

Chapter 10

Counterpoint: Long-Lasting Distress after Abortion

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Some women report no distress after abortion, but some do report distress. This chapter is about those who do.

In 1973, as a university undergraduate, I served as a volunteer abortion counselor in a clinic for low-income women, helping women to access abortions. In my training, I was told that abortion was risk-free, and since I had no contact with the women after their procedures, I did not learn about abortion-related distress until many years later. As a psychiatry resident in 1985, I was assigned a patient who had been hospitalized for severe depression after an abortion. She was married, financially secure and had been pregnant with a child she wanted - but her husband did not want another child, and her pastor advised her to submit to her husband's wishes. She told me that before the abortion, she had been well, but afterward, she experienced severe depression and guilt. Thus, I learned that not everyone who obtains an abortion actually wants one, and that the accompanying distress can be severe. In this case, there was no doubt in the mind of my patient that her symptoms were related to the abortion itself. At that time, it didn't occur to me to evaluate her for posttraumatic stress disorder (PTSD), and no one made that diagnosis, but today I would ask more questions.

A textbook of the National Abortion Federation (Baker, Beresford, Halvorson-Boyd, & Garrity, 1999) has identified many “negative reactions” (p.28-29) that some women have after abortion; some are trauma symptoms: nightmares about babies, insomnia, negative emotions of guilt, anger, worthlessness, and shame, “blocking out the experience,” avoiding things that trigger memories about the abortion, “engaging in self punishing behaviors such as substance abuse . . . and relationships with abusive partners,” suicidal thoughts, “relentless thoughts of being a bad person,” and various self-destructive behaviors (pp.28-29).

Although most researchers agree these reactions can occur, there are unresolved questions regarding the scope of the problem which may be much larger than many clinicians have realized. The distress for some can be very long-lasting. In my clinical experience, I have worked with women ranging in age from teens to more than eighty who continued to have distress they attributed many years later to the abortion.

In this chapter, we consider the conceptual framework of “Abortion as Traumatic Experience,” identified in the APA Task Force report covered in Chapter 9. Many authors have identified abortion as an event that can be traumatic for some women. Here, we will examine the evidence that many women suffer long-lasting distress specifically because of their abortion.

Diagnostic Criteria for PTSD

In 2013, the American Psychiatric Association published the 5th edition of its diagnostic manual, DSM-5, the most recent criteria for Posttraumatic Stress Disorder (PTSD). Many pertinent studies of PTSD used previous diagnostic criteria, but symptoms are similar. Many in the trauma field are removing the word “disorder” and refer only to post-traumatic stress (PTS). We will use the DSM-5 criteria as a way to organize the symptoms.

To diagnose PTSD, several specific symptoms must be associated with a specific trauma, beginning after the trauma occurred. A “subclinical” or “subthreshold” case occurs when symptoms are insufficient for a full diagnosis. Patients with only some symptoms may have substantial distress.

The National Vietnam Veteran's Readjustment Study (NVVRS) was a large, nationally representative study mandated by Congress to identify the prevalence of PTSD in American veterans of the war in Vietnam. Approximately 26% of male and female veterans in combat zones had PTSD symptoms at the time of the study, with 15% of men having full PTSD and 11% “partial PTSD” (Kulka et al., 1988; Price, 2015). Those with partial PTSD had impaired functioning. Large studies using community (non-military) samples have documented disability and increased risk of suicide with subthreshold PTSD (Marshall et al., 2001; Stein, Walker, Hazen, Forde, 1997).

A 2015 systematic review article on PTS and PTSD associated with reproductive loss (elective abortion, miscarriage and other losses) reported the prevalence rate varied depending on

how respondents were recruited. Some demographic groups are at higher risk than others. The authors state it is currently not possible to determine a definite prevalence for specific PTSD symptoms following the various types of reproductive losses (Daugirdaitė, van den Akker, & Purewal, 2015).

In the section below, the diagnostic criteria are listed with examples of how these criteria may be met, using quotations from women and comments from published studies

Death Event

Current diagnostic criteria for PTSD begin with “exposure to actual or threatened death, serious injury, or sexual violence in one (or more)” of several specified ways (American Psychiatric Association, 2013, p. 143). This can be through “directly experiencing the traumatic event,” or “witnessing in person the event(s) as it occurred to others” (p. 143).

Women sometimes see the fetus during the course of an abortion (Slade, Heke, Fletcher, Stewart, 1998; Speckhard, 1997; Urquhart & Templeton, 1991), which may allow the woman to view the abortion as a human death event, even in the absence of prior attachment (Speckhard, 1997). Seeing the fetus was associated with increased PTSD symptoms (Slade, et al., 1998).

Whether or not the woman has seen or felt something that enhances her perception of the death of a human being, her subjective experience is paramount. If she perceives the fetus as human, its loss may be experienced as the death of her own child, as it was for "M. K." (Speckhard & Rue, 1992, p.107): “I don't know how it's possible, but I know I felt when my baby died. I could feel when its life was sucked out. It was awful. I have never felt so empty.”

The experience of fetal death is not the only source of trauma. Bleeding or pain may be perceived by the woman as traumatic (Burke & Reardon, 2002; Suliman et al., 2007; Speckhard, 1997; Speckhard & Rue, 2012).

Intrusion Symptoms

The diagnosis of PTSD must include at least one intrusion symptom, including:

1. Recurrent, involuntary, and intrusive distressing memories of traumatic event(s).
2. Recurrent distressing dreams in which the content and/or the affect of the dream are related to the traumatic event(s).

3. Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic events were recurring.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)(American Psychiatric Association, 2013, p. 144).

Intrusion symptoms reported after abortion include nightmares, flashbacks and, and memories that “seemed to intrude despite trying to forget” (Dykes, Slade, & Haywood, 2010, p.11; Speckhard & Mufel, 2003). In a study comparing 331 Russian and 217 American women, 48% of the Russians and 65% of the Americans reported one or more intrusion symptoms specifically related to a past abortion (Rue, Coleman, Rue, & Reardon, 2004). Slade et al. (1998) reported, in a sample of 275 women having first trimester abortions, seeing the fetus was associated with nightmares, flashbacks and intrusive thoughts of the abortion.

