

Abortion Practice as a Perpetration-Induced Trauma

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WHAT IS THE EMOTIONAL IMPACT of doing abortions on the people who do them? There is enough written and said by them to show that this is, in fact, no ordinary medical procedure. What they say shows that the peculiar nature of their work goes far beyond the fact that it gets picketed so frequently.

The reaction to the work itself is examined in an article written in *American Medical News*, published by the American Medical Association, which reports on a meeting of the National Abortion Federation. It says that the discussions “illuminate a rarely heard side of the abortion debate: the conflicting feelings that plague many providers.... The notion that the nurses, doctors, counselors and others who work in the abortion field have qualms about the work they do is a well-kept secret” (Gianelli, 1993).

In a paper given by Dr. Warren Hern to the Association of Planned Parenthood Physicians, he says of his staff, “Attitudes toward the doctor were those of sympathy, wonder at how he could perform the procedure at all, and a desire to protect him from the trauma. Two felt that it must eventually damage him psychologically” (Hern & Corrigan, 1978). In this case, he was referring to late-term abortions. However, it is not ordinary for medical staff to regard surgery as a trauma. Dr. Hern is still an abortion specialist at this writing, and he gave this paper in front of other abortion specialists.

Another example from the article in *American Medical News* states: “A New Mexico physician said he was sometimes surprised by the anger a late-term abortion can arouse in him. On the one hand, the physician said, he is angry at the woman. ‘But paradoxically,’ he added, ‘I have angry feelings at myself for feeling good about grasping the calvaria, for feeling good about

doing a technically good procedure which destroys a fetus, kills a baby” (Gianelli, 1993). This doctor is angry at his own patients, and he is angry at himself. Doctors are not ordinarily angry at themselves for doing their work well. The way he worded the problem gives an unmistakable clue as to why this would be, but only hints at the complexity. There seem to be some negative emotions that have not been explored.

History has witnessed strong emotional reactions to intense trauma. Wars have been a prime cause of this problem in soldiers. During World War I, it was called “shell shock.” During World War II, it was called “battle fatigue.” It has also been called “combat fatigue.” Currently, the technical term for it is “Post Traumatic Stress Disorder” (PTSD). The American Psychiatric Association officially adopted the term in 1980. The basic feature is a certain set of symptoms following a traumatic event outside the range of usual experience. Table 1 summarizes the symptoms.

TABLE 1

SYMPTOMS OF POST TRAUMATIC STRESS DISORDER, SUMMARIZED FROM THE OFFICIAL DEFINITION (AMERICAN PSYCHIATRIC ASSN., 1984):

- A. Traumatic event
- B. Re-experiencing the trauma
 1. Recurrent, intrusive recollections
 2. Dreams
 3. Sudden acting or feeling the event is recurring
 4. Intense distress at cues that resemble the trauma
 5. Physical stress reactions to cues of the trauma
- C. Numbing
 1. Avoiding anything associated with the trauma
 2. Avoiding things that remind about the trauma
 3. Inability to recall something important about the trauma
 4. Markedly diminished interest in significant activities.

5. Feeling detached or estranged from others
 6. Constricted affect
 7. Sense of foreshortened future
- D. Increased arousal
1. Sleep problems
 2. Irritability, outbursts of anger
 3. Trouble concentrating
 4. Hypervigilance
 5. Exaggerated startle response

Some scholars have proposed that women who undergo abortion have a variant of PTSD which they call Post Abortion Syndrome. Controversy rages over whether this exists or not. Some studies show that it does, others show that it appears not to, and there seems to be a high correlation between the bias of the researcher and the results. Opponents of the concept of post-abortion problems believe that proponents are trying to undermine the actual benefits of abortion. Proponents, on the other hand, believe that people who are making a profit or have an ideological commitment are trying to ignore the negative. Over 300 studies with varying outcomes have been done on this matter, and it is subject to intense debate.

However, remarkably little study has been done of the doctors, nurses, counselors, and other staff in abortion clinics and hospitals. Such studies exist, but they are very few and hard to find. In fact, if it is narrowed down to scientific studies done by researchers who do not work in the abortion field and that look at a large number of people, there are really only two (Such-Baer, 1974; Roe, 1989).

