Abortion providers help their clients and themselves when they talk about the fetus

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Keywords: fetal parts, abortion stigma, abortion providers, patient-centred tissue viewing, grief and mourning, provider resilience, myth-busting

For many years, abortion activists have found themselves in a defensive position regarding the place of the fetus in public discourse and abortion politics. In attempting to hold the focus on the woman and her choice if and when to become a parent, the fetus has dropped out of the discussion. Consequently, anti-abortion activists have been able to make significant political use of visual representations of the fetus to manipulate public sentiment about the (highly photoshopped and decontextualised) fetus and against women who have abortions and the medical professionals who provide them.1 In her 2008 article “Sometimes, It’s a Child and a Choice: Toward an Embodied Abortion Praxis”, scholar and activist Jeannie Ludlow observed that abortion politics “…break down into a dichotomization of ‘fetus from woman’ or, from an anti-abortion perspective, ‘mother’ from ‘child.’ At best, a reductive way to think about a very complex issue … [which] played a role in the gradual diminishment of support for and access to abortion in the United States.” 2

Talk about the fetus carries the mark of the anti-abortion movement. Ludlow’s observation rings disturbingly true today as we cope with the results of anti-abortion campaigns to limit access, close abortion services all over the country, and threats to invalidate Roe v Wade.

In what has become a seemingly unbridgeable divide in the abortion wars, all potentially common ground and all nuance disappear regarding people’s lived experience of abortion and its moral complexities. Even among co-workers, for fear of appearing disloyal to the abortion cause, providers acknowledge a hesitancy to talk with one another about their patients’ reactions and their own emotional responses to the fetus and fetal parts.1 Many have noted the relationship between the internalised stigma, guilt, and shame associated with abortion (an experience assumed to be traumatising) and the self-censuring of abortion providers when they talk about (or decide not to talk about) their work. Having noticed a bifurcated hierarchy of abortion narratives – those that are politically necessary to tell and those that must be avoided, Ludlow enjoins us to “…normalize ordinary abortion experiences, thus reducing the effects of silence and stigma, in turn transforming patients’ experiences, enabling them to approach their abortion decisions, whether mundane or extraordinary, as free as possible from socially constructed guilt.” 2

The fact of the fetus and fetal parts is without question a part of every person’s ordinary abortion experience. But talking about the fetus continues to be relatively rare for both women who have abortions and abortion providers. Furthermore, little is known about the frequency of patient requests for viewing post-abortion fetal remains.

“Seeing pregnancy tissue is a daily experience for abortion providers, but it is seldom discussed outside clinic walls. Patients may ask to see their tissue after surgical abortion, but we do not know how, when, and why these requests occur, how clinicians respond, and if or how providers facilitate patient-centered pregnancy tissue viewing (PCV).”3

Talking about the fetus requires confronting intense cultural prohibitions associated with “the
stopping of a beating heart”, social/political debates about “personhood”, and the difference between a fetus and a viable human baby. Talking about the fetus, and viewing fetal remains, entails facing the bloody, gory parts of abortion – something providers fear will draw anti-abortion fire, particularly towards providers. Consequently, these conversations, in clinics and elsewhere, remain relatively rare.

In this atmosphere, abortion providers and advocates have inevitably been on the defensive. Anti-abortion activists have appropriated the “fetal space” in abortion discourse by spreading misinformation and skillfully manipulated images, promoting a fantasy of the “iconic, universal fetus”, an “everyman”, stirring deep annihilation anxieties about an unknown and uncontrollable future. Hann and Becker have made the sobering point that much of how we think about the fetus – its shape, size, and features – has been shaped by these anti-abortion tactics. A widespread diminished collective capacity for nuanced reflection and discussion about the significance of fetal life to society may be a troubling consequence.

