Broadening Perspectives Around Termination of Pregnancy

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P.A.T.H.S.
CHARITABLE TRUST

Focus

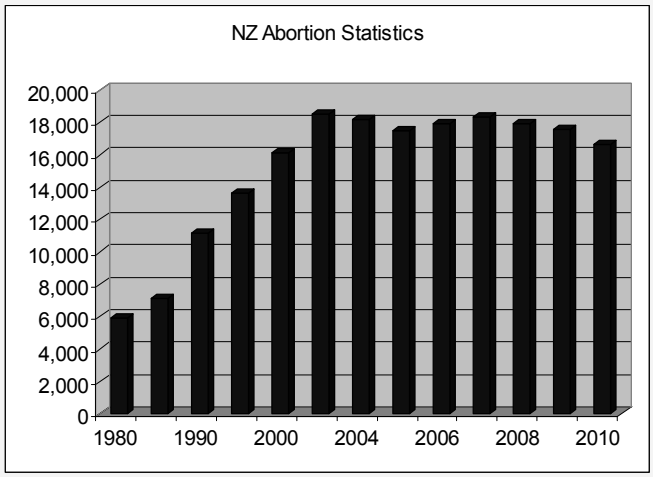
- Context of abortion in NZ
- Factors affecting clinician / health practitioners attitudes/approach
- Influences and pressures in client's decision-making around pregnancy and abortion (These factors also inhibit disclosure afterwards)
- Subjective experience of abortion
- Research in this area is limited, fraught, conflicting
- Questions are raised.
- Recommendations are made to enhance clinical practice.
- A call is made for further research.

(Gnad, 2012)

NZ ABORTION NUMBERS

(Gnad, 2012)

(Statistics NZ)



Year	Numbers
1980	5,945
1985	7,130
1990	11,173
1995	13,652
2000	16,103
2003	18,504
2004	18,210
2005	17,531
2006	17,930
2007	18,380
2008	17,940
2009	17,550
2010	16,630

Number of abortions by age of women

Year	11 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 & over
2010	84	3,389	5,150	3,411	2,242	1,649	655	50
2010	0.50%	20.40%	31%	20.50%	13.50%	9.90%	3.90%	0.30%

Number of previous abortions

	None		One		Two or More	
Year	Number	Percent	Number	Percent	Number	Percent
2010	10,223	61.5	4,427	25.6	1,980	11.9

Number of previous children

Year	None		One		Two or More	
	Number	Percent	Number	Percent	Number	Percent
2010	7,785	46.8	3,419	20.6	5,426	32.6

Duration of pregnancy (weeks)

Year	Under 8	8	9	10	11	12	13	14 & over
2010	2,168	3,836	3,316	2,601	1,993	1,346	470	882
2010	13%	23.10%	19.90%	15.60%	12%	8.20%	2.80%	5.30%

