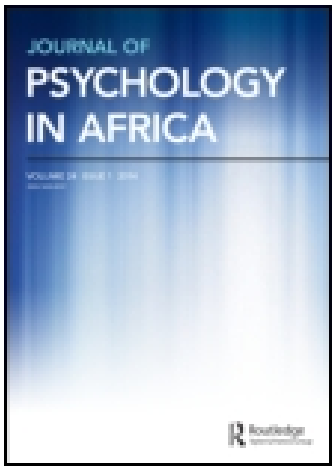

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Why We Should Avoid the use of the Term "Post-Abortion Syndrome": Commentary on Boulind and Edwards (2008)

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Boulind and Edwards (2008) present a case study of Grace, a women suffering, in their words, from post-abortion syndrome (PAS). In this commentary I argue that while Boulind and Edwards' (2008) report is useful in terms of documenting the therapeutic processes engaged in, they would have been better served in not hanging the distress experienced by Grace on the diagnostic category of post-abortion syndrome. Reasons for this are that: PAS is not a recognised category of diagnosis, despite having been initially proposed in 1981; applying a PTSD framework to abortion is questionable; PAS focuses attention on the abortion itself in isolation from the fact that abortion occurs in the context of severely problematic pregnancies and other important socio-cultural stressors; PAS, in the very manner in which it is formulated, invokes to a very complex politics of the foetus. Boulind and Edwards (2008) are careful in their documentation of the complexities of the case, and thus their use of PAS is unfortunate.

Keywords: abortion, postabortion syndrome, therapy

Introduction

Boulind and Edwards (2008) present a clinical case study of Grace, a black Zimbabwean woman whom they indicate suffered from post-abortion syndrome (PAS), which is seen as a form of post-traumatic stress disorder (PTSD). The article takes us through the various therapy sessions, indicating how, in the third session, Grace disclosed that she had undergone an abortion. After this session, her symptoms of depression reduced. The rest of the sessions consist of her talking through the decision-making process as well as the actual physical abortion. It is clear that the therapy was conducted in a thoughtful and sensitive manner, and that it provided significant relief for Grace.

In the actual article, the authors engage in the controversies found in the literature around the psychological consequences of abortion. They juxtapose research that finds few or no psychological consequences following abortion (compared with carrying an unwanted pregnancy to term) with research that finds that abortion has a negative impact. They concede that "Research findings can have significant political impact as pro-life advocates may seize on evidence for the negative psychological impact of abortion, while pro-choice advocates may focus on evidence that negative consequences are rare or even non-existent" (Boulind & Edwards, 2008, p. 541).

Given this, their use of the term post abortion syndrome (PAS) is interesting. In this commentary I suggest that the authors would have been better served by avoiding this label altogether. There are a number of reasons for this. Firstly, PAS is not a recognised category of diagnosis, despite having been initially proposed in 1981. Secondly, applying a PTSD framework to abortion has been questioned. Thirdly, PAS focuses attention on the abortion itself in isolation from the fact that abortion occurs in the context of severely problematic pregnancies and other important socio-cultural stressors. Fourthly, PAS, in the very manner in which it is formulated, invokes to a very complex politics of the foetus, something completely glossed over by Boulind and Edwards (2008).

PAS is not a Recognised Diagnostic Category

Despite acknowledging the ideological implications of research on the psychological consequences of abortion as well as the scientific controversy surrounding the issue, Boulind and Edwards (2008) spend a substantial part of their discussion in their section entitled "supporting research" describing studies that find negative consequences. Some of this research was conducted with women who have undergone illegal abortion, a somewhat strange set of literature to cite, as the health (and almost certainly as a result the psychological) consequences of illegal abortion are vastly different to those of legal abortion (Grimes, Benson, Singh, Romero, Ganatra, Okonofua & Shah, 2006).

This choice (to highlight research on the negative psychological consequences of abortion) must be seen in the context of Boulind and Edwards (2008) utilising PAS as a real, separable diagnostic category. They begin their article by stating that "Although research suggests that for most women the impact of terminating a pregnancy is largely benign (Adler, et al, 1992), for at least some, it may precipitate post-abortion syndrome (PAS) (Speckhard & Rue, 1992), a form of post-traumatic stress disorder (PTSD)" (p. 539). Thus, from the start, PAS is depicted as a realistic and unproblematic category of diagnosis.

