

2007

## Investigating the effects of an elective abortion on women's mental health

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### Recommended Citation

Schneiderman, Marilyn, "Investigating the effects of an elective abortion on women's mental health" (2007). *Graduate Research Papers*. 1471.  
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### Abstract

The purpose of this research project is to investigate evidence that an elective abortion affects a woman's mental health. Included are literature reviews and studies aimed at gathering information and quantifying these effects. Because this is a highly politicized and controversial topic, it has been difficult to find objective resources. Several areas are addressed: the difference between short vs. long-term effects on a woman's mental health subsequent to an elective abortion, evidence of delayed grief reaction and the link with post-traumatic stress disorder (PTSD). Post-Abortion Stress is defined and specific psychological sequelae are addressed such as grief, depression, anxiety and suicide ideation and attempts. Recommendations are given to help mental health professionals identify predictive risk factors for those considering abortion. Also included are suggestions for helping professionals to be more sensitive and therapeutic to those women experiencing delayed grief reactions to an elective abortion.

Running head: ELECTIVE ABORTION AND WOMEN'S MENTAL HEALTH

INVESTIGATING THE EFFECTS OF AN ELECTIVE ABORTION ON  
WOMEN'S MENTAL HEALTH

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A Research Paper

Presented to

The Department of Educational Leadership, Counseling,

And Postsecondary Education

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In Partial Fulfillment

Of the Requirement for the Degree

Masters of Arts – Mental Health Counseling

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by

Marilyn Schneiderman

June 2007

This Research paper by: Marilyn Schneiderman

Entitled: INVESTIGATING THE EFFECTS OF AN ELECTIVE ABORTION ON  
WOMEN'S MENTAL HEALTH

Has been approved as meeting the research paper requirement for the Degree of Master  
Of Arts – Mental Health Counseling

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6/15/07  
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8/20/07  
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### Abstract

The purpose of this research project is to investigate evidence that an elective abortion affects a woman's mental health. Included are literature reviews and studies aimed at gathering information and quantifying these effects. Because this is a highly politicized and controversial topic, it has been difficult to find objective resources. Several areas are addressed: the difference between short vs. long-term effects on a woman's mental health subsequent to an elective abortion, evidence of delayed grief reaction and the link with posttraumatic stress disorder (PTSD). Post-Abortion Stress is defined and specific psychological sequelae are addressed such as grief, depression, anxiety and suicide ideation and attempts. Recommendations are given to help mental health professionals identify predictive risk factors for those considering abortion. Also included are suggestions for helping professionals to be more sensitive and therapeutic to those women experiencing delayed grief reactions to an elective abortion.

## Abortion and Mental Health 1

## Investigating the Effects of an Elective Abortion on Women's Mental Health

When playing the electronic game of "Tetris," various shapes fall down the screen.

The longer the player engages, the faster the shapes fall. The object is to anticipate where the falling shapes will fit into the mix of those that have already been positioned so as to interlock at the bottom of the screen. Playing Tetris can parallel to a woman facing an unintended or unwanted pregnancy. Finances, relationships, career goals, health care, and others' expectations are some of the falling pieces she has to navigate. She must decide how or if they will all fit around her unintended pregnancy.

Many women with these overwhelming pressures have chosen induced abortion. An estimated 1.29 million abortions are performed each year in the U.S. (Alan Guttmacher Institute, 2002), which makes it one of the most frequently performed surgical procedures (Rosenfeld, 1992). It is becoming clearer that an elective abortion may serve a dual role, as both coping mechanism and stressor (Speckhard & Rue, 1992).

The intent of this research is not to judge the morality of those decisions, but to investigate through a literature review if and how that choice and procedure affected women's mental health. Therefore, the physical risks are not discussed. The psychological implications will be examined for the benefit of assisting mental health professionals in their work with clients. Topics addressed include short and long term effects on mental health, evidence of relief or increased feelings of well-being, depression, grief and resolution, anxiety, PTSD parallels and correlations with subsequent suicide. The scope of this paper will not include the volume of research citing correlations with substance abuse.