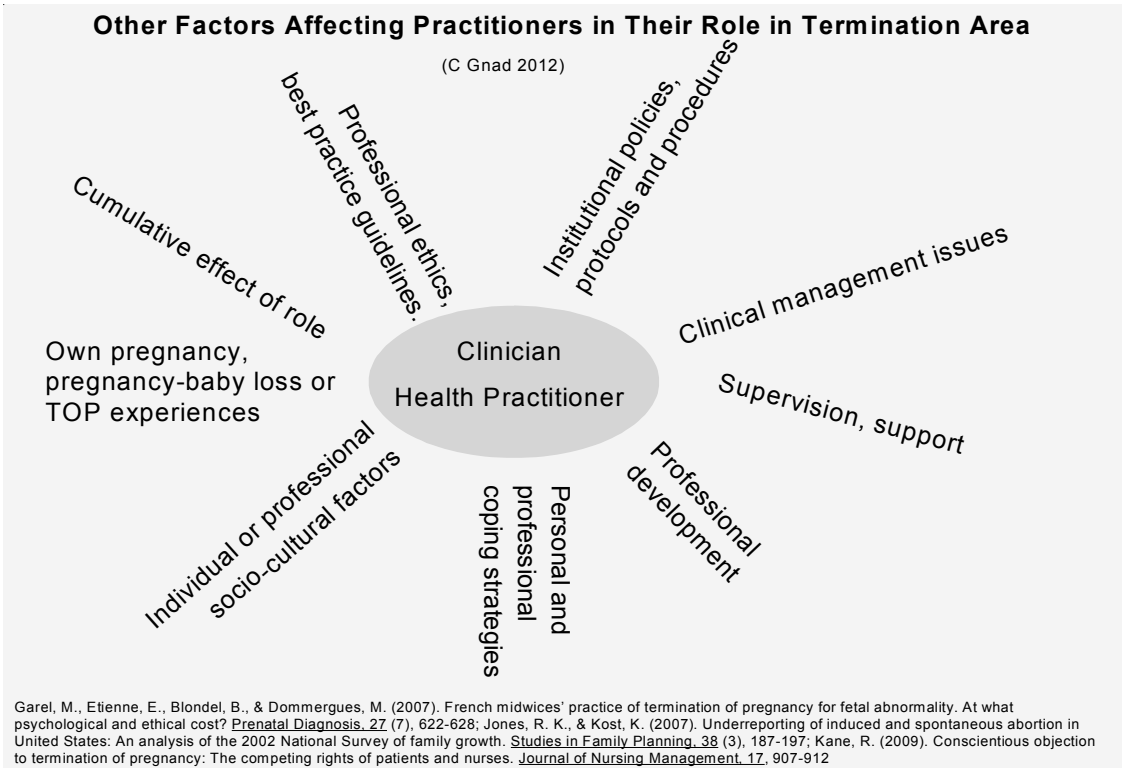
(Gnad, 2012)

http://www.abortion.gen.nz/information/statistics.html

Statistics for 2011 are not yet available, but in the year 2010

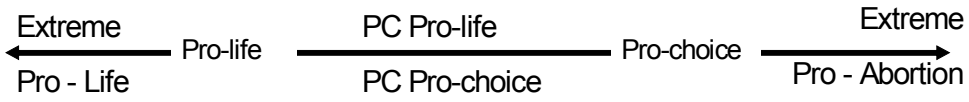
- Women aged 20–24 years had the highest abortion rate - median age of women having an abortion was 24
- Around a third of abortions are repeat abortions – where women have had one or more prior abortions
- 46.8% had no previous children, 20.6% had one previous child and 32.6% had two or more previous children
- Most terminations occurred in the first trimester and the highest number around 8 weeks gestation.
  Some 882 occurred over 14 weeks

  Surgical terminations i.e. suction curettage has been the preferred method of abortion until more recently with the introduction of EMA which are offer between 6-9 weeks. Later terminations are performed using foeticide and chemical induction, which requires a mother to birth a stillborn babe.



Garel, M., Etienne, E., Blondel, B., & Dommergues, M. (2007). French midwices' practice of termination of pregnancy for fetal abnormality. At what psychological and ethical cost? Prenatal Diagnosis, 27 (7), 622-628; Jones, R. K., & Kost, K. (2007). Underreporting of induced and spontaneous abortion in United States: An analysis of the 2002 National Survey of family growth. Studies in Family Planning, 38 (3), 187-197; Kane, R. (2009). Conscientious objection to termination of pregnancy: The competing rights of patients and nurses. Journal of Nursing Management, 17, 907-912

Continuum of Views and Beliefs



- What is my personal position?
- How has my own frame of reference developed?
- How am I fixed or open to be informed in different ways?
- How open and accepting am I of others in a different position?
- How do my views and beliefs affect my attitude and approach in my relationship with my patient, and their decision-making?

(Gnad, 2012)

