Results of Group Psychotherapy for Abuse, Neglect and Pregnancy Loss

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Abstract: The pre and post evaluation of 65 patients undergoing intensive group psychotherapy by the Hope Alive method, yielded useful information on 28 parameters. The results provide sufficient evidence of benefit to warrant continued use of this program and to investigate the various components to delineate the most effective aspects of the program. There is statistically significant global improvement, but some areas of change such as: self-esteem and relationship with partner and a hopeful outlook are greater than others. When patients did their homework assignments consistently and thoroughly, there was increased likelihood of insight, personal growth, and diminished psychological symptoms.

Keywords: Treatment, group therapy, insight, behaviour changes, abuse, neglect, pregnancy loss, abortion, depression, anger, hope, relationships

INTRODUCTION

There is a pressing need to treat men and women who have been injured by a combination of psychological conflicts arising from childhood mistreatment and later pregnancy losses. These traumatic events appear to be related to each other. To date there appears to be no treatment programs dealing with the issues that arise from both these experiences. Using a time-limited closed group psychotherapy program we found significant improvements in most major symptoms reported by patients on pre and post treatment questionnaires.

Hope Alive is an intensive group psychotherapy technique developed to address the psychiatric problems observed in women and men affected by mistreatment and pregnancy losses of all kinds. After evaluation and in consultation with the referring family physician, a recommendation is given to appropriate patients. Informed consent is required before they are included in the group, which consists of 4 to 6 women and men. Patients are given a schedule with the dates of all the sessions and referring physicians are provided with an outline of the entire process. There are 30 – 32 sessions of two hours twice per week. There are a number of unusual features including homework assignments at which patients spend considerably more time than they did in group.

LITERATURE REVIEW

A search of the literature indicates an increasingly large number of studies on problems following pregnancy loss, particularly grief. Lewis [1] early research found unresolved grief following a stillbirth interfered with the parents' ability to bond to subsequent children. Others have confirmed these results and extended the research to other types of pregnancy loss [2, 3]. Buchegger [4] states "if a couple decides to terminate a pregnancy as a consequence of the diagnostic outcome (prenatal diagnosis), the ensuing mourning process is known to be similar to mourning after stillbirth". "Deliberate termination intensifies guilt feelings, especially if, as in Down's Syndrome, the anomaly would not have affected the child's viability". After assessing 30 women at 6 weeks, 6 months and 12 months after termination, a group at the Tavistock Clinic in London concluded that whether it was a first or second trimester termination for fetal abnormality, psychological morbidity is "prevalent and persistent" [5]. Broen *et al*. [6] compared the impact on women of miscarriage (n=40) to those who had an abortion, (n=80). They found that although the short-term emotional response was greater to miscarriage, those who experienced induced abortion had significantly more avoidance of thoughts and feelings related to the event for a longer period. Compared to 12 women who gave birth to a healthy child, 12 women who terminated their child for fetal abnormality showed neural activation similar to that of those in physical pain [7]. Men also grieve following a miscarriage [8] and feel a desire to protect their partner.

Guilt and grief following the termination of an unwelcome child would be expected to be more intense since it is known that the greater the ambivalence toward the lost object the greater the difficulty in detaching. Recent studies have shown that grief, depression and poor mental health may occur following an abortion [9, 10].

Although few studies have simultaneously examined pregnancy loss and childhood mistreatment, results from a limited number of published studies suggest they may be related. Kumar and Robson [11] found that women are more likely to be depressed following the birth of a child that has been preceded by an abortion. Benedict, White and Cornely [12] did a retrospective matched pair study in families physically abusive to one or more of their children as compared to non-abusive families. They found mothers in maltreating families were younger, had shorter birth

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intervals, had less prenatal care and were significantly more likely to have a stillbirth or reported abortion or prior child death. Coleman *et al.* [13] found that compared to women with no history of perinatal loss, those with one loss voluntary or involuntary had a 99% higher risk for physically abusing their child and women with multiple losses were 189% more likely. Women with a history of one induced abortion were 144% more likely to physically abuse their children compared to women who had no abortions. We [14] found that childhood mistreatment and pregnancy loss were cyclically related. Parents coming with backgrounds [5] of abuse and neglect were more likely to terminate pregnancies. Those with pregnancy terminations were statistically more likely to abuse and neglect subsequent children. The possible reasons for this statistically significant association are complex, but they appear to include:

1) The increased likelihood of post-partum depression interfering with bonding to a child born subsequent to an abortion.
2) Interference to the instinctual protective mechanism of a parent.
3) A greater frequency of partner loss following an abortion, with anger to the abandoning partner displaced onto the fetus.
4) Poor physical and emotional health resulting partly from an unresolved grief [15, 16].

METHODOLOGY

A case-control study design was used to examine treatment outcomes in 65 people undergoing Hope Alive treatment. Twenty-eight parameters evaluating psychological and physical well-being were assessed prior to the commencement of therapy and then re-evaluated at the end. Most parameters were assessed using self-reporting on visual analog scales. For the purposes of analysis, the visual analog scale markings were converted to whole number scores from 1 to 9. Data were analyzed with SPSS using Wilcoxon signed rank tests.

Fifty-three women and twelve men completed pre- and post-treatment evaluations of Hope Alive group psychotherapy. Therapy is conducted in mixed gender groups of four or five patients, a therapist and a facilitator (someone who has successfully completed a previous group, and/or a trainee) over an average of 32, two hour sessions and two follow-up sessions at three and six month intervals.

