

The Experience of ‘*Entrapped Grief*’ Following Traumatic Abortion

Linda Finlay

Abstract:

Some abortions can result in prolonged, complex grief reactions where the effects endure in problematic ways. Research findings suggest that such women suffer a turbulent spiral of often contradictory emotions and, if insufficiently acknowledged at the time of the abortion by self or other, this emotional turmoil can become pushed down and disenfranchised. This paper discusses the nature of this entrapped grief by reviewing the literature and reporting on some phenomenological case study research. A final section discusses integrative psychotherapy approaches to working in this area. Better understanding of the experience of traumatic abortion may enable therapists to be more present to this phenomenon, in particular the voicelessness some clients may experience, rendering them unable to process their feelings about the event and associated loss.

Key Words: abortion, complicated grief, integrative psychotherapy, trauma

“There was a wound in her soul that would not stop bleeding” (Burke, 2002, p.24).

Most abortions involve difficult choices and real dilemmas for those undergoing them even when women report that having the abortion was the right decision for them. A few abortions result in prolonged, complex grief reactions where the effects endure in problematic ways. In my psychotherapy practice, I have encountered several clients who have had such traumatic abortion experiences. Seeking to understand more deeply, I set out to explore this phenomenon through research. Without assuming any moral or political stance on the rights/wrongs of abortion, I took the view that increased understanding of individuals’ (unique and shared) experience might deepen compassion for, and strengthen therapeutic work with, those women whose abortions have proved particularly traumatic.

Together with a colleague, Barbara Payman, I set out to learn through first-hand accounts about the complexity of trauma associated with some women's experience of abortion (see Finlay & Payman, 2014). We used a relational-centred, existential hermeneutic phenomenological approach (Finlay & Evans, 2009; Finlay, 2011) to explore the lived world of three women – Mia, Alex and Eve.

Our preliminary research findings suggest that a minority of women suffer a turbulent spiral of often contradictory emotions: grief and sadness, shame and anger, guilt and relief. If insufficiently acknowledged at the time of the abortion by self or other, this emotional turmoil can become pushed down, locked in, sequestered and eventually disenfranchised. When pain is too great, a woman may dissociate or 'check out' emotionally: a creative response that numbs that part of self, freezing it in time (Danaher, 2015; Doka, 2002). It's as if the energy of rejected emotions becomes trapped somehow within the body - imprisoned and entombed. That locked-in part remains both unspoken and unspoken to; an immobilized, lost part of Self in a landscape of loss.

It is this single theme of entrapped grief, which I aim to explicate further in this paper. It is my hope that this research will act as 'witness' to, and go some way to towards validating, women's experience of their traumatic abortion. Perhaps, too, it will give these women permission to grieve.

Better understanding of the experience of traumatic abortion may enable therapists to be more present to this phenomenon, in particular the voicelessness some clients may experience, rendering them unable to process their feelings about the event and associated loss. The role of therapy is then to work with the essential tension between the woman's desperate drive to deny or hide the source of her shame, and the need to release her pent-up feelings (Burke, 2002).

While the examples of dialogue offered in this paper arise out of research interviews, the relational-centered approach taken mirrors a therapy encounter and suggests how integrative psychotherapists might approach the challenge of working with women who are experiencing entrapped grief. In the latter section of this paper, entitled 'implications for therapy', I suggest some ways therapists might work with entrapped grief using phenomenological-gestalt understandings and therapeutic ways of being.

Literature review: Lived experience of grief

The explosion of literature over the last five decades addressing the issues surrounding grief, bereavement and loss has focused on new understandings, which go beyond simple stage or task models of grief (see de

Santis & Finlay, 2015, for a review). Commentators now insist on not being prescriptive about grief reactions. Individual, relational, situational and socio-cultural variables determine (at least in part) the course and experience of grief leading to a huge variability in responses (Walters, 1999; Worden, 2009). Rando (1993) argues that the intensity of grief responses is affected by numerous factors including circumstances of the death, relationship with deceased, personality and social supports available (relational and institutional) in the context of cultural beliefs, practices and norms.

Extended debates continue about the relationship between grief and post-traumatic stress disorder (PTSD) (Prigerson et al, 2000), informed by contested understandings of what constitutes trauma and PTSD. However, the growing field of research on what is variously known as *complicated grief* (Murray, 2011), *prolonged grief disorder* (Neimeyer, 2009), and *traumatic grief* (Jacobs, 1999) is of interest here. These versions involve death (commonly violent and conflicted relationships with the deceased) which gives rise to symptoms associated with trauma (Stroebe, Schut, & Finkenauer, 2001; Worden, 2009). Here emotional reactions to loss are seen to fall outside of the expected norms for the culture in which they occur. They differ from so-called 'normal grief' in the length of time and intensity of the symptoms experienced (perhaps with overwhelming expressions of grief or complete absence of expression), and/or the extent of impairment to functioning in social, domestic, or occupational activities. Between 10 and 20 per cent of bereaved people are estimated to experience complicated grief, with prevalence higher in cases of sudden or violent loss (Murray, 2011). Numerous studies suggest that bereavement subsequent to violent death is associated with adverse reactions, with higher, more enduring levels of distress than bereavement under more natural circumstances (see for example, Kaltman & Bonanno, 2003).

Along these lines, Doka (1989) has explored the concept of *disenfranchised grief*, which occurs when loss remains untold, unrecognized, invalidated and socially unacknowledged. With abortions, for instance, the individuals concerned may not feel entitled to grieve since their loss falls outside society's grieving norms. Worden (2009) recognizes how abortions can go unmourned, thus becoming a special type of loss that can lead to future complications. This applies to both women *and* men – the grief responses of male partners of women who have had an abortion are rarely acknowledged.

This burying of pain can be understood as retroflexion: a holding in of unexpressed fears, protest, grief and doubts in order to avoid awareness of psychological discomfort or turmoil (Perls, Hefferline & Goodman, 1951). Blocking sensation can be seen in terms of being a 'creative adjustment' and part of a positive 'normal' way of coping. But the response itself can also prove problematic. As Kauffman (2010) acknowledges,

Traumatic grief shame occurs in fragmentations or dissociations, defilements and humiliations, helplessness, and other overwhelming grief anxieties... Traumatic stress anxiety in grief is characterized, in part, by its disconnective, disintegrative force." (2010, p.8).