The evidence remains controversial for mental health professionals. Although there are researchers who hold that a majority of women do not suffer psychologically from an induced abortion, “virtually all scholars acknowledge that a minority of women do experience adverse (sometimes extreme) psychological effects” (Coleman & Nelson, 1998, p. 426). Available data suggest that within the first couple of years after an abortion 10% of women report severe negative psychological consequences (Zolse & Blacker, 1992).

Ten percent of over a million women annually is a significant number of women who are impacted by selected pregnancy termination. Taking into account relationships involved, (partner, parents and other relatives and friends) the number of people that might be affected by this decision rises dramatically. Many abortions are probably not disclosed for fear of judgment or rejection by others. However, relationships are affected by the stress produced in the lives of those holding that secret inside themselves (Speckhard & Rue, 1992). “Whether or not one believes that a woman should have a legal right to an abortion, all mental health professionals should agree that achieving full understanding of the relationship of abortion to women’s mental health is a worthwhile goal” (Russo, & Dabul, 1997, p. 23). Pursuing that understanding can be very difficult because of many obstacles to sort through.

#### Obstacles to objective analysis

Reviewing the literature on this topic was complicated by biases on both poles of the abortion issue. Emotionally-charged rhetoric lies in both camps. Wright and Cummings (2005) challenged the American Psychological Association’s recent “politically motivated stances” on several issues, including elective abortion. They warned of

dangers that have discouraged valid scientific inquiry because it might lead to results that are viewed as politically incorrect. Their views are hard to dismiss by the mental health field, since both Wright and Cummings have been lifelong liberal activists involved in leadership roles within the APA. Miller (1992) adds that research on the psychological aspects of induced abortion have not kept up with work done in other areas of reproductive research, citing the growing politicization of the entire subject as one of the main blockages to conducting scientific and observational research.

Another obstacle encountered in doing an objective analysis appeared as skewed availability of full-text journal articles. It was much easier to find full-text articles for the pro-choice positions. Often, the only place to find pro-life research was out of the United States, sometimes in other languages. Even some of the research conducted inside the U.S. (Reardon, 2002 & Cogle, 2003), was only cited in British or Canadian journals, suggesting a bias in the U.S. possibly due to political stigmas and polarization around this topic. There may also be a shortage of scientific research.

Methodological shortcomings and insufficient sample size are other obstacles cited (Speckhard & Rue, 1992). They analyzed 76 studies and charted 20 different shortcomings, such as interviewer bias in 43% of the studies, no or low instrument reliability in 50%, and incomplete data in 46%. A vast majority (91%) had a limited sample size,  $n =$  less than 384.

### Post-Abortion Stress Defined

Post-Abortion Stress (PAS), also referred to as post-abortion stress syndrome (PASS) is defined by Freed and Salazar (1993) as “an unhealthy emotional reaction experienced by some women after their abortions” (p.4). The onset of this condition varies from



immediately following the procedure to many years later. The cause of PAS is attributed to a woman's inability to express and process her feelings about an unintended pregnancy and abortion. This unresolved loss results in unhealthy coping mechanisms, which may not be immediately recognized, but may surface at a later time, interfering with a woman's peace of mind and ability to function normally.

#### Link to Post-Traumatic Stress Disorder

In Bankole and Rue's article on post-abortion counseling (1998), they proposed diagnostic criteria for post-abortion syndrome (PAS) as a type of post-traumatic stress disorder (PTSD). The trauma exposure cited was "when the abortion event was perceived as the death of one's child and the individual experienced feelings of fear, helplessness, horror and impacted grief" (p. 25). Criteria included re-experiencing of the abortion trauma through intrusive thoughts, flashbacks and recurrent dreams; avoidance or emotional numbing associated with detachment and social withdrawal; two or more associated features such as irritability, sleep disturbances, hypervigilance, eating disorders and secondary substance abuse.

Bagarozzi's clinical research (1994) described a sample of 18 women who sought marital/sex therapy. He noted all eighteen women shared symptoms common to individuals suffering from post traumatic stress disorders. After detailed assessment, it was evident that abortion was the single traumatic life event shared by these women.