Nightmares. A textbook of the National Abortion Federation (Baker et al., 1999) identified nightmares about babies as a possible negative reaction after abortion. In Rue et al. (2004), 30% of the American women reported nightmares associated with their abortion. A woman in Belarus reported vivid nightmares of her child in a pool of blood with arms and legs broken (Speckhard & Mufel, 2003); in the Belarusian sample, 32% had nightmares.

An American woman reported, “Three years after my second abortion I started having nightmares in which I saw myself in a baby parts cemetery and holding a dead baby in my arms and crying for the ones I lost. I was . . . holding a dead baby and trying to bring him back to life” (Burke & Reardon, 2002, p. 124). Another reported recurring nightmares about being in labor, “eager to see the baby,” but the baby “comes out dead” and “it takes me hours to calm down” (Burke & Reardon, 2002, p. 124). Some report crying for hours after they awaken, and becoming afraid to sleep at night. Some engage in substance abuse to be able to sleep.

Flashbacks. In a flashback, the traumatic event is re-experienced; the memory is intense as if it were happening now, not the past. In Rue et al. (2004), 46% of the sample of American women reported flashbacks related to a past abortion, while Speckhard and Mufel (2003) reported 76% of a Belarusian sample reported flashbacks.

A woman reported a flashback to her abortion when she required emergency treatment for an ectopic pregnancy: “Having my feet up in stirrups, the smell of the hospital, the violation of instruments entering my body and taking a life from me . . . these things all came back to me, and I felt exactly like I was having an abortion. I cried and cried. I guess I was hysterical. The doctor had to give me a sedative” (Burke & Reardon, 2002, p. 122).

Women have described flashbacks with routine gynecology exams, sometimes with anxiety symptoms such as shortness of breath and palpitations (Burke & Reardon, 2002). Although flashbacks may be brief, the fear of one can contribute to women avoiding places and activities reminding them of the abortion.

Avoidance Symptoms

“Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic events” or avoidance of external reminders such as people or places “that arouse distressing memories, thoughts or feelings associated with the traumatic events” (American Psychiatric Association, 2013, p. 144-145). A danger is women may not seek counseling to help to resolve persistent abortion-related symptoms.

Rue et al. (2004) reported 19% of the Russian women and 50% of the Americans avoided thinking or talking about the abortion; 36% of the Americans reported three or more avoidance symptoms. In a Norwegian study comparing women who had miscarriages with women who had induced abortions, the latter scored significantly higher on the avoidance subscale of the Impact of Event Scale (IES) at 2 years and 5 years after the abortion (Broen, Moum, Bødtker, & Ekeberg, 2005). All the women interviewed by Dykes et al. (2010) avoided thinking about the abortion, and “all participants spontaneously used the term ‘blocking it out’ as a universally adopted strategy” (p. 11), though as one woman stated “blocking them out . . . doesn’t work always” (p. 11). A National Abortion Federation textbook (Baker et al. 1999) reports “blocking out the experience; and avoiding anything that triggers memories of the event” as an adverse reaction. Bagarozzi (1994) and Mufel, Speckhard, and Sivhua (2002) reported avoidance.

Women in Belarus were interviewed in part to learn whether negative psychosocial reactions were the similar across divergent cultures (Speckhard & Mufel, 2003). In this non-random sample, 50% were clinically assessed as having PTSD. Many more had some symptoms.

However, very few had sought professional treatment, which may have been related to their high degree of avoidance symptoms.

Avoidance symptoms can be disruptive to lives and relationships. One woman reported quitting her job to avoid being around a pregnant co-worker: “When I found out my co-worker was pregnant, I was overcome with anxiety and fear. I didn’t want to even look at her. I knew I couldn’t take watching her belly growing each day with a baby . . . I had to leave that job because of her pregnancy” (Burke & Reardon, 2002, p. 70). She reported physical symptoms such as a “knot in my stomach” and her heart pounding when around her pregnant colleague. Women in Belarus also reported avoiding pregnant women (Speckhard & Mufel, 2003).

“Suzanne” avoided routine gynecological exams for eight years until an infection forced her to seek treatment. She had a flashback on the exam table and left without being examined (Burke & Reardon, 2002). Women in Belarus stated they avoided the clinic where the abortion took place and avoided returning for gynecological exams (Speckhard & Mufel, 2003).

Rue et al. (2004) reported 25% of the American women in that sample had “difficulty being near babies” (p. SR11). For any woman who originally hoped to have children at a better time, this would be a particularly unfortunate symptom. A woman in Belarus stated: “I can’t meet with babies. It’s too painful. I broke the relationship with my girlfriend who asked me to baby-sit for a few hours with her daughter. I was rude to her” (Speckhard, & Mufel, 2003, p. 8).

Symptoms Related to Negative Changes in Thoughts and Moods

There are seven symptoms of this type, which must be (a) associated with the trauma, (b) persistent, and (c) either begin or worsen after the traumatic incident. Symptoms include a “persistent negative emotional state (e.g. fear, horror, anger, guilt, or shame) . . . markedly diminished interest in significant activities . . . detachment or estrangement from others” and “inability to experience positive emotions” (American Psychiatric Association, 2013, p. 145).

Persistent Negative Emotional State. Guilt and shame were expressed by the women interviewed by Dykes et al. (2010). In a Belarusian sample, 80% reported guilt, though most were not churchgoers, atheism had been enforced by the Soviets for 70 years there, and there were no protesters to engender guilt (Speckhard & Rue, 2003). In another cross-cultural study,

49% of Russian women, and 78% of American women reported guilt (Rue et al., 2004). In a Norwegian sample, post-abortive women had significantly higher scores for guilt and shame compared to those who miscarried, and significantly increased anxiety compared to general public (Broen et al., 2005). Grief, anger and guilt are also discussed in Chapter 8.