Lived experience of abortion

The phenomenological feminist philosopher Simone de Beauvoir described the experience of having an abortion in terms of a woman being "divided against herself" and feeling the "contradictions in her wounded flesh." "Through all the risks she takes, the woman feels herself to be blameworthy, and this interpretation of anguish and transgression is peculiarly painful" (de Beauvoir, 1949, pp.507-8). Abortion is an inherently ambivalent experience, even when a woman has actively chosen to go through the process. Beyond the literal experience of physical flesh wounds, women who experience abortion are 'torn' at the depths of their being - ontologically, cognitively, emotionally and socially (Finlay & Payman, 2014).

Current research and statistics remain unclear as to the proportion of women undergoing abortions and the extent to which abortion is experienced in terms of protracted grief and/or enduring trauma. In a recent longitudinal study, Rocca et al (2015) engaged in successive telephone interviews with 667 women at 30 facilities across the United States between 2008-2010 (in other words, the study considered more recent abortions). Findings suggested that approximately 95% of women reported that having the abortion was the right decision for them. However, community stigma and lower social support were associated with negative emotions. While this study offers strong evidence challenging the idea that abortions are inevitably harmful and traumatic in the long-term, it may not speak to the experience of women who had abortions in earlier decades where more secrecy and stigma were involved.

Other research points to the extreme variability of women's abortion experiences, which extend across a continuum (Hess, 2006; Trybulski, 2008; Walters, 2002) from pragmatic, stoic acceptance and/or mild grief to – more rarely - "post-abortion syndrome" and/or "posttraumatic stress disorder" (Lee, 2003). At one pole, in the context of a relatively simple chemical/surgical procedure and nourishing social-emotional support, the women involved generally cope and feel equipped to deal with the abortion. At the other polarity are those who enter the abortion reluctantly and who lack sufficient medical, emotional and social support. These are the ones who are left with a heightened and chronic sense of distress, pain, betrayal and suffering. In her book '*Forbidden grief: The unspoken pain of abortion*', Theresa Burke (with David Reardon) (2002) explores the

psychological and social/cultural obstacles to healing after an abortion. She examines why friends and family erect walls of silence around the woman's grief, and argues the need to attend to those who struggling with past abortions. She describes how repressed feelings may be acted out in self-destructive behaviours, ruptured relationships, eating disorders and other mental health concerns. This and other research suggests that complicated, protracted traumatic grief responses endure (and perhaps intensify) over the long-term. Such responses are characterised by recurrent and intrusive distressing recollections of the event, persistent avoidance of stimuli associated with the trauma, and a numbing of general responsiveness (see DSM-V Criteria for Posttraumatic Stress Disorder). In such cases, pushing pain and psychic turmoil down and away, effectively entrapping the grief, becomes a way of coping.

Whatever a woman's specific reactions, the pain and any associated sense of violation, shame, self-loathing and grief resulting from her abortion experience need to be coped with. A number of adapting-accepting behaviours have been noted in the literature as offering a positive route through bereavement and loss. These include the use of resources and support systems; remembering the deceased with honour, compassion and love; and creating new, positive chapters for the future. However, failure to embrace a 'reconciled' position may result in traumatic bereavement involving complicated prolonged grief that is suppressed, postponed or displaced (Muller & Thompson, 2003): in short, a grief that is 'entrapped'.

Methodology

This paper is based on research, which engaged relational-centred, existential hermeneutic phenomenological methodology (Finlay & Payman, 2014; Finlay & Evans, 2009; Finlay, 2011). While the explicit focus was on describing the experience of 'traumatic abortion,' the story of how Barbara Payman and I collaborated as reflexive researchers, and my own reflections subsequently, have proved useful in throwing further light on our participants' experience and have thus offered another exploratory lens.

In our hermeneutic phenomenological exploration, we attempted a layered rich description of lived experience and an interpretation of subjective meanings, with the aim of capturing the phenomenon of traumatic abortion in an embodied, experiential, relational way. This approach follows Todres' (2007) and van Manen's (2014) recommendation to balance the 'texture' (poetic interpretation aiming to touch the heart of the experience) with 'structure' (rigorous scientific description), moving between both analytic closeness and reflective distance to tease out meanings in a more academic, thematic way.

In our relational-centred approach, which mirrors relational integrative psychotherapy (Finlay, 2015), meanings are seen to emerge in a co-created, dynamic relational encounter. This methodology calls for a process of attuned inquiry (Erskine, 2015). The researcher-therapist aims to explore (sensitively, respectfully and collaboratively) the subjective meanings of the person's intrasubjective and interpersonal process. Such inquiry, as Erskine (1993) notes, begins with a genuine interest in the person's experience. The approach then parallels the process of relationally-oriented psychotherapy where intuitions and understandings are seen as being born in the *between* of the embodied dialogical encounter (Finlay & Evans, 2009):

We pay close attention to the other with curiosity, empathy and compassion. When we intertwine with another in an encounter, we may well find ourselves surprised and touched by the connection we make and the transferences/counter-transferences we experience... The depth of personal introspection and the dialogical journey involved usually lays the ground...for research that has deep personal significance and this helps to ensure its evocative resonance and relevance (Finlay, 2011, pp.166, 174).

This version of relational-centred methodology draws on a range of theoretical concepts straddling different traditions: Primarily, ideas from the psychotherapy field were embraced, including gestalt theory (Hycner & Jacobs, 1995), intersubjectivity theory (Stolorow & Atwood, 1992) and relational psychoanalysis (Mitchell & Aron, 1999). We engaged the phenomenological concept of embodied intersubjective intentionality (Merleau-Ponty, 1945/1962) and Buber's (1923/2004) notion of the significance of the 'I-Thou' relationship. In addition, we drew on collaborative, creative feminist methodology, which celebrates a focus on emotional and relational dimensions and on reflexivity as a source of insight (Fonow & Cook, 1991; Stanley & Wise, 1983).

Data Collection

We engaged a relational-centred dialogue with three women (Alex, Eve and Mia) who volunteered to share their stories of having a (self-defined) "traumatic abortion." These three women were all British from middle class and well-educated backgrounds. Alex was in her 20's when she had her abortion but was trapped in an abusive marriage. Eve and Mia were two unmarried teenagers. Their abortions all took place in the 1970's.

