

Observations on the Post Abortion Syndrome

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Even though it is denied by most, the fact is that for all physicians, and especially psychiatrists, abortion is a major public health problem. The opinion of the Supreme Court who declared that it is a safe procedure is anything but the truth and is based on false testimony. The dangers both physical and psychological are enormous and are associated with significant problems. Two investigators, David Reardon, a psychologist, and Philip Ney, a psychiatrist, have produced significant reviews that clearly document the occurrence of frequent physical and psychiatric complications of abortion.

PHYSICAL

Ten percent of abortions have unintended complications. Twenty percent of these are major. Infection is most common affecting about 27 % of patients. Three to five percent of all women become sterile after abortion, or are more likely to have ectopic pregnancies. Cervical lacerations, which later result in early delivery or miscarriage, occur in 22%. One major complication is that there is a 48% greater risk of dying in later pregnancies. Finally, there is a 30% increased incidence of breast cancer in women who have had an abortion with their first pregnancy.

PSYCHOLOGICAL

There is only one positive emotional response to abortion. It is relief. The person is relieved of having to suffer the disgrace of an unwanted pregnancy if they are single, and/or having to accept the duty of rearing an unwanted child if they are single or married. Even so, 40 to 60% of the emotional reactions are negative. Fifty-five percent of women who have abortions have guilt, 31% have regrets and 33% have sleep disturbances. In one study 10% of women had serious psychiatric problems immediately after the abortion. The greatest psychiatric impact is in women under 17 years of age.

In many there is a period of five to ten years where the mechanism of denial is used to prevent

the negative emotions from causing them to suffer. Still, 25% of all aborted women saw a psychiatrist whereas only 3% of women who had normal deliveries sought help. Among the entire group 46% had feelings of self-hatred, 49% used drugs and 39% either began or increased the use of alcohol. Sixty percent reported suicidal ideas and 28 % attempted suicide. One-half of these repeated the attempt. There is an incidence of completed suicide that is six times greater in women who have had an abortion when compared to women who delivered normally.

What about men who participate in the abortion of their wives or consorts? It has been documented that 75% of these men have psychiatric problems subsequent to the event. Siblings are also affected in many instances where they know the mother had an abortion. This knowledge gives rise to doubts about being wanted. This leads to lower self-esteem. They also are more likely to have behavior disorders.

If a psychiatrist is attuned to the existence of the post abortion syndrome then he realizes that most of the 1,800,000 women who have abortions each year and the 40,000,000 who have had abortions since Roe vs. Wade are a vast group of women who desperately need help. Their consorts need help too.

ILLUSTRATIVE CASES

CASE 1: Rejection as a Bible study leader appeared to have precipitated a severe depression in a 47-year-old housewife. Immediately hospitalized, the patient improved when treated with medications, but when they were discontinued six months later, she promptly relapsed. Reinstitution of medication resulted in a partial remission. She then changed psychiatrists who changed her medication with some further improvement. Because of conflicts in her religious life she was also treated psychotherapeutically. In the fourth month of therapy, she confessed with great shame that she had an abortion one year before the onset of her illness.

The patient had made a decision for an abortion because of her age, the effort she was already

expending in caring for her three children – one of whom was dyslexic – and a large house, and many social commitments. Her husband neither discouraged nor encouraged her decision, but did support it.

Because I could not get her well medically or psychotherapeutically, I reviewed her history with her to determine if I had missed anything. I asked her again about an auto accident that she told me she had. While driving her son to treatment for his dyslexia she rolled her Volkswagen. As it rolled over she thought, “I will kill both of my sons!” I reminded her that she had only one son. “Oh!” she gasped, “I didn’t tell you, I had an abortion.” The patient further told me that when she knew she was pregnant she believed the child would be a boy, and had decided to name him Christopher. Afterward she felt extremely guilty, but she did not grieve the death of her child.

Since she had a strong faith I told her that she could resolve the grief and relieve the guilt by ritually mourning the child’s death. She assented to a service which when conducted was accompanied by profound emotional release. Within a few days all residual symptoms disappeared, her medications were tapered and discontinued. She required only minimal supportive therapy for a short time thereafter. She has been well for over 25 years.