Vincent Rue first used the term PAS in testimony to the American Congress in 1981. This was later formalised in a paper by Speckhard and Rue (1992) in which the authors presented their conclusions on the psychological consequences of abortion. On the basis of their analysis, Speckhard and Rue (1992) suggested the need for a diagnostic category of post-abortion syndrome. As a psychosocial stressor, they argued that abortion may cause mild distress through to severe trauma in some women, creating the need for a continuum of categories from post-abortion distress (PAD), post-abortion syndrome (PAS) and post-abortion psychosis (PAP). Their main focus was on PAS which they described as a variant of

post-traumatic stress disorder. They described the basic components of PAS as

(1) exposure to or participation in an abortion experience, i.e., the intentional destruction of one's unborn child, which is perceived as traumatic and beyond the range of usual human experience;
(2) uncontrolled negative experiencing of the abortion death event, e.g., flash-backs, nightmares, grief, and anniversary reactions;
(3) unsuccessful attempts to avoid or deny abortion recollections and emotional pain, which result in reduced responsiveness to others and one's environment; and
(4) experiencing associated symptoms not present before the abortion, including guilt about surviving (p. 105).

Speckhard and Rue (1992) pointed out that it took some time for post-traumatic stress disorder to be officially recognised in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). PAS, they felt, should also be included although this may also take some time. Support for its inclusion in the DSM remains in some quarters (Gómez & Zapata, 2005). However, to date (with the latest version of the DSM being published in 2000 – 19 years after Rue initially mooted the idea), PAS has not been recognised as a separable diagnostic category. And there is no support for it in the recent report on mental health and abortion brought out by a task team of the American Psychological Association (Major, Appelbaum, Beckman, Dutton, Russo & West, 2008).

Arguments Against Applying a PTSD Framework to Abortion

Speckhard and Rue (1992) proposed PAS as a form of PTSD. It has been argued, however, that there is no scientific basis for applying a PTSD framework in the case of women who have undergone a legal abortion. Rubin and Russo (2004), for example, state that "Women do not typically fear for their lives during a legal abortion (and reasonably so, given it is safer than a penicillin shot), a basic criterion for assigning a PTSD diagnosis" (p. 73). The criterion referred to here, Criterion A, is that "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (American Psychiatric Association, 2000, p. 467).

Legal abortion in the first trimester virtually never threatens death, serious injury or harm to the physical integrity of a woman. Morbidity and mortality rates are significantly lower during legal termination of pregnancy than they are during birth (Grimes, 1994). Although I have not been able to find any statistics on mortality owing to legal abortion in South Africa, statistics from the United States indicate that 9.2 per 100 000 women die as a result of pregnancy- or birth-related complications, while only 0.3 per 100 000 die as a result of legal abortions (Adler, Ozer & Tschann, 2003). Boulind and Edwards (2008) indicate that Grace met criteria for PTSD. However, they fail to engage with Criterion A.

In contradistinction to other DSM categories, in which aetiology is unclear, PTSD rests on the assumption of a particular aetiology, as outlined in Criterion A. This assumption has been called into question by a number of theorists, however, with some arguing the PTSD can develop after non-life threatening events. Rosen, Spitzer and McHugh (2008) take this point up in an editorial written in the *British Journal of Psychiatry*. They indicate that: "the PTSD 'model' has been extended worldwide to encompass an increasing array of events and human reactions across diverse cultures [they include PAS in the list they provide]. … This expansion of the PTSD model, a phenomenon referred to as 'criterion creep', highlights a critical shortcoming of traumatology: the cross-cultural medicalisation of normal human emotions" (p.3-4). In the absence of a specific aetiology, they are sceptical of the diagnosis of PTSD "when one considers that a combination of symptoms of major depression and specific phobia fully constitutes the requisite criteria for diagnosing PTSD" (p. 3).

PAS is a Reductionist Concept

The term post-abortion syndrome places emphasis on the abortion event itself. In so doing, it ignores the fact that termination of pregnancy occurs in the context of: (1) a severely problematic and unwanted pregnancy, (2) possible interpersonal, socio-cultural and economic stressors, and (3) the psychological functioning of the woman prior to the unwanted pregnancy and abortion.

Taking the first of these, an unwanted pregnancy, Boulind and Edwards (2008) concede, towards the end of the paper, that "Adjusting to giving birth following an unplanned pregnancy also poses significant challenges and, on the basis of the case material, no conclusion can be drawn as to which would have been more psychologically problematic for Grace in the long term" (p. 545). And it is precisely this point that needs to be taken into consideration. As Stotland (2001) points out, "Abortion is performed on women who are pregnant, and, for those women, abortion and childbearing are the only two alternatives" (p. 28).

