

Post Abortion Syndrome



The Silent Suffering

Post Abortion Syndrome

Unrecognised; Untreated;

The incidence of severe psychological trauma unknown

Fig 1. Total Deaths

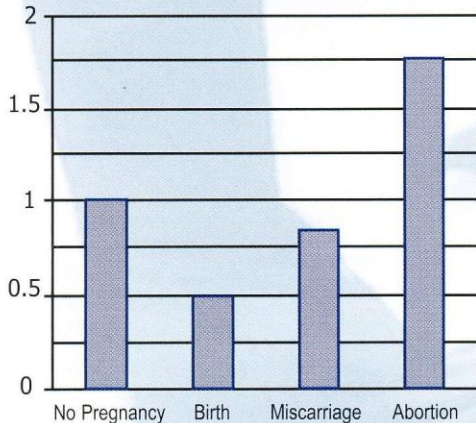


Fig 2. Deaths by Suicide

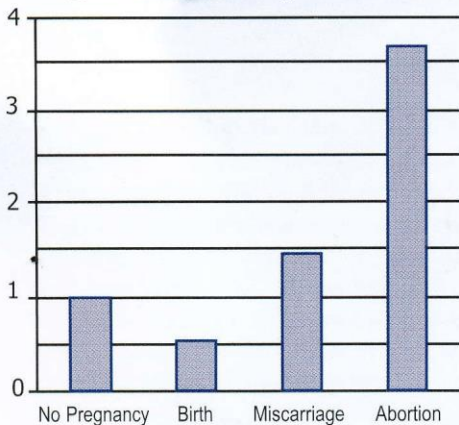


Fig. 1,2,3,4 & 5 represent the findings by ratio, of researchers who examined the death certificates of all Finish women who died within twelve months of either delivering, aborting or miscarrying, aged 15 to 49 years, between 1987 and 1994¹.

Melbourne psychiatrist Dr Eric Seal, who defined post abortion syndrome as 'a delayed or slow developing, prolonged and sometimes chronic grief syndrome...' stated: 'The post-abortion syndrome is not like a more severe form of postnatal blues. It is far more serious, more delayed in onset, more lasting and more fundamentally involved in subsequent personality development ...' He also said that 'If the syndrome persists and is not treated adequately, personality changes will gradually emerge and affect one's family life, one's working capacity, and one's social and recreational potentials to say the least.'²

Post Abortion Syndrome (PAS) is at present understood to be a type of post-traumatic stress disorder. Its outward manifestations such as, alcohol and drug abuse, suicidal behaviours, eating disorders, sexual dysfunction, replacement pregnancies, postnatal depression, domestic violence, anxiety attacks, compulsive disorders, marriage/relationship and/or family breakdown, child neglect and/or abuse, depression, emotional breakdowns and other mental health problems are increasingly evident in our communities today.

However, research on abortion trauma has been inadequate, and numerous unscientific opinion papers have only served to confuse. At present health professionals are not being trained to diagnose, treat or prevent abortion trauma, and are generally reluctant to investigate when problems arise subsequent to an abortion, offering at best, symptomatic treatment (or worse, further traumatizing and isolating the sufferer). Therapists who are concerned about abortion trauma, not unreasonably fear being professionally attacked or isolated (particularly from those with a "personal investment" in the safety of abortion) if they speak publicly or professionally of their concerns. Consequently, most women and men traumatised by abortion, have no access to the professional help they need.

In recent decades, there has been remarkable growth in understanding the importance of respecting and facilitating the grief of parents who have experienced stillbirth, miscarriage or who have given up a baby for adoption.

For many women abortion, like miscarriage and stillbirth, can also be a death experience.

The woman who aborts may develop PAS, not simply because of the death of the foetus but because the reality of her responsibility or part responsibility for that death has not allowed her to process that death as one would normally process a death loss.

