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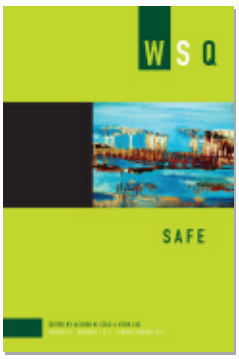

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THE THINGS WE CANNOT SAY: WITNESSING THE TRAUMA-TIZATION OF ABORTION IN THE UNITED STATES

JEANNIE LUDLOW

> *What would happen if one woman told the truth about her life?*
> *The world would split open.*—Muriel Rukeyser, "Käthe Kollwitz"

"Can you tell me what *really* happens at an abortion clinic?" My interviewer shifts forward, careful not to jar the camera she has leveled at me. It's a question I've been asked many times. I began working part time at an abortion clinic in 1996. In 2000, I began speaking to small groups—classes, student organizations, feminist organizations—about clinic work, and in 2003 I began researching U.S. abortion politics. Yes, I probably could tell her what really happens at a clinic, but I don't. Although a part of me wants to tell her that the patients at the clinic are women like her, like her mother, like me, that they come to us for help with mundane situations more often than with horror stories, I don't, because I am being recorded, and I am afraid. Instead, I ask her to be more specific. "Tell me about the really tough cases," she urges. She's already confessed that someone she is close to was conceived during rape, so I suspect that she wants to hear about women who live with violence and undergo abortion. This is a politically necessary narrative about abortion in the United States; often, pro-choice activists argue correctly that laws that limit (or ban) abortion revictimize women impregnated during rape, incest, and domestic violence. Careful not to violate patient confidentiality, I tell her about my relatively infrequent experiences with rape victims at the clinic.

Why am I reluctant to talk about the majority of my clinic experiences? It would be disingenuous to deny that I fear that the common stories would disappoint my interlocutor. Each week I do intake medical history screenings and peer counseling sessions for two to four patients at the clinic. For approximately twelve to forty patients a week, I act as surgical advocate, standing next to the women as they have their abor-

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tions, coaching them through the procedure ("Now you may feel another dilation cramp; take a deep breath and blow it out") or distracting them with small talk if they prefer, proffering cool washcloths for their foreheads, basins in which to vomit, or my hand to be squeezed. Each of these women has shared a decision-making narrative during our screening process, and many retell those narratives to me while waiting to see the doctor or during their surgeries. Most of these narratives center around women's struggles with the ordinary—and, simultaneously, monumental—details of life: managing family economics, negotiating work and child care, setting priorities, and planning for the future. Not long ago, a coworker estimated that I have acted as a surgical advocate in more than seven hundred abortions. Usually the patients and their narratives stay with me for a few weeks at most and then begin to blend into a kind of abortion chorus in my memory. Often a patient will say to me, "You were here for my last abortion, too," and I smile, nod, and say, "I hope I was helpful to you," because I don't remember her abortion.

The patient narratives that stay with me longer are the rarer or more traumatic situations. The stories of aborting fetuses conceived during rape or because of fetal anomaly and the narratives of forty-two-year-old cancer sufferers and frightened thirteen-year-olds do not merge into that chorus in the same way. These stories are easier to remember, and auditors tend to respond to them with sympathy and support, another reason for my reluctance to share the more common situations. From my experiences talking about my clinic work, I have determined that there is a hierarchy of abortion narratives from a prochoice political perspective. There are abortion narratives that are considered politically necessary to tell (rape/incest/domestic violence victims' difficulty in obtaining abortion services, clinic personnel's struggles with antiabortion protesters, the risks of illegal abortion to women's health and welfare). These narratives are considered central to maintaining public support for abortion rights and access. When I was asked to represent Ohio abortion clinics in a federal hearing to determine the constitutionality of a restrictive abortion law, these are the stories I told. I talked about how the law would hurt most those who are already hurting: women living in violent relationships and pregnant teens living in abusive or neglectful families. There are also abortion narratives that are considered politically acceptable to tell (contraceptive failure rates, a young mother's inability financially to support