Perceptions contributing to abortion-mindedness

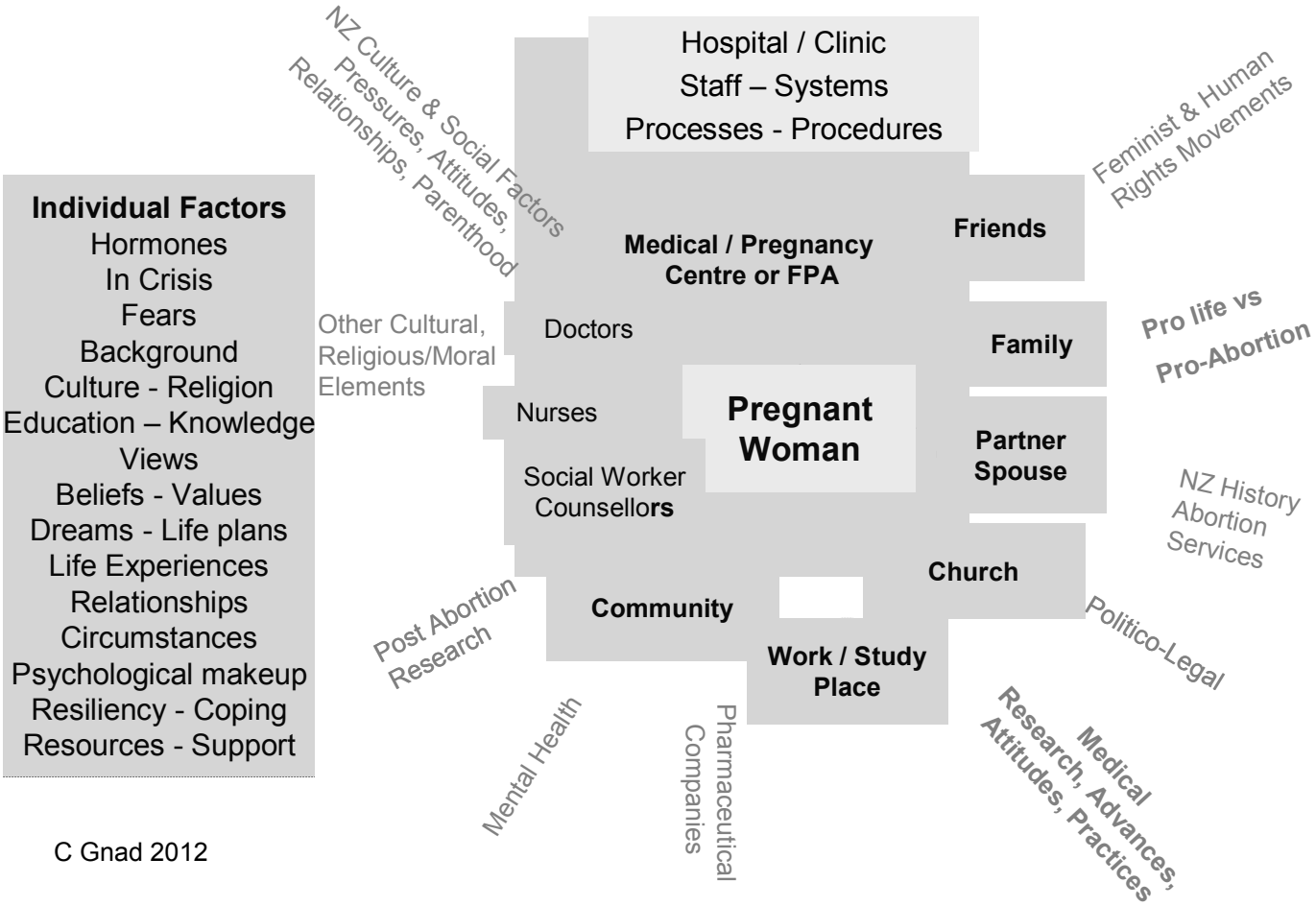
(Gnad, 2012)

- Abortion will make me "unpregnant"
- Abortion is a simple surgical procedure that will fix "the problem"
- There are no significant problems after an abortion
- It's a nothing

Abortion is not a unitary event, rather it "encompasses a diversity of experiences, and women vary significantly in how they react to this life event. Understanding the personal, social, and cultural sources of this variability is important if we are to fully appreciate how abortion affects women's mental health. Understanding the mental health implications of abortion also requires that we compare psychological responses associated with abortion with psychological responses *associated with its real alternatives*—other courses of action that might be taken by a pregnant woman in similar circumstances (i.e., facing an unwanted pregnancy). Failing to do so sets up a false comparison and ignores the reality of women's lives—once a woman is faced with an unwanted pregnancy, or one she feels financially, emotionally, or physically unable to cope with, she has few options." (Or s*he may feel or think she has few options*!)

Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., West, C.. (2009) Abortion and Mental Health: Evaluating the Evidence, American Psychologist December 2009, 863-890

Web of Influence Abortion / TOP – *Limited awareness by all parties of influences*



C Gnad 2012

FACTORS PREDICTING NEGATIVE ABORTION REACTIONS

Identifying High Risk Abortion Patients, **Dr D Reardon, Post Abortion Review Fall 1993**

Conflicts about the decision – emotional, social, moral

- Ambivalence / unresolved doubts
- Pressure or coercion
- Biased, inaccurate or inadequate information
- Lack of support to explore consequences of different options

Psychological or developmental limitations

- Adolescents / minors
- Prior emotional / mental health problems
- Inadequate network of social support
- Prior abortions

(Gnad, 2012)

Risk Factors for Psychological Reactions

APA Taskforce Report on Mental Health and Abortion (2008)

- perceptions of stigma
- need for secrecy
- low or anticipated social support for the abortion decision
- a prior history of mental health problems
- personality factors such as low self-esteem
- use of avoidance and denial coping strategies
- characteristics of the particular pregnancy, including the extent to which the woman wanted and felt committed to it…..

Many of these same factors also predict negative psychological reactions to other types of stressful life events, including childbirth, and, hence, are not uniquely predictive of psychological responses following abortion.

(Gnad 2012)

Dr Julius Fogel (1989) psychiatrist obstetrician who personally performed over 20,000 abortions observed:

Every woman, whatever her age background or sexuality has a trauma at destroying a pregnancy. A level of humanness is touched.

This is a part of her own life. When she destroys a pregnancy, she is destroying herself. There is no way it can be innocuous…

Often the trauma may sink into the unconscious and never surface in the woman's lifetime.

A psychological price is paid. It may be alienation; it may be pushing away from human warmth, perhaps a hardening of the maternal instinct.

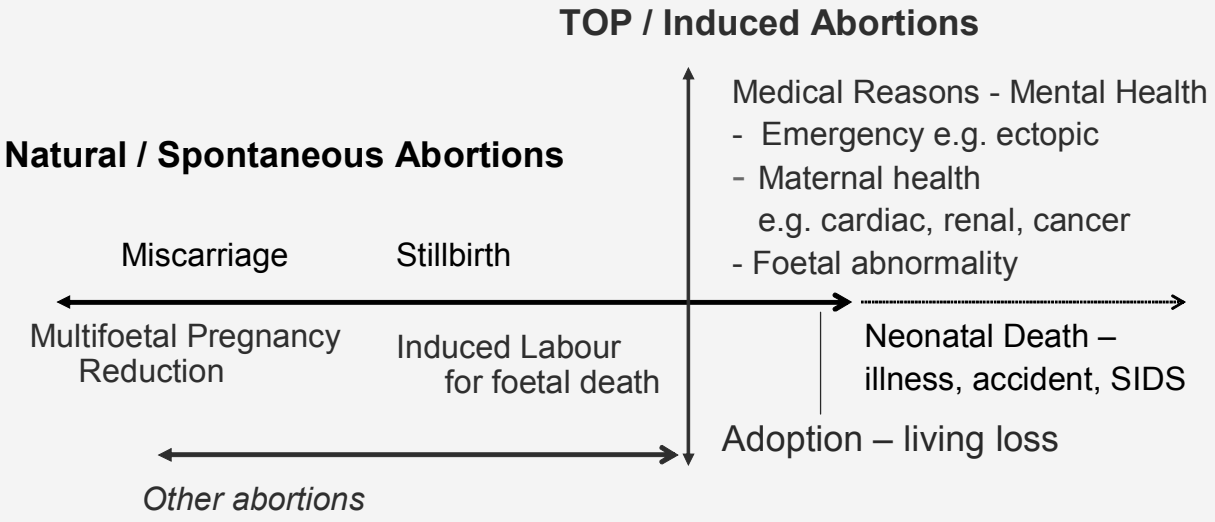
Something happens on the deeper levels of a woman's consciousness when she destroys a pregnancy. I know that as a psychiatrist.

