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Using Prolonged Exposure to Treat Abortion-Related Posttraumatic Stress Disorder in Alcohol Dependent Men: A Case Study

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Abstract

Men's reactions to a partner's abortion are an understudied area. Few studies have examined abortion as it relates to posttraumatic stress disorder (PTSD) in males, and no studies have examined the use of an empirically supported behavioral treatment for PTSD in this population. The current case study examines Prolonged Exposure for the treatment of abortion-related PTSD in a 46-year old Caucasian male who also has alcohol dependence. The patient was involved in a residential substance abuse treatment program at the time of treatment. After receiving 12 sessions of Prolonged Exposure, the patient experienced a decrease in PTSD symptoms as measured by the Clinician Administered PTSD Rating Scale (87%) and Impact of Event Scale-Revised (85%). The results of this study suggest that the literature supporting Prolonged Exposure as a first-line treatment for PTSD can be expanded to include men needing treatment for abortion-related PTSD. Implications for treatment and research are discussed.

THEORETICAL AND RESEARCH BASIS FOR TREATMENT

The psychological sequelae of elective, or induced, abortion for women continue to be a source of scholarly inquiry. Although the literature examining the impact of elective abortion in the lives of women remains fraught with methodological challenges, overall, associations between having had an abortion and subsequent negative mental health outcomes appear to be influenced by a variety of preexisting or co-occurring risk and protective factors. These include level of education, income, perceived social support, perceived stigma associated with having an abortion, and the extent to which the pregnancy was wanted (e.g., see Major et al., 2009, for review). Some women who abort a pregnancy may feel that they have made the right decision and experience relatively minor and transient, if any, psychological distress, while others may experience clinically significant symptoms of depression, anxiety, substance abuse, and even posttraumatic stress disorder (PTSD; Coleman, Coyle, Shuping, & Rue, 2009; Coyle, Coleman, & Rue, 2010; Fergusson, Horwood, & Boden, 2008; Reardon, Coleman, & Cougle, 2004).

In spite of the growing literature exploring factors that influence post-abortion outcomes for women, very few studies have been published regarding the psychological consequences of elective abortion for men. Indeed, it has been suggested that, for both social and legal reasons, men whose partners elect to have an abortion make up an invisible group (Kero &

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Lalos, 2004). Abortion is largely perceived as a women's issue in the current social context given that even in marriage, the wife does not need the husband's permission to terminate a pregnancy (Coyle, 2007). Similarly to the role of abortion in women's lives, abortion in the lives of men is likely a diverse phenomena. Male partners may or may not be involved in the process of deciding whether their partner will have an abortion, the baby may or may not be wanted by the father, and co-occurring and preexisting factors that influence the mental health of women following an abortion may influence male partners' responses to abortion in similar ways. In addition to caring for the mental health needs of male partners, it may be important to examine the responses of male partners to abortion given that the response of the male partner is also a factor in determining the response of the woman undergoing the procedure.

While little published work exists, there is some evidence that, similarly to women, men experience a wide range of emotional reactions to elective abortion. These reactions may include positive or benign emotions such as relief (Kero, Lalos, Hogberg, & Jacobson, 1999; Naziri, 2007) and feelings associated with thinking one has behaved responsibly (Kero et al, 1999), but may also include distressing emotions, such as sadness and regret (Coleman & Nelson, 1998), guilt (Kero et al, 1999; Naziri, 2007), and anxiety, particularly if the male partner reports a high degree of emotional connection to the fetus (Coleman & Nelson, 1998; Kero et al., 1999; Naziri, 2007). Feelings of helplessness and powerlessness are also common (Myburgh, Gmeiner, & van Wyk, 2001; Kero & Lalos, 2004). Further, little has been documented regarding the way in which men's feelings during the acute period following the abortion change over time. In a longitudinal study of male reactions to abortion, approximately 8% of men who were unhappy with or had doubts about their partner's decision to have an abortion at the time of the procedure continued to experience unhappiness and doubt four months after the abortion had taken place (Kero & Lalos, 2004). Similarly, Coleman and Nelson (1998) found that men may continue to experience negative emotions as long as two years following the abortion.

Elective Abortion and Substance Abuse

As noted above, while research suggests that reactions to elective abortion vary widely among women, with respect to the more severe reactions, abortion has been associated with substance use disorders in several studies (Coleman et al., 2002; Fergusson et al., 2008; Reardon et al., 2004). Mota, Burnett, and Sareen (2010), drawing on data from 3,310 women participating in the National Comorbidity Survey Replication (NCS-R; Kessler et al., 2004), found the adjusted odds ratios of 3.61 for alcohol abuse, 2.42 for alcohol dependence, 4.13 for drug abuse, and 3.87 for drug dependence for women who reported having had an abortion over the course of their lifetime compared with those who reported no history of abortion, controlling for relevant demographic variables as well as victimization history. Although this relationship has been noted in women who have experienced abortion, these relationships have not been examined in male partners.