Detachment or Estrangement from Others. Symptoms include decreased interest in activities, “detachment or estrangement from others” and “inability to experience positive emotions” (American Psychiatric Association, 2013, p. 145). This may contribute to relationship problems. Studies find reports of increased communication problems (Coyle, Coleman & Rue, 2010; Freeman, Rickels, & Huggins, 1980; Rue et al., 2004), increased sexual dysfunction (Bagarozzi, 1993, 1994; Bianchi-Demicelli, Perrin, Ludicke, Bianchi, Chatton, Campana, 2002; Bradshaw & Slade, 2003; Coleman, Rue & Spence, 2006; Coyle et al., 2010; Fok, Siu, & Lau, 2006; Miller, 1992; Rue et al., 2004; Speckhard & Mufel, 2003; Tornboen, Ingelhammar, Lilja, Moller & Svanberg, 1994) and increased separation and divorce (Barnett, Freudenberg, Wille, 1992; Bracken & Kasi, 1975; Coleman, Rue & Spence, 2006; Freeman et al., 1980; Lauzon, Roger-Achim, Achim, & Boyer, 2000; Rue et al., 2004).

Feelings of detachment may contribute to problems bonding with subsequent children (Coleman, Reardon, & Cogle, 2002; Coleman, 2009), or may contribute to increased child abuse and neglect, as detailed in Chapter 13.

Hyperarousal Symptoms

This group of symptoms has “marked alterations in arousal and reactivity” that began or worsened after the traumatic incident, including insomnia, “irritable behavior and angry outbursts . . . reckless or self-destructive behavior . . . problems with concentration” (American Psychiatric Association, 2013, p. 145).

Insomnia. A large study examined 56,824 medical records comparing women who aborted to those who delivered (Reardon & Coleman, 2006). Those who had abortions were nearly twice as likely to be treated for sleep disorders during the first 180 days after the end of pregnancy compared to those who delivered, even though women who delivered may be

expected to have sleep disturbance due to caring for a newborn. Women who aborted continued to be more likely to be treated for sleep disturbance than women who delivered for up to four years. Women with a history of sleep disorder were excluded from the study.

Reckless or self-destructive behavior. “Francine” described self-destructive behavior: “I cracked up my car three times, driving recklessly at extreme speeds. In one wreck, I broke four ribs and punctured my lung. My life became a series of calamities, accidents, and self-destructive benders” (Burke & Reardon, 2002, p. 140). Although “Francine” survived, her report is consistent with a study of Canadian government health care services showing women with an abortion history were more likely to receive treatment for accident-related injuries (Badgley, Caron, & Powell, 1977). Data from the Virginia Department of Medical Assistance Services showed women who had abortions had increased claims for treatment of accidental injuries compared to a case-matched sample of Medicaid recipients without abortions (Reardon, Strahan, Thorp, Jr., & Shuping, 2004). Records-based studies in the U.S. and Finland show post-abortive women approximately two to four times more likely to die from accidents (Gissler, Kauppila, Merilainen, Toukoma, & Hemminki, 1997; Reardon, Ney, Scheuren, Cogle, Coleman, Strahan, 2002; Reardon, et al., 2004). Increased accidental deaths persisted over eight years (Reardon et al., 2002; Reardon et al., 2004). Possible reasons: (a) increased risk taking or self-destructive behavior; (b) suicides not classified correctly; and (c) substance abuse (Burke & Reardon, 2002; Reardon et al., 2004).

Other Trauma Symptoms

Substance abuse. Substance abuse is strongly associated with PTSD, though not listed as a symptom in DSM-5. The onset of PTSD often precedes onset of substance abuse, suggesting causality (Chilcoat & Breslau, 1998, Saxon et al., 2001). Patients sometimes self-medicate to reduce flashbacks and hyperarousal; there is neurobiological evidence (Armony & LeDoux, 1997; Coleman, 2005; Jacobsen, Southwick & Kosten, 2001; Kreek & Koob, 1998).

Many studies show a strong association between alcohol or drug abuse after abortion (Coleman, 2005). Reardon and Ney (2000) considered only women with no prior history of

substance abuse, finding those who aborted were subsequently 4.5 times more likely to engage in substance abuse compared to those who delivered.

A study using data in the National Longitudinal Survey of Youth compared women who aborted (n = 213), women who delivered an unintended pregnancy (n = 535) and women with no pregnancies (n = 1,144), controlling for multiple variables (Reardon, Coleman & Cogle, 2004). Four years later, women who aborted experienced significantly higher risk for frequent marijuana and alcohol use.

Another study examined data from the Christchurch Health and Development Study, a 25-year study of a birth cohort of 1,265 New Zealand children (Fergusson, Horwood, & Ridder, 2006). Approximately 500 female participants ages 15-25 years were compared in three groups: a) never pregnant; b) pregnant no abortion; c) abortion. There was no significant difference between the never pregnant and the pregnant no abortion group, but the abortion group demonstrated significantly higher rates of illicit drug dependence, and also higher rates for other severe adverse mental health problems, after controlling for numerous potential confounders.

An Australian study (n=1,223), controlling for pre-existing substance abuse, behavior problems, and other variables, found young women with a past abortion had almost three times the risk of lifetime illicit substance use disorder (other than marijuana), and twice the risk for an alcohol use disorder, compared to those with no previous abortion (Dingle, Alati, Clavarino, Najman, & Williams, 2008).

Suicide. Suicidal thoughts and behaviors are not listed in DSM-5, but are the ultimate self-destructive behavior. Sheila Harper (2008), author of a workbook used in abortion recovery support groups, reported attempting suicide due to persistent abortion-related distress (Harper, 2009). She described having the gun in her hand when her roommate unexpectedly came home early and interrupted the attempt.

