

# End-of-Life Psychospiritual Pain and Suffering Related to Women Who Have Undergone Induced Abortion(s)

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ABSTRACT: An essential function of Hospice/Palliative Care Programs is the management of “total pain,” including physical, psychological, social and spiritual distress. This exemplar illustrates the impact of psychospiritual pain on physical pain intensity and suffering. The author noted this phenomenon particularly at the end-of-life in women who had experienced induced abortion(s) earlier in life. The essay also relates one woman’s long term suffering to Post Traumatic Stress Disorder and complicated/complex grief. Resolution is included in the paper.

This composite portrait of “Mrs. Victoria M.” reflects Dr. Cicely Saunders’s model of “total pain” by referring to physical, emotional, social, and spiritual pain in life-threatening and terminal illness.<sup>1</sup>

One challenge for nurses, physicians, pastoral care workers, and social workers is the assessment, planning and appropriate interventions around spiritual pain. Existential questions inevitably arise as dying and death become a reality. Many individuals express fear of the unknown when they ask questions like these: *What happens to me when I die? How will I die? Will I have pain that I can’t stand? What kind of a*

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<sup>1</sup> M. Cecily Saunders, *The Management of Terminal Disease: The Management of Malignant Disease Series* (London UK: Edward Arnold Publishers, 1979), pp. 193-202.

*legacy am I leaving? Is there a God? If He exists, where is He? Why is this happening to me? Am I being punished? I have done such terrible things....do you believe in hell?*

PART 1. EXEMPLAR: MRS. VICTORIA M.

*Physical Pain and Pathology*

This 56-year-old patient was referred to palliative care for assistance in the management of her end-of-life care. At age 53, Mrs. M. was diagnosed with aggressive carcinoma of the left breast with lymph node involvement. A mastectomy and a left axillary node resection were followed by chemotherapy and the estrogen-suppressant drug tamoxifen. The removal of her breast caused great concern for both Mrs. M. and her husband. Their marriage had previously deteriorated and Mr. M. was unable to provide his wife with comfort, support, or the reassurance that she desperately needed.

Two years later Mrs. M. developed a dry, irritating cough and felt pain in her lumbar-sacral spine as well as in her anterior rib cage. Cancer had recurred and now involved lungs, liver, and bone. Aggressive chemotherapy was started, and "spot" radiation to affected spinal areas gave her some relief. The bisphosphonate drug Arimidex (pamidronate) was given monthly for relief of bone pain. At this point Mrs. M. was seen again by Hospice Palliative Care.

A year later, with advancing disease, bone pain became her main concern. It was necessary for morphine to be given. She started at 10 mg (milligrams) of morphine every four hours around the clock, with 5 mg every hour as needed for breakthrough pain. This regimen did not touch the intensity of her pain, which she stated was a "10/10+++" on a numeric analog scale, for which zero signifies no pain and ten equals the very worst pain (the patient herself added the plus signs). Dosage of morphine was titrated up over the next two weeks, and a pain pump was started to give her a steady dose of narcotic via a small needle just under the skin surface of her abdomen; this is called continuous subcutaneous infusion. Her total 24-hour dose was 1,056 mg morphine, thus giving Mrs. M. a steady hourly infusion of 44 mg. The normal adult dose of

this narcotic is 10 mg every three to four hours. These numbers did not reflect added breakthrough doses that were patient-controlled.

In addition, Mrs. M.'s anxiety was not responding to the family of anxiolytics called benzodiazepines. Small doses of antipsychotic medication did not settle her.

### *Emotional Pain*

The awful truth of advancing disease and being labeled "terminal" caused Mrs. M. to be angry, sad, and (understandably) depressed. Her 28-year-old son had a learning disability and hopes for him to find a well-paying job were slim. This worried both parents. Their pregnant 27-year-old daughter was living with an abusive partner whom her parents disliked intensely. On top of these worries, and aggravating Mrs. M.'s emotional pain, was the uncomfortable distance between husband and wife. She needed love and compassion. Instead, she had a sense of worthlessness and a feeling that she had become a burden to her family. Silent tears were always present, and "death anxiety" made her agitated and restless. (Due to financial cutbacks, social workers and psychologists were not available).