another child, fetal anomaly cases). Although these narratives raise potentially difficult questions about personal choice and responsibility, they do represent situations with which most Americans can empathize, thereby posing no threat to continued public support for abortion rights and access. At my talks on abortion, I regularly hear these narratives from audience members and other activists, and often I relate them myself. When I do, I recognize that I am saying the "expected things" rather than speaking openly about what I've learned through my work at the clinic. I have spoken with my coworkers about this realization, and we have agreed that there is another category of abortion narratives. One of my coworkers refers to this kind as "the things we cannot say." These are narratives of abortion experiences that, while often exploited in antiabortion discourse, are generally not considered part of pro-choice public discourse in the United States; they are narratives of multiple abortions; of failure or refusal to use contraceptives (correctly, consistently, or at all); of grief after abortion; and of the economics of abortion provision.[1] These are the recitals that are the most familiar to clinic personnel and, although we talk about them among ourselves, we seldom move these discussions into public spaces, even explicitly pro-choice ones. The irony of our silence is that "the things we cannot say" describe the majority of our clinic experiences.

In other words, there is a politically and socially constructed gap between what we experience at our clinics and how we talk about those experiences in public. When I began to notice this gap in my own speaking about abortion, I realized that it had been constructed in part out of political necessity. I was reluctant to close this gap for fear that I might, as one academic colleague accusingly put it, "provide fodder for the other side." Abortion rights advocates have long found ourselves in defensive positions vis-à-vis antiabortion discourse, from accusations of indulgence implied by antiabortion phrases such as "abortion on demand" to those of callousness implied in recent examinations of "post-abortion syndrome" (Bazelon 2007). This defensive stance has circumscribed our own discourse. At the same time, the gap between what I see at the clinic and what I feel I can say in public has been constructed discursively from what Lane, in her 2005 documentary, *The Abortion Diaries*, calls the "silence and stigma" around abortion, even among pro-choice people. In MariAnna's words, abortion is "a topic that many people—even some who support legal abortion—find distasteful or offensive"

(2002, ix). "Distasteful" and "offensive" are socially constructed responses that cannot be separated neatly from antiabortion discourse; the adoption of these responses by self-defined pro-choice people reveals the power of cultural narratives to "structur[e] meaning in our lives and, consequently, facilitat[e] particular understandings of truth" (MariAnna 2002, 121).

Recently, I have begun to think about the relationship between cultural narratives of abortion as distasteful or stigmatized and the experiences patients have at our clinic. Sometimes, the relationship seems obvious and direct to me, such as when a college-aged patient writes on her chart that she is "a bad person" and says to me in a cheerful voice, "I expect I will feel terrible [after the abortion]. I'm sure I'll think about it a lot and always wonder about the baby, what it would have been. But I just can't have a baby right now, when I'm about to start school." At other times, the relationship is oblique; once, a woman having a late-second-trimester abortion leaned close to me at the end of her medical history screening and whispered, "Is this legal?" While I was stunned by the courage it took to show up for a surgery that she suspected might not be legal, I was also aware that the discourse around the "partial-birth abortion ban" had inspired her confusion. Because I see these relationships at work in women's abortion experiences, I have decided that I will no longer allow my fears to delimit the stories I tell.

This essay is located in the gap between witness and testimony, "between the seen and the told" (Bernard-Donels and Glejzer 2000, 5), at the site of the "things we cannot say," a location from which I hope to propose a more complex and more honest reading of abortion experiences.[2] I believe that the gap between what I have witnessed at the clinic and what I have been willing to testify about in relation to my clinic experiences indicates that abortion in the United States has been constructed as traumatic. I would like to refer to abortion in this essay as "trauma-tized"—trauma-tized in part by the fears and silence of people like me who work for women's reproductive rights. By speaking from this gap to illustrate how this trauma-tization affects my patients at the clinic, I hope to mitigate my role in its construction and replication. To that end, I situate myself as "witness" and my readers—particularly those who identify as pro-choice—as what Kacandes calls "cowitnesses" or "enablers" to/for the story of trauma, individuals who can themselves be "transformed" by the act of hearing or reading another's testimony

(2001, 95, 107). The transformations I hope for begin when I and other abortion rights activists become more comfortable telling the most common stories and adjust our public discourse to claim the rightness of women's mundane reasons for terminating pregnancies. As we articulate "the things we cannot say," perhaps we can 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. Although I am not fully optimistic about this outcome, I admit that I also long for an overtly feminist sociopolitical context in which ordinary abortion narratives become the politically necessary narratives, the ones we rehearse in order to defend abortion access.