There are reports of attempted or completed suicides coinciding with the anniversary date of the abortion or expected due date of the aborted child (Tishler, 1981). British artist Emma Beck, who committed suicide after an abortion in 2007, wrote: "I told everyone I didn't want to do it, even at the hospital . . . now it is too late . . . I want to be with my babies" ("Artist hanged herself," 2008).

A record-based study in Finland linking medical records and death certificates showed women who aborted had a 650% higher risk of death from suicide compared to women who carried to term (Gissler, Hemminiki, & Lonnqvist, 1996).

A study of more than 173,000 California Medicaid records, controlling for age and prior psychiatric illness, revealed women who aborted were 3.1 times more likely to die from suicide compared to women who delivered. The increased risk persisted over 8 years (Reardon et al., 2002). The risk was highest for younger women.

A records-based U.K. study compared suicide attempts before and after pregnancy events (Morgan, Evans, Peter, & Currie, 1997). Women who aborted had a significantly increased rate of suicide attempts after the abortion compared to previously and compared to those who gave birth. The authors concluded: “The increased risk of suicide after an induced abortion may therefore be a consequence of the procedure itself” (p. 902).

Fergusson et al. (2006) reported that young women who aborted had significantly higher risk of suicidal behaviors compared to those who were pregnant, and compared to those who were pregnant but did not abort.

Delayed Onset of PTSD

Under DSM-5 criteria, to diagnose PTSD, the symptoms must be present for at least one month. There is also a category “with delayed expression” if the full criteria are not met until at least 6 months have passed (American Psychiatric Association, 2013, p. 145-146). Thus, PTSD is a longer-term *chronic* condition compared to “acute stress disorder” in which symptoms begin immediately and persist for three days to one month.

Engelhard, van den Hout, & Arntz, (2001) reported some women after an involuntary pregnancy loss experienced late onset PTSD during their next pregnancy. A delayed reaction after abortion has been reported in Belarusian women and in Western samples (Speckhard & Mufel, 2003; Mufel et al., 2002; Speckhard, 1997; Speckhard & Rue, 2012). Circumstances such as gynecological problems, infertility, illness or accidents with subsequent children can trigger symptoms. Some women report distress did not occur until seeing the ultrasound of their first intended pregnancy, or holding their child after first completed pregnancy, which altered their view of the aborted fetus (Speckhard, 1997; Mufel et al., 2002).

This is consistent with observations in U.S. government data on PTSD from the NVVRS. The majority of the veterans with full PTSD had delayed onset after more than 6 months, with 40% first meeting diagnostic criteria for PTSD 2-5 years after being in Vietnam, and another late-onset cluster being diagnosed 6-22 years after being in Vietnam (Schnurr, Lunney, Sengupta, & Waelde, 2003).

Considering this, studies examining PTSD in the first three months after abortion may find a smaller number of cases compared to what would emerge with longer follow up.

Long-lasting Effects of Trauma

According to the National Comorbidity Survey, the effects of trauma are often very long-lasting. Over one third of people with PTSD fail to recover even after many years (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Of American veterans of the war in Vietnam with full or partial PTSD, 78% continued to experience symptoms when interviewed 20-25 years after the war (Schnurr, et al., 2003).

Several studies show symptoms of PTSD occurring 3 to 5 years after an abortion (Barnard, 1990, 1991; Broen et al, 2005; Curley & Johnston, 2013). Others have diagnosed PTSD still present 9 to 11 years after the abortion (Anderson, Hanley, Larson & Sider, 1995; Rue et al., 2004), or longer (Dykes et al., 2010). (See also Chapter 8).

Clarifying the Conclusions of the APA Task Force

Majority of Women Excluded

The Task Force on Mental Health and Abortion of the American Psychological Association concluded that “The relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy for nontherapeutic reasons is no greater than the risk of women who deliver an unwanted pregnancy” (Major, et al. 2009, p. 885). This conclusion applies only to women in these subgroups:

- Adult women, age 21 and above (excludes 18% of U.S. abortion patients who are teens; Jones, Finer, and Singh, 2010).
- Single abortion - not repeats (excludes about half of U.S. abortions; Cohen, 2007).
- First-trimester abortion (excludes 11% of U.S. abortions, which are late-term; Guttmacher Institute, 2014).
- Unwanted pregnancy (excludes the pressured/coerced and ambivalent, prevalence unknown).
- Non-therapeutic reasons (excludes those terminating due to medical reasons).

Thus, the conclusion applies to only a minority of women having abortions. More than half of U.S. abortion patients are excluded. The exact number excluded cannot be determined due to overlap between categories, and lack of definitive prevalence data for some subgroups.

Studies Not Considered

Inclusion criteria required that studies have an appropriate comparison group, though the task force additionally considered some “abortion only” (no comparison group) studies from the U.S. (but not other countries) that were viewed as providing additional insight. Due to falling outside the criteria, several studies assessed as good quality in the review by Daugirdaitė et al. (2015) were not considered.

A prospective study from South Africa (Suliman et al., 2007) was conceived by a physician who provided anesthesia for abortions, with patients referred to the study at pre-abortion counseling. The study controlled for prior mental health, with psychological rating scales before and after the abortion on the same day, and at 1 and 3 months. The baseline *point prevalence* of PTSD was 11.3%, similar to U.S. community samples. (Point prevalence is the percentage having the disorder at the current point, not cumulative lifetime prevalence). Prevalence of PTSD at 3 month follow up was 18.2%, which the authors considered high; this was higher than the results of Rue et al. (2004) but lower than other studies such as Engelhard et al. (2001). Because PTSD symptoms at 3 months were partially explained by severity of pre-existing PTSD symptoms and disability, and also by post-termination dissociation, the authors recommended screening in advance to determine which women may be at risk for PTSD, to assure those affected receive appropriate follow-up treatment.

Prevalence

The fifth conclusion of the APA Task Force (Chapter 9), that the “majority” of women do not suffer symptoms, is not helpful in establishing whether or not abortion can be traumatic. It is widely accepted that PTSD occurs only in a percentage of those exposed to any trauma.