Bagarozzi (1994) noted what was striking from these individuals was their complete denial that undergoing an abortion was a traumatic experience for them. He viewed this denial as a major contributing factor to development of PTSD. "Understanding the dynamics of unconscious denial and other key intrapsychic defenses ...is crucial to the

successful treatment of these women and their relationships with their husbands/partners, men in general and significant others in their lives” (p. 26). He further emphasized that it is important to understand that some clients, even when questioned directly during intake interviews about past abortions, intentionally deny having had an abortion. Others might share their abortion history, but unconsciously deny its impact. Thus, it is imperative for the therapist to be alert for cues of what he termed “delayed stress reaction.” Bagarozzi cited a list of symptoms that could signal possible delayed stress reaction: flashbacks of the surgical procedure, nightmares of being trapped and unable to help others who are suffering, the sudden onset of sadomasochistic interactions or accident proneness where the client receives pain or punishment to alleviate unconscious feelings of guilt, sexual dysfunctions with no physiological basis, uncharacteristic emotional outburst or episodes of rage, the sudden onset of psychosomatic symptoms and impacted grief reactions.

In a recent comparative study, retrospective data were collected from 331 Russian and 217 American women who had experienced one or more abortions, but no other pregnancy losses (Rue, Coleman, Rue & Reardon, 2004). “The primary purpose of the study was to examine whether or not abortion was perceived as traumatic, and if so, whether or not its manifestations were equivalent to PTSD symptoms in both American and Russian women” p. SR6. They discovered that a significant number of the post-abortive American women, 14.3%, met the full diagnostic criteria for posttraumatic stress disorder while 65% (American) experienced multiple symptoms of increased arousal, re-experiencing and avoidance associated with PTSD. Interestingly enough, the corresponding figures were less for Russian women who also reported less childhood

traumatic experiences than the Americans. The researchers concluded that earlier experience of trauma increased the likelihood for post-abortive PTSD.

Data were collected in 1994 at U.S. and Russian public and private hospitals and clinics. All women between the ages of 18 and 40 were surveyed until 992 women with at least one pregnancy loss had been identified. Then the sample was narrowed to only those women who had one or more induced abortions and no miscarriages, stillbirths or adoptions (n=548). In order to avoid using pathology-oriented subjects, mental health facilities were purposefully excluded as data collection sites. At the time of the abortion experience, the mean age of the Russian women was 22.11 and for the American women, 23.07.

Data gathering instruments included the Institute for Pregnancy Loss Questionnaire (IPLQ) and the Traumatic Stress Institute's (TSI) Belief Scale administered in health care facilities. In the U.S., each subject completed a written questionnaire. In Russia, a staff physician interviewed each subject and completed the questionnaire on her behalf to minimize cross-cultural misinterpretations of question wording.

The study found that abortion can increase stress and decrease coping abilities. These effects were particularly noted in women who had a history of adverse childhood events and prior traumata.

Limitations were using non-standardized measurements and comparing data collected from two very different instruments, one written and one verbal. The Russian women interviewed face to face, and perhaps by male physicians, could be less likely to be fully honest in their responses due to the personal nature of the subject.

## Evidence of PAS in Women

### *Psychiatric Admissions*

There is much debate about whether abortion or childbirth is associated with greater psychological risks. Reardon, Cogle, Rue, Shuping, Coleman and Ney (2003) compared psychiatric admission rates of low-income women in timed intervals from 90 days to 4 years after either an abortion or childbirth. They found that overall, for every time period, women who experienced an abortion had a significantly higher relative risk of psychiatric admission when compared with women who had delivered.

They eliminated from the study all women who had inpatient psychiatric treatment during the year before the childbirth or abortion. Their final population was  $n = 56,741$  using records from California's Department of Health Services of women who had received funding for either an abortion or delivery in 1989. All women whose first known pregnancy ended in abortion were selected as the case population ( $n = 15,299$ ). The control group consisted of those women whose pregnancy ended in childbirth and who had no known subsequent abortions ( $n = 41,442$ ). Only first-time admissions were examined within the 4 years after the 1989 pregnancy date. The mean age of the women who delivered was 25.5. For those who had an abortion, it was 24.8.

Overall, 434 women were admitted at least once for inpatient psychiatric care within the four years after their first known abortion or delivery. Women who had experienced an abortion were 2.6 times more likely to be admitted for psychiatric treatment during the first 90 days than the women who had live births.