Elective Abortion and PTSD

While historically authors have argued that abortion is an inherently traumatic experience, and have even suggested a unique form of traumatic stress disorder known as Postabortion Syndrome (PAS) (Speckhard & Rue, 1992), available data do not suggest that elective abortion, in and of itself, is inherently traumatic nor that it results directly and independently in symptoms of traumatic stress for most women (e.g., Majors et al., 2009). However, some women do experience continued intrusive and unwanted memories of the abortion, subsequent avoidance of abortion-related reminders, as well as emotional numbing, increased physiological arousal, and other negative emotional states following an abortion (Rue, Coleman, Rue, & Reardon, 2004; Suliman et al., 2007; van Emmerik, Kamphuis, &

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Emmelkamp, 2008). Similarly, it has been suggested that it is possible for a man to experience his partner's abortion as traumatic (Lauzon, Roger-Achim, Achim, & Boyer, 2000). Coyle, Coleman, and Rue (2010) observed that disagreement over the abortion decision was associated with increased risk for hyperarousal symptoms as well as for meeting full diagnostic criteria for PTSD in male partners, and inadequacy of pre-abortion counseling was associated with increased risk for avoidance symptoms in men. Empirical findings suggest that these men may experience reactions such as intrusive thoughts and disruptions in relationships as well (Coyle, 2007). Only one known case study has addressed male reactions to abortion (Holmes, 2004), and no case studies have addressed this issue in the context of PTSD.

Elective Abortion and Psychotherapy

Given that several studies have documented psychological distress in men following abortion, some authors have suggested that, similarly to women, pre-abortion counseling or post-abortion psychotherapy may be useful. Indeed, some men who have been involved in an abortion report that they would have liked to have been offered psychotherapy after the experience (Lauzon et al., 2000). While there is promising evidence that postabortion interventions may be beneficial for men (e.g. Coyle & Enright, 1997), because it is often assumed that abortions have little emotional impact on men, men who are involved in abortions are not likely to be offered psychotherapy to assist in coping with the experiences. Further, when men are seen by therapists for mental health concerns, they are not likely to be asked about past abortion experiences as part of general assessment, including an assessment of trauma history (Coyle, 2007). Men may also not openly express emotions related to this experience, given that societal demands and conformity pressures suggest that it should not be a cause of distress or concern for them (Coyle, 2007). Indeed, masculinity has been associated with men's decreased likelihood to seek professional help, and psychological help in particular, for a variety of mental and physical health concerns (e.g., Levant, Wimer, Williams, Smalley, & Noronha, 2009).

With respect to possible PTSD generally, the effectiveness of prolonged exposure therapy (PE) for PTSD is well established (see, for example, Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010, for review). PE is an evidence based treatment for PTSD that combines imaginal exposure, in which the patient relives the traumatic event by repeatedly describing the traumatic memory aloud in great detail, and in vivo, or "real life," exposure, in which the patient confronts previously avoided reminders of the trauma in his or her environment. It is also notable that PE in combination with interpersonal therapy has demonstrated promising results in addressing complicated grief, a prolonged grief reaction that may be experienced in response to a traumatic loss (Harkness, Shear, Frank, & Silberman, 2002; Shear et al., 2001; Shear, Frank, Houck, & Reynolds, 2005). Further, with respect to substance use disorders, a growing body of evidence is accumulating demonstrating the efficacy of imaginal exposure in reducing PTSD and substance-related symptoms in patients with PTSD (Brady, Dansky, Back, Foa, & Carroll, 2001; Coffey, Stasiewicz, Hughes, & Brimo, 2006; Riggs & Foa, 2008). This suggests that PE may be effective in reducing symptoms of alcohol abuse and dependence in individuals with PTSD as well.

Given that no articles to date have examined the use of PE in men with abortion-related PTSD and alcohol dependence, the present article reviews the course of prolonged exposure treatment for abortion-related PTSD in one such patient: JB. After having lived with PTSD symptoms for 20 years, JB's PTSD symptoms were alleviated after 12 sessions of prolonged exposure provided during the course of his residential substance abuse treatment program.

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CASE INTRODUCTION

The patient, JB, was a 46-years old Caucasian male and divorced at the time of the current treatment episode. The patient was assessed approximately five days after he entered a residential substance abuse treatment program, and he remained in the treatment program throughout the course of therapy. Prior to his residential treatment admission, JB had been arrested 2 times for driving under the influence. He was admitted to substance abuse treatment as a condition of probation. However his involvement in this treatment was completely voluntary and not a requirement of his substance abuse treatment program.

PRESENTING COMPLAINTS

At the time of the initial assessment, the patient met full criteria for major depression, alcohol dependence, and PTSD. His PTSD symptoms included intrusive recollections, distress in response to reminders, physical reactions to reminders, persistent avoidance of reminders, feeling detached from others, feeling emotionally numb, problems with irritability and anger, and being overly alert.