THE THINGS WE CANNOT SAY

The sedative is working; the patient is woozy and relaxed yet awake and aware. As usual, I stand at her left shoulder where I can speak with her and maintain eye contact and still see enough of the doctor's actions to anticipate and explain them. The nurse and the clinic director, who performs our ultrasounds, are the only other people in the room. The vital-signs monitor beeps the rhythm of the patient's heart. The patient is nervous and clutches my left hand tightly; she does not want to know what the doctor is doing, so we chat. As a strong cramp grips her abdomen, she pulls my arm and says softly, "I have a really good reason for doing this, but abortion shouldn't be used as birth control." I know better than to try to reason with sedated patients; often they don't know what they're saying. But in the spirit of keeping her mind off the doctor, I say that most women have really good reasons for having abortions. "No," she says, gritting her teeth through another cramp. "People should not just have sex and do this for an easy way out."

I could dismiss this patient's statement as a combination of drug-induced rambling and difficulty with her own decision, but I know that many self-described pro-choice people, including activists, politicians, and academics, agree with it. What is meant by the statement, "Abortion should not be used as birth control," as Senator Hillary Clinton articulated in a 2005 speech, is that abortion should be an exception, not a normal aspect of women's reproductive lives. It should not "ever have to be exercised or only in very rare circumstances" (Clinton 2005). Correlative

activist phrases include "safe, legal, and rare," and the assertion "To decrease abortion, we must increase comprehensive sex education." This is, to my thinking, the least risky pro-choice narrative that exists in the contemporary neoconservative United States, which is doubtless why politically liberal people such as Clinton have adopted it. This narrative is effective; it is hard to argue against reducing unintended pregnancies and increasing individual responsibility for sexuality.

As my experience with this patient indicates, however, this narrative tends to trivialize most abortions; she calls abortion an "easy way out" of an unwanted pregnancy. This construct compels us to focus on "exceptional" circumstances—situations in which the woman had very little choice in the matter—to justify abortion's continued legality and accessibility; reduced choice means reduced culpability. As noted above, many pro-choice activists respond to legal challenges to abortion by invoking politically necessary and politically acceptable circumstances. Because they are presented so frequently, these circumstances have become reinscribed as the "appropriate reasons" to have an abortion, and they render all other reasons for aborting questionable at best and frivolous at worst. Statistically, however, these "appropriate abortions" are rare. Only 1 percent of abortions in the United States are of fetuses conceived via rape or incest and fewer than 1 percent are of fetuses with severe anomalies; fewer than 20 percent of abortion patients are aged nineteen or younger. Much more common are abortions performed for economic reasons or to correct mistakes that people have made. Among women having abortions in the United States, the two most frequently given reasons for choosing abortion are financial (57 percent of women having abortions are poor or low income and 21 percent report that financial hardship has influenced their decision to abort) and lack of readiness for responsibility (21 percent of abortion patients) (Alan Guttmacher Institute [AGI] 2005).

These are the women I see in the clinic; our demographics correlate with the national statistics. Because our patients complete an intake screening form that asks, "How do you define abortion?" and "How do you feel about your decision?" I know that many patients "used to think abortion was wrong" but now believe that "it is a woman's choice," a way not to have to change one's life because of a mistake. Many tell me during screening that they feel guilty because they did not use contraceptives consistently and correctly. Nationally, 43 percent of women with

unintended pregnancies were using no contraceptive method at all during the month they conceived, and those who were using contraception did not use it correctly every time they had sex. Both my experiences and data from the Alan Guttmacher Institute suggest that contraceptive failure is not much more common than failure to use contraceptives. When pro-choice activists insist on the legitimacy of abortion by invoking the former and do not mention the latter, we reinscribe the gap between the pro-choice narrative of "appropriate abortions" and women's lived experiences.