Reardon's et al (2003) conclusion was that psychiatric admissions were more prevalent among low-income women who had an induced abortion than among those

who carried to term in all time intervals from 90 days to 4 years. A noted strength of this study is the large comprehensive sample size. Limits of this study were lack of access to complete medical and psychiatric histories prior to the one year before the study.

Differences in these prior histories may have influenced results. Research that accessed complete medical histories would be helpful.

#### *A Comparison of Abortion with Deliveries*

The same sample of 249,625 women who had received funding for either an abortion or delivery in 1989 under the government medical insurance program for low-income individuals was also studied over four years to compare outpatient mental health claims for state-funded abortions versus deliveries (Coleman, Reardon, Rue & Cogle, 2002). Again, using California's state records, their study found an overall 17% higher rate of care for the abortion group (n= 14,297) in comparison with those who gave birth (n= 40,122) during the 4-years after the event. The researchers controlled for preexisting psychological difficulties, age, months of eligibility and number of pregnancies. Within 90 days after the pregnancy termination, the abortion group had 63% more insurance claims than the birth group with decreasing percentages of 42% at 180 days, 30% at 1 year and 16% at two years. All time periods showed a higher percentage of mental health insurance claims for the abortion group.

#### *A Comparison of Abortion with Miscarriage*

A recent longitudinal study conducted in Norway compared the course of mental health after miscarriage and after induced abortion (Broen, Moum, Bodtger & Ekeberg, 2005). Both of these life events can cause mental distress. The researchers' objective was to determine if there were differences in patterns of normalization after these two

pregnancy termination events. All 120 subjects were interviewed face-to-face by a female psychiatrist at the main hospital in Norway at four time intervals after the pregnancy termination: 10 days (T1), six months (T2), two years (T3), and five years (T4). The women's mental health before the pregnancy termination was evaluated through self-report and diagnostic measures by the interviewer. Forty of the 120 women experienced miscarriage and 80 had experienced induced abortions. Several questionnaires were used: Impact of Event Scale (IES), Quality of Life, Hospital Anxiety and Depression Scale (HADS), and another addressing their feelings about their pregnancy termination.

Women who had miscarried had more mental distress at 10 days and six months after the pregnancy termination than those who had undergone abortion. But, they also showed significantly quicker improvement on their IES scores for avoidance, grief, loss, guilt and anger throughout the observation period. However, those women who experienced induced abortion had significantly greater IES scores for avoidance and for the feelings of guilt, shame and relief than the miscarried group at two and five years after the pregnancy termination. From this study, one could conclude that women who miscarry may experience more grief shortly after their pregnancy termination and those who choose abortion experience more relief. However, the emotional response can significantly change over five years, indicating a delayed grief reaction. It would be interesting to continue the study after ten and twenty years to see if this trend continued.

#### *Short-Term Grief*

Almost 50% of U.S. pregnancies are unintended and half of these end in abortion, (Henshaw, 1998 as cited in Williams, 2001). There is a shortage of research regarding

grief response following induced abortion. Williams conducted a descriptive study which compared 93 women. Forty three had a history of elective abortion within the past 1-14 months and 48 never had an abortion. None of the participants reported any documented psychiatric history and no perinatal losses with the past 5 years.

Williams noted an overall trend toward higher grief intensities in the abortion group. Other factors seemed to contribute to differences such as presence of living children, pressure from others to have the abortion and the number of abortions experienced. Williams suggested women who have had abortions need to have their grief acknowledged after an elective abortion, given time to grieve and have their sense of loss validated. She concluded, "Remember that the ability to grieve a perceived loss following elective abortion is essential for promotion of coping and prevention of possible depressive reactions" (p. 182). If counselors minimize or avoid discussing the trauma experienced by some women, they may further intensify the negative result leaving women to feel "abandoned by their counselors and isolated from other women experiencing similar difficulties" (Speckhard & Rue, 1992, p. 96). Grief may also appear years later (Joy, 1985). "I have found that women respond very favorably to counseling that uses a grief resolution format" p. 375.

#### *Long-Term Effects Studied*

Retrospective satisfaction was discussed in a case study by Avalos (1999) who interviewed four women. Avalos reported that some women reflecting on their past abortion decision felt it was the right decision to make. However, there were also those who felt varying degrees of pain, grief and loss, viewing their abortions as mistakes. Avalos observed that often the perception and interpretation of the abortion experience

changed over time in response to the individual's development and varying life circumstances. It appeared that the most satisfied group consisted of women still involved with the partner with whom they became pregnant.