Fig 3. Deaths by Accident

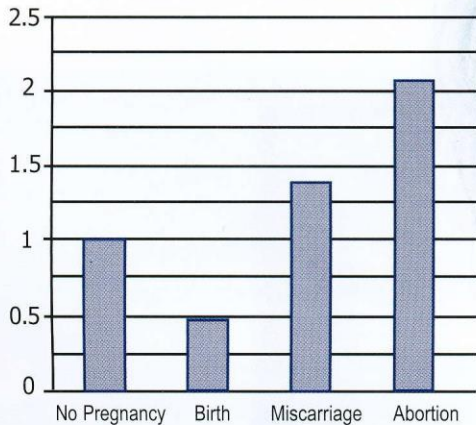


Fig 4. Deaths by Homicide

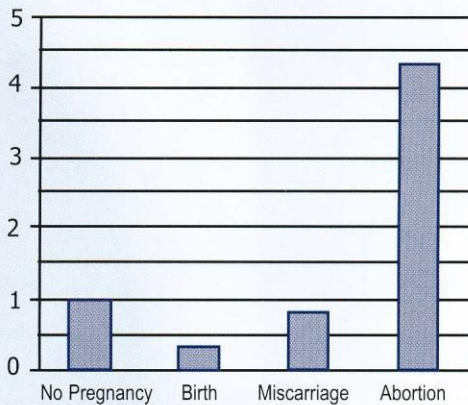
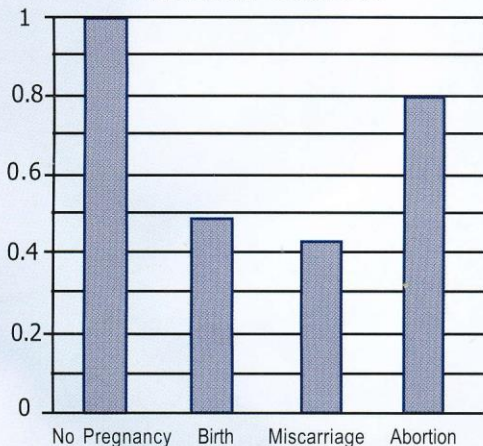


Fig 5. Deaths from Natural Causes



This unprocessed grief is complicated by the fact that abortion is not a socially recognised loss. The woman who aborts has no social support in which to gradually process the pain she has experienced. There has been no formal leave-taking such as a funeral where the woman can share her loss and grief with friends and loved ones. If she does share what she did with a loved one, she is likely to experience rejection, disapproval, humiliation, anger, and/or harsh judgement.

Abortion decisions are often made in a state of crisis. Fears of rejection, feeling unable to cope, panic, confusion and a loss of confidence in self. A greater dependence on others at this time of crisis, make women vulnerable to being pressured into unwanted abortions by husbands, boyfriends, family, and even health care providers. Many women have abortions still in a state of indecision, trusting in the judgement of health professionals, or have found themselves powerless to stop or 'get off' the abortion process. Some are so overwhelmed with a sense of responsibility for loved ones that they are, what is termed 'disconnected from self'.

The very nature of women and their expected roles can make many women vulnerable to being pressured into aborting for the convenience of others.

No matter what the stage of foetal gestation, the PAS-prone woman believes at some level that what is destroyed in the abortion is an unborn baby. But rather than making the decision consistent with her real feelings and convictions, she moves into 'denial'. In this she was probably assisted by those significant others to whom she turned to for help and by health personnel associated with the provision of abortion, who are usually skilled at depersonalizing the abortion experience because they are trained to, because they usually believe what they are doing is right, and because it is their job. And the woman in her crisis wants or hopes this depersonalization will work.

The cardinal features of PAS are **denial and suppression**. Typically the abortion is followed (but not always) by years of unrecognised negative reactions, the woman not consciously associating the problems she is experiencing with the abortion.

Denial is a psychological protective mechanism that usually works well for some years, but sooner or later, many women can no longer handle the internal stress and become increasingly emotionally disabled. Professor Philip Ney, a researcher and therapist of international standing states, "...they are usually

It is a fallacy to assume that abortions are only done for unwanted babies. Frequently, it is not the baby that is unwanted, but the problems surrounding the pregnancy that are unwanted. In fact, abortion can often involve a very much wanted baby.

able to keep up a facade, but easily decompensate with serious physical or psychiatric illnesses in times of crisis."