HISTORY

JB reported that approximately 20 years ago he was married with two children under the age of 6, and employed as a first responder. He and his wife were struggling financially: his wife stayed home with the children, and his ability to provide for the family was a considerable source of tension in the relationship. While he was able to earn enough money to provide basic necessities for his family, he was very unhappy with his current employment, and had increasingly voiced a desire to start his own business. As this would be a considerable financial risk, his wife had serious concerns about it. When his wife became pregnant with their third child, she expressed ambivalence about continuing the pregnancy. She expressed fears that he would not be able to either maintain his current job, given his dissatisfaction, or that he would not succeed if he went into business on his own. She had discussed the possibility of an abortion with her older sister prior to talking to the patient, and her sister was in support of her having an abortion and encouraged her to do so. JB did not wish to terminate the pregnancy so, as an initial compromise, the two of them attended a counseling session. He recalled being told that the decision about whether or not to have the baby rested fully with his wife, which was upsetting to him. However, following this, after a long and difficult conversation, JB and his wife agreed that they would make the best of the situation and have the baby. The next day, his wife's sister took her to have the abortion and she went through with the procedure. She then told the patient when he returned from work the following day. He reported feeling shocked, helpless, and numb initially. She told him that she would not bring another child into the world if she could not feel confident that he could provide for it and blamed him for the pregnancy. He withdrew from the conversation and sat alone, ruminating about the situation, and imagining what the unborn child would have been like.

In the subsequent weeks JB withdrew socially, began taking additional shifts at work, and began drinking more to help him avoid thinking about the abortion and experiencing associated feelings of inadequacy. He also began avoiding work assignments that might involve pregnant women. As his drinking became more problematic and he continued to withdraw from relationships, including avoiding his wife, their relationship deteriorated, eventually leading to divorce. Several years passed before he sought treatment for both alcohol dependence and major depressive disorder, which he had been diagnosed with prior to the current treatment episode. The patient had previously been employed as a first responder for 15 years and had also served in the military. In these jobs he had witnessed

several potentially traumatic events, but his ex-wife's abortion was the event that continued to cause him substantial distress.

ASSESSMENT

The patient was evaluated via semi-structured clinical and diagnostic interviews that included the National Women's Study (NWS) Event History-PTSD Module (Resnick, 1996), Clinician Administered PTSD Scale (CAPS, Blake et al., 1995), the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998), the Impact of Event Scale-Revised (IES-R; Weiss& Marmar, 1997) and the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). The NWS was used to assess the patient's trauma history and establish the presence of the necessary criterion A event for PTSD diagnosis. The CAPS was then used to establish a current diagnosis of PTSD. The IES-R was administered to obtain a measure of his PTSD symptoms over the course of treatment while the BDI-II measured his depressive symptoms over treatment.

CASE CONCEPTUALIZATION

Mowrer's Two Factor Theory (1947) was used to conceptualize the development and maintenance of the patient's PTSD symptoms. The patient's PTSD symptoms developed and were maintained as a result of classical conditioning and operant conditioning. The circumstances surrounding the abortion contributed to the patient's experience of the event as traumatic and to his subsequent distress. At the time of the trauma, the patient experienced a variety of negative emotions including helplessness, guilt and sadness. These feelings became paired with the abortion, and as a result he felt these negative emotions any time he was reminded of the trauma. Hearing someone talk about pregnancy or abortion, interacting with his ex-wife, and hearing words his ex-wife used when she told him about the abortion were all reminders of the trauma. The patient avoided these things in an attempt to avoid the negative emotions he felt at the time of the trauma. His avoidance of these events provided immediate relief, but they actually prolonged his fear reaction. Because escaping the distressing situation resulted in experiencing less fear and anxiety, over time the connection between these reminders and danger was strengthened. The patient continued to avoid these situations, and he never learned that they were not dangerous. His use of alcohol was also a way of avoiding the mental, physical, and emotional reactions to the trauma of his ex-wife's abortion. The patient's alcohol use also contributed to his depressive symptoms and helped to maintain his PTSD symptoms.

COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

The patient was treated for PTSD as a participant in an ongoing study on PTSD treatment with alcohol dependent individuals. The patient received one relaxation session and 12 sessions of PE. The sessions took place biweekly over the course of 6 weeks. The patient's symptoms were reassessed weekly by a research assistant following the first week of treatment.

A full description of PE for PTSD may be found elsewhere (Foa, Hembree, & Rothbaum, 2007), as well as modifications of the approach in residential, substance abuse treatment settings, such as that described here (Henslee & Coffey, 2010). Sessions 1 and 2 consisted of psychoeducation and breathing retraining. The construction of the in vivo, or "real life" exposure hierarchy was completed during session 3. Session 4 included discussion of the treatment rationale, an introduction to imaginal exposure, and approximately 20 minutes of imaginal exposure. The patient participated in approximately 45 minutes of imaginal exposure per session in sessions 5 through 11. For homework, the patient was asked to conduct that week's agreed upon in vivo exposure daily following session 3, and, in

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addition, to listen to the recording of the imaginal exposure conducted during session once daily following session 4 outside of session.

