Posttraumatic Stress Disorder and Trauma
Elective Abortion and Stress Disorders
Self-Study

Contributors
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Recommended Reading

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Additional Reading and Research on Abortion and Mental Health

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Learning Objectives

1. The learner will increase knowledge of stress reactions and disorders after abortion.
2. The learner will describe the incidence, risk, and protective factors among the women who are vulnerable to developing stress and trauma disorders after abortion
3. The learner will recognize barriers to the diagnosis and treatment of PTSS/PTSD after abortion
4. The learner will apply sensitive, compassionate, and appropriate communication techniques to women who have experienced PTSS/PTSD from a recent or past abortion
5. The learner will accurately evaluate, diagnose, and treat women who have experienced PTSD after abortion.

While many women experience relief after aborting an unwanted pregnancy, some find abortion to be a stressful event. Unresolved stress after abortion, like that of any pregnancy loss, has the potential to adversely affect subsequent pregnancies. The incidence of stress disorders after abortion may be larger than previously recognized.1 This module focuses on the subpopulation of women who experience stress disorders after abortion.

"Elective abortion" (EAB) refers to ending unwanted pregnancies due to psychosocial factors such as poor timing, lack of partner support, as well as ending wanted pregnancies due to fetal anomalies or multiple fetal reductions.

Stress after abortion follows a similar trajectory to stress associated with other reproductive events ranging from sub-clinical symptoms, such as post-traumatic stress symptoms (PTSS) to those meeting DSM-5 criteria for PTSD and ASD. This includes acute, delayed, latent, and chronic presentations, which sometimes worsen over time.

The etiology of PTSS/PTSD after abortion remains controversial. Many conclude stress after abortion stems from pre-morbid or co-morbid mental health and not the abortion itself. This suggests that *mental health before abortion predicts mental health after abortion* (Biggs et al 2017; Robinson et al, 2009; Major, et al 2008). Others found trauma stems from the unwanted pregnancy, or associated factors surrounding it, such as having no partner nor financial support for the pregnancy (Mota, 2010; Fergusson, et al 2006). Still others conclude stress can stem from the abortion procedure itself, as well as from a combination of variables (Curley 2014; Coleman, 2011; Mota, 2010; Speckhard and Rue 1993).

Indeed, varied methodological designs have yielded varied results. To date, the evidence remains inconclusive. While resolving this controversy is beyond the scope of this self-study, a brief overview on some of these methodological constraints will be presented. For purposes here, and similar to PTSD associated with other reproductive events, the etiology of stress and trauma disorders after abortion will be considered multifactorial, stemming from any single to a combination of factors.

In an effort to present a balanced perspective, the articles included in this self- study reflect a range of approaches to the literature on PTSS/PTSD after abortion, while focusing on women in need of treatment.

1. Prevalence

Controversy: Politics, stakeholders, and varied evidence result in under recognition, missed diagnoses, and lack of treatment for women who experience distress after abortion.

Prevalence: Estimates range from 12% -30% of significant, persistent stress responses for PTSS/PTSD (Hamana, et al 2013, Bradshaw and Slade 2003). Given that about 25% of women in the US have experienced an induced abortion, and an average estimate of 20% of these report distress that does not remit over time, the learner will appreciate this is a significant population of women.

Compared to postpartum depression (PPD): Low estimate of 12% for stress after abortion vs. average estimate of 15% for PPD shows close prevalence. Yet, there is little recognition for abortion distress.

Highest population at risk: Women <25 yrs have the highest incidence of PTSS/PTSD after EAB due to limited coping skills and unrealistic expectations after abortion.

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Highest population having abortions: Women < 25 yrs have the highest incidence of single and repetitive abortions.

2. Protective Factors

o Adequately informed of psychological risks after abortion

o Adequately screen for risk factors

o The woman has sufficient time for decision making

o The woman has partner support from FOB

o The women makes decision without feeling coerced

o The woman has sufficient resources, support for viable alternatives ie adoption, parenting

o The woman has adequate family, friends or social support

3. Risk Factors

Biological: Pre-morbid and co-occurring mental health/substance abuse disorders, Early Adverse Life Events, history of physical/emotional/sexual abuse; family/genetic vulnerability to mood/anxiety disorders

Psychosocial: Lack of partner/social support, social isolation, secrecy of pregnancy to significant others, feeling forced to abort, conflicted decision to abort,

Demographic Younger age, single status, lack FOB support, lack of education, low SES