One feature of those two studies is that they were done by people with a bias in favor of abortion availability. Yet, in contrast to the studies of post-aborted women, they both note the high prevalence of symptoms that fit under Post Traumatic Stress Disorder. The one published in 1974, before the term PTSD was adopted, noted that “obsessional thinking about abortion, depression, fatigue, anger, lowered self-esteem, and identity conflicts were prominent. The symptom complex was considered

a ‘transient reactive disorder,’ similar to ‘combat fatigue’” (Such-Baer, 1974).

The other study did not mention the old term for PTSD, but it did list symptoms: “Ambivalent periods were characterized by a variety of otherwise uncharacteristic feelings and behavior including withdrawal from colleagues, resistance to going to work, lack of energy, impatience with clients, and an overall sense of uneasiness. Nightmares, images that could not be shaken, and preoccupation were commonly reported. Also common was the deep and lonely privacy within which practitioners had grappled with their ambivalence” (Roe, 1989).

SYMPTOMS: FITTING THE PTSD CRITERIA
ABORTION PRACTICE AS STRESSOR

It is necessary first to establish that the stressor is sufficiently traumatic to be etiological for the symptoms. Events that are merely unpleasant, or mildly traumatic but not extraordinary, are insufficient. Everyone has arguments and bruises. Many have divorces and broken legs. Does performing abortions lead to more than these normal stresses? Do abortion staff ever express it that way?

Sallie Tisdale was a nurse in an abortion clinic for a time. After she left, she wrote about her experience in *Harper's Magazine*: “There are weary, grim moments when I think I cannot bear another basin of bloody remains, utter another kind phrase of reassurance.... I prepare myself for another basin, another brief and chafing loss. ‘How can you stand it?’ Even the clients ask.... I watch a woman’s swollen abdomen sink to softness in a few stuttering moments and my own belly flip-flops with sorrow.... It is a sweet brutality we practice here, a stark and loving dispassion” (Tisdale, 1987). This woman is a nurse, so she is accustomed to ordinary medicine and all its normal squeamish details. These words suggest more stress than ordinary medicine.

When *American Medical News* looked at a workshop at the National Abortion Federation, it entitled the report “Abortion

Providers Share Inner Conflicts.” It says: “A nurse who had worked in an abortion clinic for less than a year said her most troubling moments came not in the procedure room but afterwards. Many times, she said, women who had just had abortions would lie in the recovery room and cry, ‘I’ve just killed my baby. I’ve just killed my baby.’ ‘I don’t know what to say to these women,’ the nurse told the group. ‘Part of me thinks, ‘Maybe they’re right’” (Gianelli, 1993). Again, this is an atypical remark for a nurse.

Warren Hern, an abortion specialist, gave a paper to the Association of Planned Parenthood Physicians in which he had studied his own staff. “We have produced an unusual dilemma. A procedure is rapidly becoming recognized as the procedure of choice in late abortion, but those capable of performing or assisting with the procedure are having strong personal reservations about participating in an operation which they view as destructive and violent.... Some part of our cultural and perhaps even biological heritage recoils at a destructive operation on a form that is similar to our own, even while we may know that the act has a positive effect for a living person. No one who has not performed this procedure can know what it is like or what it means; but having performed it, we are bewildered by the possibilities of interpretation. We have reached a point in this particular technology where there is no possibility of denial of an act of destruction by the operator. It is before one’s eyes. The sensations of dismemberment flow through the forceps like an electric current.... The more we seem to solve the problem, the more intractable it becomes” (Hern & Corrigan, 1978). This is a doctor who is saying outright that this is unusual and stressful.

In a book that vigorously asserts the need for abortion to be available, Don Sloan, another abortion doctor, also indicates the stressful nature of abortion in contrast to medical practice. “As the pregnancy advances, the idea of abortion becomes more and more repugnant to a lot of people, medical personnel included. Clinicians try to divorce themselves from the method.” He goes into graphic detail and describes the need to check the body parts

to make sure everything is out. "Want to do abortion? Pay the price. There is an old saying in medicine: If you want to work in the kitchen, you may have to break an egg. The stove gets hot. Prepare to get burned" (Sloan & Hartz, 1992, pp. 239-40).