To be able to reach the conclusion that, in general, the psychological reactions seen after a woman has undergone an abortion are owing to the abortion rather than to an unwanted pregnancy, research that makes a meaningful comparison between women with unwanted pregnancies who carry to term and those who terminate their pregnancies needs to be conducted. Without these kinds of comparative data (women who abort compared to women who carry an unwanted pregnancy to term and either keep the child or give him/her up for adoption), there is the danger of ascribing experiences to an abortion when they may in fact have been the result of an unwanted pregnancy. For example, Boulind and Edwards (2008) comment that "there are few comprehensive case descriptions of PTSD precipitated by abortion" (p. 539). The assumption here is that the PTSD is necessarily precipitated by the abortion rather than the severely problematic situation of an unwanted pregnancy.

Even where research compares the psychological consequences of termination of pregnancy with those of taking an unwanted pregnancy to term, the conclusions need to be treated with caution. This is clearly illustrated by the exchanges that took place in the *British Medical Journal* with respect to two studies. Reardon and Cougle (2002), using data from the US National Longitudinal Survey of Youth, found that, amongst married women, those who carried their unwanted pregnancy to term were less likely to become depressed than those who terminated their pregnancy. However, there was no difference for unmarried women. A flurry of letters was sent to the *British Medical Journal* in response to this paper, many of which raised concerns with the manner in which the research had been conducted. In a paper published in the same journal, Schmiege and Russo (2005), using the same data as Reardon and Cougle (2002), concluded that terminating an unwanted pregnancy did not lead to more risk of clinical depression than carrying an un-

wanted pregnancy to term. They argued that the manner in which Reardon and Cougle (2002) coded and analysed their data was flawed. In particular they accused Reardon and Cougle (2002) of misidentifying unwanted first pregnancies and excluding women who were at the highest risk of developing depression following childbirth. Again a number of letters concerning Schmiege and Russo's (2005) results and how they conducted their research appeared in the *British Medical Journal*.

The controversy evident in these exchanges speaks to the methodological difficulties of separating out the effects of a severely problematic pregnancy from the effects of a legal abortion. Short of (unethically) assigning women with unwanted pregnancies to an experimental group (terminating the pregnancy) and a control group (carrying to term), having matched the two groups in terms of pre-pregnancy functioning and other relevant variables such as partner support and material conditions, a clear-cut answer in terms of the psychological consequences of abortion (per se) is probably unlikely to emerge. Nevertheless, I argue that we need to take the judgement of the recent APA task team seriously, namely that:

> *A critical evaluation of the published literature revealed that the majority of studies suffered from methodological problems, often severe in nature. … The best scientific evidence published indicates that among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first trimester abortion than if they deliver that pregnancy.… The prevalence of mental health problems observed among women in the United States who had a single, legal, first-trimester abortion for nontherapeutic reasons was consistent with normative rates of comparable mental health problems in the general population of women in the United States (Major et al., 2008, p.3-4).*

With respect to the interpersonal, socio-cultural and economic context within which unwanted pregnancies occur and within which women may contemplate terminating a pregnancy, several of these are referred to by Boulind and Edwards (2008). Grace's father died from AIDS, her mother is HIV+ and has symptoms of AIDS (but refuses ARV treatment) and her friend passed away recently after testing positive for HIV. The stresses and emotions (such as sadness, anger, depression, suicidal ideation, trauma and frustration) experienced by the families of people infected by HIV are starting to be documented (Tshilio & Davhana-Maselesele, 2009; Webb-Robinson & Wilson, 2008). Given the high level of HIV infection in the southern Africa, the contextual stress of family members and friends being diagnosed by HIV and passing away, whether the person affected is in a direct caregiving role or not, needs to be given cognisance as a significant contextual factor.

Other contextual factors referred to by Boulind and Edwards (2008) are the lack of support Grace experienced in the decision-making process, economic hardships, the relatively supportive attitudes of the staff in the hospital (despite her expectations to the contrary), and lack of support from close friends and family (she refers repeatedly to the difficulty of having to face the dilemma of an unwanted pregnancy and the abortion on her own). Stigma is also alluded to in that "Grace had not mentioned the abortion for fear that I would be critical of her … She was afraid I would be disappointed in her and felt ashamed, anticipating that others would label her 'a slut'" (p. 541). Grace clearly feared the attitude of the staff of the hospital as "she was surprised that no one asked her any questions or tried to talk her out of it" (p. 543).