The woman may appear well adjusted and unaffected, but may experience trauma on the anniversary of the abortion date, or the expected date of the birth. These anniversary reactions may not start until many years after the abortion. Some women may even experience monthly 'anniversary' reactions.

The onset of delayed symptoms is often precipitated by a triggering event, such as:

- an anniversary date (abortion date/due date of birth)
- the death of a loved one
- failure to conceive
- a subsequent birth of a "wanted" child, although not always the first subsequent birth
- the loss of another child
- miscarriage
- birth of a niece/nephew, grandchild or friend's child
- the onset of menopause
- the deterioration or break-up of a relationship
- some other event associated with children or reproduction.
- one of life's crises

Symptoms of PAS can include:

- **Frequent weeping:** crying may continue for years, sometimes lasting for hours or days at a time.
- **Depression and a sense of loss:** while post abortion blues generally fade within a few months, prolonged deep depression is not uncommon, sometimes becoming unmanageable.
- **Loss of self-esteem:** damage to a woman's self-confidence and self-respect is even worse when these traits are already weak.
- **Difficulty concentrating**
- **Extreme or chronic anger or rage**
- **Dramatic personality changes, values disorientation**
- **Grief and anxiety:** although the abortion may have occurred 10 or 20 years previously, the grief can be as profound, intense and as real as if it was yesterday.
- **Feelings of guilt:** innate, and often very intense.
- **A sense of hopelessness**

"When I woke [after the abortion] I knew I'd done something terrible" ...

The first few years after the abortion were fine, with no real physical or psychological problems at all, other than the immediate reaction. "Then when I had my first baby I went into shock. It suddenly hit me that this was a baby." [Alice] describes the years between her first baby and the abortion counselling:

"I had panic attacks and five years of really bad illness and thinking I would die ... I went to the doctor every month and although the abortion was on my records he didn't see it was the cause." Alice did not realise the cause either, and just thought she was ill. It was her mother who eventually suggested the illness and attacks might be due to the abortion...

"In the last few years I've had counselling (for the abortion), which finished about two years ago and since then, for the first time, I've lived a normal life."

1994 UK Parliamentary Report by the Commission of Inquiry into the Operation and Consequences of The Abortion Act.

- **Self-destructive behaviour** (sometimes described as feelings of 'self-hatred'): suicidal thoughts and attempts; alcohol and/or drug abuse; abusive relationships; eating disorders; unnecessary risk taking; repeat abortions and or on the job burn-out (workaholism).
- **Feelings of sadness and remorse**
- **Sleep disorders and nightmares:** 'These nightmares generally deal with images of aborted fetuses and themes of death and judgement. Because of the disturbing nature of some of these nightmares, women may resort to drastic measures to reduce their recurrence, by drugging themselves to sleep with drugs or alcohol, or by finding casual sexual partners to keep them company throughout the night'³
- **Anxiety attacks**
- **Sexual dysfunction:** loss of pleasure from intercourse; painful intercourse; frigidity; sexual coldness; an aversion to sex and/or males in general; confused sexual identity; and/or the development of a careless sexual lifestyle.
- **Relationship problems:** inability to function properly with partner, family, friends or colleagues at work; a string of unsuccessful relationships; inability to bond with, overprotective of, or withdrawn from subsequent children.
- **Increased tendency towards violence**
- **Inability to communicate; Irritability**
- **Flashbacks:** 'Flashbacks can be as short as a millisecond recall of a traumatic scene, or as long as a two-day psychotic episode in which the woman believes she is re-living her pregnancy and abortion experience. ...Flashbacks of the abortion trauma may be experienced as a visual or auditory memory with or without the attendant emotional experience, and/or physical sensations being recalled. Frequently, the PAS woman is able to partition or split off her emotional responses to the abortion memories which are devoid of emotional content. However, the repression of emotion is usually not strong enough for the flashbacks not to cause feelings of anxiety.'⁴