CASE 2: Susan despaired of meaning. She had been raised in a nominally Catholic home, but her only exposure to faith was the Ten Commandments that were posted above the head of her bed. She had trained as a nurse and in time married a nominally Jewish medicine resident. At his request she converted to Judaism. Within a few years she had three children. Then she got pregnant a fourth time. Her husband did not want to have another child so he forced her to have an abortion. She resented this, so being angry and having no way to express it, she turned it against herself and became depressed. She was also profoundly guilty about having the abortion. Because of suicidal ideation she consulted a psychiatrist who saw her three times a week for three years. During her therapy there were episodes when she became intensely suicidal. Her analyst thought that she should be desensitized to abortion so she had her work in an abortion clinic for a year. This did not help, but instead made her worse for she had increasing guilt about

helping destroy children like her own. Later when she had another bout of suicidal ruminations she was admitted late on a Saturday afternoon when I was on call. The nurse reminded me that she had been admitted, but I forgot to see her in the rush of my duties.

I started home when I remembered that I had to write her admission note. I returned to my office put on my white coat and went to the ward. I got her chart and went to her room expecting to spend no more than 15 minutes with her. On entering her room I asked her why she was admitted and she began to tell me her story. One hour and 15 minutes later she finished relating the story of the suffering that she had been through. I forgot the lateness of the hour and my hunger. When she finished she plaintively asked me, “Dr. Wilson, do you know what is wrong with me?”

“I do.”

“What is it?”

“Your life has no meaning.”

“I knew that. Why wouldn’t they tell me that?”

“Most psychiatrists do not believe in existentialism, so they could not tell you,” I said.

“Is there any answer to it?”

“Yes, but I cannot tell you what it is. You are not my patient, and I am not sure your doctor would approve of my answer.”

Susan quickly responded, “I won’t tell my doctor if you don’t.”

With this promise I said to her, “The answer is Jesus.”

“I knew that. Why wouldn’t they tell me about him?”

“People cannot tell you about someone they do not know, or believe in,” I replied.

“Tell me about him,” she begged.

I told her about Jesus and how he changes lives and gives lives real meaning. I briefly told her what he had done in my life and ended by asking if she would like to have him as her Lord and Master. She eagerly assented and prayed for him to come into her life and heal her. He did! She was healed of her depression. She still had to deal with the abortion, which she did some months later in group therapy with women who were depressed. She was then completely healed. When she told the group about her abortion and its aftermath, four other women in the group began to weep; when asked what was wrong they confessed that they, too, had abortions. They participated in the healing and were all healed. For the last 27 years she has had no further problems.

OBSERVATIONS ON GRIEF FOLLOWING ABORTION

Julian Marias in his book, *Metaphysical Anthropology*, describes the process of human bonding using the term installation. This has a meaning similar to Bowlby’s attachment described in his work published in 1982. Attachment is a word that implies that people are externally joined as siamese twins are joined. Marias’ use of the term installation conveys the idea that they internally become one. His choice of meaning for installation comes from the Spanish language use of a word for installation that implies that two people become one. He states that when a person falls in love he/she over a period of time gradually installs the beloved into themselves and becomes one with them. This also takes place in the object of their love. They then live their lives for one another, and where one goes the other goes too. This is a psychospiritual

phenomenon. By this we mean that it occurs supernaturally and takes place in the person's mind. It contains both a cognitive and an emotional element.

When a woman becomes aware that she is pregnant there is an instant and complete installation of the baby in the mother's life. The mother begins to live her life for the child and prepares for its birth. If a father is present and available the same process takes place in his mind. The child is not able to begin bonding until the last trimester of pregnancy when he/she develops an awareness of the emotional environment of the home and begins the process. This is continued after birth. The child is born with a radical need for love that has to be fostered during these first dependent years of life. This only changes when the child begins separation and individuation. Installation only occurs when there is an emotion of love.

When installation has taken place it is difficult to uninstall the loved one. This is why the loss of a mate is so traumatic. The separation takes place through the process of grieving. Holmes and Mazuda made it the most traumatic of all stresses. The same is true of divorce. Grief is the aftermath of the loss of a loved one. One of my patients spontaneously told me that when her husband died it felt as if part of her had been amputated without anesthesia. I have had patients tell me the same thing about the death of a child. With abortions, as with miscarriages, there is no provision for grief to occur.

