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# Psychiatric Sequelae of Abortion: The Many Faces of Post-Abortion Grief

by E. Joanne Angelo, M.D.

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Induced abortion is the surgical or medical intervention in a pregnancy for the purpose of causing the death of the embryo or fetus (If the procedure results in a live birth, the outcome is a preterm delivery, not an abortion.). Every abortion, then, is an iatrogenic death. Every post-abortion woman has undergone a real death experience — the death of her child.

Grief is a natural consequence of death. Current obstetrical and psychiatric literature abounds with articles about grief following perinatal death — death due to spontaneous abortion, premature birth, stillbirth, and Sudden Infant Death Syndrome. However, it is only in recent years that the medical profession has begun to understand that perinatal loss can be followed by a grief reaction similar to the loss of an older child or an adult as illustrated by the following statement in *Clinics of OB/GYN* in 1986. "I can state most assuredly that couples with recurrent, unexplained or explained early pregnancy losses grieve as intensely as those with later losses or losses of live-born children. Their grief is not visible, however, since society, family, friends, press, or clergy do not support or are not trained to support them. The grief is very real and if unattended can eventually be felt by them to be aberrant, unnatural, or even unhealthy."<sup>1</sup>

Hospital obstetrical units have developed teams of physicians, nurses, and social workers to help parents deal with perinatal death and the issues of grief, anger, and guilt which it raises. The September 1990 issue of the *British Journal of Obstetrics and Gynecology* states: "Ways of helping parents cope with their losses have been recommended and have reduced the frequency of prolonged emotional disturbance and of abnormal grief reactions . . . Ways of facilitating the grieving process have been identified. These include seeing and holding the dead baby, giving it a name and taking photographs; all help make the situation a reality and to create memories. It is difficult to grieve when no memory of the individual exists."<sup>2</sup>

In addition to the 20 to 30 percent of pregnancies thought to end in spontaneous abortion in this country, there is now one elective abortion for

every three live births.<sup>3</sup> Evidence is mounting that the reaction to the loss of a child from induced abortion is part of the same continuum of grief. In an editorial in the *Lancet* (March 2, 1991) entitled, "When is a fetus a dead baby?," the author acknowledges that grief follows early pregnancy loss regardless of its cause, "There is no doubt that the profession, led by society, more readily accepts that miscarriage, termination, stillbirth, and neonatal death lie in a spectrum of the same grief. . . . Why should the death of a baby be a unique zone of grief? Perhaps it is because to the parents, and to the mother in particular, an unknown potential has been lost."<sup>4</sup> With half of all pregnancies resulting in fetal death, our society is facing a potential epidemic of invisible mourning and pathological grief.

Grief after induced abortion is often more profound and delayed than grief after other perinatal losses. Grief after elective abortion is uniquely poignant because it is largely hidden. The post-abortion woman's grief is not acknowledged by society because the reality of her child's death is not acknowledged. In order to gain her consent for the abortion she has been told that the procedure will remove a "blob of tissue" a "product of conception", or a "pre-embryo." She has been assured that her "problem will be solved" and that she will be able to "get on with her life" as though nothing significant had happened.

Yet the pregnant woman knows by the changes in her body that something very significant is happening to her: her menses have stopped, her breasts are enlarging, she is sick in the morning (or all day long), and she knows that the process which has begun in her will most likely result in the birth of a baby in nine months time if allowed to run its course. She is aware of the expected date of delivery and she has often thought of a name for her baby as she has begun to picture the child as he or she would be at birth (Bonding begins very early in pregnancy.). All of these feelings and fantasies about her pregnancy must be denied in order to undergo an elective abortion. The pregnant woman is asked to deny the fact that she is carrying a child at all!