Both nurses and both doctors were still quite firm in their belief in the need for abortion at the time they made these statements. Their idea that dealing with abortion constantly was an unusual and significant stressor, more so than ordinary medicine, did not by any means come from opposition to abortion.

RE-EXPERIENCING AND DREAMS

Having recurrent, intrusive recollections of the trauma is one of the symptoms. Hern's paper said: "Six respondents denied any preoccupation...outside the clinic. Several others felt that the emotional strain affected interpersonal relationships significantly or resulted in other behavior such as an obsessive need to talk about the experience" (Hern & Corrigan, 1978).

Those symptoms may not seem to show much, since many people will have those kinds of problems with more minor events throughout their lives. However, one symptom is unmistakable and remarkably widespread: dreams. Dreams are so common that a mention of them, even a slight one, can be expected in almost all presentations on the subject of abortion staff's emotional reactions.

In academic literature, for example, we find such cases mentioned in an editorial discussing sessions in which abortion staff are talking about their feelings. The author supports these sessions as a way to keep abortion staff doing the work: "Their distress was typified by one nurse's dream. This involved an antique vase she had recently wished to purchase. In the dream she was stuffing a baby into the mouth of the vase. The baby was looking at her with a pleading expression. Around the vase was a white ring. She interpreted this as representing the other nurses looking upon her act with condemnation. One can clearly see the feelings of shame and guilt reflected in this dream. But more importantly, the dream shows that unconsciously the act of

abortion was experienced as an act of murder. It should be noted that this nurse was strongly committed intellectually to the new abortion law. Her reaction was typical. Regardless of one's religious or philosophic orientation, the unconscious view of abortion remains the same. This was the most significant thing that was learned as a result of these sessions" (Kibel, 1972).

In another case, several doctors looked at the emotional impact on staff of late-term abortions with the D & E procedure. They published this in *American Journal of Obstetrics and Gynecology*: "The two physicians who have done all the D & E procedures in our study support each other and rely on a strong sense of social conscience focused on the health and desires of the women. They feel technically competent but note strong emotional reactions during or following the procedures and occasional disquieting dreams" (Kaltreider, Goldsmith, & Margolis, 1979, p. 237). The same authors discussed dreams in a 1977 paper presented to the annual meeting of Planned Parenthood physicians. "As the doctor tends to take responsibility and assume guilt for the procedure, she or he may have disturbing and recurrent ruminations or dreams" (Goldsmith, Kaltreider, & Margolis, 1977, p. 6).

American Medical News reported this from the National Abortion Federation workshop: "They wonder if the fetus feels pain. They talk about the soul and where it goes. And about their dreams, in which aborted fetuses stare at them with ancient eyes and perfectly shaped hands and feet asking, 'Why? Why did you do this to me?'" (Gianelli, 1993). A news item in *ObGyn News* on emotional reactions to the late-term D & E procedures reports that one-fourth of the staff members reported an increase in abortion-related dreams and/or nightmares (Jancin, 1981).

Hern's paper recounts more dreams. "Two respondents described dreams which they had related to the procedure. Both described dreams of vomiting fetuses along with a sense of horror. Other dreams revolved around a need to protect others from viewing fetal parts, dreaming that she herself was pregnant and needed an abortion or was having a baby.... In general, it

appears that the more direct the physical and visual involvement (i.e., nurses, doctor), the more stress experienced. This is evident both in conscious stress and in unconscious manifestations such as dreams. At least, both individuals who reported several significant dreams were in these roles" (Hern & Corrigan, 1978).

Former abortion doctor McArthur Hill gave his story at a pro-life conference. "We used medications to try to stop the labor of women in premature labor so that the pregnancy could progress to term. Sometimes, the aborted babies were bigger than the premature ones which we took to the nursery. It was at this point that I began to have nightmares.... In my nightmares, I would deliver a healthy newborn baby. And I would take that healthy newborn baby, and I would hold it up. And I would face a jury of faceless people and ask them to tell me what to do with this baby.