The patient's in vivo hierarchy included several situations for which the patient estimated his Subjective Units of Distress, or SUDS, rating. When constructing the hierarchy, the patient recalled how uncomfortable he had been when a female peer discussed making a decision about an unplanned pregnancy. He used that information to help estimate his SUDS level in other situations he had been avoiding because of the trauma. The items on his hierarchy included talking to his ex-wife on the telephone, seeing his ex-wife in person, talking to his ex-wife's sister on the telephone, reading a story in which abortion is mentioned, reading a magazine article about abortion, seeing a picture of an abortion protest, watching a movie scene about abortion, hearing women discuss pregnancy decisions, going to an abortion clinic, and hearing a woman say the words his ex-wife said to him during their argument about the abortion. The in vivo homework assignments were selected based on the estimated SUDS rating for the event and the feasibility of completing the in vivo assignment in a residential treatment setting.

Because of the length of the patient's trauma narrative used during imaginal exposure, it was divided into two parts beginning at session 5. This was done in order to increase the number of iterations of the trauma narrative done in each session. In part 1 of the trauma narrative, the patient goes to pick his wife up at her sister's house, and she tells him that she has had the abortion. In part 2 of the narrative, the patient, his wife, and his children return home, the patient thinks about the abortion, and feels a sense of loss as he wonders what having another child would have been like. In sessions 5 through 10, imaginal exposure focused on the first part of the patient's trauma experience. In sessions 10 through 12, imaginal exposure focused on the second part of the patient's experience. When the patient's SUDS ratings had decreased on part 1, imaginal exposures began to focus on part 2.

The patient progressed well through prolonged exposure. He was very compliant with assigned homework, and he completed most of the identified cues on his in vivo hierarchy. He was also compliant in doing imaginal exposure homework assignments, in which he listened to audio-recorded imaginal exposure sessions daily between treatment sessions.

The graph below depicts the patient's IES-R scores during the time he was receiving prolonged exposure treatment. His baseline score was 46, and a baseline score of 33 is generally indicative of a probable diagnosis of PTSD (Creamer, Bell, & Failla, 2003). His symptoms declined steadily over the course of treatment. The largest recorded decline in symptoms occurred following session 5 (i.e., week 3 of treatment), when his IES-R score dropped from 33 to 10. At the end of the six-week treatment, his IES-R score was 6, reflecting an overall symptom reduction of 85%. A 70% reduction from baseline in PTSD symptoms generally signal that PE can be terminated (Foa et a., 2005).

The patient's SUDs ratings were obtained immediately before starting imaginal exposure in sessions 4–12 and every 3–5 minutes during each imaginal exposure session. Changes were seen in the patient's SUDs ratings over the course of therapy. Average SUDS ratings for sessions were obtained by adding all SUDS ratings for the imaginal exposure and dividing by the total number of SUDS ratings. The patient's average SUDs rating during imaginal exposure was 73.8 at session 4. His peak SUDS rating was 80. Despite the decrease in overall symptoms reflected by his steadily declining IES-R scores, the patient continued to exhibit relatively high in-session SUDS on part 1 of his trauma narrative until the 10th session. At session 10, the patient's average SUDs rating on part 1 of the narrative was 37.8. His peak SUDS rating was 40. The average SUDs ratings on part 2 of his narrative declined between sessions 10 and 12. At session 10, his average SUDS for part 2 of his narrative was

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60.6, and his SUDS peaked at 68. In the final session, his average SUDS for part 2 of his narrative was 47.5. His SUDS peaked at 50.

In addition to distress as captured by SUDs ratings, the patient reported that during his initial imaginal exposure sessions, he experienced tightening in his chest and an “empty feeling” in his stomach. In addition, he frequently became tearful during the imaginal exposure sessions. By the last session, he reported that these physical symptoms were considerably less intense, if present at all. His overall CAPS Severity score was 50 at the initial assessment and was reduced to 4 upon re-administration at post-treatment.

The patient also experienced a decline in depressive symptoms. The patient's baseline BDI-II score was 27, corresponding to the high-moderate severity range. Over the course of treatment his BDI-II scores dropped steadily. When his symptoms were assessed two weeks after beginning treatment, his BDI-II score was 14, corresponding to the low-mild symptom range. The patient's score at the post treatment assessment was 6, suggestive of no depression.

While reflecting on cognitive changes that occurred during the course of treatment, the patient stated that initially learning his ex-wife had already had the abortion was a complete shock to him. When he arrived at the house the day his ex-wife had the abortion, he expected that she may have changed her mind or begun having doubts about her decision to have the baby, but he never expected that the abortion would have already occurred. He reported that as a result of the repeated imaginal exposures, he had realized that there was nothing he could do. Once he learned of the abortion, it had already occurred, and there was nothing he could have done to change that. He reported believing that his standard substance abuse treatment had aided in his “exposure,” as he was encouraged to discuss his feelings related to the abortion, his role in it, and its impact on his substance use. He believed that the treatments had worked together to contribute to the decline of his symptoms.

COMPLICATING FACTORS

One factor to consider in reviewing this case is the patient's multiple diagnoses. Because the patient was treated as a part of a PTSD study, treatment sessions focused solely on PTSD while the patient remained actively involved in a residential substance abuse treatment program. In other treatment contexts, a clinician would need to use clinical judgment to make decisions regarding whether to treat the patient's alcohol dependence, depression, and PTSD concurrently or sequentially. The patient's residential treatment program included but was not limited to an emotions group.