Society offers her no support in grieving. Her decision to undergo an abortion is made very quickly without time for calm reflection or seeking advice. The whole process is usually kept secret from her family and friends and professional colleagues, and often even from the father of her child. Abortion clinics offer no "Perinatal Loss Team" to help her deal with her confusing and perhaps overwhelming feelings. She is typically alone, without her partner during the procedure. There is no dead child to hold, no photographs, no funeral, burial, or grave to visit, no consolation from friends, relatives or clergy. Her only memories are of a rushed, painful procedure and of her own efforts to convince herself that what her "abortion counselor" had told her was true. The psychological defense mechanisms of denial and repression are massively in effect by the time she leaves the clinic. It is not surprising then, that "exit poll" research and studies of the immediate post-abortion days, weeks and months find that women feel relieved and claim to have no adverse psychological aftereffects

of elective abortion. When pain and bleeding remind her of the physical assault on her body and when the sudden and unnatural endocrine changes cause her to become emotionally labile, society continues to expect her to act as if nothing had happened. Her attempts to comply with those expectations are at great personal expense. She may begin to dose herself with alcohol or sleeping pills to deal with her nightmares and her feelings of grief and guilt; she may throw herself into intense activity —work or study or attempts to repair her intimate relationships or to develop new ones. When waves of sadness, anger, emptiness, and loneliness overwhelm her she berates herself for not “feeling fine” as is expected of her.

Women who have chosen abortion are often haunted by the obsessive thought, “I killed my baby!” They find themselves alone to cope not only with the loss of the child they will never know, but also with their personal responsibility in the child’s death. Their guilt is not merely subjective or neurotic; it is objective and real. Reminders are all around them — the expected date of delivery, children the same age that their children would have been, a visit to the gynecologist, the sound of the suction machine in the dentist’s office, a baby in a television ad, a new birth, another death experience. Each of these may trigger a breakthrough of guilt, grief, anger, and even despair. This cycle typically continues for many months or years before appropriate help is found because until recently mental health professionals have failed to recognize the many faces of post-abortion grief.

### **Uncomplicated Bereavement (Normal Grief)**

Grief is the subjective experience which follows the death of a loved one. Psychiatrists agree that the period of mourning after a significant loss normally continues for at least a year after the death, and that if “grief work” is not accomplished appropriately, unresolved grief can produce a variety of psychological and psychosomatic symptoms over time.

Horowitz divides normal grief into four stages:

1. **OUTCRY** which occurs immediately after the death when there may be an intense expression of emotion and an immediate turning to others for help and consolation.
2. **DENIAL PHASE** during which the bereaved person may avoid reminders of the deceased and focus attention on other things and during which an emotional numbness or blunting may occur.
3. **INTRUSION PHASE** during which negative recollections of the deceased become frequent, including bad dreams and daytime preoccupations which may interfere with concentration on other tasks.
4. **WORKING THROUGH** during which the bereaved person begins to experience both positive and negative memories of the deceased, but without the intrusive, disturbing quality which they had had previously

and when emotional numbness lessens. The process of working through has reached completion when the bereaved person once again has the emotional energy to invest in new relationships, to work, to create, and to experience positive states of mind.<sup>5</sup>

### **Pathological Grief**

Pathological grief occurs when the normal stages of grief are intensified, prolonged or delayed and when the bereaved person is not able to resume normal functioning due to the development of other psychiatric or psychophysiologic symptoms. Horowitz gives the following examples of pathological grief.<sup>6</sup>

Immediately following the death the OUTCRY may be intensified into a panic state where behavior is erratic, and self-coherence is lost in a flood of uncontrolled fear and grief. Alternatively, the bereaved person's withdrawal may be exaggerated into a dissociative state or a reactive psychotic state.

When the DENIAL PHASE is pathological the following may occur; "overuse of alcohol or drugs to anesthetize the person to pain. Some persons may seek to jam all channels of consciousness with stimuli, avoiding thinking and feeling about the death. To escape feeling dead and unreal, one may engage in frenzied sexual, athletic, work, thrill-seeking, or risktaking activities."<sup>7</sup>

Risk factors for the development of pathological grief are listed in Michels' 1990 textbook *Psychiatry*:

"Some circumstances are likely to increase the severity or duration of grief reactions. These include pre-existing high dependency on the deceased, pre-existing frustration or anxiety in relating to the deceased, unexpected or tortuous deaths, a sense of alienation from or antagonism to others, a history of multiple, unintegrated earlier losses or simultaneous losses, and real or fantasied responsibility for the suffering or death itself. When several of these factors are present, a complicated bereavement reaction may result that warrants diagnosis as one of the anxiety or depressive disorders (including Post-traumatic Stress Disorder), an adjustment disorder, reactive psychosis, or a flare up of a pre-existing personality disorder."<sup>8</sup>