They were to go thumbs up or thumbs down, and if they made a thumbs down indication, then I was to drop the baby into a bucket of water which was present. I never did reach the point of dropping the baby into the bucket, because I'd always wake up at that point" (Prolife Action League, 1989).

Bernard Nathanson, speaking of the time when he was a pioneer in setting up abortion clinics, spoke of nightmares of a clinic doctor. "I also recall well being cornered by the wife of one doctor at the cocktail party we gave when the Sixty-second Street clinic opened. She drew me aside and talked in a decidedly agitated manner of the increasingly frequent nightmares her husband had been having. He had confessed to her that the dreams were filled with blood and children, and that he had later become obsessed with the notion that some terrible justice would soon be inflicted upon his own children in payment for what he was doing" (Nathanson, 1979, p. 141).

The fate of the fetus is the most common theme, but Sallie Tisdale reports another effect:

I have fetus dreams, we all do here: dreams of abortions one after the other; of buckets of blood splashed on the walls; trees full of crawling fetuses. I dreamed that two men grabbed me and began to drag me away. 'Let's do an abortion,' they said with a sickening leer, and I began to scream, plunged into a vision of sucking, scraping pain, of being

spread and torn by impartial instruments that do only what they are bidden. I woke from this dream barely able to breathe and thought of kitchen tables and coat hangers, knitting needles striped with blood, and women all alone clutching a pillow in their teeth to keep the screams from piercing the apartment-house walls. Abortion is the narrowest edge between kindness and cruelty. Done as well as it can be, it is still violence—merciful violence, like putting a suffering animal to death. (Tisdale, 1987).

The image of the men grabbing her and forcing her through pain in private parts of her body suggests that in this dream, abortion is associated with rape.

Only two of these cases, Nathanson and Hill, are given by people who now oppose abortion. The remaining accounts are from people who still advocated for it at the time the dreams were reported.

NUMBING

Markedly diminished interest in significant activities is a symptom of numbing, as is a more constricted expression on the face. Both of those symptoms can easily be due to other things and can be a matter of interpretation. Feeling detached or estranged from other people may also be due to other causes, but there is also quite a bit of evidence for it coming from abortion work. In fact, the method of doing abortions in an assembly-line fashion could well be a manifestation of this. When this is done, most commonly the doctor has no contact with the patient until her legs are up in the stirrups. Unlike most of medicine, being detached from the patient is built into the system.

Nurse Sallie Tisdale talks of numbness. “There is a numbing sameness lurking in this job; the same questions, the same answers, even the same trembling tone in the voices.” The numbness is not merely in the sameness, though. “Still, I’ve cultivated a certain disregard. It isn’t negligence, but I don’t always pay attention” (Tisdale, 1987).

It is in the nature of this kind of symptom that it will be reported more by the people who have left the field than by the

people who are still in it. After all, it is part of the symptom to avoid noticing what is happening. Talking with those who have left does lead to a rich set of illustrations of the point, as the following shows.

“We don’t have conversations,” said Joy Davis, a former employee of Dr. Tucker. “Sometimes the employees faint. Sometimes they throw up. Sometimes they have to leave the room. It’s just problems that we deal with, but it’s not talked about.” She goes on, “if you really dwell on it, and talk about it all the time, then it gets more personal. It gets more real to you. You just don’t talk about it, try not to think about it.... If Dr. Tucker ever caught you discussing something like that—is this right what we’re doing? He’d fire you. When I was active in the abortion clinics, I don’t know that any of us had any feelings about anything. We didn’t really have a lot of feelings about the women, about the moral issues.”

Judith Fetrow worked at a clinic in San Francisco. Later, at a pro-life conference, she offered an analysis. “When I started at Planned Parenthood, I saw two types of women working at the clinic. One group were women who had found some way to deal with the emotional and spiritual toll of working abortion. The second group were women who had closed themselves off emotionally. They were the walking wounded. You could look in their eyes, and see that they were emotionally dead” (Prolife Action League, 1993).