Changes in pre-natal medical care, imaging technology, and public sentiment have changed the climate. Against much controversy, in a 2011 National Public Radio interview, Frances Kissling spoke out about the necessity for abortion advocates to acknowledge that because “multiple values are at stake, … the values of women, as moral decision-makers and as persons entitled to a good life, and the value of fetal life, … we can no longer pretend the fetus is invisible.” She continued: “… [its] value may not be equal to that of the pregnant woman, but ending the life of a fetus is not a morally insignificant event … it’s a sad reality that abortion does involve the demise of the fetus.”

For many who choose to have an abortion, that sad reality – the “demise of the fetus” – is actually felt to be the loss of a child that might have been, might someday be, or was the wished-for but not viable baby. That loss does matter and merits recognition, grief, and the mourning so necessary to the processes of acceptance and meaning-making. The psychic pain of grief is part of life and should not be equated with trauma. Indeed, even as they may grieve, most women who have had an abortion are not traumatised, nor even necessarily depressed. Ludlow demonstrates how the view of women who have abortions as depressed, and of abortion as traumatic, is a result of anti-abortion rhetoric. It must be considered that the intense stigma campaigns that regularly inundate the public and the carefully orchestrated harassment outside clinic doors, often bordering on and sometimes erupting in violence, are themselves traumatogenic. As she has noted: the anti-abortion movement has “trauma-tized” abortion and, I would add, pathologised women for their responses to abortion stigma and their otherwise very normal grief response to loss.

The view of abortion as traumatising is profoundly undermined, perhaps especially so as medical abortions become more and more common, by the narratives of women and providers who speak to the relative “ordinariness” of abortion and the relief that often comes with a well-reasoned decision not to become a parent yet or again. Notably, Yale Law Professor, Priscilla Smith, has discussed how women’s respect for the importance of motherhood and the bonds of love with children already born shape decisions to seek abortion. The decision to abort may be a reflection of mothers’ good parenting, even as they grieve the loss of the aborted fetus.

As a psychoanalyst, I have often thought that our collective difficulty talking about the significance of the fetus can lead to a disservice to women who have abortions. Even as we recognise that abortion is not always (or even often) traumatic, I want to emphasise that, in honouring and witnessing a person’s distress over the death of their fetus, we can facilitate grieving and meaning-making that helps to reduce of feelings of guilt, and shame.

Many abortion providers, activists, and researchers have called for increasing alignment of abortion practices with patient-centred perspectives that support choice, autonomy, and access to information. One important example is the growing practice of patient-centred tissue viewing (PCV) described by Hann and Becker in this journal. As the authors emphasise, accurate information about the fetus and opportunities for sharing in the viewing of fetal remains can lessen the impacts of internalised abortion stigma for both patient and provider. Additionally, by engaging directly with one of the most uncomfortable realities of abortion, the experience of viewing and responding to fetal remains in this highly intimate and emotion-saturated situation contributes to increased tolerance for painful and often contradictory emotions, capacity for mourning, and resilience of both patient and provider. These benefits go potentially far beyond the individuals involved.
Recent research on the experiences of abortion providers has pointed to an increase in positive teamwork and esprit du corps that develops as a consequence of deeper connections among workers who share work-related narratives.12

PCV promises to make very positive contributions to the project of normalising and humanising abortion care and societal views of abortion providers. Among Hann and Becker’s conclusions is the possibility that PCV and related practices are necessary correctives for the highly negative psychological impacts on providers and their teams associated with pervasive public misinformation about the fetus and powerful injunctions against talking about the fetus and fetal remains.3 These injunctions, by producing significant areas of avoidance and disjuncture in communication, interfere with building safe environments conducive to sharing and learning in our clinics.

PCV offers a powerful and positive approach to opening up these taboo subjects and creating transformational discussions in our clinics.13 With appropriate support and preparation for providers, I believe that widespread inclusion of PCV services will contribute significantly to increased emotional resilience and nuanced meaning-making for clients and provider teams.

Disclosure statement
No potential conflict of interest was reported by the author(s).

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