### *Social Pain*

Mrs. M. had lost her identity as wife, mother, and bank executive. Previously an independent woman, she felt totally dependent on her care-providers and her family was of minimal assistance. The family missed her healthy paycheck and spoke aggressively to her: "How can we possibly manage without your money coming in?" This caused Mrs. M. much grief, since she blamed herself for their dilemma.

### *Spiritual Pain*

With unmanageable pain, escalating "death anxiety," intractable nausea and vomiting, and increasing shortness of breath despite all medications, her situation was horrendous! Although we are always warned not to proselytize, it was now the time for re-checking her beliefs, her spiritual issues, and the meaning that she saw in her life and suffering. Earlier on she had described herself as a protestant with no church affiliation and

no desire to discuss "religion." In addition, pastoral care was unavailable at that time.

After the nursing staff notified me about Mrs. M.'s increasing anxiety, I returned to the hospital one evening at midnight and went to her room. This lovely lady was moaning, tossing and turning, totally unable to find a comfortable spot to rest. Tired and a little at wits end myself, I pulled up a chair and asked the question, "Victoria, how are things between you and God?" Her response was startling as she began to cry and speak at the same time, "If there is a God..., He surely would have nothing to do with me. I can never be forgiven for what I've done.... You must promise if I tell you, you will not tell anyone...not the nurses, not my doctor, not my family, not anyone. I have done an unpardonable thing...I have committed murder...I killed my own baby." Sobbing loudly, Mrs. M. carried on, "Now look at me.... I'm all wizened and dying.... This is my punishment.... I deserve every bit of it.... God will never forgive me.... I can never forgive myself. Help me, help me.... I can't go on this way!"

By then our hands were intertwined and Mrs. M. hung on like a person sinking into a fearful abyss. For a few moments it seemed like looking into a kind of hell here on earth. The fear and torture were right there in her eyes.

My experiences at the bedside have taught me that only God can help a care-provider when facing powerful existential crises and the suffering of the human spirit. My simple and only response then was: "Vicki, God loves you. You can be forgiven, honestly Vicki." The loud sobbing softened and her handgrip relaxed a little. She frowned and claimed, "You're only a nurse, not a minister.... How can you make a promise like that?" "Because I believe it," was all I could say.

By then her pillow was soaked with tears. A fresh pillowcase, repositioning her fragile body, and sponging her face settled her for a moment. Mrs. M. then blurted out, "I had an abortion.... Do you understand...an abortion.... I killed my own baby! The baby would be 22-years-old now. I was almost five months pregnant.... My husband kept insisting that we 'needed my income and couldn't afford another child'.... He kept on nagging me that I must 'get an abortion.' He told me... 'You know...it can't amount to much...they'll just remove a bit of

tissue!' He finally took me out of the country.... I was too far along to get an abortion at home. My husband didn't even come into the clinic with me. He just dropped me off and drove away. The people in the clinic weren't too friendly.... They kept asking me why I waited so long. It was the worst experience of my life.... The pain was worse than having my other children.... It was even worse than what I'm having now! I had no idea how big my baby would be, they wouldn't let me see my baby because its skull was crushed or something, but I saw a five-month pregnancy on television when I was in my forties.... I cried myself to sleep that night. I just wonder who that baby would be today.... He might have been the one who would comfort me now... oooh, what an awful thing, killing my baby! That baby might not have had a learning problem...might not have lived with an abusive jerk! Well, what do you expect, look at her mother.... I took it for all these years!"

Mrs. M.'s talking and crying lasted more than two hours. She was having an emotional and spiritual catharsis. Every word spoken by this patient was a profound example of psychospiritual pain that had affected her deeply over many years. Now as she faced death, Mrs. M. was terrified.

Her situation mirrored by 23 others that have surfaced over the 27 years of my work in palliative care. Twelve of these cases have been suitably documented for research and publication. These unfortunate women range in age from 19 to 96 years. Mrs. M. and the other patients often did not get in touch with the spiritual pain of their induced abortions until decades later.