Obstetrical: History of prior abortion(s), medical complications of abortion procedure, inadequate pre-abortion/post abortion counselling, later gestational age of pregnancy, viewing embryo/fetus, high- risk pregnancy, unsatisfactory abortion experience

4. Barriers

o Political paradigm: Dominant political paradigm assumes all women feel relief after abortion, contrary to increasing evidence. This limits healthcare providers from recognizing women who feel differently.

o Lack of consensus: Inhibits moving the science forward to develop targeted interventions for women who desire these. This has left an unacceptable gap in services.

o Latent, delayed responses: Can present as no adverse responses

o Secondary substance use: Often masks symptoms of PTSS/PTSD

o Limited history taking: Clinicians often do not conduct a detailed psychiatric assessment after abortion. Thus, the emergence of new or worsening of symptoms within weeks or months after the abortion ie suicidal or self-injurious behavior, development of panic d/o, or increased substance use, can often be missed.

5. Phenomenology

Unresolved past abortion

- Can emerge within obstetrical events, subsequent pregnancies, pregnancy losses, other deaths, or stressful events

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Psychiatric diagnoses associated with abortion

- MDD, Adjustment Disorders, GAD, PTSD, ASD, and Substance Use Disorders.
- Recognizing and treating PTSD after abortion can be effective to resolve distress
- PTSD after abortion has the potential to lead to disrupted attachment to subsequent pregnancies. Recognizing and resolving this can facilitate healthy attachment to babies.

Variants of PTSS/PTSD associated with abortion

- Avoidant symptoms: increased substance use, self-injurious behavior, increased risk for suicide, high-risk sexual behavior, avoid talk of abortion, fears of becoming pregnant, sexual problems, self-destructive tendencies, IPV, abusive relationships, avoiding person, places, reminders of abortion experience
- Intrusive Symptoms: dreams of baby, flashbacks of abortion procedure, images of fetal child at varying ages, intense fear of pregnancy, fear of pelvic exams, intense desire to become pregnant again, need/compulsion for replacement baby
- Symptoms typically emerge 8-12 years after abortion
- Development of panic, anxiety, and depressive disorders several months after abortion
- Survivor guilt, protracted guilt, acting out behavior, promiscuity, low self-worth
- Anniversary reactions ie. Dates of anticipated birth, date of abortion, Mother's Day
- Prolonged grief, absence of grief, complicate grief, traumatic grief, disenfranchised grief
- Mounting of defenses: denial, minimization, repression of significance of abortion
- Amnesia: unable to recall critical facts of abortion such as number of abortions, memory of abortion procedure, significant details of abortion
- Trauma triggers include subsequent pregnancies, abortions, deaths, births, pregnant women, babies, activities around "saving children", difficulty with attachment to subsequent pregnancies

6. Methodological Constraints

Design Limitations

- The inability to randomize inhibits rigorous methodologies to collect data on women who experience stress after abortion
- High attrition rates; Often women who are lost to follow up differ in terms of more distress than those who compete the study
- Participants who have had abortions often withhold reliable abortion data, ie numbers of abortion, gestational age, etc.
- Use of non-equivalent comparison groups, ie comparing women who wanted pregnancies (controls; delivery) with women who have unwanted pregnancies (abortion group, obtained or denied).
- Prospective studies still have serious limitations when studying this population, ie high attrition rates (Biggs et al 207), and classification issues in studies where participants who desire abortion later change their minds in favor of parenting (Biggs et al 2017; Fergusson et al 2006)

7. Treatment

Effective Treatment

- Follows similar principles for other types of perinatal loss, grief, ie. Stages of Grief Kubler-Ross
- Phase-oriented treatment of trauma, ie. Stabilization, processing, integration (Herman, 2000)

Clinical Vignette

Sally is 25 y G2P0 referred by her PCP for psychiatric evaluation. Sally reports a past history of GAD and MDD, Moderate, both of which have worsened over past year. She has been taking escitalopram 20 mg and Alprazolam 0.25mg po prn approximately 1-2 times a day for one year. She works as a nurse and is completing her last year of a Bachelor of Nursing program.

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Sally reports she had an EAB at 6 weeks gestation?), a year ago where her former boyfriend was the FOB, and an SAB about 6 months ago where her husband was the FOB. She required going back to clinic several times due to partial evacuation of fetus. She has been trying to get pregnant without success since her marriage.