Some women will go to great lengths to avoid stimuli that will trigger painful flashbacks. Common triggers include the sound of a vacuum, re-entering a hospital, seeing or hearing anything related to pregnancy or abortion, giving birth, being again in the position taken during the suction procedure, experiencing vaginal penetration and/or cervical stimulation of any sort or being pregnant again.
- **Emotional numbness, withdrawal behaviour or inappropriate emotional responses**
- **Compulsive behaviours:** will often function as outlets for accumulated anxieties. Typical compulsive behaviours utilized by post abortive women include anorexia, bulimia, workaholism, compulsive washing, and sexual hyper-activity.⁵
- **Feelings of isolation, alienation and victimisation**
- **An atonement child / repeat abortion:** an attempt at self therapy, a deliberate pregnancy (consciously or sub-consciously) trying to "make up" for the aborted baby, or the re-enactment' of the traumatic incident in an attempt to overcome or understand it. Nationally the repeat abortion rate is 39%, however, for teenagers it is 18% (one in five); for the under 25's it is 39% (two in five) and for the under 30's it is 52% (over half).⁶
- **Anniversary reactions:** around the time of the abortion date and/or the due date of the birth, which may not start until many years post event, and can include major depression, anxiety, headaches, abdominal pain, eating irregularities, sleeping difficulties, abusing children, gastro-intestinal symptoms or complaints relating to the reproductive system.
- **Impaired efficiency in all walks of life**
- **Memory loss**
- **Intense interest in or aversion to babies/Negative and jealous feelings:** projected towards pregnant women and mothers of newborn babies.

The severity and incidence of PAS is often related to how well "affirmed" a woman is, eg. women from an emotionally unstable or dysfunctional background are much more likely to suffer severe psychological and emotional trauma. While researchers may differ as to the incidence of abortion trauma, there is remarkable consensus about which women are most at risk.

These include the young⁷, the traumatised, those isolated or dispossessed, those whose coping mechanisms have already been compromised, the sexually abused, those with developmental or psychological limitations, the mentally ill⁸ and those who abort for health reasons. Rather than screening these vulnerable women out of the abortion solution or even warning them, their preexisting emotional state or impaired decision-making ability when in crisis, is being used to explain their poor abortion outcome. Dr Vincent Rue calls this a new type of victim blaming⁹.

The political environment that has resisted the recognition of PAS has historical parallels.

By the mid-1890's, Sigmund Freud, had identified and presented his findings of the trauma of child sexual abuse. However, it was an unsustainable diagnosis in the political climate of the times, and within a year Freud, recoiling from its implications, withdrew his findings and began exploring the possibility that stories of sexual abuse were invented by the victim as part of her 'erotic fantasies' (blame-the-victim strategy). It took the feminist movement of the 1970's before sexual abuse and its impact could be seriously explored in the 1980's.

The recognition of Post-traumatic stress disorder (PTSD) also evolved because a political movement (the anti-war movement of the Vietnam era) created a social and political environment that nurtured the victim, and supported serious exploration of their trauma. Before the recognition of these traumas, the PTSD sufferer and the sexual abuse victim tended to be blamed for their own affliction. Those who advocated for these people, were also viewed with suspicion.

In neither the trauma of sexual abuse or PTSD was the medical profession implicated as it is with PAS.

In 1992, the British Journal of Psychiatry published a review of over 70 studies, which found that psychological or psychiatric disturbances occur in association with abortion and seem marked, severe or persistent in approximately 10% of cases¹⁰

Henry David's record link of 1.1 million Danish women, one of the best methodologically designed studies of the early 80's, found women who aborted were 53% more likely than delivering women to be admitted to a psychiatric hospital. Women who aborted were **more than twice** as likely as women in general to be admitted to a psychiatric hospital. But women who aborted, and who were separated, divorced or widowed were nearly **four times** as likely as those (in the same category) who delivered to be admitted to a psychiatric hospital.

Unfortunately, David limited his study to only three months post event, and did not identify how many of those delivering women admitted to a psychiatric hospital had abortion histories. (A subsequent delivery is one of the common triggering events for the onset of PAS).