A coworker indicates that the patient in the next procedure room is "difficult." She's been uncooperative since her ultrasound appointment, complaining about having to speak with a physician before setting up her abortion appointment (this extra step is the outcome of the hearing at which I testified). "She said she's done this before, and she doesn't need to talk to anybody before her abortion," my coworker explains. I look at the patient's chart. She's a thirty-nine-year-old mother of four. Although she has written on the front of the chart that she has "been here before," her gestation history inside is incomplete. She lists her childbirths but no previous abortions. I ask if we are certain that the woman is a "sister" (repeat patient) and am assured that she has had several abortions with us. I enter the procedure room. The patient is lying on the gynecological table and does not sit up. I introduce myself and compliment her hairstyle, which is very short. She smiles and compliments mine (also very short). Something inspires me to ask, "Did I tell you that last time?" She nods and we laugh. As her procedure begins, the patient says to me, "Just as soon as I can, I'm getting myself to the doctor to get my tubes tied." During the procedure, we talk about her children and the difficulties of working a swing shift. She says her boyfriend asked her to marry him, and that she will do so after she gets her tubal ligation. When her abortion is finished, she says softly, "Thank you, again." Then, more loudly, she says to all of us, "I love you guys, but I hope I never see you again!"

According to the Alan Guttmacher Institute, among women having abortions, 12 percent have had one or more previous abortions, 25 percent have had one or more previous births, and 36 percent have had both previous abortion(s) and previous birth(s) (2005). This means that 48 percent of U.S. abortion patients have more than one abortion, and 61 percent are mothers when they abort. These previous situations can shape a woman's

abortion experience. If I had done the medical screening and peer counseling for the woman mentioned above, the missing abortion history would have compelled me to ask how she was feeling about having multiple abortions. I suspect that her "difficult" behavior grew out of her frustration with having another unplanned pregnancy and, in turn, led to her advocate's unwillingness to question her about those feelings. Because her medical screening was incomplete, I do not actually know why this patient had multiple abortions. I do know that asking why does not help her in her present situation as a single mom of four who does not want more children and does want to build a life with the man who has asked her to marry him.

When I am screening women who have had multiple abortions, I do ask directly about the repetition. These women tell me most frequently that they feel shame "for getting myself into this situation again" and fear "that I won't be able to get pregnant again if I want to." In these women's responses, I hear echoes of antiabortion rhetoric. I trace such women's fear that abortion will render them sterile to claims made by "crisis pregnancy centers." More important, to me, I hear the result of the refusal of pro-choice advocates to address repeat-abortion situations. The silence and stigma surrounding ordinary abortion experiences seems to be aggravated by multiple abortions. Yet when I consider the obstacles that prevent women from using contraceptives consistently and correctly (economics, heteronormative relationship dynamics, the vagaries of daily life), the incidence of three, four, or five abortions over the course of the thirty-plus years that a woman is fertile and sexually active seems neither shameful nor unreasonable. It is time we publicly address the needs of repeat-abortion patients.

When I am silent about "the things we cannot say" and focus on exceptional circumstances, I reinscribe a discourse of "appropriate abortion" that in turn feeds a cultural climate in which abortion patients feel "guilty" or "like bad people" for exercising their right to decide whether and when to become parents. Thus, I delegitimate the most common reasons women decide to abort. As witness to the effects of this delegitimation on my patients, I invite my reader-cowitnesses to join me in challenging the notion of "appropriate abortions," that is, to join me in articulating "the things we cannot say." When someone states, "Abortion shouldn't be used as birth control," I will reply, "But that's exactly what it is—a way for women to control when we give birth." And when,

during a conversation about why abortion must remain safe, legal, and accessible, someone invokes exceptional circumstances, I will inject a dose of normalization into the discussion; I will define the gap by drawing attention to it. I will say, "Yes, of course abortion must remain legal for victims *and* for those of us who forget our pills or diaphragms and who do not want babies right now." I believe that when witnesses are willing to testify to "the things we cannot say," including to some phenomena that may be read as politically ambiguous, the continuous process of narrative structuring, to use MariAnna's terms, will shift, making way for more diverse, and perhaps even for contradictory, "understandings of truth" about abortion (2002, 121).