Much has been written about the resolution of grief, but only in the 80's was anything written about grief with abortion. One of the most important contributions was by Stack, who in his discussion of the psychological consequences of spontaneous abortions wrote that a number of factors give rise to unresolved grief. (1) Others usually do not know that the woman is pregnant. (2) The woman is embarrassed to mention that she has lost a baby. (3) She has frequently not resolved the ambivalence of the early narcissistic stage of the pregnancy. (4) She has not identified the fetus as a person, but rather considered it part of herself. (5) She is not able to identify the lost person as someone else. (6) She rarely sees the baby that she has lost, and so can only fantasize about its sex, size and personality of this person who never was to be. (7) There is

no funeral. (8) There is rarely recognition by the caregivers that a significant event has occurred. (9) Caregivers, relatives and friends encourage denial and intellectualization and rarely encourage the woman to cry or talk about her loss or assume the role of a bereaved person. (10) The suddenness and unpredictability of a spontaneous abortion does not allow the woman a period of anticipatory grieving and preparation for the loss. (11) Guilt is almost a universal feeling experienced by a woman who miscarriages. (12) A sense of helplessness when a woman is bleeding and neither she nor the physician can do any thing about it.

We observed that all of these factors are present in women who have an induced abortion. In addition, there is the fact that the woman intentionally took the life of her own child. We have noted in our introduction that regret and guilt is almost universal at some time after the abortion. We have seen it manifest twenty years after the event. We must note that murder is a universal taboo in all societies and many women see it as such. It was articulated by a patient I saw in Madagascar who sobbed, “My baby, my baby, why did I kill you?” continuously for 15 minutes. To deny there are psychological consequences of induced abortions is patently wrong in the face of the evidence.

Buckles observed that grief after abortion needs to be resolved. She believes that women have unfinished business with the “little ghost within,” described by Francke. This unresolved grief must be worked through. She did not describe the means by which it is accomplished.

In 1944 Lindemann did describe how grief can be resolved. His observations were based on his experiences after the Coconut Grove fire in Boston. Because he so clearly and succinctly described the process, I will take the liberty of quoting him rather than trying to summarize his comments.

Religious agencies have led in the dealing with the bereaved. They have provided comfort for giving the backing of dogma to the patient’s continued wish for continued interactions with the deceased, have developed rituals which maintain

the patient's interactions with others and countenanced the morbid guilt feelings of the patient by "divine grace" and making up to the deceased at a time of later reunion. While these measures have helped countless mourners, comfort alone does not provide adequate assistance to the mourner's grief work. He (she) has to review his (her) relationship with the deceased and has to become acquainted with the alterations in his own modes of emotional reaction. His fear of insanity, his fear of accepting the surprising changes in his feelings especially the overflow of hostility, have to be worked through. He (she) will have to express his sorrow and sense of loss. He will have to find an acceptable formulation of his (her) future relationship to the deceased. He (she) will have to verbalize his (her) feelings of guilt, and will find persons around him (her) who he (she) can use as primers for the acquisition of new patterns of conduct.

Our own observation is that his formulation and its application in Fisher's "Widow's Program" are relevant in dealing with post abortion syndromes whether they arise after spontaneous or induced abortions. In Lindemann's view, faith is an asset and we also find this to be true. I use faith in my dealing with patients whether their faith is strong or weak or even non-existent.

TREATMENT

In 1978 I was introduced to an intervention that eventually received the name of Requiem Healing by Kenneth McAll, a psychiatrist from the United Kingdom. Dr. McAll had been a Christian missionary surgeon in North China before WWII and spent four years in a Japanese concentration camp. On his return to England he trained as a psychiatrist. In time he observed that women who had abortions or were intimately involved in procuring abortions for others often develop anorexia nervosa or other psychiatric syndromes. When he had a service for the aborted fetus the anorectic would be healed. He collected over 441 cases with long-term follow-ups. He also treated other problems that were associated with abortion and applied his procedures to these cases with similar results. After I spent some time observing his

interventions and helping him collate his data, I applied them in my own practice with similar results. This is how the service is conducted.

If I ascertain that there have been un mourned losses of aborted and miscarried fetuses I determine the significance of the lost fetus to the person(s). Next I ascertain what feelings the person had at the time of the loss and in subsequent days and weeks. This is done with an empathetic understanding of the patient's pain. When they in time experience emotions that they have previously repressed or denied I then use their faith or my faith, and try within its limits to help them understand the future that they will have with the lost person.