### **Depression**

Pathological or unresolved grief has long been recognized as a precursor to serious depressive illness. Shakespeare's Macbeth says, "Give sorrow words; the grief that does not speak knits up the o'erwrought heart and bids it break . . ." The current *Diagnostic and Statistical Manual of Mental Disorders* states, "morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment, or psychomotor retardation, or prolonged duration suggests that bereavement is complicated by a Major Depressive Episode."<sup>9</sup>

In a review article, "Mental Health and Abortion" in the *Psychiatric Journal of the University of Ottawa* (1989), Phillip Nay concludes that although depression was once a frequent indicator for induced abortion, "depression is likely to be worsened by abortion because it increases guilt and causes another loss."<sup>10</sup>

Depressive disorders are the most common reason for psychiatric referral of post-abortion women in my experience. Suicidal ideation, impairment of the ability to carry out daily functions at work, school, or home, somatic symptoms such as weight loss and insomnia make psychiatric care imperative. Psychiatric intervention often includes anti-depressant medication and/or hospitalization, as well as intensive psychotherapy. Although the diagnosis of Major Depressive Episode is made and appropriate initial treatment instituted, the significance of the early pregnancy loss through abortion as a causative factor is often overlooked. This may occur for a number of reasons.

1. The patient may not volunteer her abortion history, and may be reluctant to answer routine questions about her reproductive history because of intense shame and guilt and because of a lack of a trusting relationship with her therapist, which takes time to develop.

2. A long time may have passed since her abortion, and the psychiatrist may not be aware of the very common delay of eight to ten years from the induced abortion until the woman seeks help for her depression, which has become so severe that she can no longer function and her life is in danger. An eight to ten year delay in seeking help has been a common finding in outreach programs to post-abortion women across the United States.<sup>11</sup>

3. So many other negative factors in the history could account for the woman's depression: alcohol and drug abuse, failed marriages, job stress, intrusive obsessive thoughts which may appear to be psychotic in nature. An example of the latter is the case of a 75 year old woman in a nursing home who was heard muttering over and over again "I killed my baby!", and who, in fact, had an abortion sixty years before.

4. Society's "blind spot" regarding the significance of perinatal loss and the grief following induced abortion is shared by many psychiatrists and other mental health professionals. If her tentative attempts to share her profound grief and guilt with her therapist are not heard or are belittled, the post-abortion woman's sense of worthlessness and despair may increase and she may be confirmed in her conviction that no one will ever understand or be able to help. She may discontinue her medication, cancel appointments, and sink even more deeply into depression.

Peterson, who is studying post-abortion women in Germany, believes that when deep feelings of guilt which have been suppressed for a long time are followed by "a breakthrough of destructive deep awareness, with chaos and panic, revulsion and hate" these feelings must be acknowledged and the woman helped to come to "acceptance of existing reality, responsibility and feeling of guilt toward the dead child."<sup>12</sup> It is my experience that only when the therapist can endure the flood of primitive emotions which the patient



needs to pour out over a number of sessions without rejecting her or asking her to diminish their intensity, can he or she begin to help the post-abortion woman in her work of mourning.

Although there are no visual memories of her child, no pictures, no shared experiences to help her work through the grief process, she has frequently formed a mental image of her child. It is in fact that mental image which has been haunting her, intruding itself into her thoughts day and night. Often the image is of an infant being torn to pieces sucked down into a tube, crying out in pain, or reaching out to her for help. She has often named her child and may have regularly occurring conversations with him or her in her mind. The work of therapy involves allowing her to share these images and to accept her guilt while at the same time the therapist is kind and supportive to her. Gradually she will learn to accept the reality of what has happened and her own responsibility in the death of her child. In time she can begin to develop a mental image of her child no longer suffering and crying out to her but at peace and at rest.

The treatment of depression in a post-abortion woman involves more than providing for her safety and physical well-being (emergency psychiatric care) or offering her appropriate anti-depressant medication if indicated. One must also allow her to share the overwhelming guilt, sorrow, anger and self-hate which she has harbored perhaps for years and which she has attempted to deal with by dosing herself with alcohol, drugs, and frenzied activity. Her fantasies about her dead child must also be acknowledged for these are her only memories of her baby. Gradually these fantasies can be shaped in a more positive and consoling manner so that she can finally put them to rest. Clergy can be helpful in this process both in helping the woman seek forgiveness and in offering prayers and/or a memorial service for her baby.