Victoria was expressing guilt, fear, shame, anger, and a grief response.<sup>2</sup> We discussed the awful details of her abortion and its aftermath. Mrs. M. just wanted to tell it all once she got started. We talked about the issue of wife abuse in depth as well. Mrs. M. had a deep anger and resentment towards her husband, and she held him partly responsible for her abortion and the dreadful things that followed. Mrs.

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<sup>2</sup> Elizabeth Ring-Cassidy and Ian Gentles. *Women's Health after Abortion: The Medical and Psychological Evidence*, 2nd ed. (Toronto, Ontario: deVeber Institute for Bioethics and Social Research, 2003), pp. 160-62.

M. had barely been able to walk out of the abortion clinic and she was bleeding heavily. Her husband finally returned, reeking of alcohol. By the time they returned to their own city, she was bleeding so heavily that emergency room treatment was essential. A dilatation and curettage (D&C) followed to remove placental remains, and she required two blood transfusions. Mrs. M. found that she did not want to be near her children when she arrived home. She said, "I just didn't want to touch my kids, my husband or anyone. I know I was terribly depressed...but couldn't admit it. My life changed after that.... I had nightmares, trembling...terrified and scared of everything.... I didn't know why."

Finally, I offered to pray with this very distressed patient. Mrs. M. said, "Yes, yes, please pray for me and my little lost baby." After this, and acts of nursing care comfort, including an anti-anxiety medication, she settled, exhausted, on her pillows.

With Mrs. M.'s consent, a pastor from one of the local churches started visiting her daily. They prayed, read the Bible together, and spoke of forgiveness. She never discussed her abortion with him. Six days later, I was present when Mrs. M. made a confession of her faith, through tears of joy!

Amazingly, her morphine requirements dropped steadily over this time until the pump was delivering 325 mg of morphine every 24 hours, instead of the previous 1,056 mg per 24 hours that had not helped her pain. Thus the hourly rate had been titrated slowly down to 13 mg instead of 44 mg per hour...an amazing difference prior to her previously required dosages. Mrs. M. died gently three days after taking communion.

Addressing pain of the human spirit has always been a part of the "total pain" model that Dr. Cicely Saunders introduced at the first hospice in the United Kingdom, St. Christopher's Hospice.<sup>3</sup> Dame Saunders's model is used consistently in hospice and palliative care settings. It underscores the need for professional and volunteer care providers to address the needs of the "whole person." These needs include the patients' physical, emotional, social, and spiritual pain and

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<sup>3</sup> Saunders, 1979. See n. 1.

suffering. The model is also well recognized as a basic concept in the art and science of nursing.<sup>4</sup> Thus, in taking a nursing history, we must identify the need to include pastoral care and clergy in the plan of care. With the patient's consent, pastoral care and clergy should be called in as soon as possible. Women may not reveal their innermost secrets to a man, and this makes it essential for nursing and members of the clergy to have good patterns of communication. In fact a multi-disciplinary team with frequent patient care rounds is recommended for all hospice palliative care programs.<sup>5</sup>

## PART 2: WHAT DOES THE EXEMPLAR ILLUSTRATE?

### *Psychospiritual Pain and Its Impact on Physical Suffering*

Mrs. M.'s guilt and shame made her fear punishment, both during her dying and after death. All of these emotions and concerns that related to the abortion earlier in her life caused great death anxiety. This resulted in ever escalating doses of morphine, anxiolytics, and antipsychotic medications that failed to give her relief from physical pain.

The nursing literature on end-of-life care recognizes that spirituality is very important although many nurses have less confidence in this area of human need.<sup>6</sup> The North American Association of Nursing Diagnosis

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<sup>4</sup> *The Compendium of Standards of Practice for Nurses in Ontario* (Toronto, Ontario: College of Nurses of Ontario, 2005).

<sup>5</sup> Jean Echlin. *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice* (Ottawa: Canadian Hospice Palliative Care Association, 2002).