The research was conducted in the UK (a context which could be seen as being more accepting of abortion than other countries). At the time of these interview dialogues, all three women were receiving ongoing support in their own psychotherapy. They viewed this research as an opportunity to explore further, and work through, this particular traumatic episode in their life. They also wanted

to share their story with others, perhaps to counteract their sense of being alone with the experience. With our ethical concerns foregrounded, the women were prepared for the possibility that the dialogue could well be emotionally intense and that it had the potential to re-traumatize. Our participants trusted us to handle their material sensitively and supportively while we took care not to transgress boundaries between research and therapy.

Gathering data involved an unstructured, relational-centred interview dialogue plus the writing of extensive reflexive notes following both interview and supervision sessions. Barbara interviewed Alex and Mia while I acted as her supervisor; I interviewed Eve with Barbara as my source of support. We started the dialogues (audio-taped for subsequent transcription) by inviting each woman to “tell her story.” We strove for an attitude of openness and empathy, one which would help us attune to, and share in, our participants’ experiences while holding onto our own presence to ensure a safe, bounded space for our participants.

Data Analysis

The analysis process involved ‘*empathic dwelling*’ (Churchill et al, 1998), where we aimed to stay with, and listen to, the women’s descriptions, constantly striving to be open to both implicit and explicit communications. We also engaged in ‘*reflexive, embodied empathy*’ (Finlay, 2005), using our bodily experience as a way of tuning into our participants so as to achieve both a kinaesthetic and emotional sensing of the other. In intuitively attuning to their experience, we opened ourselves to being touched and moved. If when reading a transcript we had a visceral reaction to particular passages, we took that as a signal to slow down and attend to implicit meanings, which we might otherwise have missed. At this stage of the research we also engaged in an iterative and dialectical process of hermeneutic reflection (Finlay, 2003) in an attempt to tease out reflexively, which perceptions belonged to researcher and which to participant.

The analysis was finally progressed by thematizing four existential meanings: ‘Feeling Torn,’ ‘Cutting Shame,’ ‘Monstrous (M)Othering,’ and ‘Entrapped Grief’ (see Finlay & Payman, 2014 for further elaboration). We were aware of many other emotions and themes, which emerged quite quickly: guilt, shame, loneliness, horror, existential anxiety, and abandonment. But these words, in themselves, somehow lacked the depth and trauma implicit in the women’s narratives. We delved deeper and, following van Manen (2014), allowed the reflective writing process to take us into a more unknowing place to find the *existential darkness* within.

Overall, the analytic process remained fluid and ever-evolving, with imaginative leaps of intuition as well as systematic working through iterative versions over

time. In this paper I have chosen to present one of these iterations: our attempt further to unpack the meanings within the emergent theme of 'entrapped grief.'

Findings: Entrapped grief

The extracts below, from the experiences of Alex, Eve and Mia, show something of the nature of entrapped grief. Their grief relates both to the loss of their 'baby' and to the losses (of Self, of taken for granted understandings, of relational connection) associated with their trauma experience of being physically and emotionally violated. Each woman's history included multiple stories of how significant others repeatedly neglected their safety and emotional needs. This was part of a deeply significant, broader relational trauma reaching beyond the abortion.

In their different ways each woman was holding in her grief, unable to speak of it while at the same time detaching from that part which felt the grief. For Alex, tears were nearer the surface; expressing grief in therapy is a recent growth for her. Eve and Mia, in contrast, displayed more ongoing dissociation, which seemed to leave the researcher-therapist 'holding' their grief, sadness and tears.

The source of the women's grief is ambiguous: they are indefinitely confused about what they feel and struggle to know what or who is lost (was it just 'cells' which were removed, or a child?). Are they entitled to grieve? Are they worthy of support? In response to their radical uncertainty and shame, their grief is suppressed and thus remains unresolved. Boss (2000) discusses this concept in terms of 'frozen sadness' that comes with 'ambiguous loss.'

Whatever the course and manifestation of the women's grief, all had, in their different ways, kept a silent secret for decades. Their experience had remained largely disowned; it was both unworked through and a continuing source of secretive silencing, shame and guilt. In such traumatic grief, there is a sense of unsafety that replays the violence (for instance, in self-persecution or self-disenfranchisement) that has already happened, perhaps continually repeated in day-to-day lived experience (Kauffman, 2002).

Four linked subthemes associated with the women's experience of entrapped grief have emerged in our research as figural: 'A shameful silence,' 'self-persecuting guilt,' 'coping through dissociation,' and 'a toxic context'.

A shameful silence

Kauffman has powerfully pointed to the way that death, loss and grief are tied ineluctably to shame:

Death and loss are prone in various undertows of subjectivity to be experienced as saying something (shameful) about oneself: shame of one's own mortality, shame at having lost a loved one, shame at not having loved well enough or been loved well enough, shame about one's own grief and its vulnerabilities, shame at the self-absorption of grief... and most remarkably, shame of shame (Kauffman 2010, p.5).

The women in our study defend and protect themselves through secrecy (not telling others they have even had an abortion) and denial. Mia, for instance, talked of thinking of "cells" that had been removed rather than a "baby" in the years before her therapy). They don't want to be reminded of their self-perceived 'bad-ness' and they don't want to be exposed to negative judgment from others. Here, the shame has to do with the women's sense of their *being*, not just shame about their doing (i.e. having an abortion) (Wheeler, 1997). Some forty years after her abortion, Mia still remembers the "excruciating embarrassment" and the "public humiliation" of the surgical experience itself that was infused with all-encompassing shame where she felt naked and exposed to the world. As Tomkins notes with reference to shame: "The humiliated one ... feels himself naked, defeated, alienated, lacking in dignity or worth" (1963, p.118).

For Alex, Eve and Mia, their shame was multi-layered: they felt exposed and judged by others for getting pregnant and for undergoing an abortion. But their deeper shame is the more generalised felt sense of unworthiness before the abortion and 'badness' that followed it. It was a deep-felt cut of shame that divided them internally and externally (Finlay & Payman, 2014). When shame is toxic, it is "an excruciatingly internal experience of unexpected exposure. It is a deep cut felt primarily from the inside. It divides us from ourselves and from others" (Bradshaw, 1988, p.5).