WITNESSING AND TRAUMA-TIZATION

> *Witnessing . . . entails responsibility. And it's not without its own risks.* Se paga por ver *(one pays for looking).*—Diana Taylor, *Disappearing Acts: Spectacles of Gender and Nationalism in Argentina's "Dirty War"*

It feels risky to write about abortion in the context of witnessing for four reasons. First, I never want my witnessing to compromise a patient's confidence or dignity. However, if I name my work "witnessing to abortion," readers may expect my testimony to reveal confidences, including "horror stories" about patients' experiences as I recounted above. Often revealing anything at all runs a risk of violating trust. Let me try to explain. My position of relative power over my patients has been created in part by their confidence in me—their confidence that they can tell me things they cannot tell other people, and their confidence that I know what to do and say. When I care appropriately for patients, I use this power to ease their way through some aspects of their experience: decision making, surgery, recovery, and communication with loved ones about these stages. However, my role as liaison/witness is often complicated if not thwarted by feelings of shame on both ends of any communication. Many abortion patients are unwilling to share their abortion experiences with others, even when I assure them that doing so would be profoundly helpful. Numerous patients tell me that they never knew anyone who had an abortion; this is statistically unlikely. In fact, many a young patient's mom has confided in me that she too had had an abortion years earlier. Often, these apparently loving and supportive mothers will

say, "I wish I could tell her, so she would know she wasn't alone," but they seldom do, despite my urging. One mother said, "I just can't. She would be so disappointed in me." I recognize that in writing about these mothers' shame or embarrassment I risk seeming judgmental of them. I do not intend to blame but, rather, to testify to the tragedy of their socially inflicted shame and how it overpowers their desire to support their daughters. I do so to point out how these loving mothers' social silencing ultimately reinforces the shame and secrecy that surround abortion in the United States.

The second reason I am nervous about witnessing to abortion is also related to the issue of the confidence my patients put in me. As Moor explains, caregiving surrogate witnesses might "extend [the] socio-medical gaze (and ear) onto the patients' broader lives" (2003, 226). A caregiver's testimony, Nettleton worries, might unintentionally further subject patients to the vast "web of medical power and surveillance" (qtd. in Moor 2003, 226). For abortion patients, whose experiences are circumscribed by concerns about privacy and political discord, this surveilling gaze would be particularly problematic. Tal's view concurs and extends Moor's and Nettleton's. Tal argues that "it is a short step from empathy to appropriation, and health professionals should monitor themselves carefully for signs that they are replacing survivors' stories and testimonies with their own narratives" (1996, 220).

The third reason it feels risky to me to write about abortion in the context of witnessing is that I do not want to imply that abortion is an atrocity. Although the trope of witnessing is imbricated with experiences of trauma, abortion is not trauma, in and of itself. My experiences as both abortion patient and provider demonstrate that abortion does not, by definition, victimize women, although of course there are women whose abortion experiences are traumatic, and their stories must be heard and respected. In the public domain, pro-choice abortion narratives are particularly rare; an online search reveals hundreds of abortion "horror stories" and poems attributed to women who regret their abortions and only a few sites dedicated to pro-choice narratives.[3] In spite of this dearth, abortion providers have not typically responded by becoming surrogate witnesses, perhaps because many of us use our activist time fighting reduced access and providing abortion services. Still, perhaps we need to run the risk and witness to the ubiquity of nontraumatic abortion. This is part of why I am writing this essay.

The fourth reason it feels risky to testify to "the things we cannot say" is that my testimony might be appropriated by antiabortion interests. What if opponents of abortion took my words and used them against my patients? What if they read my admission that many women have multiple abortions or fail to use contraceptives as evidence that women use abortion cavalierly, thereby concluding that it should be illegal? I acknowledge that these responses are possible, and I am prepared to take responsibility for them. The risk feels minimal because these arguments are already deployed to justify antiabortion laws and regulations. For example, the law about which I testified in federal court imposed on women aborting in Ohio a twenty-four-hour waiting period with informed consent given in a face-to-face visit with a physician. On the surface, this law seems perfectly reasonable: certainly I should consult with a physician before undergoing surgery. What most observers did not realize is that Ohio already had a twenty-four-hour informed-consent law, a law which allowed women to obtain the required information via videotape or audiotape, thus providing women who were several hours from the closest clinic with a way to obtain abortions without incurring additional expenses for travel or child care and without drawing attention to their decision. The passage of a second law regulating that the consultation be in person implies that women approach abortion decisions casually and must be forced to think them through. I am willing to testify to the full reality of abortion practices in the Unites States, thereby running the risk of potential appropriation by antiabortion forces, because "to *not* put the experience in words will not make it go away" (Kacandes 2001, 140). Rather than continue to allow "horror stories" to shape the discourse of abortion advocacy, I want to remember—and testify—that, as poet Judith Arcana writes, "Abortion is, in the ordinary motherhood-type way, the concern of women who are taking responsibility for the lives of their children" (1994, 160).