In the NVVRS, lifetime prevalence of PTSD – veterans who had ever suffered – was 30.9% for full PTSD and 22.5% for partial PTSD (Kulka et al., 1988; Price, 2015). Thus, the majority of combat veterans did not meet full criteria for PTSD, though slightly more than half, 53%, had at least some symptoms over their lifetimes. At the time of the study only 15.2% of male combat veterans had current full PTSD. Similarly, the National Women’s Study showed 31% of women who were raped have PTSD symptoms at some time afterwards, with 11% still having it currently (Kilpatrick, 2000). Thus, a majority of combat veterans and a majority of rape survivors did not meet diagnostic criteria for full PTSD. Yet PTSD in these groups is still considered a substantial clinical problem meriting attention.

The Problem of Non-response

Recently, a 4-year nationally representative longitudinal study was conducted of U.S. abortion patients, compared to women who sought abortion but were unable to obtain one (Biggs, Rowland, McCulloch, & Foster, 2016). Authors reported only a 1% prevalence of PTSD symptoms attributable to the index pregnancy, but the methods used did not allow researchers to pinpoint whether symptoms were due to the pregnancy, the abortion, or other factors.

The Turnaway Study, which was the source of the data (Biggs et al., 2016), started with only a 38% participation rate. Women were offered \$15 for informed consent by phone, and \$50 for a telephone interview about a week after an abortion or after being turned away (Dobkin et al., 2014), but only 38% completed that first interview (Rocca, Kimport, Gould, & Foster, 2013). Of those, 65% continued through the 4 years. Thus, final results are based on only about 25% of the much larger group originally invited.

Some studies indicate that low participation rates or high drop-out rates may distort results. After a workplace disaster in Norway, 246 employees were required to participate in medical evaluations for PTSD (Weisaeth, 1989). At baseline pre-disaster, employees had a record of cooperation with the company medical officer. After the disaster, some were resistant and required repeated contacts; eventually participation reached 100%. The initial resistance was significantly associated with severity of PTSD at 7 months. The authors stated that if the initial refusals had been accepted, “the potential loss to the follow-up would have included 42% of the PTSD cases, and 64% of the severe PTSD cases would have fallen out, resulting in distorted prevalence rates of PTSD” (Weisaeth, 1989, p. 131). Additionally, “The initial resistance in many who later developed PTSD was found to relate to the psychological defences such as avoidance which is seen both PTSD and acute post-traumatic stress syndrome.”

Relief vs. Stress

Many expect relief after abortion, an outcome reported in the literature. The APA Task Force reported “Abortion can be a way of resolving stress associated with an unwanted pregnancy, and, hence, can lead to relief. However, abortion can also engender additional stress of its own” (American Psychological Association, 2008, p. 10). Several authors have stated that relief can be followed by or coexist with trauma symptoms (Curley & Johnston, 2013; Mufel et al., 2002; Speckhard & Mufel, 2003; Speckhard & Rue, 2012); the existence of short-term relief does not negate the reality of trauma symptoms in some of the very same women, or in other women. Additionally, some authors have reported dissociation around the time of the abortion, which may be mistaken for relief, but which is associated with risk of subsequent PTSD (Speckhard & Rue, 2012; Suliman, 2007).

Conclusions

It is certain that for some women, abortion is a traumatic stressor capable of causing PTSD symptoms. In my own clinical experience, women have reported nightmares *specifically related to the abortion*, not past sexual abuse. Flashbacks are triggered by reminders of the abortion, not previous trauma. When this is the case, the woman herself may be the best judge of

what is distressing for her. For the women I have treated, most, if not all, would say that the most central aspect of their distress is the loss of the child. There are certainly women who do not think of the fetus as a child, but for those who experience distress, this is often a central issue. (See also Chapter 7, on attachment as a risk factor).

There are pre-existing psycho-social risk factors and neurobiological and genetic factors influencing who develops PTSD and who does not. This is reported in many studies, not only abortion samples (Price, 2015; Sherin & Nemeroff, 2011; Strahl, 2012). Nonetheless, for many women, abortion is a cause or a contributing cause of PTSD symptoms. For others, abortion may be an additional trauma exacerbating PTSD symptoms or adding symptoms.

Because of risk factors, some authors recommend pre-abortion screening to identify the most vulnerable (Curley & Johnston, 2013). Opportunities for women to consider their risks and possible alternatives to abortion may help prevent later distress. Screening and prevention are extremely important because distress after abortion can be very long-lasting and very disabling.

Cross-cultural research indicates that although not all women experience trauma symptoms, those who are distressed report similar types of symptoms across cultures, including avoidance, intrusion, hyperarousal symptoms, and negative emotions. Even after many decades of state-enforced atheism, low religiosity, and lack of protestors, many Belarussian and Russian women still experienced guilt.

Because PTSD symptoms can be delayed, it is important to provide follow up and availability of treatment options over time. However, for women to access appropriate treatment, clinicians must be aware that some women experience abortion as a stress and may be vulnerable to abortion-related mental health problems.

Many of my patients have reported that prior mental health treatment was not helpful, because therapists did not believe that the abortion was the cause of their distress, and therefore they did not address the patient's identified concerns. This has led women in growing numbers to seek help through alternative sources such as peer-led support groups. The Abortion Recovery InterNational Care Directory reports that their website receives more than 50,000 contacts annually, seeking referrals to local support groups. Rachel's Vineyard conducts approximately one thousand weekend retreats annually worldwide, Sheila Harper's SaveOne has 145 chapters worldwide, and Project Rachel has 162 local branches throughout the U.S. There are too many groups to name or count them all. This shows that many women are identifying abortion as a

source of distress and are seeking help. Yet they will likely not be discovered in research utilizing large databases since these support groups are usually free of charge, and are not reimbursable by health insurance, being peer-led.