Studies that look specifically at the decision-making process engaged in around the resolution of an unwanted pregnancy stress the importance of factors such as the level of support from partner and family, local social and cultural norms including gender relations, and the material conditions under which these women live (Puri, Ingham & Matthews, 2007; Whittaker, 2002). In terms of the abortion itself, factors such as supportiveness and attitudes of the staff and local anti-abortion activity may affect the experience of women who terminate their pregnancies and may well affect their reactions afterwards. Remennick and Segal (2001), for example, explored "macro-level factors such as legislation, practice and public attitudes towards abortion and micro-level life contexts including reasons for the termination, relationship with the partner, material resources and social support". The researchers found that women's experiences of abortion are "shaped by both social context and concrete life circumstances" (p. 49).

Given these factors (that termination of pregnancy occurs in the context of a severely problematic pregnancy and that there are a range of contextual issues that undergird responses to the pregnancy and abortion), the focus on the actual abortion in isolation from these factors as is implied by the term post abortion syndrome is problematic. PAS places the abortion in the foreground, neglecting the stress and possible trauma inherent in, firstly, the discovery of an unwanted and severely problematic pregnancy, secondly, the fears around economic hardship, thirdly, the difficult process of deciding how to resolve an unwanted pregnancy, especially in the absence of support, fourthly, the expectation (whether real or imagined) of criticism, stigma and social isolation, not only because of the abortion but also because of the pregnancy (Grace, remember, spoke of fears of being considered "slut" – the sex thus becomes the issue rather than the abortion), fifthly, the potential lack of support and caring amongst health service providers, sixthly, the lack of support structures after the end of the pregnancy, and finally, general contextual stressors such as having to cope with family members affected by HIV and the death of close family and friends.

Grace was clearly struggling and was helped significantly by the therapy. But the question I ask is whether the depression noted was due solely to the abortion or to the range of stressors identified in her life. Given that she concludes that she "would probably do the same again were she in the same predicament now" (Boulind and Edwards, 2008, p.543), we have to wonder whether the abortion, in and of itself, was really the cause for her depression, and whether placing emphasis on the abortion *per se* through a diagnosis of PAS is warranted.

Grace did not appear to suffer from psychological problems prior to the onset of the depression that led her to seek therapy. Nevertheless, it bears mentioning that the APA task team found that in all of the credible studies they reviewed, prior mental health functioning was the strongest predictor of mental health post-abortion. They conclude that "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" (Major et al., 2008, p. 4).

The Politics of PAS

Despite the debate on the psychological consequences of abortion, and evidence that points in a contrary direction to the inevitability of psychological consequences, the notion of PAS has taken root in much anti-abortion activism. Previously

anti-abortion activism centred on the rights of the foetus. Inevitably this butts up against the rights of women to bodily integrity and reproductive decision-making, leaving an impasse. This is resolved, however, by the introduction of PAS. What PAS does is to construct not only the foetus as the victim but also the woman. The insinuation of therapeutic care in the talk of PAS has allowed anti-abortion activists to be portrayed as caring and respectful of the woman's experiences (Hopkins, Reicher & Saleem, 1996). Consider, for example, the following excerpt from a conference held in 2001 by the National Alliance for Life:

> *Abortion has only been legal in South Africa for a few short years, so you haven't experienced the other side of the coin that we have in America and that is Post Abortion Syndrome both in women and men. The issue of Post Abortion Syndrome has grown so big and so strong that it sometimes seems to eclipse the issue of abortion itself. We have tens of millions of hurting mothers and fathers who mournfully cry out for their wives and their unborn babies that are no more (Mattes, 2001).*

Key to this is the concept of denial contained within PAS. In other words, women who claim that there are no negative consequences are merely suppressing the painful experience. In this way anti-abortionists can declare that most women are adversely affected by abortion, and that by making them aware of the severe psychological consequences of abortion, they (the anti-abortion activitists) are really on their (the women's) side.