A woman who worked for a doctor in Louisiana for a few months recounted an incident in a telephone conversation. “The one thing that sticks out in my mind the most, that really upset me the most, was that he had done an abortion, he had a fetus wrapped inside of a blue paper. He stuck it inside of a surgical glove and put another glove over it. He was standing in the hall, speaking with myself and two of his assistants. He was tossing the fetus up in the air, and catching it. Like it was a rubber ball. I just looked at him, and it’s like, doctor, please. And he laughed. He says, ‘Nobody knows what this is.’” Doctors who are accustomed to surgery which removes body parts do not generally

toss those body parts around like a toy. The doctor seems to have a numbed attitude toward the fetus, an attitude of emotional anesthesia.

Luhra Tivis worked for George Tiller of Kansas, and I asked her directly about whether she saw any sign of him being detached from others. “He had this weird thing. It was a small office, there weren’t that many people there. I did all of his correspondence and everything, but if I had a certain kind of a question or procedural change, I was supposed to go through my supervisor, and she would go to him. I mean, it’s ridiculous, because it was a small office. And then sometimes he would circumvent that himself, and then I’d get in trouble. So it was like he was trying to hold people off, and not have to deal with any more of the staff than he absolutely had to.”

This estrangement from others can be expected to have a negative impact on the quality of the medical care. As one example, Judith Fetrow reported from her former work at a San Francisco Planned Parenthood clinic. “The most horrifying complication that I witnessed was a woman who stopped breathing during the abortion. [The doctor] just walked out of the room when he was finished. Despite my telling him that the client was not breathing, he left me alone with her. When [the doctor] was forced to return, we didn’t even follow emergency protocol for that situation. It was a miracle that this woman didn’t die” (Prolife Action League, 1993).

In her book Carol Everett tells how she administered several abortion clinics in Dallas but eventually came to oppose abortion. She describes a case in which the doctor telephoned and said, “The coroner called with the results of the autopsy. The cause of death was hemorrhaging from a cervical tear. I went numb. ‘We could have saved [her] life!’ my mind screamed. We only needed to have sutured her cervix. We had everything we needed in the clinic to save [her] life, with one exception—a doctor willing to take the time to re-examine his patient to determine the cause of the bleeding.... Even a first-year intern would have checked for the source of such profuse bleeding” (Everett & Shaw, 1992, p. 21).

It is common, when telling these stories, to interpret this kind of callous disregard as just being sloppy, or as incompetence. That judgment may be more true in some cases and less true in others.

However, this does fit into the pattern of being a symptom of Post Traumatic Stress Disorder.

PREVALENCE

On the question of the dreams, Dr. Hern said that two out of 23 workers reported them (Hern & Corrigan, 1978). A news item in *ObGyn News* which focused on late-term abortions said that one-fourth of the workers had them (Jancin, 1981). Nurse Sallie Tisdale's remark that they all had them at her clinic was probably poetic license. That symptom is clearly common enough that it should be expected to arise among a good-sized group, but not among all individuals.

There is much less data for other symptoms. Many of those symptoms are fairly subjective, and any one of them can be caused by a lot of different things. Having a professional psychologist or psychiatrist look over individual cases with these symptoms in mind has not been done for abortion staff. The studies have noted the symptoms without saying how common the symptoms are.

However, looking at "negative emotions" as a whole provides some information from the academic studies. The study done in 1974, which was very soon after the country-wide legalization, reported: "A total number of sixty-six questionnaires were distributed, and forty-two were returned.... In this particular sample, almost all professionals involved in abortion work reacted with more or less negative feelings" (Such-Baer, 1974, p. 438). The article also reports that those who have contact with the fetal remains have more negative feelings than those who do not, as would be expected if abortion practice leads to PTSD symptomatology. "Whether the professional had contact with the fetus significantly affected emotional reaction. Those staff members who had contact with the fetus reacted with much more discomfort to abortion work." Additionally, among the group of

professionals who had fetus contact, there was very little variability in emotional response: "All emotional reactions were unanimously extremely negative" (Such-Baer, 1974, p. 439). This figure comes from an article whose concern is to ease the problem in order to make abortion workers more available. This one sample, with a two-thirds response rate, and taken by people whose sympathies were with abortion work, found negative emotions among all workers with fetal contact.