The psychological imperative is to keep safe and distance themselves from their emotions and from others through silence. This began as a creative and helpful solution, enabling them to gain some relief from the shame and some protection from facing the full horror of their traumatic experience. As time went on, however, in the internal/external disconnect the women were effectively abandoning their younger selves, just as others had done. It also meant that they were cutting off from others who might have become a source of solace.

In the following dialogue Eve talks of how difficult it has been, and remains, for her to talk about her abortion experience. Aged sixteen at the time, she had kept her pregnancy a shameful secret for several months until her mother spotted it, whereupon the abortion was immediately – if shadily – arranged. She felt silenced by her family who took the decision for her to have a "termination" ('abortion' was a taboo word in her family) out of her hands and then refused to

speak about it again. Eve was led to understand that she had done something terribly wrong that must be cut out of existence and swept under the carpet. In the wider context of the family's own suspect actions, social stigma, and cultural rejection of unmarried pregnant teenagers (she lived in a small town with a strong Catholic presence), a deep shame had been born into her family.

Even after several years of working with a therapist, Eve had not really openly expressed her grief. In dialogue with the researcher-therapist she begins to find her voice.

Eve: (Coughing) excuse me. Yeah (they said) "we'll discuss everything and then when we have a decision about what you're going to do then this is what you will do".

Linda: I'm conscious of your throat. (yeah thank you) Its just (more coughing from Eve) like you're being strangled and silenced.

Eve: I actually do this in therapy.

Linda: Do you?

Eve: Yeah.

Linda: It's so hard (more coughing from Eve) to get your voice out.

Eve: Yeah Yeah it becomes very croaky, very tingly and I think there is something about me not voicing stuff.

Linda: There is part of you that is resisting it because that is what you...were told (yes) "shut up" (yes) "keep it down".

Eve: Yes, yeah, to automatically follow; to please.

Linda: So it's taking a lot of courage for you to go against your all your scripts, to actually speak like this.

Eve: Yeah yeah. Okay (breathes out; pause).

Linda: Is that new to hear that?

Eve: I guess it is! It's a jigsaw puzzle that's kinda slotted in there that I am going against the scripts; I am going against the family.

Linda: Yeah you're speaking about a taboo subject which you should have kept secret and you're telling me everything (yeah); and you're using the word 'abortion' which you were told not to...It is huge that you're talking about it in therapy and in here (yeah)... Can we just focus on your throat a minute 'cos this whole thing about voice seems important with you feeling it come and go. Can you say what your throat is feeling?

Eve: It actually feels quite choked. When I concentrate it feels as if I'm being choked in the centre. Not all the way around the neck but the centre.

Linda: Just the centre.

Eve: Yeah the centre. There is something pressing.

Linda: If your throat could speak, what would it be saying?
 Eve: ... (It is like it was. I) couldn't swallow...it's difficult to think about.
 Linda: Take your time; and breathe (said with a smile).
 Eve: Yeah! (slightly tearful). I'm just thinking about what the throat would say to your question (long pause). There is something there about, it would want to silence them, it would want to say "shut up" to the family members...
 Linda: Like you've been silenced.
 Eve: Yeah, "My turn to speak!! Shut up!!" (said with some force).
 Linda: Yeah, yeah. (long pause) Having said that now, how's it feeling?
 Eve: It feels okay (said with a gentle smile).

Alex, too, had been silent about her experience for over 40 years – a self-imposed imprisonment which contributed to her sense of crippling, pervasive guilt (Hepburn, 2012).

Self-persecutory guilt

Hepburn (2012) discusses the difference between remorse and guilt, arguing the latter promotes self-destructive behaviour where the person feels too unworthy to be reprieved. This kind of self-persecutory grief often seems to occur in response to feeling overwhelmed by things over which the sufferers have had little control – i.e. they may themselves have been victims. High levels of persecutory guilt then become resistant to change.

Alex's experience was of this tortured kind. She had been a young mother of two locked in a failing marriage with a violent, controlling man when she fell pregnant again. Not wanting or feeling able to bring another child into this toxic environment, and without telling anyone, she decided to have an abortion. The sense of guilt and self-loathing that followed was so great that she had found a way to actively repress the memory for 40 years. Only in the last year had her disturbing memories begun to resurface in therapy, prompting her motivation to explore her experience more in this research.

The abortion itself remains a traumatic memory for Alex. From her perspective of being a "loving mother," she viewed her decision to have a termination categorically as "killing a baby": surely the ultimate betrayal for which she must be punished. Reluctant as she was to proceed, she felt "forced" into it by a pregnancy born out of marital rape. With her marriage in its death throes, she had the responsibility of keeping herself and her two daughters safe. Later she

recognised that she could have had the baby and still left her husband; but at the time, in the context of her distress and stressful home life, she felt she had no alternative.

My experience takes me back to my marriage, to a marriage that developed into being very abusive and not pleasant and physically aggressive... And in my mind I had already decided it had to end for my state of mind, my safety and the children...Then I discovered I was pregnant and my emotion at the time was one of horror... state of almost panic...This is very difficult to say, but I will because it's important, that the physical act of making that baby was fairly um, it was like marital rape...I'd gone through a really bad year and my hair was falling out, I'd developed alopecia with all the stress.

Her guilt lies in feeling like she has murdered a baby. Sharing this, she has to talk in the second person as if owning it fully in the first person is too difficult:

That is the hardest thing: that I am responsible for it. And I don't know if I'm crying for me, or crying for forgiveness. But certainly it's really painful...It's like you committed some awful crime! ... You have killed something. And it's, and even now it makes your heart pound. It makes your heart pound because you... You can imagine that, it's a life, a little life...All those things come to your mind again...when you've got to shut it out. You can't think it's a real living being. You can't.

Mia, too, experiences guilt but has locked it down in order to maintain an empathic certainty that she had "done the right thing." Yet, in her interview, she begins to recognise and take some responsibility. The pervasive, pernicious sense of her having been a 'killer' begins to take shape. This was something she had previously wanted to evade.