(Coleman McCarthy "The Real Anguish of Abortions," The Washington Post, Feb. 5, 1989 – Interview with Dr Julius Fogel)

(Gnad, 2012)

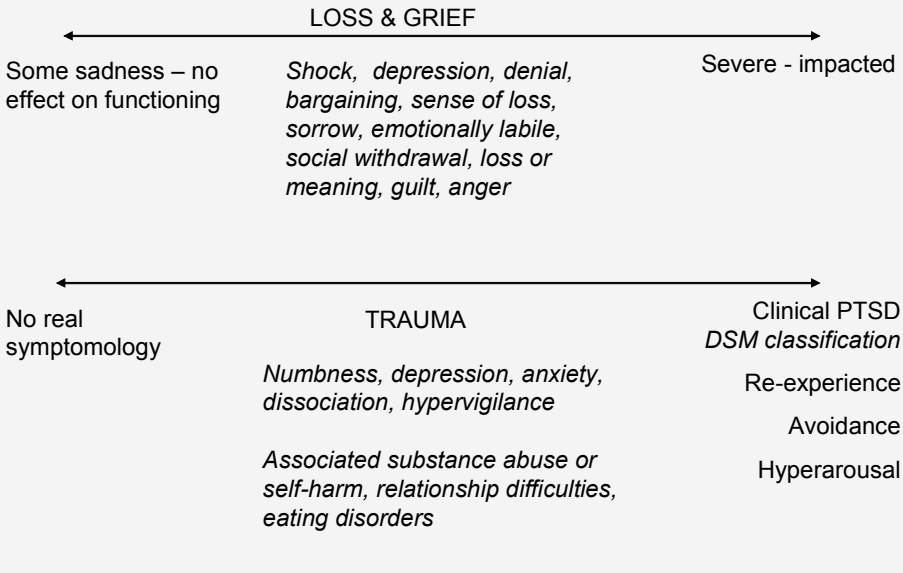
Spectrum of Pregnancy-Baby Loss

(Gnad, 2012)



(Gnad, 2012)

Continnuums of Loss / Grief and Trauma
(Gnad, 2012)



Use of DSM IV American Psychiatric Association manual can assist assessment.
Other ways of gauging levels of trauma (Niedemeyer – Traumatic Loss) Six Dis processes of Traumatic Loss.

Trauma, Loss and the Quest for Meaning (2001)
Robert A. Niemeyer
(http://web.mac.com/neimeyer/Home/Scholarship.html)

6 DIS- Processes of Traumatic Loss

- *Disconfirmation*
- *Dislodgement*
- *Discontinuity*
- *Dissociation*
- *Disregulation*
- *Disengagement*

(Gnad, 2012)

Abortion and Mental Health: Evaluating the Evidence

From article American Psychologist Dec 2009

"The question of how abortion relates to mental health has been asked in several different ways. These differences in framing are important, as they determine the research designs necessary to address the question, the answers obtained, and the conclusions drawn.

Much of the public debate over abortion and mental health has framed the question as follows: *Does abortion cause harm to women's mental health?* Both scientific and ethical considerations limit our ability to answer this question."

Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., West, C.. (2009) Abortion and Mental Health: Evaluating the Evidence, American Psychologist December 2009, 863-890

Some Limitations & Methodological Issues

- Inadequate control for co-occurring risk factors….
- Sampling bias and size
- Incorrect data interpretations and inferences made – causal vs associations
- Record based and clinical studies fail to identify less severe problems associated with abortion
- Few longitudinal studies – longer term effects, delayed reactions
- Poor measurement of mental health outcomes

(Gnad, 2012)

(Major, B., Applebaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). *Abortion and Mental Health: Evaulating the Evidence. American Psychologist, 64 (9),* 863-890, Robinson, G. E. (2008). *Is there an "Abortion Trauma Syndrome"? Critiquing the evidence*. Harvard Review of Psychiatry, 17 (4), 268-290)

Some Limitations & Methodological Issues

- Use of inappropriate control groups or lack of comparison groups
- Attrition due to sensitivity of topic and participants change of location
- Inadequate measurement of reproductive history, problems of underreporting and lack of information regarding the abortion context
- Few studies done around the issues for men
- Statistical problems

(Gnad, 2012)