The largest published study involved interviews with 130 abortion workers in San Francisco between January 1984 and March 1985 (Roe, 1989). Unfortunately, the study did not report on the prevalence of the symptoms but only noted that they were widespread. The authors did ascertain differing definitions of what was going on in abortion work, and they were not expecting to find what they found. "Particularly striking was the fact that discomfort with abortion clients or procedures was reported by practitioners who strongly supported abortion rights and expressed strong commitment to their work. This preliminary finding suggested that even those who support a woman's right to terminate a pregnancy may be struggling with an important tension between their formal beliefs and the situated experience of their abortion work.... At this point in the research, the methodological decision was made to interview only practitioners who identified themselves as pro-choice and were committed to continuing their abortion work for at least six months.... It was felt that these practitioners, as most free of pre-existing anti-choice sentiments and most resistant to their potential influence, would provide rich insight into the current dilemmas and dynamics of legal abortion work." This lowered the sample to 105 workers. Results showed that 77 percent brought up the theme of abortion as a destructive act, as destroying a living thing. As for murder: "This theme was unexpected among pro-choice practitioners, yet 18 percent of the respondents talked about involvement with abortion in this way at some point in the interview. This theme tended to emerge slowly in the interviews and was always presented with obvious discomfort." If this is the case, one would expect it to arise much less frequently on written

surveys and questionnaires.

In talking about how abortion providers share inner conflicts, *American Medical News* referred to abortion clinics as “America’s most controversial battlegrounds” in a “political war.” If Post Traumatic Stress Disorder is prevalent, then the term “battleground” may be more real and less of a metaphor than is commonly thought.

ALTERNATIVE EXPLANATIONS

Two alternative explanations have been offered in the literature. One is simply that the phenomenon is actually burn-out, as is frequently found in the helping professions. For those that believe that abortion provision is a helping profession, this explanation has obvious appeal. It is also a more easily solvable problem. It only requires vacation breaks and rotation of duties. Burn-out can be an explanation for numbing and for irritable outbursts. Considering the high-volume, high-speed nature of most abortion practice, there is no reason to discount the phenomenon of burn-out as a possibility, especially among counselors. However, its presence does not preclude the possibility of PTSD. It may only provide a confounding variable to take into account in analysis. More importantly, burn-out does not explain dreams or other forms of intrusive imagery.

A second alternative explanation has been suggested in the scholarly literature as a way to account for the prevalence of the dreams. In one editorial: “Whether it is properly explained by parents or haphazardly accumulated in a piece-meal fashion, the child inevitably mixes fact with fantasy. Unable to conceptualize the whole process in sophisticated terms, the child thinks in concrete terms. He visualized an ‘egg’ in ‘the stomach’ and believes that a formed baby develops at the outset, growing for nine months into a full size infant.” The author believes that this is the way to account for the dreams. “As one grows one’s intellectual concept of reproduction matures. But the primitive fantasies remain in the unconscious.... Therefore, even those who become intellectually committed to abortion have to contend with

their own unconscious view of a fetus as a real baby. The emotional trauma observed in these nurses was a result of the psychic conflict between their intellectual commitment, on the one hand, and their unconscious views, on the other. Inwardly, they experience themselves as participating in an act of murder” (Kibel, 1972).

If seeing the fetus as a baby is merely a figment of the imagination, a symbol, an oversimplification, the solution is simple. The best way to counter a fantasy is to show the reality. Modern technology shows photographs of embryos and fetuses, and sonograms show their movements in real time. A strong dose of reality should put a fantasy to rest. However, this technique seems to be counter-productive. (See, for example, editorial “Warns of Negative Psychological Impact of Sonography in Abortion,” 1986).

CONCLUSIONS: IMPLICATIONS

Defenders of abortion believe that it is a form of medicine. Opponents believe it to be killing. If abortion is the taking of a human life, then certain psychological consequences could be expected among those who perform abortions. Human history is tragically full of instances of massive violence. We know what those kinds of reactions might be. If we find no such aftermath, the case that abortion is not violence at all is strengthened. If those reactions can be found, then other implications follow. For example, there would be questions about the sustainability of abortion practice through the course of time (MacNair, 2000). There are policy implications for the legal status of requiring doctors or medical students to participate in abortions if such a practice is actually implicated as etiological in a mental disorder. In fact, a warning to those who are contemplating entering the field of abortion provision may be in order if it were to be established as other dangers to health are.