Mia's particular story was one of having a violent haemorrhage following a botched abortion at the age of fifteen. Up until the point when she 'birthed' a fist-sized blood clot into the toilet, there hadn't been, there just wasn't a baby, I was making sure there wasn't a baby! I was doing the right thing! I had no regrets at all about it, no regrets about the abortion.

For the teen-aged Mia, the cells growing within her were not a baby but merely objects destined to be surgically removed. As she put it, "It's easier if it's 'cells' and it's harder if it's a 'baby.'" Then came the traumatic arrival of the blood clot. Now in her 50s, she acknowledges the guilt and remorse she had tried so hard to suppress (the passage that follows has been paraphrased drawing directly on words spoken shown by the quotation marks):

"I was pretty freaked out by that (blood clot)...and that somehow I had been responsible for the 'reality' of the baby, which I had, I suppose, mutilated...and then it's sitting in the loo." It was something of a living nightmare. I was faced with "suddenly realising the horror of what I had done." Years later I would wonder if those "cells in my womb" were actually a baby? Had it been "hurt" by the "scraping" of the abortion? Did it "feel pain?" Had it then been "growing in a deformed way?" Was it "alive?"... "What is in my head is the blood clot in the bathroom, toilet. Um and I think for me THAT is the horror, that is the image ...but also that suddenly realising the horror of what I had done, um and the full implications really, which I hadn't understood... the baby hung on in there or it was the cells that remained. That is, there is something horrific about that... which I feel some guilt about. It's as much about thinking about this baby that is growing in a deformed way, by something I had done, or been party to."

Hepburn (2012) distinguishes between guilt as remorse and (self-) persecutory guilt which is experienced as pervasively crippling. With persecutory guilt, the possibility of reparation, (self-) forgiveness and self-development is disallowed in a kind of narcissistic avoidance, as the tortured individual feels too worthless to deserve reprieve. In object relations terms, faced with environmental failure (abuse, absence of care), the infant splits bad from good, identifying him or herself with the bad in order to manage it.

While Mia seems to carry more remorse, Alex feels this persecutory guilt more acutely. It is as if she has "taken possession of the whole traumatic dynamic" (Hepburn, 2012, p. 93). In addition to seeking to deny the abortion, her project (out of awareness) over the last few decades has been to dissociate from both her painful grief and her guilt.

Coping through dissociation

At the time of the research interview Alex was teetering between holding on to the blissful oblivion of denial and detachment and cathartically expressing her grief.

Alex: it was a terrible thing I had to do. I didn't really want to do it. (blows nose and more sobbing)... I deal with most things in life as being very controlled and locking away into compartments...

Barbara: You were somehow detached from it.

Alex: Yes, I certainly felt detached from it.

Barbara: Protecting yourself.

Alex: Yes, 'cos I'd learned to do that... here you are on like automatic pilot... you do the normal things, like you go to the bathroom, you have

your breakfast, it's unreal... you go to sleep and you wake up and it's unreal. And you *want* it all to be unreal. You want it all to be a dream and have it not have happened. And you want to have it all so that you don't have to think about it all. But you can't escape from it...I'd been very well in control all these years. It was like it had a lid on it, it had been tucked away...I didn't really grieve properly; I suppose because I had to pretend it like never happened.

In the dialogue with Alex, her grief was evident in her sobbing. She herself was also aware of dissociating and actively pushing her grief down.

In contrast, both Eve and Mia appeared flat and desensitised, even frozen, offering very little emotional expression during the interview. Viewing their researcher-therapist's emotional expression with some curiosity and awe, both women acknowledged that they themselves were not feeling very much. For us as researcher-therapists, the potential for *secondary traumatisation* was great and we both left the interviews holding in tears. We needed to support each other in supervision to stay with the poignantly painful stories and harrowing images evoked.

The dissociation (enacted in different ways) evident in all three women is perhaps not surprising, given the nature of the original trauma, which included both the abortion itself and the toxic relational environment the young women experienced at the time. In hiding their truth and flawed selves both from themselves and others, the women dissociated, disconnecting body from spirit. Erskine (1993) notes how dissociation allows a person to remove themselves cognitively and emotionally from their traumatic experiences while still adapting the external demands. That defensive response – I prefer the gestalt idea of 'creative adjustment' – can become sedimented and habitual. Such fixated ways of being interrupt the person's ability to be in contact with both self and other. This gap in the connection between self and environment is figural in the final theme: a toxic context.

A toxic context

While the women's stories and the context of their abortions differed, all three shared the experience of not having a supportive environment at the time. There was no space (physical or relational) in which to express their tears, fears and doubts or to receive any tender loving care. All three women were 'forced' by their circumstances to face their abortion and its aftermath in relative isolation. Their shame, guilt and grief needed to be suppressed, for they didn't feel they had anyone to talk with. As a result, all took more than their fair share of responsibility for their actions. Each made reference to 'killing' their baby as if the problem simply lay in them as 'murderers'. Yet the pregnancy occurred in partnership and

decisions to have an abortion were taken in consultation with medical/surgical teams. Wider systems and contexts were involved. And as both Alex and Mia were minors, their families had clear responsibilities.

In addition to lacking a supportive (m)Other, each woman had to struggle to manage punitive, toxic relationships in a historical and cultural context (1970's), which was less accepting of abortion (Walters, 1999). School-age teenage pregnancy, in particular, was still seen as a somewhat shocking event, with considerable stigma attached to it. This societal judgment became amplified as it was internalised and entrapped (through both denial and retroflection), eventually finding expression in the women's own self-criticism and self-disenfranchising censure (Worden, 2009).

For Alex, her persecutory husband and cold, absent mother contributed to the toxic environment in which, lacking outside support, she chose to guard her secret. Eve and Mia experienced their mother's response as uncaring, if not actively punitive. Both teenagers were denied a loving, supportive family at a time of dire need, but neither recognised that the version of care they received had troubling, coercive, even abusive elements.

Alone in the middle of the night and haemorrhaging into the toilet bowl, 15-year-old Mia hesitated to wake her mother, whom she knew would be drunk. Fearing that she was about to die, she eventually took the step to wake her. Her mother's response was to offer Mia alcohol to "relax" before advising her to preserve the blood clot sitting in the toilet in a glass so that it might be taken for testing the following day. She then returned to bed.