An important point is that it was the women themselves who founded the very first national support group organization. Women who have had abortions have written most of the widely used support group workbooks, who head many of the national and international abortion recovery organizations, and who lead almost every local group. Some organizations such as Project Rachel and Rachel's Vineyard make use of both peer support volunteers as well as professional counselors. When a dozen women get together for a support group, usually the leader or co-leader is personally post-abortive. Women who feel that they were helped through these programs are eager to “give back” by helping others with abortion recovery. Many women who were distressed by their abortion experience also gravitate toward pregnancy resource centers where they volunteer in order to give women the range of choices they wish they had been offered.

There is more to know about women's experiences than what is currently in the large data sets. To better understand the full picture and the range of experiences, more qualitative work would be helpful in order to listen to women's stories and understand, rather than dismiss those who experienced trauma. Studies that evaluate the effectiveness of peer-led alternative support programs will also be useful.

References

- American Psychiatric Association (2013). *Desk reference to the diagnostic criteria from DSM-5*. Washington, D.C.: Author.
- American Psychological Association, Task Force on Mental Health and Abortion. (2008). Report of the Task Force on Mental Health and Abortion. Washington, DC: Author. Retrieved from <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>
- Anderson, R.L., Hanley, D.C., Larson, D.B., & Sider, R.C. (1995). *Methodological considerations in empirical research on abortion*. In P. Doherty (Ed.), *Post-abortion syndrome: Its wide ramifications* (pp.103-115). Dublin: Four Courts Press.
- Armony, J.L., & LeDoux, J.E. (1997). How the brain processes emotional information. In R. Yehuda & A.C. McFarlane (Eds.), *Psychobiology of posttraumatic stress disorder* (259-270). New York: Academy of Sciences.
- Artist hanged herself. (2008, Feb 22). *The Telegraph*. Retrieved from <http://www.telegraph.co.uk/>

- Badgley, R.F., Caron, D.F., Powell, M.G. (1977). Report of the Committee on the Operation of the Abortion Law. Ottawa: Ministry of Supply and Services, pp.313-321.
- Bagarozzi, D. (1993). Post traumatic stress disorders in women following abortion: Some considerations and implications for marital/couple therapy. *International Journal of Family and Marriage, 1*, 51–68.
- Bagarozzi, D. (1994). Identification, assessment and treatment of women suffering from post traumatic stress after abortion. *Journal of Family Psychotherapy, 5*(3), 25–54. doi:10.1300/j085V05N03_02
- Baker, Anne, & Beresford, T. (2009). Chapter 5, Informed consent, patient education and counseling. In M. Paul, E. S. Lichtenberg, L. Borgatta, D. A. Grimes, P. G. Stubblefield, & M. D. Creinin (Eds.), *Management of unintended and abnormal pregnancy: Comprehensive abortion care*. Chichester, UK: Wiley-Blackwell.
- Baker, Anne, Beresford, T., Halvorson-Boyd, G., & Garrity, J. M. (1999). Chapter 3, Informed consent, counseling, and patient preparation. In M. Paul, E. S. Lichtenberg, L. Borgatta, D. A. Grimes, & P. G. Stubblefield, (Eds.), *A clinician's guide to medical and surgical abortion*. Philadelphia, PA: Churchill Livingstone.
- Barnard, C.A. (1990). *The long-term psychosocial effects of abortion*. Portsmouth, NH: Institute for Pregnancy Loss.
- Barnard, C.A. (1991). Stress reactions in women related to induced abortion. *Association for Interdisciplinary Research in Values and Social Change Newsletter 3*(4).
- Barnett, W., Freudenberg, N., & Wille, R. (1992). Partnership after induced abortion: a prospective controlled study. *Archives of Sexual Behavior, 2*, 443-455.
- Biggs, M.A., Rowland, B., McCulloch, C.E., Foster, D.G. (2016). Does abortion increase women's risk for post-traumatic stress? Findings from a prospective longitudinal cohort study. Retrieved from <http://bmjopen.bmj.com/content/6/2/e009698.full?sid=b5362408-d3b6-4800-8857-f045635a1ff0>
- Bianchi-Demicelli, F., Perrin, E., Ludicke, F., Bianchi, P.G., Chatton, D., & Campana, A. (2002). Termination of pregnancy and women's sexuality. *Gynecologic and Obstetric Investigation, 53*, 48-53. *BMJ Open 6*, e009698 doi:10.1136/bmjopen-2015-009698
- Bracken, M.B., & Kasi, S. (1975). First and repeat abortions: a study of decision-making and delay. *Journal of Biosocial Science, 7*, 473-491.
- Bradshaw, Z., & Slade, P. (2003). The effects of induced abortion on emotional experiences and relationships: A critical review of the literature. *Clinical Psychology Review, 23*, 929-958.
- Burke, T., & Reardon, D. C. (2002). *Forbidden grief: The unspoken pain of abortion*. Springfield: Acorn Books.
- Broen, A.N., Moum, T., Bødtker, A.S., & Ekeberg, Ø. (2005). The course of mental health after miscarriage and induced abortion: a longitudinal, five-year follow-up study. *BMC Medicine, 3*,18. doi: 10.1186/1741-7015-3-18. Retrieved from <http://www.biomedcentral.com/1741-7015/3/18>
- Chilcoat, H.D., & Breslau, N. (1998). Posttraumatic stress disorder and drug disorder. *Archives of General Psychiatry, 55*, 913-917.
- Cohen, S.A. (2007). Repeat abortion, repeat unintended pregnancy, repeated and misguided government policies. *Guttmacher Policy Review 10*(2). Retrieved from www.gutmacher.org/pubs/gpr/10/2/gpr100208.html
- Coleman, P.K. (2005). Induced abortion and increased risk of substance abuse: A review of the evidence. *Current Women's Health Reviews, 1*, 21-34.
- Coleman, P.K.. (2009). The Psychological Pain of Perinatal Loss and Subsequent Parenting Risks: Could Induced Abortion be more Problematic than Other Forms of Loss? *Current Women's Health Reviews, 5*, 88-99.
- Coleman, P. K., Reardon, D. C., & Cogle, J. (2002). The quality of the caregiving environment and child developmental outcomes associated with maternal history of abortion using the NLSY data. *Journal of*

Child Psychology and Psychiatry and Allied Disciplines, 43, 743-758.