<sup>6</sup> R. Virani, D. Sofer, "Improving the Quality of End-of-life Care," *American*

refers to spirituality as an integrating life principle. It is totally pervasive of an individual's whole being, transcending the biologic and psychosocial nature.

The defining characteristics of spirituality in this nursing diagnosis nomenclature include the individual's value and belief systems as well as their perception of the meaning of life and existence.<sup>7</sup> O'Gorman points out that a person's sense of spirituality is separate from religion and cultural ties. Religion is described as a group's perception of God. Spirituality is an individual's perception of relationship with God. It follows that nurses and all health-care providers need to be responsible for spiritual care. Presence, authenticity, and availability are spiritual tools.<sup>8</sup> In fact, blessed is the multi-disciplinary team that includes on-site chaplains and the availability and accessibility of community priests, rabbis, shamans, and pastors who can tolerate night calls.

In addition, Dr. Daniel Hinshaw speaks effectively about the redefinition of hope in terms of the person who is dying—a hope that they will not be abandoned or die alone, the hope that pain and other distressing symptoms will be appropriately managed, the hope they will not be forgotten, and the hope of forgiveness and reconciliation. He suggests that health-care providers must enter into the patient's suffering in order to provide relief of spiritual pain, both for the patient and themselves. This type of pain cannot simply be relegated to the clergy. Hinshaw also quotes Dr. Christina Puchalski's method for taking a spiritual history, which is effective and opens opportunity for identification of these needs.<sup>9</sup>

### *Complicated Grief*

Another important variable that comes to light in Mrs. M.'s study is the powerful post-abortion grief experience that is highlighted in her expressions of psychospiritual pain. From the "Report On Bereavement and Grief Research" in *Death Studies* come the simplest definitions.

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<sup>7</sup> L.J. Carpenito, *Nursing Diagnosis: Application to Clinical Practice*, 9th ed. (Philadelphia: Lippincott, 2001).

<sup>8</sup> M.L. O'Gorman, "Spiritual Care at the End of Life," *Critical Care Nursing Clinics of North America* 14/2 (2002): 171-76.

<sup>9</sup> D.B. Hinshaw, "The Spiritual Needs of the Dying Patient," *Journal of the American College of Surgeons* (June 2002 June): 565-68.

“Bereavement refers to the loss of a loved one by death; grief refers to the distress caused by death.” In addition this research points out that

progress is being made in distinguishing complicated grief from normal grief and in identifying the risks that it poses. Researchers hypothesize that a small, but significant percentage of the population experience complicated (also known as traumatic or pathological) grief and that these individuals are at greatest risk for adverse health effects.<sup>10</sup>

Moreover, in the June 1, 2005 edition of the *Journal of the American Medical Association*, Katherine Shear and colleagues claim that complicated grief can be reliably identified through the Inventory of Complicated Grief (ICG). It includes the following characteristics:

- (1) a sense of disbelief following the death,
- (2) anger and bitterness over the death,
- (3) recurrent pangs of painful emotions, with intense yearning and longing for the deceased,

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<sup>10</sup> “Report on Bereavement and Grief Research,” *Death Studies* 28/6 (2004): 498, 501, 521, 529, 532.

- (4) preoccupation with thoughts of the loved one, often including distressing, intrusive thoughts related to the death.<sup>11</sup>

Therefore, looking at this current exemplar, we see Mrs. M. slowly dying of breast cancer and all the while agonizing about the baby she lost through induced abortion twenty-two years earlier. Her history included an attempt on her own life at the estimated time of delivery for the pregnancy. Mrs. M. was very ambivalent about her abortion and certainly felt coerced by her husband. These are blatant risk factors for psychological problems after abortion.<sup>12</sup> In addition, Ring-Cassidy and Gentles indicate that one of the post-abortion physical problems includes "women's overall risk of breast cancer is increased by 30%, with ten of fifteen U.S. studies confirming the abortion-breast cancer link."<sup>13</sup>

#### POST-TRAUMATIC STRESS DISORDER

According to the newer science of psychoneuroimmunology, the mind

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<sup>11</sup> Katherine Shear, Ellen Frank, Patricia R. Houck, Charles Reynolds. "Treatment of Complicated Grief: A Randomized Controlled Trial," *Journal of the American Medical Association* 293/21 (2005): 2601.