There are certainly implications on the need for therapy or other interventions. It would need to be established first whether there is a problem and exactly what it is. Once this is established, remedies need to be sought. There are now many who are

seeking remedies to "burn-out" for abortion practitioners. If they are correct that this is the problem, then those interventions should be successful. However, if the problem is something else, then they are seeking invalid remedies. They are not then being as helpful to the individuals as they had hoped.

The possible relationship to PTSD symptomatology in other groups of perpetrators, especially socially-sanctioned killing, may also be important. A major study of the government data on veterans, for example, has found that the symptom pattern of PTSD did differ somewhat between those who said they had killed and those who said that they had not (MacNair, 1999). Those who had killed had more severe PTSD symptoms and were much more characterized by the intrusive imagery symptoms and by explosive outbursts. Also higher for these groups were hyperarousal, alienation, survivor guilt, and a sense of disintegration. If this pattern holds in other groups of perpetrators, such as those who carry out executions, torture of prisoners, and so on, then there can be a better over-all understanding of what actively participating in killing does to the human mind.

FUTURE RESEARCH

The case for widespread PTSD among abortion practitioners, including both clinical or sub-clinical levels, cannot yet be strongly made. However, the evidence so far accumulated shows that the effort required for further research is certainly warranted.

There are several different paper-and-pencil scales, some fairly sophisticated questionnaires with symptom checklists, which can give relative PTSD scores for those who fill them out. These are not as good as psychiatric interviews and would never be sufficient for an actual diagnosis, but they can be helpful in screening or comparing large groups. A control group of other doctors would be necessary.

In-depth interviews, either psychiatric or academic, could yield much more information. Methods of achieving co-operation in such interviews would need to be considered. Previous studies have succeeded, but these were carried out by scholars who favor

abortion provision. Those who oppose abortion are likely to receive a more hostile reception.

Another possible study involves the symptom of physiological responses to reminders of the stressor. In an elaborate form, this is actually used diagnostically by the Veterans Administration. A simpler form may allow for normal biofeedback equipment to be used, with pictures rather than elaborate scripts. This simplification would preclude diagnosis, but (as with the questionnaires) it could allow for screening or comparison of groups. A literature table at a medical convention, for example, could have doctors go through a very quick procedure and collect data in this way, allowing for the control group simply by dividing doctors into those who say they have done abortions and those who have not. This method is not likely to reach those that do large numbers of abortions—such doctors are relatively few in number. Nevertheless, it could be a good comparison.

There are some major confounding variables in any study. One is the fact that it may be difficult to ascertain who is and who is not doing abortions. Not all those participating are willing to say so. Some do not care to admit it, and some are suspicious about revealing it to others. Since it stands to reason that a greater amount of practice may lead to greater severity of symptoms, it would be necessary in a study to ascertain how frequently respondents perform abortions; doing so by simply asking them may not provide strictly accurate answers. This has long been a problem in studying the emotional after-effects of women who have had abortions, so the possibility that it would be problematic in this case also should be considered.

Another variable is the direction of causation. Might those people who have been through traumatic events already be more inclined to participate in abortions? If numbing is a response to trauma, then those who were abused as children or who have been combat veterans could be over-represented among those who do abortions. Even if it were established that PTSD symptoms are higher among such doctors and nurses than among other doctors and nurses, this is a variable which would

need to be statistically controlled and otherwise taken into account.

Finally, the very nature of the current political debate can have an impact on the study. Abortion providers are likely to be suspicious of the motives of researchers who are clearly abortion opponents, and scholars are likely to be suspicious of results if there is a clear bias. Those who are advocates of abortion legalization, however, will also have a bias which can influence interpretation of results. The ideal situation would involve a research team which includes people of both positions who can then serve as checks and balances on each other. Failing that, at least increasing accumulation of evidence over time may lead to greater interest in having different perspectives which can then offer different and innovative strategies for study.

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