- Coleman, P.K., Rue, V.M., & Spence (2006). Intrapersonal processes and post-abortion relationship challenges: A Review and consolidation of relevant literature. *The Internet Journal of Mental Health* 4,(2). Retrieved from <http://ispub.com/IJMH/4/2/3804>
- Coyle, C.T., Coleman, P.K., Rue, V.M. (2010). Inadequate Preabortion Counseling and Decision Conflict as Predictors of Subsequent Relationship Difficulties and Psychological Stress in Men and Women. *Traumatology*, XX(X), 1-15. doi: 10.1177/1534765609347550
- Curley, M., & Johnston, C. (2013). The characteristics and severity of psychological distress after abortion among university students. *The Journal of Behavioral Health Services & Research* 40(3), 279-293.
- Daugirdaitė, V., van den Akker, O., & Purewal, S. (2015). Posttraumatic stress and posttraumatic stress disorder after termination of pregnancy and reproductive loss: A systematic review. *Journal of Pregnancy*, 2015:646345 doi: 10.1155/2015/646345.
- Dobkin, L.M., Gould, H., Barar, R.E., Ferrari, M., Weiss, E.I., Foster, D.G. (2014). Implementing a Prospective Study of Women Seeking Abortion in the United States: Understanding and Overcoming Barriers to Recruitment *Women's Health Issues* 24(1), e115–e123. Retrieved from www.ansirh.org/sites/default/files/publications/files/dobkin-jan14-implementing_a_prospective_study_of_women_seeking_abortion.pdf
- Dingle, K., Alta, R., Clavarino, A., Najman, J.M., Williams, G.M. (2008). Pregnancy loss and psychiatric disorders in young women: An Australian birth cohort study. *The British Journal of Psychiatry*, 193, 455-460. doi: 10.1192/bjp.bp.108.055079
- Dykes, K., Slade, P., & Haywood, A. (2010). Long term follow-up of emotional experiences after termination of pregnancy: women's views at menopause. *Journal of Reproductive and Infant Psychology*, 1-20. doi:10.1080/02646838.2010.513046 .
- Engelhard, I.M., van den Hout, M.A., Arntz, A. (2001) Posttraumatic stress disorder after pregnancy loss. *General Hospital Psychiatry*, 23, 62-66.
- Fergusson, D.M., Horwood, L.J., & Ridder, E.M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology & Psychiatry* 47, 16-24.
- Freeman, E.W., Rickels, K., & Huggins, G.R. (1980). Emotional distress patterns among women having first or repeat abortions. *Obstetrics and Gynecology*, 55(5), 630–636.
- Fok, W.Y., Siu, S.S.N., & Lau, TK. (2006). Sexual dysfunction after a first trimester induced abortion in a Chinese population. *European Journal of Obstetrics & Gynecology*, 126, 255-258.
- Gissler, M., Hemminiki, E., & Lonnqvist, J. (1996). Suicides after pregnancy in Finland, 1987–94: register linkage study. *British Medical Journal*, 313,1431. doi: <http://dx.doi.org/10.1136/bmj.313.7070.1431>
- Gissler, M., Kauppila, R., Merilainen, J., Toukoma, H., & Hemminki, E. (1997). Pregnancy-associated deaths in Finland 1987-1994--definition problems and benefits of record linkage. *Acta Obstetrica et Gynecologica Scandinavica*, 76(7), 651-657. doi: 10.3109/00016349709024605
- Gutmacher Institute (2014). Fact sheet: Induced Abortion in the United States. New York: Author.
- Harper, S. (2008). *SaveOne: A guide to emotional healing after abortion*. Garden City, NY: Morgan James Publishing.
- Harper, S. (2009). *Survivor*. Garden City, NY: Morgan James Publishing.
- Jacobsen, L.K., Southwick, S.M. & Kosten, T.R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Psychiatry*, 158(8), 1184-1190.

- Jones, R.K., Finer, L.B., & Singh, S., (2010). Characteristics of U.S. abortion patients, 2008, New York: Guttmacher Institute, 2010.
- Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives General Psychiatry*, 52(12), 1048-60.
- Kilpatrick, D. G. (2000). The mental health impact of rape. Retrieved from <https://mainweb-v.musc.edu/vawprevention/research/mentalimpact.shtml>
- Kreek, M.J., & Koob, G.F. (1998). Drug dependence: Stress and dysregulation of brain reward pathways. *Drug and Alcohol Dependence*, 51, 23-47.
- Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R., & Weiss, D.S. (1988). Contractual Report of Findings from the National Vietnam Veterans Readjustment Study, Volume I: Executive Summary, Description of Findings, and Technical Appendices. National Vietnam Veterans Readjustment Study. Retrieved from: www.ptsd.va.gov/professional/articles/article-pdf/nvvrsv_voll.pdf
- Lauzon, P., Roger-Achim, D., Achim, A., & Boyer, R. (2000). Emotional distress among couples involved in first trimester abortions. *Canadian Family Physician*, 46, 2033-2040.
- Major, B., Appelbaum, M. Beckman, L., Dutton, M. A., Russo, N. F., & West., C. (2009). Abortion and mental health: Evaluating the evidence. *American Psychologist*, 64(9), 863-890.
- Marshall, R.D., Olfson, M., Hellman, F., Blanco, C., Guardino, M., Struening, E. (2001). Comorbidity, Impairment, and Suicidality in Subthreshold PTSD. *American Journal of Psychiatry*, 158, 1467-1473. doi: 10.1176/appi.ajp.158.9.1467
- Miller, W.B. (1992). An empirical study of the psychological antecedents and consequences of induced abortion. *Journal of Social Issues*, 48, 67-93.
- Morgan, C.M., Evans, M., Peter, J.R., & Currie, C. (1997). Suicides after pregnancy: mental health may deteriorate as a direct effect of induced abortion. *British Medical Journal*, 314, 902.
- Mufel, N., Speckhard, A. & Sivuha, S. (2002). Predictors of posttraumatic stress disorder following abortion in a former Soviet Union country. *Journal of Prenatal & Perinatal Psych & Health*, 17, 41-61.
- Price, J.L. (2015) Findings from the National Vietnam Veterans' Readjustment Study. *U.S. Department of Veteran Affairs, PTSD: National Center for PTSD*. Retrieved from <http://www.ptsd.va.gov/professional/research-bio/research/vietnam-vets-study.asp>
- Reardon, D.C., & Coleman, P.K. (2006). Relative treatment rates for sleep disorders and sleep disturbances following abortion and childbirth: A prospective record based study. *Sleep* 29(1), 105-106.
- Reardon, D. C., Coleman, P. K., & Cogle, J. (2004) Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study. *American Journal of Drug and Alcohol Abuse*, 26, 369-383.
- Reardon, D.C., & Ney, P. (2000). Abortion and subsequent substance abuse. *American Journal of Drug and Alcohol Abuse*, 26, 61-75.
- Reardon, D.C., Ney, P.G., Scheuren, F.J., Cogle, J.R., Coleman, P.K., Strahan, T. (2002). Deaths associated with pregnancy outcome: A record linkage study of low income women. *Southern Medical Journal*, 95, 834.
- Reardon, D.C., Strahan, T.W., Thorp, Jr. J.M., Shuping, M.W. (2004). Deaths associated with abortion compared to childbirth—a review of new and old data and the medical and legal implications. *Journal of Contemporary Health Law and Policy*, 20(2), 279-327.
- Rocca, C.H., Kimport, K., Gould, H. & Foster, D.G. (2013). Women's emotions one week after receiving or