(Major, B., Applebaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). *Abortion and Mental Health: Evaulating the Evidence. American Psychologist, 64 (9),* 863-890, Robinson, G. E. (2008). *Is there an "Abortion Trauma Syndrome"? Critiquing the evidence.* Harvard Review of Psychiatry, 17 (4), 268-290)

The Christchurch Health and Development Study (2006; 2008)

David M. Fergusson, PhD, L. John Horwood, MSc, Joseph M. Boden, PhD

Department of Psychological Medicine, University of Otago, Christchurch

- A longitudinal study
- Cohort studied at birth, 4 months, 1 year, annual intervals to 16 and at 18, 21, 25, 30 (a total of 22 occasions)
- Extensive data gathered - pregnancy, pregnancy outcomes and mental health

(Gnad, 2012)

Reactions to abortion and subsequent mental health

David M. Fergusson, PhD, L. John Horwood, MSc, Joseph M. Boden, PhD

*British Journal of Psychiatry (2011) 195: **420-426***

Conclusions

Abortion was associated with both positive and negative emotional reactions. The extent of negative emotional reactions appeared to modify the links between abortion and subsequent mental health problems.

NB. Association vs Causality
More research needed

(Gnad, 2012)

Existing research around the impacts of TOP / abortion

USA two main post abortion websites

- Pro-abortion: Guttmacher Institute http://www.guttmacher.org/

- Pro-life: Elliott Institute http://afterabortion.org/

How a researcher frames the question of the relationship between abortion and mental health shapes the findings and interpretations

(Gnad, 2012)

American Psychiatric Association Task Force Report on Mental Health and Abortion 2008

http://www.apa.org/pi/women/programs/abortion/index.aspx

- **Report of the APA Task Force on Mental Health and Abortion**
- **Executive Summary of the APA Task Force on Mental Health and Abortion** 2008
- **Abortion and Mental Health: Evaluating the Evidence. (**This article, published in the December 2009 *American Psychologist* evaluates the empirical research addressing the relationship between induced abortion and women's mental health. The article updates the findings of the 2008 *Report of the Task Force on Mental Health and Abortion* with six new studies.)
- **APA Task Force Finds Single Abortion Not a Threat to Women's Mental Health** (APA Press Release, August 2008)

Some key findings of the TFMHA cntd

- Importance of taking pregnancy intendedness and wantedness into account when seeking to understand psychological reactions
- Some women do experience sadness, grief, and feelings of loss…. some clinically significant disorders
- Several factors predictive of more negative psychological responses
- Unlikely to be a single definitive research study

(Gnad, 2012)

Some key findings of APA Task Force Report on Mental Health and Abortion

- Methodological problems
- Relative risk mental health problems of *unplanned pregnancy* ending in single elective first trimester termination similar to delivering the pregnancy
- Positive associations observed between multiple abortions and poor mental health
- Terminating a wanted pregnancy late in pregnancy due to fetal abnormality - negative psychological reactions equivalent to those who miscarry

(Gnad, 2012)

Impact of Past Abortion on Subsequent Pregnancy, Birth and Post Partum Experiences. Evidence to date.

P.A.T.H.S. Research Project – Literary Review – 2010

- Poster presentation at NZCOM Conference 2010
- Search - nursing, midwifery, obstetrics/gynaecology, counselling
- Usual focus physical complications / mental health problems. Other impacts worth attention.
- Outcomes valid across health related fields.

Findings and References available online at

http://www.postabortionpaths.org.nz/Articles/Research.asp

(Gnad, 2012)

Gnad, C. Dip Ns, Dip Couns, Dip NFP Mngmt, Trip, H. RN,MHSc (Nursing) PhD Cand (Otago), Carr, C. BBusMngmt, NZDipBus, DipMktng, Gormley, J. BPhEd Hons

How Can Research Influence Clinician / Practitioner Approaches?

Depends on

- What research aware of or adhere to

- How research used in the clinical setting
  - Dogmatic truth vs guide to possibilities
  - Patients do not necessarily fit research patterns
  - Patient ultimately own expert
  - As a basis to inform or not inform patient care

Research can inform practice, but depending on the above may impact the effectiveness of patient-centred care

(Gnad, 2012)

Scope for Further Research.