PAS does not, however, abandon the notion of foetal personhood. Although the shift from the rights of the foetus to the psychology of the woman appears to move the focus away from the foetus, the foetus is still portrayed as a fully fledged human being. Speckhard and Rue's (1992) first component of PAS is "exposure to or participation in an abortion experience, i.e., the intentional *destruction* of one's *unborn child*, which is perceived as traumatic and beyond the range of usual human experience" (p. 105, my emphasis).

The politics of foetal personhood is a complex one. As indicated by Williams, Alderson and Farsides (2001), "Different constructions of the fetus lie at the centre of reproductive, abortion and disability politics … the status of the fetus is socially, culturally and politically constructed, and varies depending on who is caring for it, who is attributing the meanings, and what the work goals are" (p. 225/226).

Constructions of the foetus have undergone significant change over time. Until about seventy years ago, pregnancy could only be reliably diagnosed by the quickening (movement of the foetus in the womb). This meant that prior to this, abortions could be seen as unblocking menstrual obstruction rather than as the removal of a foetus (Luker, 1985). In stark contrast, modern ultrasound technology has contributed to the construction of foetal personhood, a highly charged and controversial notion.

A full discussion of the feminist debate around foetal personhood is not possible here, and readers are referred to Mitchell (2001) who examines:

> *Several of many semiotic and material practices through which fetal images are produced, interpreted and experienced. … Throughout this book my concerns are two: first, to show how [i.e., the power relations that make it possible that] these collections of echoes have become taken for granted as windows onto fetal reality and second, to illuminate the links between this technologically mediated reality and the politics of gender and reproduction. Talk about the fetus and ultrasound are inseparable from talk about women and power (p. 4).*

Suffice it to say that PAS, as envisaged by Speckhard and Rue (1992), views the foetus as a fully fledged child (albeit unborn), which is "destructed" through a termination of pregnancy. In this way, pregnancy becomes a bifurcated phenomenon of two subjects: the woman and the fully fledged child she carries in her womb. These two subjects are potentially at war with each other, with the woman, as the stronger party, being depicted as the perpetrator of violence.

Boulind and Edwards (2008), perhaps inadvertently, perpetuate this bifurcated view of pregnancy. Although it is not clearly stated at which stage of gestation Grace terminated the pregnancy, it appears, from the description of events, that the abortion occurred within the first few weeks. In light of this, Boulind and Edwards' (2008) description of Session 10 of the therapy is interesting:

> *The next session would be followed by the four week July vacation. I suggested that Grace needed to work towards two goals. First she needed to mourn for her lost baby (p. 544).*

It seems, thus, that the therapist introduced the construction of the foetus as a fully formed baby. There is no indication that she was merely following the narrative provided by the client. Following the suggestion from the therapist, Grace takes this narrative up in working on a collage which contains a picture of the "baby" which was never born.

Conclusion

Boulind and Edwards' (2008) case study is carefully documented and does, I think, add to our understanding of therapeutic encounters with women who present for therapy post-abortion. Their formulation of the case gives the reader a useful and full picture of the contextual issues and processes involved in the case. I therefore think that their use of PAS is quite superfluous and, in fact, detracts from the case. Their need to hang the case on an unrecognised diagnostic category, that reduces the complex set of situations they discuss to the event of an abortion, is unfortunate in the light of their careful documentation of the case. A reminder of the complexity of issues involved in psychological responses post an abortion comes from Major et al (2008) who conclude that:

> *The TFMHA [task force on mental health and abortion] reviewed no evidence sufficient to support the claim that an observed association between abortion history and mental health was caused by the abortion per se, as opposed to other factors. The review identified several factors that are predictive of more negative psychological responses following first-trimester abortion among women in the United States. Those factors included perceptions of stigma, need for secrecy, and low or anticipated social support for the abortion decision; a prior history of mental health problems; personality factors such as low self-esteem and use of avoidance and denial coping strategies; and characteristics of the particular pregnancy, including the extent to which the woman wanted and felt committed to it (p. 4).*

In closing it may be useful to consider a further contextual factor with which women who undergo abortions will need to deal, and that is the political usage of PAS. Rubin and Russo (2004) argue that abortion politics, including talk of PAS, makes abortion a more threatening, stressful and stigmatised event

than it would otherwise have been. They discuss how therapists may need to work with the client to reappraise some of the anti-abortion rhetoric, such as the suggestion that there inevitably will be psychological fall-out and feelings of guilt.

Footnote

[1] PAS should not be confused here with Parental Alienation Syndrome, which also has the acronym of PAS. Arguments have been made that this syndrome should also be included in the DSM

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