ACCESS AND BARRIERS TO CARE

Treatment in this case was provided through a research study at no cost to the patient. The thorough initial assessment in this case allowed for a targeted brief intervention with weekly assessment of progress throughout treatment.

One possible barrier to accessing treatments similar to that outlined here is the limited number of providers who currently use prolonged exposure to treat PTSD. Despite the fact that PE is an empirically supported treatment for PTSD, it remains under-utilized in clinical practice (Becker, Zayfert, & Anderson, 2004). A number of factors, including lack of familiarity and perceived barriers to implementation, are likely to impact the decision of clinicians not to use exposure procedures to treat PTSD. Thus, exposure for the treatment of PTSD may not always be available to clients who are seeking treatment for PTSD. This is particularly true within substance abuse treatment settings, as it is not typical for PTSD to be treated concurrently with substance use disorders in residential treatment settings.

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FOLLOW UP

Follow up assessments were conducted 3 months and 6 months after treatment ended. Three months after treatment, JB reported that he continued to be abstinent from alcohol and other illicit substances. He endorsed one avoidance symptom during administration of the CAPS, feeling detached from others. He did not endorse any re-experiencing or hyperarousal symptoms. His CAPS Severity Score was 16, and his IES-R score was 5. His BDI- II score was 6.

Six months after treatment ended, JB reported continued abstinence from alcohol and other illicit substances. He did not endorse any symptoms during administration of the CAPS. His CAPS Severity Score was 3, and his IES-R score was 0. His score on the BDI-II was 3, suggesting that improvements in depressive symptoms were also maintained.

TREATMENT IMPLICATIONS OF THE CASE

As noted previously, for women, numerous factors influence post-elective abortion mental health outcomes, and the same may be true for men. The nature of the event itself may be very different for each sex and may have different mental health sequelae as a consequence. Factors such as the degree to which the loss of the fetus was sudden or unexpected, the amount of involvement in planning for the abortion, the desire to have the unborn child, and how bonded a man feels with the fetus may impact a man's response to abortion. For some men, like the patient in this case, it may be reasonable to expect higher rates of posttraumatic stress symptoms and other mental health conditions, such as major depressive disorder and substance use disorders. Further research is needed to clarify these issues.

In addition, beliefs about masculinity, or schema related to the traditional male role, may also place men at risk for negative post-abortion mental health outcomes. For example, in the present case, concerns about his ability to fully live-up to the role of provider seemed to contribute significantly to post-abortion distress, and may have even contributed to the onset of PTSD symptoms, as his partner's worry about his stability and capacity to provide for the family were connected to his thoughts about his being responsible for the death of his unborn child. Research on masculinity has noted that rigid adherence to schema regarding the primacy of work, the importance of pursuing social status, winning, and maintaining dominance have been related to a variety of negative mental and physical health outcomes for men, including greater emotion dysregulation, domestic assault, greater perceived barriers to health care, decreased likelihood of seeking professional psychological help, and worse health behaviors (e.g., Tager, Good, & Brammer, 2010; Boman & Walker, 2010; Levant, Wimer, Williams, Smalley, & Noronha, 2009; Mahalik, Lagan, & Morrison, 2006; Morrison, 2011). Further, research on masculine gender role stress suggests that men who report that situations related to the enactment of their gender role are stressful for them, including those related to performance failure (e.g., being passed up for a promotion at work, needing a spouse to help support the family), have higher rates of negative mental and physical health outcomes, including greater PTSD symptom severity, thought suppression, and anxiety sensitivity (McDermott, Tull, Soenke, Jakupcak, & Gratz, 2010), reduced willingness to seek psychological help (Smith, Tran, & Thompson, 2008), and greater rates of alexithymia and decreased social support (Jakupcak, Osborne, Michael, Cook, & McFall, 2006). Taken as a whole, this literature suggests that conformity to masculine norms and masculine gender role stress may moderate the relationship between the experience of abortion and negative post-abortion mental health outcomes for men. If future research supports this perspective, gender-sensitive pre-abortion counseling as well as post-abortion psychotherapy might be used to prevent or ameliorate abortion-related symptoms and distress for men.

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The results of the present study illustrate that PE significantly reduced abortion-related PTSD symptoms within nine sessions, with symptoms continuing to improve through session twelve, in one man with comorbid depression and alcohol dependence. While the independent contributions of PE versus substance abuse treatment on symptom reduction cannot be discerned in the present case, the fact that symptoms of PTSD and reexperiencing specifically were ameliorated suggests that these comorbid diagnoses did not interfere with treatment for posttraumatic stress. This is hopeful, given accumulating research suggesting that a diagnosis for PTSD increases risk for relapse in substance dependent populations (Brown, 2000; Read, Brown, & Kahler, 2004), and that receiving treatment for PTSD during substance abuse treatment significantly reduces risk for relapse (Ouimette, Moos, & Finney, 2003).