In another study, it was noted that younger women and those who had more children before their abortion were more likely to view their abortion negatively (Major, Cozzarelli, Cooper, Zubek, Richards, Wilhite, & Gramzow, 2000). Their study conducted assessments 1 hour before the abortion, and intervals after the abortion of 1 hour, 1 month and 2 years. They measured preabortion and postabortion depression and self-esteem, postabortion emotions, decision satisfaction, perceived harm and benefit, and posttraumatic stress disorder. Their attrition rate was 50% at the 2 year mark when they concluded that 72% of the 50% remaining in the study were satisfied with their decision, and that 80% (of the 50%) were not depressed. However, negative emotions increased and decision satisfaction decreased over time. This begs the question, would dissatisfaction continue to increase after 5, 10 and 15 years? The high (50%) attrition rate skews the data. What happened with the other 50%? Again, more research is needed to address this.

Warren Miller (1992) used data collected as part of a longitudinal study of 967 women living in the San Francisco Bay area during the mid-1970's to develop a model of the psychological antecedents of abortion and related theoretical models of the long-term psychological consequences of abortion. Miller's project, called the Psychology of Reproduction (POR) Study, began in 1972 and gathered data from 967 women distinguishing three subsamples: never-married women, just-married women with no children and married women who had just borne their first child. Ages ranged from 18-



27 and were stratified for each subsample. Mean age for the entire sample was 22.6 years. Although much of Miller's emphasis was on the psychological antecedents to reproductive behaviors, much effort was also devoted to exploring the psychological consequences of reproductive decisions and events.

Data was collected from a nonclinical, probability sample, prospective in design. Interviews were conducted at four points in time: an initial interview and then each year for 3 years on the anniversary of the initial interview. Interviews gathered information about psychological and behavioral domains. An unusually high retention rate was maintained of 99% throughout the three follow-up intervals, which is why this dated study is included here. During the three one-year intervals, there were 487 conceptions. Of these, 371 resulted in a birth, 65 were terminated by induced abortion and 51 ended in a spontaneous abortion or miscarriage.

The women were asked how they felt during the first couple weeks after the abortion. Twenty-two (44%) reported they felt only relief, 19 (38%) indicated their relief was mixed with distress, and 9 (18%) felt distress only. Miller concluded that when a woman was ambivalent about her decision, she was more prone to regret that decision. Sources of ambivalence were her own childbearing desires or coercion by her partner to have the abortion. In addition, social norms and social support were also predictors of late post-abortion emotional upset. It was noted that the women who were in a strong relationship with their partner and capable of making an independent decision were less prone to late post-abortion upset.

Russo and Dubul (1997) cited Congleton and Calhoun's findings (1993) which found women who described themselves as having post-abortion distress were more likely to be

more religious and associated with conservative churches in comparison with women who did not report post-abortion distress. Their sample consisted of 1,189 Black and 3,147 White women. They concluded that “the major predictor of a woman’s well-being after an abortion, regardless of race or religion, is level of well-being before becoming pregnant (p. 28).”

Miller concluded that much of the “scattered research” (p. 91) that deals with psychosocial consequences of an abortion, focuses on very short-term effects and may have little bearing on longer term post abortion regret. Miller encourages the need for longer term research to be conducted.

### *Grief*

Although “relief” is often experienced immediately after an abortion, counselors need to be aware of the possibility of a delayed grief reaction in a small but significant percentage of women (Joy, 1985). Joy found that “a significant number of women are requesting counseling for a depression problem found to be an expression of an unresolved grief issue over a prior abortion” p. 375. For some, the grief intensified as the due date approached. For others, the grief appeared years later, perhaps connected with the discovery of infertility or other life event. Often these women had difficulty dealing with their feelings of anger and guilt. Just expressing these feelings in a safe counseling environment proved beneficial. Some researchers concluded that risks of both subsequent preterm delivery and depression should be included in the informed consent before an induced abortion (Thorp, Hartmann, & Shadigian, 2002).