CONCLUSION: HEALING DISCOURSES

Next to the words "reason for having an abortion," the patient has written, "I'm not responsible enough for a baby." I ask how she came to her decision. She launches into a story, which I paraphrase:

> After my first abortion when I was eighteen, I felt like a total failure. My parents were supportive, but I knew I had let them

> down. My boyfriend turned out to be a real loser—not dad material, you know?—so after I told everybody and dropped out of school to be a mother (giving up an athletic scholarship), I ended up getting an abortion anyway. This time, no one knows except my fiancé. It was his idea, really. He's starting grad school in the fall, and he says we need to live our own lives before we try to support another one. But then I got to thinking: I'm only twenty. I could go back to school. I was a good student, loved science. I'd like to be a nurse. So I've decided to make this abortion the next step in getting myself back on track. I'm in a good relationship; I'm not disappointing anybody. I'm going to feel good about this and move forward with my life. This probably sounds weird, but I'm almost glad I got pregnant.

This patient's reported reason for choosing to abort her pregnancy is one of the two most common reasons given by women in the United States: "not ready for responsibility" (AGI 2005). Clearly, though, this women views her second abortion as a step toward responsibility to and for herself. MariAnna explains that women's abortion stories "function in two seemingly conflicting ways: first, to reaffirm certain cultural narratives; second, as a commentary on our social environment and the cultural scripts into which women are cast" (2002, 121). In this patient's story I hear the tension between self-determination (*I'm going to feel good about this and move forward*) and the cultural scripts that define a woman's proper place in a heteronormative relationship (*his idea, really . . . he says we need to live our own lives*). Although this young woman is telling me her individual story, the situation to which I am witness is a social one, defined and reified by cultural narratives of "heterosexuality, romance, motherhood, reproduction, family, and acceptable norms of female identity and behavior" (MariAnna 2002, x). That this patient's empowerment is enabled by the silence surrounding her abortion (*no one knows. . . . I'm not disappointing anybody*) indicates that individual empowerment does not guarantee freedom from cultural narratives that work to define and shame her. That kind of freedom comes only through social change.

Kacandes, following Judith Herman, Martha Minow, and others, notes that witnessing and cowitnessing to social violations can be valuable, even in the absence of "any personal psychotherapeutic healing" because the process of analysis that accompanies cowitnessing compels us

to recognize a trauma(-tization) that, "precisely because it has yet to be fully witnessed . . . still exist[s]" (Kacandes 2001, 135). I understand this to mean that even if my witnessing to this patient's turn toward self-determination does nothing to help her honor her abortion experience and her life goals in (spite of) a patriarchal social system, I will still be a successful witness if my reader-cowitnesses receive my narratives and, in turn, witness to others about "the things we cannot say" (paraphrasing Kacandes 2001, 140). Thus, together, we all may "broaden the scope of the possible . . . and allow for a wider range of responses" (Taylor 1997, 265) to contemporary abortion politics. I am hopeful that my resolution to testify to the most common reasons women decide to abort will inspire others to recognize and counter the ongoing trauma-tization of abortion in the United States. Can I get a witness?

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NOTES

1. For an examination of grief after abortion and its relationship to the fetal body, see my "Sometimes It's a Child *and* a Choice" (2008).

2. I do not intend to analyze the impacts of antiabortion discourse on patients; there are many feminist/progressive analyses that accomplish this, including Solinger 2001; Mason 2002; Saletan 2004; Feldt and Fraser 2004; and Jacob 2006.

3. See www.imnotsorry.net, which invites "positive abortion experiences"; www.4exhale.org, which offers pro-choice postabortion counseling and e-cards; and the recently closed www.heartssite.com, which invited people to speak "from the heart" about their abortions.

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