The rapid reduction of the patient's symptoms as measured by the IES-R suggests the importance of psychoeducation and patient homework. Discussing common reactions to traumatic events and learning how PTSD develops and is maintained prepared the patient to begin exposure. After discussing the ways in which PTSD impacted his life and having his reactions normalized, the patient began to allow himself to think about the trauma and to experience the emotions that were connected with it, something he had been avoiding for years. Because the patient was extremely compliant with homework, by session 5 he had completed several hours of in vivo and imaginal exposure. In response to repeated exposures to his trauma narrative and to reminders of the trauma, his IES-R scores decreased dramatically.

In addition, while PTSD symptoms based on the IES-R declined rapidly, there remained a slight discrepancy between symptoms reported on this measure and in-session SUDs. Although, a 70% reduction of PTSD symptom severity is a very useful guideline when treating PTSD with PE (Foa et al., 2005; Foa et al., 2007) and was achieved within nine sessions (actually this reduction was achieved after only his second imaginal exposure session, which occurred during session 5), to be conservative, additional treatment sessions were recommended due to his elevated in-session SUDs ratings. During the course of sessions 9–12 sessions, his IESR scores plateaued but his in-session distress ratings continued to decline. In cases where substantial symptom reduction has been achieved but in-session distress remains, additional sessions of PE should be considered.

RECOMMENDATIONS TO CLINICIANS AND STUDENTS

As noted, the prevalence of abortion-related mental health concerns in men remains unknown. The present case report, in highlighting potential factors that may result in negative post-abortion outcomes in men, will hopefully sensitize mental health providers, as well as others, to not only the possibility that men may be negatively impacted by their partner's abortion, but under what circumstances, such as rigid adherence to certain masculine ideals, this may be particularly true. Further, even anecdotal evidence that well-established evidence-based treatments for symptoms of posttraumatic stress are effective in ameliorating post-abortion PTSD in this population provides hope that, if identified, existing technologies can be provided to support men through the abortion experience.

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References

Beck, AT.; Steer, RA.; Brown, GK. Beck Depression Inventory – Second Edition. Psychological Corporation; San Antonio, TX: 1996.

Becker C, Zayfert C, Anderson E. A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. Behaviour Research and Therapy. 2004; 42(3):277–292. [PubMed: 14975770]

Blake DD, Weathers FW, Nagy LM, Kaloupek DG, Gusman FD, Charney DS, Keane TM. The development of a Clinician-Administered PTSD Scale. Journal of Traumatic Stress. 1995; 8:75–90. [PubMed: 7712061]

Bowman EKO, Walker GA. Predictors of men's healthcare utilization. Psychology of Men and Masculinity. 2010; 11(2):113–122.

Brady KT, Dansky BS, Back S, Foa EB, Carroll K. Exposure therapy in the treatment of PTSD among cocaine-dependent individuals: Preliminary findings. Journal of Substance Abuse Treatment. 2001; 21:47–54. [PubMed: 11516926]

Brown PJ. Outcome in female patients with both substance use and post-traumatic stress disorders. Alcoholism Treatment Quarterly. 2000; 18(3):127–135.

Coffey SF, Schumacher JA, Stasiewicz PR, Henslee AM, Baillie LE, Landy N. Craving and physiological reactivity to trauma and alcohol cues in PTSD and alcohol dependence. Experimental and Clinical Psychopharmacology. 2010; 18:340–349. [PubMed: 20695690]

Coffey SF, Stasiewicz PR, Hughes PM, Brimo ML. Trauma-focused imaginal exposure for individuals with comorbid posttraumatic stress disorder and alcohol dependence: revealing mechanisms of alcohol craving in a cue reactivity paradigm. Psychology of Addictive Behaviors. 2006; 20(4):425–435. [PubMed: 17176177]

Coleman PK, Coyle CT, Shuping M, Rue V. Induced abortion and anxiety, mood, and substance abuse disorders: Isolating the effects of abortion in the national comorbidity survey. Journal of Psychiatric Research. 2009; 43(8):770–776. [PubMed: 19046750]

Coleman PK, Nelson ES. The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. Journal of Social and Clinical Psychology. 1998; 17(4):425–442. [PubMed: 11657677]

Coleman PK, Reardon DC, Rue VM, Cougle J. A history of induced abortion in relation to substance use during pregnancies carried to term. American Journal of Obstetrics and Gynecology. 2002; 187(6):1673–1678. [PubMed: 12501082]

Coyle CT. Men and abortion: A review of empirical reports concerning the impact of abortion on men. Internet Journal of Mental Health. 2007; 3(2):15312941, 20070101.

Coyle CT, Coleman PK, Rue VM. Inadequate preabortion counseling and decision conflict as predictors of subsequent relationship difficulties and psychological stress in men and women. Traumatology. 2010; 16:16–30.