Admission to Psychiatric Hospital (Rates per 10,000)		
Total no	All groups	Women divorced/ separated/widowed
All women 1,169,819	7.5	
Delivering 71,378	12	16.9
Aborting 27,234	18.4	63.8

(David's findings were opposite to the much publicized, much quoted but inherently flawed¹⁹ Brewer²⁰ study which found abortion psychologically safer than childbirth)

'I went to the doctor when I was seventeen years old and said, look, "I had an abortion two years ago and I'm really depressed about it. What can I do?" And he just said "Oh don't worry about it. There is no reason to feel guilty". And that went on until I was 22 years old.

I went to see a psychiatrist; I was in hospital for two weeks with severe depression after the birth of my second child, and no one seemed to care less. They just wanted to brush it under the carpet.

In the end it was the pastor from the church who was the only one willing to say, "well yes - you have a right to feel guilty". Not that he put me down, but - I didn't want people telling me that I didn't have to feel guilty, because I knew I was. I did feel guilty, and being able to admit my guilt and face it was the turning point, I think. That was three years ago and it's been better since then. I can honestly say in the last year that I've coped a lot better than I've ever coped.'

A transcript of Philip Satchell's talkback program on Adelaide radio station 5AN from 3.30 to 4.00pm, 26th February 1988.

Australia's annual abortion rate is around 90,000. We can therefore expect, each year a further nine thousand women exposed to serious psychological problems who will have no access to the professional help they need, because health practitioners are politically bound not to recognize their trauma.

Given the serious limitations of many of the studies to date (short term and or superficial questionnaires) and their frequent interpreter bias coupled with the tendency of PAS to be labelled by its presenting symptoms, 10% undoubtably underestimates the true picture.

There is a growing tendency among some researchers now to evaluate abortion outcomes through well designed record based studies, in areas where abortion trauma is known to present. These record based studies are now linking induced abortion to increased rates of psychiatric illness^{11,12}, substance abuse¹³, and premature death in the categories of suicide¹⁴, accident, homicide and natural causes¹⁵, with evidence the higher death rate associated with abortion continues on for at least eight years¹⁶.

Of alarming concern is a 1990 study¹⁷ published by the Institute for Abortion Recovery & Research in Portsmouth NH, which found, of the 80 women it surveyed, three to five years after the abortion event, 18% meet the full criteria for post-traumatic stress disorder.

Dr Patricia Casey, Professor of Psychiatry, Dublin, advises those working in this area to use models of treatment used in treating other forms of bereavement and major trauma¹⁸. Dr Joanne Angelo, Assistant Clinical Professor of Psychiatry Boston, advises that the overwhelming needs of the PAS sufferer may be more than one discipline can or should try to meet, and suggests a multifaceted team approach²¹. However, a great deal more work urgently needs to be done in this area.

* **It is important to note** that abortion referral agencies and institutions, because of their role in facilitating denial and dehumanising the unborn, have a conflict of interest, and are inappropriate venues for abortion grief therapy.

*'Abortion is such a profound event in one's life, that one must either thoughtfully integrate it into one's life, or fearfully suppress it. Neither is easy. The former requires great fortitude and honesty. The latter is simply unhealthy. It is a fundamental principle of psychiatry that suppression of emotions is the cause of numerous psychological and physical ailments. Suppressed feelings create their own internal pressures, sap emotional energy, and cause turmoil in one's life until it bursts forth in a way which can no longer be ignored.'*²²

Abortion Grief Australia

ABN 23 590 559 243

PO BOX 426

Melville WA 6956

Administration +61 404 448 532

National Helpline 1300 139 313

Email info@abortiongrief.asn.au

In a political climate not conducive to a balanced investigation of the after effects of abortion, AGCA has been in a unique position to gain insights into abortion trauma, pregnancy crisis issues and how the health community is responding to the needs of these people.

Since 1990, AGCA has run a national crisis line which for the last six years has been listed in the 24 hour emergency section of the 'White Pages' in most Australian states. A significant number of our calls are from health and welfare professionals, unable to access information on abortion trauma through their own peer sources.