Joy (1985) noted that guilt frequently manifested in anger turned inward, resulting in

depression as a form of self-punishment. It appeared helpful in counseling to explore the rationale and rehearse the situation that contributed to an elective abortion decision. She cited other interventions that have been helpful for assisting women in grieving and processing their loss: 1) explore the psychological meaning of the loss to the client, what it represented to her, 2) give her a safe place to express strong feelings such as anger and resentment toward those who pressured her into this decision and towards herself, 3) the “what if” fantasy, where the client is encouraged to imagine her situation had she not terminated the pregnancy. The reality of her present situation can then be compared with the fantasized situation, allowing her to re-evaluate her choice, re-experience any ambivalence that was present and express her feelings in a supportive environment.

4) In those cases where the woman feels she had murdered the fetus and was full of regret, Joy recommended using the Gestalt technique, “empty chair” to “talk” to the fetus, expressing feelings of sorrow and asking forgiveness. This is followed by the client speaking for the fetus, offering understanding, compassion and forgiveness. It appears asking for and receiving forgiveness is a critical part of grief and guilt resolution. The client can then say her good-byes after she has grieved her loss.

For some cases, the client may be stuck in self-directed anger and unable to offer or receive forgiveness. When this occurs, it was recommended that the “empty chair” exercise be used again to continue to explore the payoff for the client’s continual self-punishment, helping her identify when she will be satisfied that she has suffered enough. Then, explore with her more useful ways to redirect her energies toward resolving her internal conflict (Joy, 1985).

Post-abortion grief is often unrecognized and untreated. Therefore those affected by PAG find themselves unsupported and alone (Layer, Roberts, Wild, Walter, 2004). This lack of recognition conveys to the woman that her PAG is unjustifiable, which over time perpetuates her silence and delays her mourning (Freed & Salazar-Phillips, 1993; Speckhard & Rue, 1993). Unexpressed grief can lead to avoidance-type behaviors such as isolation, avoiding contact with babies and pregnant women or avoiding the topic of abortion in conversation. This can lead to what has been earlier discussed as a delayed grief reaction.

Layer et al (2004) interviewed 35 women involved in a spiritually based PAS support group, ages 18-65. The participants were referred to the group by social service agencies, a clinician, churches, pregnancy centers, friends or media. A pretest and posttest design was used to measure changes in shame and other symptoms related to PTSD. Data analysis revealed a dramatic reduction in shame and posttraumatic stress in the participants studied. They measured intrusion, avoidance and hyperarousal. No significant change was noted in intrusive thoughts. However, the avoidance and hyperarousal subscales showed significant improvement at the .001 level.

Through interviews, qualitative data was collected using open-ended questions such as “What thoughts or feelings had you experienced before joining the group as it related to your abortion?” (p. 348). Responses to this question surfaced four themes: 46% stated they experienced fear, depression and/or isolation following their abortion. 40% recorded feelings of guilt and shame and 25% reported made comments that could be attributed to denial following their abortion. Lastly, self-loathing and self-destructive-

ness were reported by 25% of the women. Also, participants noted a heightened sense of moodiness and depression just prior to the start of the group. A prominent benefit reported was women experiencing forgiveness and reconciliation. “This occurred in relationship to others involved in the abortion decision, toward themselves, and with God following completion of this spiritually based group intervention” (p. 348).

Some of the limitations of this study were small sample size, lack of biopsychosocial information and lack of a control group. In summary, improvement in well-being was achieved, lessening shame and PTSD symptoms for women experiencing PAG. Clinicians were encouraged to consider screening and referrals for clients with PAG, noting most are offered free or at nominal fees.

### Anxiety

When compared to women who deliver an unintended pregnancy, women who abort their unintended pregnancies are more likely to experience subsequent problems with anxiety (Cogle, Reardon, & Coleman, 2005). The study used data collected from the National Survey of Family Growth from a sample of 10, 847 women aged 15-34 who had experienced an unintended first pregnancy with no prior history of anxiety. Researchers found that compared to the group who carried to term, those who aborted were 30% more likely to subsequently report symptoms associated with generalized anxiety disorder. Women under the age of 20 exhibited even greater differences in rates of GAD than those carrying to term.