Coyle CT, Enright RD. Forgiveness intervention with postabortion men. Journal of Consulting and Clinical Psychology. 1997; 65(6):1042–1046. [PubMed: 9420366]

Creamer M, Bell R, Failla S. Psychometric properties of the Impact of Event Scale—Revised. Behaviour Research and Therapy. 2003; 41(12):1489–1496. [PubMed: 14705607]

Fergusson DM, Horwood LJ, Boden JM. Abortion and mental health disorders: Evidence from a 30-year longitudinal study. British Journal of Psychiatry. 2008; 193(6):444–451. [PubMed: 19043144]

Foa EB, Hembree EA, Cahill SP, Rauch SAM, Riggs DS, Feeny NC, Yadin E. Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. Journal of Consulting and Clinical Psychology. 2005; 73:953–964. [PubMed: 16287395]

Foa, EB.; Hembree, EA.; Rothbaum, BO. Prolonged exposure therapy for PTSD. Oxford University Press; New York: 2007.

Foa, EB.; Rothbaum, BO. Treating the trauma of rape: Cognitive behavioral therapy for PTSD. Guilford; New York: 1998.

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Foa, EB.; Riggs, DS. Treatment for comorbid posttraumatic stress disorders and substance use disorders. In: Stewart, SH.; Conrod, PJ., editors. Anxiety and substance use disorders: The vicious cycle of comorbidity. Springer; New York: 2008. p. 119-137.

Henslee AM, Coffey SF. Exposure therapy for posttraumatic stress disorder in a residential substance use treatment facility. Professional Psychology, Research & Practice. 2010; 41(1):34–40.

Jakupcak M, Osborne TL, Michael S, Cook JW, McFall M. Implications of masculine gender role stress in male Veterans with posttraumatic stress disorder. Psychology of Men & Masculinity. 2006; 7(4):203–211.

Kero, Lalos. Reactions and reflections in men, 4 and 12 months post abortion. Journal of Journal of Psychosomatic Obstetrics and Gynecology. 2004; 21(2):81–91.

Kero A, Lalos A, Hogberg U, Jacobson L. The male partner involved in a legal abortion. Human Reproduction. 1999; 14(10):2669–2675. [PubMed: 10528006]

Kessler RC, Berglund P, Chiu WT, Demler O, Heeringa S, Hiripi E, et al. The National Comorbidity Survey Replication (NCS-R): Design and field procedures. International Journal of Methods in Psychiatric Research. 2004; 13:69–92. [PubMed: 15297905]

Kornfield SL, Geller PA. Mental health outcomes of abortion and its alternatives: Implications for future policy. Women's Health Issues. 2010; 20(2):92–95. [PubMed: 20211428]

Lauzon P, Roger-Achim D, Achim A, Boyer R. Emotional distress among couples involved in first-trimester induced abortions. Canadian Family Physician. 2000; (46):2033–2044. [PubMed: 11072583]

Levant RF, Wimer DJ, Williams CM, Smalley KB, Noronha D. The relationships between masculinity variables, health risk behaviors, and attitudes toward seeking psychological help. International Journal of Men's Health. 2009; 8(1):3–21.

Mahalik JR, Lagan HD, Morrison JA. Health behaviors and masculinity in Kenyan and U. S. male college students. Psychology of Men and Masculinity. 2006; 7(4):191–202.

Major B, Appelbaum M, Beckman L, Dutton MA, Russo NF, West C. Abortion and mental health: Evaluating the evidence. American Psychologist. 2009; 64(9):863–890. [PubMed: 19968372]

McDermott MJ, Tull MT, Soenke M, Jakupcak M, Gratz KL. Masculine gender role stress and posttraumatic stress disorder symptom severity among inpatient male crack/cocaine users. Psychology of Men & Masculinity. 2010; 11(3):225–232.

Morrison, JA. Psychology of Men & Masculinity. 2011. Masculinity moderates the relationship between symptoms of PTSD and cardiac-related health behaviors in male veterans. Advance online publication. doi: 10.1037/a0024186

Mota NP, Burnett M, Sareen J. Associations between abortion, mental disorders, and suicidal behaviour in a nationally representative sample. The Canadian Journal of Psychiatry. 2010; 55(4): 239–246.

Mowrer O. On the dual nature of learning—a re-interpretation of 'conditioning' and 'problem-solving.'. Harvard Educational Review. 1947:17102–148.

Myburgh M, Gmeiner A, van Wyk S. The experience of biological fathers of their partners' termination of pregnancy. Journal of Interdisciplinary Health Sciences. 2001; 6(1):28–37.

Naziri D. Man's involvement in the experience of abortion and the dynamics of the couple's relationship: A clinical study. The European Journal of Contraception and Reproductive Health Care. 2007; 12(2):168–174. [PubMed: 17559016]

Harkness KL, Shear M, Frank E, Silberman RA. Traumatic grief treatment: Case histories of 4 patients. Journal of Clinical Psychiatry. 2002; 63(12):1113–1120. [PubMed: 12523870]

Holmes MC. Reconsidering a “woman's issue:” Psychotherapy and one man's postabortion experiences. American Journal of Psychotherapy. 2004; 58(1):103–115. [PubMed: 15106403]

Ouimette P, Moos RH, Finney JW. PTSD treatment and 5-year remission among patients with substance use and posttraumatic stress disorders. Journal of Consulting and Clinical Psychology. 2003; 71(2):410–414. [PubMed: 12699036]