- More comprehensive NZ statistics of physical complications
- Further NZ longitudinal studies around relationship between TOP / abortion and mental health problems e.g. anxiety, depression, eating disorders, relationship problems
- Which groups of people are more at risk of negative abortion reactions and why?
- Is there a link between TOP / abortion and
  - subsequent post natal depression
  - breastfeeding, bonding and attachment issues
- Exploration of the experiences of clinicians /practitioners in working alongside those considering/ undertaking TOP/abortion.

(Gnad, 2012)

Questions Raised

- What does full information mean and look like for abortion / TOP?
- Only a percentage of people willingly undertake counselling as part of their decision-making. Ought pre- TOP/abortion counselling be an integral part of the process? If so, what, where, and how?
- How does the counselling received (or not received), and the type of counselling affect outcomes in decision-making, and reactions later?
- Is there a need for screening for risk factors for negative abortion reactions?
- What helps or hinders people accessing or availing themselves of follow up support?

(Gnad, 2012)

Recommendations to Enhance Clinical Practice

- Know own position - expand knowledge and awareness
- Slow down decision-making process
- Assess for risk factors for negative reactions
- Involve other agencies outside abortion services
- Offer range of information for support
- Normalise potential grief and trauma with client
- If client raises the issue know it is significant

(Gnad, 2012)

Other Recommendations

- Include questions around pregnancy baby-loss as part of intake or client history around family – specifically ask re miscarriage, stillbirth, neonatal death, abortion or TOP, adoption
- Perform clinical assessment of individual symptoms associated with loss and trauma
- Do not discount, dismiss, minimise client experience
- Some methods to work with abortion loss and trauma

  – Acceptance & commitment therapy, EMDR, EFT, CAT, Narrative

(Gnad, 2012)

Aspects to consider working with post abortion clients

THEN & NOW

- Balance of power in clinical setting then, and therapeutic setting now
- Is or was it a TOP / abortion decision or a pregnancy choice? How was it viewed then, how is it viewed now?
- Cannot anticipate reactions – expectations then, change over time
- Information
- Client's ability to process, and work through implications then - pressured time frame, in crisis

  Readiness to confront issues and psycho-spiritual responses now

(Gnad, 2012)

Aspects to consider cont.

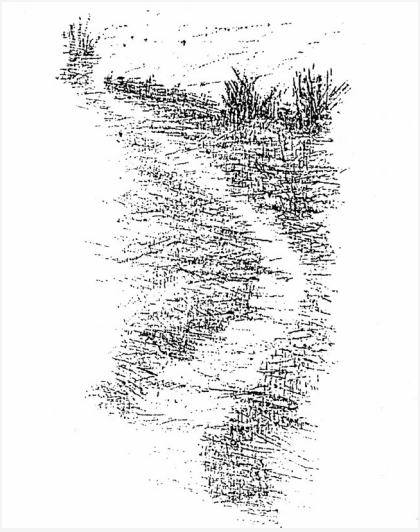
- Patients' perceptions and understanding
- Degree of ambivalence
- Isolation – lack support or psychological withdrawal or not coping
- Pregnancy intendedness and wantedness
- Stage of pregnancy
  – early: less significant, later: more complex

(Gnad, 2012)

OVERVIEW of the 10 STEPS of RECOVERY used in P.A.T.H.S. counselling

(developed from original *Guidebook for Post Abortion Syndrome Recovery,* Victims of Choice, Naperville, 1996)

1. **Pre-pregnant woman**
2. **The pregnancy**
3. **The abortion decision**
4. **The abortion**
5. **The accommodation stage**
6. **Hurts**
7. **Anger**
8. **Forgiveness**
9. **The Baby**
10. **Carrying on**



N.B. P.A.T.H.S. offers a two day training seminar for working with the 10 Steps

P.A.T.H.S.
(Post Abortion Trauma Healing Service)
Charitable Trust constituted December 1997

P.A.T.H.S. Charitable Trust

CONTACT US

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Carolina Gnad (MNZAC) for

- Counselling
- Supervision – general and specialised
- Spiritual direction
- Workshops, seminars
- Professional development modules

Dawnings

www.dawnings.co.nz

Specialty areas pregnancy decision-making, and abortion or termination loss and trauma, any pregnancy-baby loss or birth trauma