Since abortions are often unreported, the results may underestimate the prevalence of GAD as a post-abortive reaction. The researchers concluded that their study suggests that therapists who are treating women for GAD may find it helpful to inquire about their

client's reproductive histories. "Women struggling with unresolved issues related to a past abortion may benefit significantly from counseling that addresses this problem," (Cogle et al, 2005, p.139). The researchers referred to nearly a dozen other studies published in the last three years linking abortion to increased risk of depression, substance abuse, suicidal behavior, and death from heart disease. Legislation has been introduced in Congress to increase funding for research and treatment programs in this area due to the increasing concern about the mental health effects of abortion on women (Cogle et al 2005).

The above findings conflict with those advocating that carrying an unintended pregnancy to term is more emotionally harmful to women than abortion. Russo and Zierk (1992) contend that "there is no clear, independent association between a woman's abortion history and her feelings of well-being and self-esteem" p. 269. Their sample included 5,295 of women ages 22-30 who completed the Rosenberg Self-Esteem Scale assessment in 1987. The mean score for women who had had an abortion (33.3) was almost identical to the overall mean. The mean among women with one abortion (33.6) showed little difference from those women with no abortions (33.2). However, they did report that women with repeat abortions were "more likely to say that they had nothing to be proud of and to wish that they had more self-respect" (p. 269). They concluded that health professionals assisting women distressed after resolving an unwanted pregnancy should explore stressors and low self-esteem that may have existed prior to their pregnancy (Russo & Zierk, 1992).

But what about the hard cases of rape and incest? Did anxiety lessen after an abortion? Testimonies were collected over a nine year period from 192 women who

became pregnant as a result from sexual assault (rape) or incest (Reardon, Makimma, & Sobie., 2000). Of the 56 who chose an elective abortion, one reported no regrets, 49 reported regrets, and 6 did not state how they felt about their abortion. Some of those who carried their unintended pregnancy to term shared how their feelings toward their baby changed during the initially unwanted pregnancy and the rewards they felt in subsequent years for making that choice.

### Suicide Linkage

A Finnish study conducted between 1987-94, used nationwide data to determine rates of suicide associated with pregnancy by the type of pregnancy (Gissler, Hemminki, & Lonnqvist, 1996). Overall, 15% of all deaths in women were suicide during this time period. The suicide rate after an abortion was three times the general suicide rate and six times that associated with birth.

A longer Finnish study, 1987-2000, used three national health registers to obtain information on deaths from external causes (n=5299) for women aged 15-49 years, linking them to pregnancy-associated deaths (n=212) (Gissler, Berg, Bouvier-Colle & Buekens, 2005). An increased risk was observed for women after abortions, especially those in the 15-24 year age group. The strength of this study is the use of national records that include data on all induced abortions performed in Finland. Mortality rates of the group studied were compared with a matched group of non-pregnant women of reproductive age. The mortality rates and risk ratios were age-adjusted using the age distribution for all pregnant women.

Of the 212 observed pregnancy-associated deaths, 8 occurred during pregnancy, 81 after a birth (34.4%), 39 after a spontaneous abortion or ectopic pregnancy and 92

after an induced abortion (43.4%). Eighty four percent of the deaths occurred between 43 days to a year after the pregnancy termination. The proportion of accidental deaths was the highest among women who had a recent induced abortion (72.5%) or a spontaneous abortion (60.6%). This contrasts to pregnant women or women with a recent childbirth (37.5%) and among non-pregnant women (33.5%) (Gissler et al, 2005). These researchers concluded that elevated mortality risks after a terminated pregnancy should be recognized when providing health and social services. They also recommended that a check-up visit be done after an induced abortion to detect signs of depression and in rare cases psychosis.

Of 81 women studied who were in post-abortion support groups, 54% reported having suicidal thought, suicidal behaviors or dysphoria for which they sought treatment prior to abortion. Nineteen percent of the women reported suicide attempts before their abortion and 16.1% post-abortion. Women with multiple abortions had the highest rate of suicide attempts, 25%, which increased to 50% post-abortion (Franco, Tamburrino, Campbell, Pentz & Jurs, 1989). (More information cited in the next section.)