During the research dialogue, Mia's shame shouted of the unworthiness she felt. She did not seem to feel entitled to any love and care at any point during her abortion and subsequent miscarriage. Somehow she had internalized others' presumed negative judgments of her and the feeling was so pervasive that she did not recognise, let alone protest, the absence of loving care and attention to her health and safety.

It was only when Barbara offered a different perspective, one of compassion and sadness for this young girl whom no one was caring for, that Mia began to recognise that she might have expected and received care. Over the course of the interview she began to experience what she had been missing for so many years and connected with that part of herself which had so yearned for care.

Barbara: I can give you a bit of (pause) feedback about feeling - if you want at this stage (?)...
Mia: Yeah I think I would, yeah.

Barbara: I think the part of your story that is shouting so loud, at this particular moment to me, is your mother's absence and that at fifteen you had no sense of being supported by her and you didn't really know what it was to ask for help. So I'm feeling immensely sad around that.

Mia: Well I don't have any sadness. I have a (pause), I suppose, it's such an acceptance of it.

Barbara: ...the way you tell the story of going to get your mum ... (yet) you just had no expectation of support and help from her, and indeed you didn't get it. Yes, she went to get some gin but the endless times she abandoned you, and the time she was with you she -

Mia: (interrupts) I've not thought (of it) like that before.

Barbara: She physically abandoned you when she went back to sleep (ironic outtake of breath, a little tearful). I'm a mother, there is no way on earth I'd have left a daughter like that.

In gestalt terms, by blaming themselves, Alex, Eve and Mia have detached from the 'field' and their shame can be seen as the affect arising from, and exaggerating, a disconnect with their field (Wheeler, 1997). The shame represents their chronically unmet relational needs while their dissociation can be seen as mirroring the splits and atrophies of their field. Taking this perspective gives us clues about how to work with women who have experienced traumatic abortion.

Discussion: Implications for therapy

Dwelling with passages like those above reveals the multiple, interacting layers of trauma, grief and dissociation involved in the women's abortion experiences. While the abortions themselves were traumatic at both a physical and emotional level, a possibly more significant trauma occurred in the aftermath where, in both medical and relational terms, neither due care nor support were provided and where social stigma and cultural judgements added their poison. Horror, guilt, grief and shame arose out of this toxic brew, yielding a complex mix of existential, physical, psychological *and* social trauma. An argument is made by Rando (2003) and others that the trauma experience needs to be dealt with before grief can be worked through.

As Erskine (1993) has demonstrated, dissociation arises not only as a defensive response to traumatic events but also in the absence of a protective, reparative relationship. He argues that clients who are dissociated will benefit from relationally-oriented psychotherapy that engages contact through gentle, attuned enquiry into the client's experience. The task of therapy, then, is to offer a context

where the client can begin to contact, own and thereby integrate those dissociated parts of themselves. Contact with the therapist (or relational researcher) offers the safe, affirming space a person needs in order to begin to drop their defences and to feel and remember again.

It is important for integrative psychotherapists to understand this layered dynamic as it offers clues for possible intervention. Space doesn't permit a full examination of the therapeutic approach to traumatic abortion. However, four intertwined routes appear helpful:

- i. Holding and mirroring the grief;
- ii. Raising bodily awareness;
- iii. Emotional expression, 'truth telling' and unfinished business; and
- iv. Opening to the wider field. Here I'm following the compassionate, here-and-now phenomenological-gestalt approach of Erskine (2014), Gendlin (1996) and Wheeler (1997).

Holding and mirroring the grief

The examples offered above demonstrate something of the therapeutic and transformational potential of research that adopts a relational-centred approach. In this research, both Barbara and I drew on our capacity for embodied empathy and stayed present (during the interview, analysis and writing up stages) to the women's grief-trauma experience as a listening/non-judgmental caring person. It could be argued that we played a critical relational role: that of holding of grief/sadness, which allowed the women to tell us their story. For instance, where we teared up, we were somehow expressing the tears that Eve and Mia were not yet ready to own or express. Alex still tussled with not wanting to feel and express her emotions, but she was actively creating a narrative, which made sense as she continued her journey towards integration.

In the following passage, Barbara explores her attuned, 'holding' role and her 'maternal counter-transference':

I felt highly protective and supportive of Mia as she told her story. She evoked my deep compassion, and I can see that I was monitoring throughout what was 'missing relationally' for her; and feeling the impact of this 'absence' in an underlying feeling of sadness. Whenever I referred to sadness with her during the interview, she reported she wasn't feeling any, so it is not unlikely that I was 'holding' her suppressed sadness as well as my own 'internal tears of compassion'. My prime, 'relational role' was... to help enable her to tell her story, was to 'take care' of the sadness that could potentially overwhelm her and possibly then prevent her telling her overall story in the way she wanted and that we had 'contracted' for.

Perhaps if we do go along this line of thought of 'containing feelings for the other', one way we could think of it could be as a type of 'maternal counter-transference'... I was very overtly aware of how an 'attentive and loving mother' would be responding to the various scenes I was hearing being described; I was feeling this strongly, and clearly, and probably with much protective 'maternal fervour' (!) (Barbara Payman, reflexive notes, August 10, 2011)

I too had a relational role to play in holding Eve's grief. I became so touched during the interview itself that I simply could not stop my tears. It started with the poignant recognition that while Eve had been silenced and marginalised in her family of origin, she had worked hard to ensure Adam (the name she gave her aborted child) had a presence and place alongside her other children.

Linda: That speaking, and that voice, taking you out of the corner, as the metaphor, but also you're doing that for Adam too. You're taking (yeah I'm doing it on behalf of). He's now got a voice and a presence in the family (yeah yeah). So it's like both of you having that.

Eve: And that's what a mum would do. With a youngster. (yeah) Do it for them.

Linda: Which your mum didn't really do for you. (no) (pause)

Eve: And I've not really figured out, I wanted to do something with this, put a marker on for him, and I haven't as yet worked that out. *This was my reconciliation* (Eve hands Linda a piece of paper which turns out to be an 18th birthday letter to her child which she had written earlier).