- being denied an abortion in the United States. *Perspectives on Sexual and Reproductive Health*, 45(3), 122–131, doi: 10.1363/4512213
- Rue, V.M., Coleman, P.K., Rue, J.J. & Reardon, D.C. (2004). Induced abortion and traumatic stress: a preliminary comparison of American and Russian women. *Medical Science Monitor*, 10(10), SR5-16.
- Saxon, A.J., Davis, T.M., Sloan, K.L., McKnight, K.M., McFall, M.E., & Kivlahan, D.R. (2001). Trauma, symptoms of posttraumatic stress disorder, and associated problems among incarcerated veterans. *Psychiatric Services*, 52(7), pp. 959-964. <http://dx.doi.org/10.1176/appi.ps.52.7.959>
- Schnurr, P.P., Lunney, C.A., Sengupta, A., & Waelde, L.C. (2003). A descriptive analysis of PTSD chronicity in Vietnam veterans. *Journal of Traumatic Stress*, 16(6), 545–553. doi: 10.1023/B:JOTS.0000004077.22408.cf
- Sherin, J.E., & Nemeroff, C.B. (2011). Post-traumatic stress disorder: The neurobiological impact of psychological trauma. *Dialogues in Clinical Neuroscience*, 13(3), 263–278. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3182008/>
- Slade, P., Heke, S., Fletcher, J., Stewart, P. (1998). A comparison of medical and surgical termination of pregnancy: choice, emotional impact and satisfaction with care. *British Journal of Obstetrics & Gynaecology*, 105(12), 1288-95. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/9883920>
- Speckhard, A. (1997). Traumatic death in pregnancy: The significance of meaning and attachment. In C.R. Figley, B.E. Bride, and N. Mazza (Eds.), *Death and trauma: The traumatology of grieving* (pp. 67-100). Washington, D.C.: Taylor & Francis.
- Speckhard, A., & Mufel, N. (2003). Universal responses to abortion? Attachment, trauma, and grief responses in women following abortion. *Journal of Prenatal & Perinatal Psychology & Health Volume*, 18e(1), 3-37.
- Speckhard, A.C., & Rue, V.M. (1992). Postabortion syndrome: An emerging public health concern. *Journal of Social Issues*, 48, 3, 95-119.
- Speckhard, A.C., & Rue, V.M. (2012). In C.R. Figley (Ed.), *Encyclopedia of trauma: An interdisciplinary guide* Thousand Oaks, CA: SAGE Publications. doi: <http://dx.doi.org/10.4135/99781452218595>
- Strahl, N.R. (2012). Biological effects of physical and psychological trauma. In C.R. Figley (Ed.), *Encyclopedia of trauma: An interdisciplinary guide*. Thousand Oaks, CA: SAGE Publications. doi: <http://dx.doi.org/10.4135/99781452218595>
- Stein, M.B., Walker, J.R., Hazen, A.L., Forde, D.R. (1997). Full and partial posttraumatic stress disorder: findings from a community survey. *American Journal of Psychiatry*, 154(8), 1114-9.
- Suliman, S., Ericksen, T., Labuschgne, T., de Wit R., Stein, D., Seedat, S. (2007). Comparison of pain, cortisol levels, and psychological distress in women undergoing surgical termination of pregnancy under local anaesthesia versus intravenous sedation. *BMC Psychiatry*, 7(24). doi:10.1186/1471-244X-7-24
- Tishler, C. (1981). Adolescent suicide attempts following elective abortion. *Pediatrics*, 68(5), 670-671.
- Tornboen, M., Ingelhammar, E., Lilja, H., Moller, A., Svanberg, B. Evaluation of stated motives for legal abortion. *Journal of Psychosomatic Obstetrics and Gynecology*, 15, 27-33.
- Urquhart, D.R., & Templeton, A.A. (1991). Psychiatric morbidity and acceptability following medical and surgical methods of induced abortion. *Journal of Obstetrics and Gynaecology*, 98, 396-399.
- Weisaeth, L. (1989). Importance of high response rates in traumatic stress research. *Acta psychiatrica Scandinavica Supplementum*, 355,131–137.