After the abortion, she had her obstetrical clinical rotation and found it too distressing to be around pregnant women and babies. She failed the course and decided to take a year off from school. When she sought treatment, she was back in the nursing program, pre-occupied with failing the course, and frequently worried about her ability to be around babies and to pass the course. She often fantasized how old the baby would be, and what it would look like.

After the abortion, she began texting, sexting and meeting men online outside of her marriage. She states she does not know why she does this but feels a compulsion, which gives her initial relief and, and then remorse. She has had difficulty stopping this behavior, and had high guilt, and remorse.. Over past few months she reported experiencing increasingly depressed mood, sadness, high anxiety, frequent worry, difficulty focusing, and felt that medication was no longer effective.

Additionally, she had a strong yearning to become pregnant, having nightmares of babies, and was preoccupied w/ pregnancy. She stated she would frantically take OTC pregnancy tests, sometime 5-6 x, /day right before her menses to see if she was pregnant. Her OB/GYN exam was normal and uneventful post EAB and SAB. Her menstrual cycle is likewise WNL. She has no medical problems, takes no medications other than those stated, and denies any allergies.

What would be the treatment plan for this patient?

- Control symptoms of depression and anxiety with agents which are compatible in the event of pregnancy ie. SSRIs, Wellbutrin, others for anxiety? Stop/taper Alprazolam.
- Educate on risk reduction for high risk, sexual acting out behavior
- Focus on identifying and expressing feelings associated with acting out behavior
- Monitor for safety, increased severity of symptoms, hopelessness for the future
- Evaluate risk for substance abuse, ie. Cannabis, alcohol

What risk factors have made her vulnerable for a stress disorder after abortion?

- Age under 25
- Previous history of MDD and GAD
- Medical complications of EAB procedure

What intrusive symptoms of PTSS/PTSD associated with the abortion does she demonstrate?

- Baby dreams, sense of failure, preoccupation to become pregnant w/ replacement baby, grief, guilt, sadness
- Worsening of depression, anxiety since abortion

What avoidant symptoms associated with the abortion does she demonstrate?

- _Sexual acting out, avoiding pregnant women and babies

Sally frequently states she will never forgive herself for the EAB, has increasing doubts about herself ever becoming pregnant, and feels she is being punished.

What therapeutic approaches would you take for Sally?

- Help Sally understand reasons for deciding to abort, often made in haste, desperation;
- Encourage her to accept decision, even if reasons have changed, or would choose differently
- Assist to develop compassion for herself, self- acceptance, self-soothing techniques
- Instill hope for future; challenge automatic thoughts, such as fears of not becoming pregnant
- Acceptance Therapy, Emotionally Focused Therapy, Interpersonal Therapy w/ focus on role and grief, trauma-focused cognitive-behavioral therapy (CBT), eye movement desensitization and reprocessing (EMDR), and Prolonged Exposure can be effective.

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What are the therapeutic tasks?

- Provide education of grief, PTSD
- Assist with tasks of grieving; ie, Kubler Ross (Denial, Guilt/Anger, Bargaining, Depression, Acceptance)
- Promote finding meaning in the abortion experience
- Facilitate forgiveness of self and others, including from aborted baby
- Encourage patient to come to her own understanding and beliefs about the experience

What strategies would you use to implement phases of trauma treatment?

- Stabilization: Provide education on abortion stress, validate her feelings and experience,
- Processing: When symptoms are stable, encourage narrative of what happened "Tell me what happened" Tell me about your experience" 'What was this like for you? " "What were you expecting" "How was this different from what you expected"
- Use terms that pt uses, ie 'abortion', 'termination', 'fetus', 'baby', 'death', 'passed'
- Integration: Facilitate integrating this experience into the women's life in ways that are meaningful for her.

Take Home Points:

- Some women experience stress and trauma disorders after abortion.
- The ethical principle of beneficence, as well as that of justice (diversity and access to care), oblige healthcare providers to recognize and treat women who experience adverse outcomes to abortion
- Women who experience stress and trauma disorders after abortion have a right to compassionate, comprehensive, and effective healthcare
- Similar to PTSD after other types of reproductive events, the etiology can be multifactorial
- Diagnoses and treatment of PTSS/PTSD after abortion follow similar principles to other types of reproductive loss.
- Recognizing and treating PTSS/PTSD after abortion has the potential to reduce the incidence of repetitive abortions, and improve outcomes of subsequent pregnancies.

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