### **Suicide**

“Women in the first year after childbirth and during pregnancy have a low risk of suicide” is the conclusion reached by Appleby after studying all women aged 15 to 44 who committed suicide in England and Wales from 1973 to 1984.”<sup>13</sup> The actual number of suicides in this group was only one-sixth of that expected relative to other women of the same age leading him to conclude, “Motherhood seems to protect against suicide. Concern for dependents may be an important focus for suicide prevention in clinical practice.”<sup>14</sup>

The same study found, however, that the suicide rate after stillbirth was six times that for all mothers after childbirth. While the birth of a living child seems to “protect against suicide”, it would appear that the birth of a dead child greatly increases the risk of suicide. What then of the risk of suicide after elective abortion when the mother is not only dealing with the death of her child but with her responsibility in causing that death? In my search of the literature I have not found any such demographic studies.

It is well known that youthful suicides are increasing at an alarming rate, and that the majority of these occur between the ages of 15 and 24 years which is the same age group where most induced abortions occur.<sup>15,16</sup> Most adolescent suicides occur in the middle and upper socioeconomic class as do most abortions. "Suicidal behavior in 'normal' adolescents" is the topic of a 1989 study published in the *American Journal of Orthopsychiatry*. Sexuality and loss were two of four risk factors which caused a nearly five fold increase in the risk of suicidality in a sample of 300 public high school students in grades 9-12 in a small Northeastern community.<sup>17</sup> Although the report of the study does not include data about abortions, the correlation between teen sexual activity, pregnancy and loss through abortion is apparent in this population.

The newsletter of the American Suicide Foundation observes that, "Specific crises and environmental stressors may precipitate suicidal behavior, although it can be hard to appreciate the stressfulness of a seemingly minor event that falls on the shoulders of an adolescent who is already burdened with depression."<sup>18</sup>

Some case vignettes from my own practice may illustrate why elective abortion is anything but a minor event in the lives of young women and their partners.

"Lorna", a 22 year-old woman in the military was referred to me because of an eating disorder. In our first visit she told me that for the past year since her elective abortion she had wanted to die. In fact she had made a suicide attempt two days before her scheduled abortion when she felt that she could neither go through with it nor face the rest of her tour of duty in the military as a single parent. When she was unsuccessful in causing a fatal automobile accident after she had overdosed on drugs and alcohol, she had been admitted to a psychiatric inpatient unit.

Her psychiatrist advised her to go through with the abortion which had been scheduled for her the next day. Since that time her cocaine and alcohol use had escalated and her weight had continually dropped. She was haunted by a strong desire to be united with her baby, and by the urge to kill herself. In the year in which I worked intensely with her she made several suicide attempts and was re-hospitalized once. Before she moved out of the area she thanked me for having helped her, saying: "I'm not going to kill myself now, but when I die I know that's how it will happen." A year later it did happen.

A 23 year old single woman whom I have called "Joyce" was referred to me after a suicide attempt which also involved a planned drunk driving accident. Her obsessive thought was, "I want my babies!" She had had two abortions, one at the age of 17, and one at the age of 18 while in high school. She was the youngest in a large family and still living at home. Her fear was that if she told her parents (who were older and in precarious health) that she had become pregnant and had the abortions they would "drop dead of heart attacks." She suffered alone for six years with her guilt and her longing for her lost children. When an uncle who was a priest returned from overseas she planned to tell him her tragic story. Before she could talk with him he suddenly died of a heart attack. Mourning his death and now convinced that she would never be able to share her guilt and grief without risking further losses, she planned her own death both to end her pain and to achieve a reunion with her children and her uncle.



An 18 year old gas station attendant, "Peter", shot himself and died three months after his father's unexpected death. Only his closest friend knew that at the time of his suicide he was despondent over his girlfriend's abortion. Their child had been conceived on the day of his father's death. In Peter's mind a mental image of the child had formed: he had told his friend that he would have a son and that he planned to name the boy after his father. The loss of that child and all that he represented to Peter was more than he could bear.