We are acutely aware of the need to educate health care and welfare providers and the broader community of the special needs of pregnant women in crisis and the far reaching ramifications of abortion trauma.

A Tax Deductible Charity

1. Gisler, M., et al., *Acta Obstetrica et Gynecologica Scandinavica* 76:651-657 1997. The graphs are taken from *The Post-Abortion Review*, Vol 8, No 2, Elliot Institute, www.afterabortion.org
2. Transcript from "Post Abortion Syndrome Seminar" Melbourne 1988.
3. Wanda Franz, Ph.D., Submission to 'The Medical and Psychological Impact of Abortion' US Congress, House of Representatives, Human Resources and Intergovernment Relations Subcommittee, Committee on Government Operations 101st Congress, First Session, 16th March 1989.
4. Wanda Franz, Ph.D., Submission as previously cited.
5. Wanda Franz, Ph.D., Submission as previously cited.
6. Pregnancy Outcome In South Australia 2002 / Pregnancy Outcome Unit Epidemiology Branch, Department of Human Services. Adelaide, November 2003.
7. Campbell, Franco & Jurs (1988). "Abortion in Adolescence" *Adolescence*, 23 (92), 813-823.
8. Ney P. A Wickett (1989). "Mental Health and Abortion." *Psychiatric Journal of the University of Ottawa*, Vol. 14, No. 4, 506-516.
9. Rue V "The Psychological Realities of Induced Abortion." *Post-Abortion Aftermath* (A collection of writings generated by various experts at a "Post-Abortion Summit Conference" Washington DC, Sept. 1993) Edited by M. Mannion, published by Sheed & Ward. p5-43.
10. Zolse G & C Blacker (1992) "The Psychological Complications of Therapeutic Abortion" *British Journal of Psychiatry*, 160, p742-74
11. Reardon et. al., 'Psychiatric admission of low-income women following abortion and childbirth' Canadian Medical Association Journal 168(10):May 13, 2003.
12. Coleman et. al., 'State-funded abortions versus deliveries: A comparison of outpatient mental health claims over four years,' *American Journal of Orthopsychiatry* 72(1): 141-152, 2002.
13. Coleman et. al., 'A history of induced abortion in relation to substance use during subsequent pregnancies carried to term' *American Journal of Obstetrics and Gynaecology* 187(6) 1673-1678 Dec 2002.
14. Gissler M., et al., "Suicides after pregnancy in Finland, 1987 - 94: register linkage study" *British Medical Journal*; Dec 1996; Vol. 313:1431 - 34.
15. Gisler, M., et al., *Acta Obstetrica et Gynecologica Scandinavica* 76:651-657 (1997).
16. Reardon et al., 'Pregnancy outcomes Associated with deaths: a record linkage study of low income women' *Southern Medical Journal* 2002: 95(8):834-841
17. Barnard, 1990 *The Long Term Psychosocial Effects of Abortion* (Institute for Abortion Recovery & Research Portsmouth, NH) .984 women were randomly selected for follow-back from their abortion. 60% gave wrong phone numbers at the abortion clinic, so the sample obtained was 80 aborted women. Three to five years post event, 18% of the sample met the full diagnostic criteria for Post-Traumatic Stress Disorder and 46% displayed high-stress reactions to their abortions.
18. Casey P "Treatment of Post-Abortion Syndrome" *Post-Abortion Syndrome* Edited by Dr Peter Doherty, published by Four Courts Press (1994) p73-81.
19. In 1994, the UK Parliamentary Commission of Inquiry into the effects of abortion
20. Brewer, "Incidence of post-abortion psychosis: A Prospective study," *British Medical Journal*, 1:467-477 (1977).
21. Angelo EJ "The Negative Impact on Women and Families" *Post Abortion Aftermath*.
22. *The Post-Abortion Review*. 'Women Who Abort: Their Reflections on the Unborn'. Vol. 4, No. 1, p4. Elliot Institute, www.afterabortion.org