Powers MB, Halpern JM, Ferenschak MP, Gillihan SJ, Foa EB. A meta-analytic review of prolonged exposure for posttraumatic stress disorder. Clinical Psychology Review. 2010; 30:635–641. [PubMed: 20546985]

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Read JP, Brown P, Kahler CW. Substance abuse and posttraumatic stress disorders: Symptom interplay and effects on outcome. Addictive Behaviors. 2004; 29:1665–1672. [PubMed: 15451135]

Reardon DC, Coleman PK, Cougle JR. Substance Use Associated with Unintended Pregnancy Outcomes in the National Longitudinal Survey of Youth. The American Journal of Drug and Alcohol Abuse. 2004; 30(2):369–383. [PubMed: 15230081]

Resnick, H. Psychometric review of National Women's Study (NWS) Event History-PTSD Module. In: Stamm, BH., editor. Measurement of stress, trauma, and adaptation. Sidran Press; Lutherville, MD: 1996. p. 214-217.

Rizvi SL, Vogt DS, Resick PA. Cognitive and affective predictors of treatment outcome in cognitive processing therapy and prolonged exposure for posttraumatic stress disorder. Behaviour Research and Therapy. 2009; 47:737–743. [PubMed: 19595295]

Rue VM, Coleman PK, Rue JJ, Reardon DC. Induced abortion and traumatic stress: a preliminary comparison of American and Russian women. Medical Science Monitor: International Medical Journal of Experimental And Clinical Research. 2004; 10(10):SR5–SR16. [PubMed: 15448616]

Shear K, Frank E, Houck PR, Reynolds C. Treatment of Complicated Grief: A Randomized Controlled Trial. JAMA: Journal of the American Medical Association. 2005; 293(21):2601–2608.

Shear MK, Frank E, Foa E, Cherry C, Reynolds CF, Vander Bilt J, Masters S. Traumatic grief treatment: A pilot study. The American Journal of Psychiatry. 2001; 158(9):1506–1508. [PubMed: 11532739]

Sheehan DV, Lecrubier Y, Sheehan KH, Amorim P, Janavs J, Weiller E, Hergueta T, Baker R, Dunbar G. The Mini- International Neuropsychiatric Interview (M.I.N.I.): The Development and Validation of a Structured Diagnostic Psychiatric Interview for DSM-IV and ICD -10. The Journal of Clinical Psychiatry. 1998; 59:22–33. [PubMed: 9881538]

Smith JP, Tran GQ, Thompson RD. Can the theory of planned behavior help explain men's psychological help-seeking? Evidence for a mediation effect and clinical implications. Psychology of Men & Masculinity. 2008; 9(3):179–192.

Speckhard A, Rue V. Postabortion syndrome: An emerging public health concern. Journal of Social Issues. 1992; 48(3):95–119.

Suliman S, Ericksen T, Labuschgne P, de Wit R, Stein DJ, Seedat S. Comparison of pain, cortisol levels, and psychological distress in women undergoing surgical termination of pregnancy under local anaesthesia versus intravenous sedation. BMC Psychiatry. 2007; 7:1–9. [PubMed: 17214899]

Tager D, Good GE, Brammer S. “Walking over `em”: An exploration of relations between emotion dysregulation, masculine norms, and intimate partner abuse in a clinical sample of men. Psychology of Men & Masculinity. 2010; 11(3):233–239.

van Emmerik AP, Kamphuis JH, Emmelkamp PG. Prevalence and prediction of re-experiencing and avoidance after elective surgical abortion: A prospective study. Clinical Psychology & Psychotherapy. 2008; 15(6):378–385. [PubMed: 19115456]

Weiss, DS.; Marmar, DS. The Impact of Event Scale - Revised. In: Wilson, JP.; Keane, TM., editors. Assessing psychological trauma and PTSD: A practitioner's handbook. Guilford; New York: 1997. p. 399-411.

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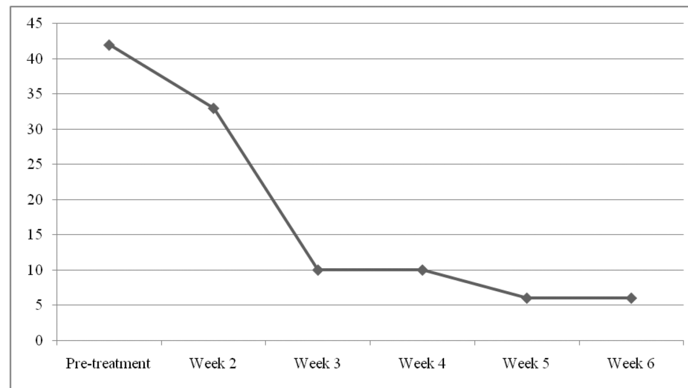

Note: The IES-R was administered to patient at the initial assessment. Three treatment sessions occurred between the first and second administration of the IES-R. Two sessions treatment sessions occurred between subsequent IES-R administrations.

Figure 1.

Patient's PTSD symptoms over the course of treatment as measured by the Impact of Event Scale-Revised (IES-R; Weiss& Marmar, 1997).