### **Post-Traumatic Stress Disorder**

Post-traumatic Stress Disorder is one of the Anxiety Disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders*. "The characteristic symptoms involve re-experiencing the traumatic event, avoidance of stimuli associated with the event or numbing of general responsiveness, and increased arousal . . . The most common traumata involve either a serious threat to one's life or to physical integrity; a serious threat or harm to one's children, spouse, or other close relatives and friends . . . . The disorder is apparently more severe and longer lasting when the stressor is of human design."<sup>19</sup> A list of life events which may cause sufficient stress to produce Post-Traumatic Stress Disorder includes abortion.<sup>20</sup> The most familiar type of Post Traumatic stress disorder or P.T.S.D., is "Post Vietnam Syndrome." Following induced abortion, many women experience similar symptoms. In fact the similarities are so striking that some clinicians have coined the term "Post Abortion Syndrome."

Characteristic symptoms of Post Traumatic Stress Disorder include: recurrent and intrusive distressing recollections and/or dreams of the event, sudden acting or feeling as if the traumatic event were recurring (flashbacks), and intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma; persistent avoidance of stimuli associated with the trauma, emotional numbness and an inability to feel emotions of any type, especially those associated with intimacy, tenderness and sexuality; and increased symptoms of arousal i.e. startle responses, recurrent nightmares and sleep disturbances. A case vignette follows.

"Alice", an attractive professional woman in her early thirties, was referred because of marital problems, sleeplessness, anxiety and a sense of being hyperalert and over-reactive to loud noises. These latter symptoms interfered with her work which placed her constantly in the public eye. She had had a traumatic abortion a year before, arranged for her by her husband in a clandestine manner. She had been experiencing frightening dreams, daytime flashbacks, intense anger and loathing for her husband and suicidal preoccupations for the past year. "I killed my baby! I don't deserve to live!" were the intrusive thoughts which haunted her waking hours. She had been seriously contemplating suicide.

### **Anniversary Reactions**

Suicide attempts on the expected date of delivery of the aborted child or subsequent anniversaries of that date or the date of the abortion are

common. Tishler describes two adolescent girls who attempted suicide on the approximate date the fetus would have been born had it come to term although one of them was not consciously aware of the significance of the date prior to her medication overdose.<sup>21</sup>

Thirty out of 83 women surveyed regarding post-abortion coping reported anniversary reactions associated with the abortion or the due date in a 1989 study from the Department of Psychiatry of the Medical College of Ohio. In addition to intense and persistent emotional pain after abortion, these anniversary reactions were characterized by physical symptoms most commonly involving the reproductive system — abdominal pain and dyspareunia, also headaches, chest pain, eating irregularities and increased drug and alcohol abuse. The authors state, “The time-specific relationship of the symptoms to the original experience is often not recognized by the subject and appears to be an attempt to master through reliving rather than remembering. Unresolved grief and pre-existing dysphoria have been suggested as increasing the likelihood of anniversary reactions.”<sup>22</sup>

If the conflicted issues could be sequestered on a subconscious level throughout most of the year and arise only under camouflage to some extent, then a protective role is certainly possible. The woman might be able to receive concern and attention from others without necessarily having the conflict identified.<sup>23</sup> The authors advise physicians and therapists to ask about particular events which may have occurred around the time of year when the patient presents poorly explained physical or psychiatric symptoms. It is easy to see how excessive medical work-ups could lead to unnecessary tests and procedures and even unnecessary surgery.

The authors also report that women in the non-anniversary group in their study mentioned self-punishment as their reason for having a hysterectomy or tubal ligation or for suicidal behavior.

The following case illustrates an unusual anniversary reaction:

“Akiko”, a Japanese college student, was referred for presumed Premenstrual Syndrome (PMS) which was in fact an acute anniversary reaction to her abortion which recurred monthly. One or two days each month her dormitory staff reported that she would not come out of her room for meals or for classes and spent the time crying inconsolably — a most unusual occurrence among Asian students in their experience.

Akiko had had an abortion the day before she left Japan to come to the U.S. to study early childhood education. Her first college classes focused on pre-natal development. During a film showing intra-uterine life she suddenly became aware of the actual developmental stage of the fetus she had aborted a few weeks before. From then on, each month on the anniversary of her abortion she had become overwhelmed and inconsolable by sadness and guilt which she could not share with anyone.