To do this the therapist must have some theologic understanding of the afterlife in order to help the patient formulate a picture of the future relationship. If the therapist lacks this understanding he/she can turn to a minister or chaplain who does have such understanding. I warn you that not all theologically educated persons do understand. Catholic priests and orthodox Anglicans usually do since they have a service for the dead. Some Protestant ministers do have a concept of the afterlife and may have learned about requiem healing so they too can cooperate. The person selected must be capable of communicating a hopeful biblical understanding of the afterlife to others.

To start, those conducting the service have to convey to the patient an understanding of the necessity for grieving and the hope that she has for the future; there must be an act of relinquishment of the relationship and a decathexis of the child. This is done with prayer visualization. In this intervention the patient visualizes themselves holding the baby in their arms and approaching the threshold of the divide between their existence and God's kingdom. Since God is light we have them visualize the light of God in the background facing them. Then they visualize one or more angels coming to the foreground. The baby is then passed to the angels who, after the woman declares her love for the child and confesses her regret about having the abortion, carry the baby off into the light of God's presence. As this takes place the woman then tells the baby good-bye. Almost always there is an emotional release at some point in the

ceremony. To provide closure the Eucharist can be celebrated after the child is released. It is, however, not necessary to achieve healing. The Eucharist is a symbol of hope, which accounts for it providing closure.

DISCUSSION

During the last three decades medicine has increasingly considered the spiritual dimension of patients' lives. So much so that 80 medical schools now have courses in spirituality. Psychiatry, however, has not shown as much interest probably because it had its own quasi religion psychoanalysis. However with its diminishing popularity, in the advent of psychotropic medications and managed health care, medicine has turned to pill pushing. Today a patient gets 15 minutes of the psychiatrist's time and a change in medications if necessary. In addition to the forgoing, there is also the problem of the worldview taught in most residency programs in which the nature of man is seen as a bio-psycho-socio-cultural being; and the spiritual dimension of his being is denied. Why we do that is not clear to me for every man has a god even if it is himself. Secular humanism declares this emphatically.

But does man have a spiritual dimension? Can it be diseased? The answer is yes. C. S Lewis in his book *Miracles* points out that there is a supernatural dimension to man's being. To realize this all we have to do is think about thinking. Thinking is a supernatural phenomenon. Because man has this supernatural dimension, God can communicate with him and can be installed in him. It is this installation that provides the marked changes in personality that occurs with salvation. William James has described these in 1902 in his book *The Varieties of Religious Experience*. He commented that the only thing that changes a radically bad man into a radically good man is conversion.

But is there a God? The answer is again yes. Norbert Weiner said that mathematically there are eleven dimensions of existence. God exists in all eleven. We know this because we can see him in the things he has made, namely the universe.

Now if man has a supernatural dimension and God is supernatural, it is possible for him to communicate with us and to install himself in us. But first we have to recognize that we are born without that relationship. This means that we are spiritually diseased at birth and have to be regenerated in order to have a right relationship with him. If we are not regenerated we will not live the life he has called us to live, and we will have another spiritual disease called sin. Sin is transgression against God. W. M. McKay, a scholar at Cambridge, wrote a book entitled *The Disease and Remedy of Sin* in the early part of the last century. But this is not the only spiritual disease, there is another: It is called fanaticism. It is unequivocally a spiritual disease, and it can occur in Christians and non-Christians alike. Finally, there is another disease called demonization. One sees this very commonly in the third world where animistic religions are practiced. Every one of these diseases is described or noted in the Bible.

One other aspect of man's existence is also ignored by modern psychiatry. It is existentialism. It is defined as a 20th century philosophical movement embracing diverse doctrines but centering on analysis of individual existence in an unfathomable universe and the plight of the individual who must assume ultimate responsibility for his acts of free will without any certain knowledge of what is right or wrong or good or bad. This is the secular view, however; this is not what Soren Kierkegaard described.

Even so, man does exist. If he is a Christian his universe is not unfathomable. He is responsible, but he does have knowledge of what is right and wrong, and can strive to live by the values he is taught. His relationship with God gives him meaning, and he can be a moral animal. His belief system provides him with a futurology, and he can look to the future with confidence when he faces or contemplates his finitude or that of others. Without a belief system he despairs of meaning, morality and death.

There is no doubt in my mind that the symptoms of depression, self-hatred and guilt that we see in these women and men are of spiritual origin. Their despair is the primary cognitive aspect of

the depression. Connected to it is the emotion of sorrow.

What is the existential problem of the women who have had abortions? The answer is that they despair of morality and death. This is why a requiem healing service relieves them of their despair.