Linda: Can I read it out loud? (absolutely)
December 2004 To Adam – born and died 20 December 1978 (pause as Linda tears up) I don't think I can read it out (shared tearful laughter)

Eve: Better you than me!

Linda: *My Angel,*
You were loved but taken from me
You are gone, but will never be forgotten
You will always be in my heart, though we are far apart
Rest with Sweet Jesus until we meet again. (Linda has to break off because her tears momentarily overwhelm her.) I'll just do this last bit.
Love Mummy.

Linda: Hmmm (nods through tears with smile), it's very beautiful. Sorry I'm not supposed to lose it as well.

Eve: No, that's fine! (said in a strong voice in contrast to Linda's wavering one and a little more laughter shared).

Linda: That's sooo beautiful.

Eve: Thank you for being tearful with me. Um because nobody is. So it's almost, so it's, when somebody dies, you'll share that grief and (Eve tears up) nobody has.

Linda: Not even in therapy?

Eve: No, no. She was kinda strong and contained....

Linda: Whereas this is relation-centred.

Eve: It's a different experience.

Linda: ... I see it as absolutely important to be present here. Your pain is here, your grief is here (Eve nods and tears up) and no, I have to be present to that. It's the only way I can honour your (Eve blows nose) your story and also Adam's story, life, as well.

In such ways through the attuned relationship, grief is validated (Erskine, 2014). Then work can begin on releasing bodily awareness and/or engaging any unfinished business.

Raising bodily awareness

Somatic therapists argue that the body remembers traumatic events (through brain encoding) and that healing necessitates attention to the body as well as the mind. The body is also the source of protective mechanisms (such as dissociation) that the client may have evolved. In short, the body has a wisdom that can be both celebrated and tapped.

In Levine's (2010) evolutionary-based approach to *somatic experiencing*, he asserts how the structure of trauma (including activation, freezing, dissociation and collapse) is based on the evolution of survival behaviors. He argues that therapists have a role to play in helping clients recognise the emotional and physical signs of any embodied frozen trauma and hear the *voice of the body*. There is value in enabling clients to become aware of their bodily felt sense and how their freeze responses (for instance) are natural and engaged when releasing inbuilt mechanisms to reset the emotion-body system.

He argues that during some episodes of traumatic stress, experience can become disconnected. A person with PTSD might later report disturbing memories, images and emotions but cannot make sense of them (dissociated meaning). Alternatively, they might be unable to feel emotion (dissociated affect). Clients may lurch between traumatic images and terror while being blocked in

their ability to feel their body or emotions in the moment. Levine's model can be helpful in identifying which bits are dissociated and gently leading them back into consciousness.

Rothschild (2003) builds on these ideas with her *somatic and resourcing approach to trauma*. Specifically she recommends helping clients to identify emotions by observing clients' non-verbal expressions and linking these to client's experience by asking such questions as "What are you aware of in your body right now?" Therapist and client can then begin to work with any hyper arousal as it occurs and start to engage memories (both negative and positive) that can then become resources. Cautioning against working with flashbacks, which may well involve a re-experiencing of helplessness and terror, she recommends helping clients to control flashbacks, for instance, through awareness of current body sensations, which can anchor clients in the present, enabling a separation from past responses.

Gendlin (1996), a phenomenological philosopher and psychotherapist, recommends a slightly different approach: that of tuning into the body's wisdom through *Focusing*. Focusing involves attending to intuitive gut feelings (whether on the part of client or therapist) and becoming aware of ongoing processes through relationship with one's own felt sense. Here the therapist might ask the client to be explicit about bodily experience via such questions as "How is what you are talking about making you feel in the middle of your body?" or "What might that body sensation be saying?" Or "What does that part of your body want to say?" It might be possible at that point to engage a dialogue with the body related to any parts previously shut out or frozen. An example of *Focusing* is my dialogue with Eve above regarding her blocked throat.

Gendlin recommends that therapists also ask themselves the same questions in search of exactly the right words or images for this bodily felt sense of the client's experience. The insights gained from this can in some circumstances trigger an "Ah ha!" moment where there is a sudden release of tension and a new way of capturing the experience in language is born.

But *Focusing* is more than technique. It is a gentle, compassionate, phenomenological way of being which is respectful to one's own (and the other's) being and pace of movement. It helps us to listen, to pay attention to our bodily gestures (Fleisch, 2009) and to our experiencing at that point between what we are conscious of and what we are not quite aware of. We tune into subtle bodily feelings that may be trying to tell us something. As we feel time slowing down and space opening up, we become open to receiving sensations, symbols and words that are fresh and alive. As Gendlin (1996) says, if we are open to the wisdom of the body it will both guide and surprise us.

Gendlin argues that what comes from the inward experiencing and bodily sensed edge of awareness has a special intricacy, one that goes beyond simply being in touch with body sensations. At first what is sensed is ambiguous and unclear, but as you pay attention to the sensing, words, images or clearer physical sensations arise. In the process of *Focusing*, a physical shift then occurs and a new insight or solution arises.

Emotional expression, ‘truth telling’ and unfinished business

Erskine (2014) emphasises the importance and significance of ‘truth-telling’ towards actively expressing grief and other emotions that have been retroflected, inhibited and contained. He recommends that people with protracted grief be offered a way to express their grief to an interested, attuned listener. As he notes, in the absence of validating communication, the person cannot say ‘goodbye’ because there has been an incomplete ‘hello.’ Untold stories are left to be enacted in more damaging physiological reactions, nightmares, recurrent images, fears, and obsessions.

The therapist’s role is to counteract the pervasive silencing and shaming voices by facilitating expression and encouraging the process of completing (as far as possible) unfinished business, perhaps through experiments or visualisations (Erskine, 2014). Tentoni (1996) for example recommends clients may be helped to reach emotional closure through the use of gestalt empty chair work to dialogue with the foetus/baby. Similarly, Merle-Fishman (2010) describes advising a client to write a letter to the lost baby.

Engaging such dialogues, the importance of naming and ‘taming the shame’ and giving voice to experience to stop the vicious cycle of silence and secrets cannot be over-emphasised. As Burke (2002, p.248) notes, “Healing involves naming, claiming, and taming an unspeakable wound so that you can move out of the silence and beyond the secret.” Brené Brown, of the Shame TED talk fame, makes a similar point: “Shame hates it when we reach out and tell our story. It hates having words wrapped around it- it can’t survive being shared. Shame loves secrecy. When we bury our story, the shame metastasizes” (Brown, 2012).