In the context of helping her to work through her grief, I asked Akiko about how women in Japan deal with post-abortion grief. I learned that it is common for mothers in Japan to request memorial services for their children whom they believe they have “sent from dark to dark.” At Buddhist temples parents rent stone statues of children for a year during

which time prayers are offered for the babies to the god Jizu. More recently, the goddess Mizuko Kanon is believed to be better able to care for these water babies who arrive with smashed heads and shredded bodies because she has large hands with webbed fingers. Parents regularly visit these statues and leave toys, flowers and written messages for their babies.<sup>24</sup>

### **Psychosomatic Symptoms**

In addition to the psychophysiological anniversary reactions described above, the chronic stress of unresolved post-abortion grief can also provide classical psychophysiological reactions as the following case illustrates.

“Jerry” was doubled over in pain before a scheduled media presentation. He had not had time for breakfast and forgotten the antacid medication he regularly took to control the peptic ulcer which he had recently developed. Jerry’s wife had aborted their first child without his knowledge, and had aborted their second child without his consent. After the birth of their third child, Jerry had become over-protective of the boy, spending every waking moment with him, even changing his work schedule so as to be alone with him while his wife worked. A divorce ensued and sole custody of the child was awarded to his ex-wife. Jerry’s grief became profound and his psychosomatic symptoms increased.

### **Family Issues**

As has been described above, post-abortion grief may be responsible for marital conflicts, problems with sexual intimacy, and parent-child relationship difficulties. Two additional case vignettes will further illustrate these issues.

“John” was a 28 year old office worker who entered psychotherapy because of a depressed mood, difficulty sleeping, lack of concentration at work, and conflicts with his wife and children. After several apparently unproductive sessions with his therapist, he reported a dream during which a former girlfriend brought him into a room and introduced him to a ten year old boy, stating, “This is your son!” Only then did he recall her pregnancy with their child and his active participation in her abortion. Subsequent work with him revealed that it was his unresolved grief and guilt over that child’s loss which was responsible for his current symptoms.

“Jeannie” was a six year old girl who was referred for evaluation of school phobic symptoms. Her separation anxiety began at kindergarten and had not abated in first grade. She often stayed home complaining of stomach aches and headaches. She would only go to school accompanied by her mother, and terrible scenes occurred each time her mother was encouraged to leave with crying, screaming and kicking. Jeannie’s mother was afraid to leave her at school in that state even though the teachers assured her that within a few minutes after her mother’s departure Jeannie was able to enter the classroom and participate with the other children.

Jeannie’s mother had aborted her previous pregnancy — a decision which she deeply regretted. This next child was burdened with her mother’s pathologically intense attachment to her which did not allow for age-appropriate separation and growth for her child.

## Conclusion

In 1973, an article in the Journal of the National Medical Association stated, "Early information would tend to alert the physician to the need for systematic follow-up of all abortion patients . . . The epidemiologic consequences of abortion may (therefore) become statistically relevant in the not-too-distant future with far-reaching public health significance."<sup>25</sup>

With 26 million abortions in this country in the 18 years since *Roe v. Wade*, and the continuing rate of 1.6 million abortions per year, we can no longer deny the public health significance of their psychological and psychophysiological sequelae. Epidemiological studies are urgently needed which are statistically sound and which follow women and men for at least ten years post-abortion.

In the meantime, case reports remain valid psychiatric documentation of the many faces of post-abortion grief. The traditional teaching of our profession has not been by means of controlled studies with a sample of several hundred and statistically significant standard deviations. Sigmund Freud, Eric Erikson, Viktor Frankl, Jean Piaget, and Robert Coles have told us about individuals who they have studied in depth. Their detailed case studies have led to lasting insights into human development and the origins and treatment of psychopathology.

The best treatment for any illness, of course, is primary prevention. Primary prevention of the negative psychiatric sequelae of abortion involves the prevention of abortion itself by means of offering compassionate alternatives such as support in child bearing, child rearing and adoption, but more importantly the prevention of untimely pregnancy by teaching the true meaning of and reverence for human sexuality.

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