<sup>12</sup> Ring-Cassidy, pp. 138-44.

<sup>13</sup> Ring-Cassidy, pp. 18-28.

and body are not separated in the way that the medical Cartesian model suggests. This model of mind/body dichotomy has hopefully had its day! The newer model illustrates how a cascade of events in the human stress response will trigger the storage of traumatic events in the mid-brain's limbic system. Memories of this nature in the hippocampus and amygdala are accessible at both conscious and unconscious levels. Thus, horrifying flashbacks, nightmares, fears, and ongoing reminders of very traumatic events can surface throughout the life span. The body's response leads to lowered immunity, and future or present disease and Post-Traumatic Stress Disorder (PTSD).

For Mrs. M., her abortion was an extremely traumatic life event, a time when she was close to death from hemorrhage. The event actually perpetrated both severe physical and emotional trauma. She suffered depression, suicidal ideation and attempted suicide, and complicated grief response around her abortion. Now, the impending loss of her own worldly existence seemed to enhance her existing PTSD.

In study of the DSM-IV TR criteria for Post Traumatic Stress Disorder, Mrs. M. had several of the classic signs and symptoms including:

- (A) The person has been exposed to a traumatic event in which both of the following were present:
- The person witnessed, experienced, or was confronted with an event(s) that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
  - The person's response involved intense fear, helplessness, or horror.
- (B) The traumatic event is persistently reexperienced in one (or more) of the following ways:
- Recurrent and intrusive and distressing recollections of the event, including images, thoughts or perceptions.
  - Recurrent distressing dreams of the event.
  - Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- (C) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present prior to trauma) as indicated by three or

more of the following:

- Efforts to avoid thoughts, feelings or conversations associated with the trauma.
  - Feeling of detachment and estrangement from others.
  - Restricted range of affect (unable to have loving feelings).
- (D) Persistent symptoms of increased arousal as indicated by two (or more) of the following:
- Difficulty falling or staying asleep.
  - Hypervigilance.
  - Exaggerated startle response.
- (E) Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.
- (F) The disturbance causes clinically significant distress or impairment in social, or other important areas of function.
- Chronic: if duration of symptoms is three months or more.
  - Delayed onset: Symptom onset is at least 6 months after the stressor.<sup>14</sup>

Clearly, Mrs. M.'s history of, and reaction to her earlier abortion fulfill the criteria for Post Traumatic Stress Disorder.

While it is far too late to help those who have died in spoken and unspoken grief, it is not too late to help future sufferers. Even though the numbers in my ongoing study are few at this moment, we must take seriously the lifetime trauma of women after induced abortion. Many suffer symptoms of complicated grief and post-traumatic stress with physical, social, and psychospiritual sequelae. Lowered immunity, mental health issues, abandonment of their own values and often their religion and spirituality affect not only the woman as wife and mother but also affects the entire family. Children feel abandoned and may not have the nurturing they need; partnerships deteriorate and collapse;

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<sup>14</sup> *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Text Revision (American Psychiatric Association, 2000).

divorce and family breakdown occur; the impact reaches the larger community. Healthcare costs escalate, and much of society suffers, without ever knowing why.

#### THE CHALLENGE

Currently, there is nothing in the literature reflecting psychospiritual pain as an end-of-life issue after an earlier in life induced abortion. Therefore research and publications must be done now. Those who counsel women about to make life-affecting decisions about abortion must tell them all of the problems that might be in their future, including physical disease as well as emotional, social, and spiritual suffering. Health-care providers and clergy involved in hospice palliative care work must be sensitive to and aware of the type of existential crisis presented by patients like Mrs. M. and the others I have encountered. Indeed, all individuals dealing with dying and death should be knowledgeable regarding the impact of psychospiritual pain on end-stage pain and suffering.