Beyond challenging the silence, the therapeutically-oriented research dialogues presented above allowed the women to have a long-missing quality of relational contact and communication around their original abortion experience. This enabled the expression and exploration of the women’s experience, which proved helpful in their long-term journey to find and integrate themselves.

The antidote for entrapped grief lies in the person finding a voice and having a space to express and make sense of experience. The therapeutic relationship,

whether occurring in the context of therapy or relational research, allows an opportunity to share, to begin to say the unsayable, to give voice to experience, perhaps for the very first time. It offers a safe space in which to be witnessed and to begin making sense of experience. In their 'truth telling,' the previously disavowed feelings of the three women in this study are more fully acknowledged.

Once the silence is broken, individuals can follow through by engaging in various imagined dialogues, activities or experiments. All three women followed up their research encounters with further therapy work focused on grappling with 'unfinished business' (Erskine, 2014). Alex enacted a funeral service with candles for her lost baby; Eve did further cathartic work with her grief while being supported in a group; and Mia used empty chair experiments to talk with both her baby and her mother about the abortion (Tentoni, 1996).

Opening to the wider field

Perhaps the most critical intervention for women whose abortion experience has left them with entrapped, self-persecutory grief and guilt is to help them see that the responsibility for the abortion lay also with others. To this end it might be helpful to begin exploring any hidden longings a woman may have, or any disowned anger and resentment she may harbour against her partner, family or wider relational world. In the process, any denial on the part of the woman that she merits compassion and is entitled to be seen and cared for can be challenged.

Alex, later in her therapy, was invited to think about how she would advise her daughter if she ever found herself in a similar situation. Alex immediately went into supportive mode, which she could see contrasted dramatically with her own self-treatment.

In Eve's case, the discussion in the interview around the role of her family enabled her to view her own responses as more reasonable and understandable:

Eve: Thank you for just being and sharing.(yeah) That's a new experience for me too, to have somebody to share the pain, the grief, yeah. ... I haven't dealt with what I felt towards members of the family. That's what I haven't dealt with yet.

Linda: They cut off from you and made you cut off from yourself and took away your control, took away your voice (yeah). They made you feel bad, in the wrong (yeah) and um,(not given choice). You were not given choice, you were lost and

too young. And I have a huge compassion for that 16-year-old.

Eve: You know, it's the first time that I've heard that actually. I would have been in that grief, that numbness, that shock. Yeah.

Linda: Sorry, that's the first time you've heard?

Eve: That's the first time I've heard that that's where I would have been.

Linda: Wow, okay. I think that's really important (yeah).

Eve: Yes, it's been important to hear where I went really.

The process of opening to the wider field also involves appreciating the impact of the broader social-cultural context and being aware of prevailing norms and beliefs, including those involving stigma. Asking "What would be the difference if your pregnancy happened today, in this day and age?" might, for example, help the individual see the particular challenges she faced. She might also perceive more acceptance in the eyes of those around her today.

As Wheeler (1997) notes, to take a field model seriously means that we have to regard a phenomenon (such as traumatic abortion and entrapped grief) as being of the whole inner and outer field. Interventions then might be geared to acknowledging a previous lack of support in the field and how this person is entitled to support now. "Who would you have liked to help you back then? Who can help you with this now?"

In the therapy context, with its focus on the present moment, the therapist is also part of the 'field' and needs to take care not to replay what might be experienced as invasive or shaming responses. Instead, the therapist has choices about how best to attend to and honour the client's experience. Interventions can be geared to showing the client the relevance of the relational context. If, for instance, a client 'loses voice' or is not yet ready to speak, Wheeler (1997) recommends saying something like, "I want to support you to pay close attention to that feeling and honouring it. Can I ask you about what I am doing right now, or not doing, that would make your comfort level go down?"

Conclusion

The stories of the three women sketched above remind us of the more that lies behind apparently simple biographical facts such as having an abortion. It is critical to understand the meaning of the abortion and any loss involved for the individuals concerned, and consider these in the context of collective meanings and cultural norms. If a client discloses she has had a 'traumatic abortion', it behoves us to explore what that means *to her* and for her world. Only then can we help the client make sense of and work through the experience. We

need to strive to understand better the depth and enduring nature of the trauma and disenfranchised grief experienced by some women after undergoing abortions (and their male partners), and how these impact an individual's felt sense of Self and way of being in the world (Finlay & Payman, 2014).

Applied to the psychotherapy field, this research highlights the value of careful, compassionate, slow relational phenomenological dwelling, both with meanings and with the broader relational-cultural context. Understanding disenfranchised grief rests on exploring the discrepancy between individual and collective meanings (Doka, 2002).

While the examples of dialogue in this article arose out of a research encounter, the elements of inquiry, attunement and respectful interpersonal involvement offered a healing presence (Erskine, 1993; Finlay & Evans, 2009). As researcher-therapists, we offered significant witnessing and validation to the women. Through our presence, reflexivity, self-disclosure and contact, the women's awareness of their dissociation and expressions of grief grew.

It is useful to be reminded of the potentially profound impact of attuned relational listening and presence. I will never forget the look on Eve's face as I mirrored her internal tears. She first looked taken aback. Then she smiled in a kind of wonder. A few days later I got this email:

"I do really want to thank you for listening and most importantly of all – feeling the experience with me and sharing your emotion – a real first for me to have shared my felt sense of grief. Thank you!"

Author:

Linda Finlay is a practicing Integrative Psychotherapist (UKCP registered) in Scarborough, North Yorkshire, UK, where she teaches both psychology and qualitative research methodology at the Open University, UK. She also teaches/mentors psychotherapy students at various institutions across Europe. Her particular research interest is in applying hermeneutic phenomenological, relational and reflexive approaches to exploring the lived experience of disability and trauma. She has published widely being best known for her textbooks on qualitative research. Her two most recent books, published by Wiley, are: *"Phenomenology for therapists: Researching the lived world"* and *"Relational Integrative Psychotherapy: Engaging process and theory in practice."*

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Date of publication:
10.12.2015