### Predictive Factors

It would be helpful for counselors and health professionals to be aware of predictive factors that could increase vulnerability to negative effects for some women following an elective abortion. Based on an extensive review of pertinent literature, Speckhard and Rue (1992) specified several such variables that increased risks for post-abortion psychological problems including: second-trimester abortions, having prior children or prior abortions, more pronounced maternal orientation, coercion felt by others to abort, prior emotional problems, pre-existing unresolved traumatization, biased pre-abortion



counseling, abortion occurring during adolescence, decision ambivalence and a perceived lack of support. In addition, women who have an abortion for medical or genetic reasons are more susceptible to developing depressive symptoms (Rosenfeld, 1992).

Women who have had multiple abortions and held conflicting social values also reported an increase in post-abortive psychological difficulties (Franco, Tamburrino, Campbell, Pentz, Jurs, 1989). This came from a study of 81 surveys that were returned out of 150 women participating in patient-led support groups for women who identified themselves as having struggles after an abortion experience. At the time of their abortions, 78% of the women were single, between 15 and 25 years old. Ambivalence about their abortion was reported by 47 (66%), and more than one-third felt coerced into their decision. Although this study did not use random sampling, the results can help counselors be more aware of predictive risk factors for some women.

Freed and Salazaar (1993) stated that all that is necessary for a woman to develop PAS (post-abortion stress) symptoms is for her not to process her emotions and grieve her loss. The connection with grieving the loss and resolution was cited by thirty women who agreed to be telephone-interviewed (about 45 min.) by a female psychiatrist for the purpose of learning about stress following abortion (Speckhard, 1987). The intent of this research was to learn about how abortion functions as a stressor. So, only women identified by clinicians and other subjects as having a stressful abortion experience were interviewed. The research design was exploratory and descriptive. Sixty-two percent were between the ages of 14-25 years old at the time of their abortion. The elapsed time period between the abortion and the interview was 5-10 years for most (64%). Fifty percent had abortions in their first trimester; 46% during the second trimester. (The time

lapse between the abortion and the interview was 5-10 years for 64% of these women who agreed to talk about their abortion experience.) Many expressed relief in having someone willing to listen in a non-judgmental way to their story, some sharing their experience for the first time. Seventy-three percent reported a decreased ability to express emotions, described as numbness, inability to feel, or shut-down.

All the subjects reported having one or more grief symptoms which occurred immediately or long after the abortion event. Other symptoms that they reported and related to their abortion were substance abuse addiction (50%), increase drug use (58%) and increase in alcohol use (61%). They further identified experiencing feelings of depression (92%), hopelessness (69%), and helplessness (69%). Nightmares were experienced by 54% and flashbacks related to the abortion experience.

A limit of this study was the small sample size. It also could be said that the results could not be generalized to every woman experiencing an abortion, since only those who self-reported as struggling with their abortion were interviewed. However, the researcher gave valuable information for mental health professionals to be aware of to help validate and normalize grief reactions of their post-abortive clients.

### Conclusion

Facing an unintended pregnancy is a stressful life event. It appears that often women who choose abortion to resolve this crisis experience immediate relief. The pressure lifts and they get on with their lives. However, a significant number of women, roughly estimated at 7-10%, develop psychological difficulties: primarily anxiety, depression, avoidance type behaviors, suicide ideations and attempts, and symptoms that suggest post-traumatic stress. This estimated percentage is likely to be a very conservative

figure, given the reluctance of many women to participate in studies that require disclosure and self-exploration of this highly personal and sensitive subject. Abortion is often a subject to avoid and/or deny. This secrecy contributes to the development of post-abortion stress and further isolates women from the help they need to resolve their grief. Due to delayed grief reaction, it would be helpful to see research designed that would address the long-term effects on mental health, such as ten or more years after an elective abortion. More research and investigation is needed to help assist those women.

Mental health professionals can be helpful in preventing future harm by learning to identify predictive factors in clients who are more vulnerable to increase risks for psychological pathology. They could then offer alternatives to pregnancy termination or referrals to those agencies and professionals who have experience in dealing with crisis pregnancies. For women seeking therapy after an abortion decision, sensitivity and support from professionals in helping them process their grief and the situational stressors they experienced could help avert clients from developing more serious psychological difficulties. Counselors need to be alert for the significant percentage of these women who experience delayed grief reaction. In addition, they could provide referrals for local support groups to encourage women in their healing process and grief resolution.

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