...as the ruinous experience of the self" (Parson, 1984).

In summary, four factors appear to constitute this devastating traumatic matrix, nearly always resulting in post-traumatic self-fragmentation: 1) an experience of severe vio-
translation, 2) lack of support (abandonment or betrayal), 3) self-blame/shame, and 4) the loss of innocence, normal idealism, and meaning.

Post-Traumatic Repetition

Survivors who have been so shattered often become victims of repetitive self-destructive symptoms, behaviors, and interactions with individuals, particularly their closest friends and relatives. As Parson states: "in my clinical experience with... survivors of traumatic experiences, I have been struck by the utter pervasiveness of [their] 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).

Victims of post-traumatic self-fragmentation often use alcohol, tranquilizers, or other substances

Consider the following case of Carol, a 21 year old college student, who had been a victim of childhood sexual abuse, and also survived an abortion at age 18. During her early twenties, 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".

In summary, victims of post-traumatic self-fragmentation develop repetitive symptoms with splitting and dissociation as mental defenses; often using alcohol, tranquilizers, or other substances; and intermittently becoming self-destructive, depressed, and/or antisocial.

Post-Traumatic Fragmentation: Syndromes & Psychodynamics

1. Personality Disorders, Schizo-affective and Bipolar Disorders, Multiplicity of Self, Family Fragmentation, and Childhood Behavioral problems are all syndromes which may have been caused by unresolved traumatic experiences and dissociative defenses.

2. Persistent Post-traumatic Self Fragmentation involves five different part-self fragments of combinations of fragments: Ego, Protector, Child, Victim, and Aggressor.

3. Various fragments - some "good" and some "bad" - are established to serve different functions:
   a) The "victim" is a "bad-self" which suffers from periodic uncontrolled reliving of
painful and shameful traumatic experiences (flashbacks) causing a repetitive cycle of victimization.

b) The “aggressor” is a “bad-self” fragment which embodies “killer” rage and reflexive defensive responses which fend off potential attackers.

c) The “protector” is a “good-self” fragment which embodies over-controlling behavior to protect “victim” and “child” fragments. It can be a fairly adaptive, but unstable, defense.

d) The “ego” and “aggressor” fragments may collude to take dangerous risks to control anxiety and panic but can easily cause self-injurious consequences.

e) Activation of the “aggressor fragment” precipitates violent outbursts; when aggressor and protector fragments merge, this can lead to aggressively over-protective behavior.

f) Internalized aggression toward the “victim fragment” cause self-mutilation and suicidal behaviors.

g) Merging of ego, aggressor, and protector fragments may appear to be stable “good-self” although formed as a pathologically narcissistic defense to deny the presence of “split-off” internal “victim” and “child” fragments.

6. Splitting is associated with the “all or none” phenomena caused by the concurrent presence of both “good-self” and “bad-self” fragments. The overvalued or “good-self” is maintained through the use of denial of internal “shame” associated with victimization, and by projecting or “blaming” others. The “good-self” tends to over-identify with selected victims, becoming aggressively protective toward potential adversaries, and “rescuing” other perceived victims. When this defense breaks down, the “bad-self” emerges. This may be associated with a “flashback” or re-enactment of traumatic event, causing the victim to experience one of more of the post-traumatic emotions of fear, guilt, grief, and shame.

7. Relationships are disturbed. The presence of fragmentation predisposes to a higher likelihood of unstable and destructive (sadistic, masochistic, abusive, and battering) relationships.

8. Although the “ego” and “protector” fragments use defenses to suppress emotional pain, they also create cognitive difficulties, memory lapses, and organizational problems.

Unrestrained victimization ultimately causes accidents, illnesses, broken relationships, incarceration, death, or institutionalization.
9. Recurring stress and victimization may cause an “addiction” to internal “brain chemicals” - adrenaline, endorphins, and opioids. The need to create these temporary but desirable moods and states of mind - invulnerability, tranquillity, and relief from pain - may be significant factors in activating the repetition phenomenon.

10. Unrestrained victimization ultimately causes accidents, illnesses, broken relationships, incarceration, death, or institutionalization.

11. There is a very high incidence of concomitant abuse or addiction to alcohol, prescribed medications, and illicit drugs.

12. These patients usually suffer from personality disorders including: Narcissistic Personality Disorder, Borderline Personality Disorder, or even Multiple Personality Disorder, all of them associated with unstable internal identity, dissociative states, aggressive outbursts, hyper-vulnerability to perceived abandonment, and shifts from over-idealization to devaluation of others.

Summary

Abortion, the most frequently performed surgical procedure in this country, may often be experienced by the “abortee” as a traumatic event causing post-abortion emotional symptoms, particularly when there are predisposing factors. Symptoms often meet the criteria of Post-traumatic Stress Disorder, which is a recognized psychiatric disorder. However, a more severe disorder, Acute Stress Disorder, has been recently identified and characterized by dissociation, memory lapses, and evidence of self-fragmentation.

What are the factors which are likely to produce more severe symptoms? The severity of the violation, the lack of support from others, subsequent self-blame and shame, and the loss of idealism and purpose comprise the post-traumatic matrix which causes fragmentation and chronic and repetitive symptoms. The most vulnerable women have been victims of child abuse or prior traumatic events, adolescents, and women who feel abused, abandoned, and betrayed by others, including health care workers.

Based upon the authors experience with victims of a variety of traumatic events, there is often a chronicity to the disorder which does not resolve itself quickly.

Joel Osler Brende, M.D., FAPA

Joel Osler Brende is a psychiatric medical director of a state hospital and an associate professor of psychiatry. Dr. Brende makes frequent presentations and leads training workshops in the area of psychological, physiological, emotional, and spiritual after-effects of stress and trauma. He belongs to a number of professional societies and is a Diplomate of The American Board of Psychiatry and Neurology, The American Board of Medical Hypnosis, and a Fellow of The American Psychiatric Association. He and his wife, Jacqueline, a travel writer, live in Columbus, Georgia and have seven children.

The following publications of Dr. Brende are available from:

Trauma Recovery Publications
458 Morning Glory Drive
Sparta, Georgia 31087
Phone: (706) 444-9190 (706) 563-9893

Post-Traumatic Assessment Packet for Victims & Survivors
Trauma Recovery for Victims & Survivors Vietnam Veterans: The Road to Recovery
A Workbook For Survivors of War
A Workbook For Victims & Survivors Coping With Trauma & Stress in Spanish
Post-Traumatic Stress & Recovery in the Bible
Twelve Themes & Spiritual Steps
Overcoming Trauma & Stress