All patients were referred by family physicians to the psychiatrist usually for the evaluation and treatment of a persistent depression. About 40% of the patients referred were considered suitable for this group psychotherapy. Inclusion criteria included: a stable life situation, agreement and support of the referring physician, the ability to think symbolically and benefit from insight, able to tolerate intense emotions without acting out, intellectually capable of understanding explanations that used abstractions and had the time to devout to group psychotherapy with homework.. Forty five percent had other forms of psychotherapy or counselling prior to being referred. Of those included in the group, 100% were on antidepressants, often in combinations, 45% were also on anti-anxiety, 34% also on anti-psychotic or some other medication eg. for ADHD, at the time of referral.

The typical patient was female, aged 42 years, who came from a divorced family with neglect and divorce because of alcohol, is now married with 2 children from 4 pregnancies (the others were an abortion before marriage and a miscarriage between the girl and boy), working part time, and depressed for 3 years following a fight with her boss. There was temporary symptom improvement on 5 different antidepressant medications, worsening marital relations, loss of libido, little enjoyment in eating but gaining weight, sleep loss, irritability with her children culminating in uncontrolled screaming for which she feels guilty, poor self esteem, moderate level of anxiety, major persistent depressive mood, feeling life is not worth living and she doesn't deserve to be alive but would not commit suicide. She states, "Now I must get to the bottom of this or my family will fall apart and then I won't care what happens to me".

Data was gathered from clinical observations and a self-report questionnaire which included a combination of visual analog scales, multiple choice questions and questions requiring descriptive answers. These scales have been checked for validity and reliability and reported in previous studies [17, 18].

The Phases of the Hope Alive Treatment Programme

1. Informed consent, Introductions and Commitment to confidentiality, completion etc.
2. Defences and resistances to knowing and growing, with role-plays, e.g. "Please listen to me" etc.
3. Learning from past painful experience, patterns in family trees, tracing triggers etc.
4. Changing patterns of anger, seeing pain behind the rage, learning appropriate assertion etc.
5. Recognizing the fear behind the fear and learning when and how to face it or to run.
6. Real and imagined guilt: learning about tragic triangles and contributors to tragedies.
7. Discovering the authentic person behind the Dancer and Urchin Masks.
8. Grieving the loss of the Person I Should Have Become and welcoming the Person I Am.
9. Identifying, welcoming, committing then mourning unresolved pregnancy losses.
10. Reconciliation with Perpetrators, Observers and Victims, forgiving and forgetting.
11. Negotiating realistic expectations with mate, children, family and employers.
12. Attenuating unwelcome and unnecessary pair bonds.
13. Making difficult decisions using their recognition of key conflicts and their blueprint.
14. A project to help prevent what happened to you, happening to other susceptible people.

15. Celebration of gains made and finding joy in life.

16. Expressions of gratitude and respect: good good-byes.

Each phase is accompanied with "home work" designed to initiate consideration of aspects not usually brought to mind. Spontaneous insights are recorded in a journal the patient keep close by. About eighty percent of the patients did almost all their homework, most of the time. They soon realized that the more effort they put into their assignments, the more insight they gained. Anyone who missed more than 3 sessions for any reason was discharged.

RESULTS

The distribution of demographic variables for these patients whose mean age was 42.57 years, Standard Deviation 11.22 yrs, indicates they are not significantly different from most Canadians according to Statistics Canada (Table **1**). The most common reason for attending the group was chronic anxiety or depression for which most patients were taking medications. Of those on medication at the time of referral, 62% were able to discontinue all psychotropic medication and 38% significantly reduced one or more by the end of the group. Ninety-six percent of the group reported childhood mistreatment in at least one form. Sixty two percent had one or more abortions. Fifty percent had one of more miscarriage and 39% had both. The interval between pregnancy loss and time of referral ranged from 1 to 24 years. The closest association of types of mistreatment was between verbal and physical abuse (Table **2**). This data is taken from the results of another questionnaire given to the patients in the same groups. That questionnaire is designed to determine the effects of transgenerational abuse and neglect [19, 20].

The drop out rate was 14%. The average attendance rate was 92%. The majority did at least 80% of their homework. The Medical Plan of British Columbia, Canada funded the treatment. The average cost for 32, two hour sessions in a group of 4 was approximately $3200 per person.

The overall group changes (Fig. **1**) show significant improvement along with most of the other 21 clinical variables measured (Table **3**). No significant improvement was observed in obsessive thinking and physical health. There was a significant decrease in the patient's desire to hurt or kill themselves.

On the post-treatment questionnaire we asked what factors the patients felt where most helpful in their treatment. We use a step-wise analysis to determine which of these factors was most closely associated with different areas of improvement (Tables **4**-**7**). It appeared certain group

Table 1. Demographic Frequencies

Marital Status			
Categories	**Frequency**	**Valid Percent**	**Cumulative %**
No Response	1	1.5	1.5
Married	34	52.3	53.8
Single	17	26.2	80.0
Divorced	3	4.6	84.6
Separated	3	4.6	89.2
Common Law	5	7.7	96.9
Widowed	2	3.1	100.0
Occupation			
No Response	2	3.1	3.1
Professional	7	10.8	13.8
Service Industry	18	27.7	41.5
Support Industry	8	12.3	53.8
Clerical	7	10.8	64.6
Business	8	12.3	76.9
Unemployed	5	7.7	84.6
Student	5	7.7	92.3
Tradesman	1	1.5	93.8
Retired	3	4.6	98.5
Disability	1	1.5	100.0

Table 2. Impact of Abuse and Neglect

	Physical Abuse	Verbal Abuse	Sexual Abuse	Physical Neglect	Emotional Neglect
Verbal Abuse	.587*				
Sexual Abuse	.353*	.280*			
Physical Neglect	.440*	.431*	.327*		
Emotional Neglect	.376*	.555*	.266*	.454*	
Impact On My Life	.387*	.567*	.289*	.437*	.657

Partial correlation coefficients, controlling for age, sex, marital state.
*p<.000

exercises and new insights were most useful to the overall improvement.

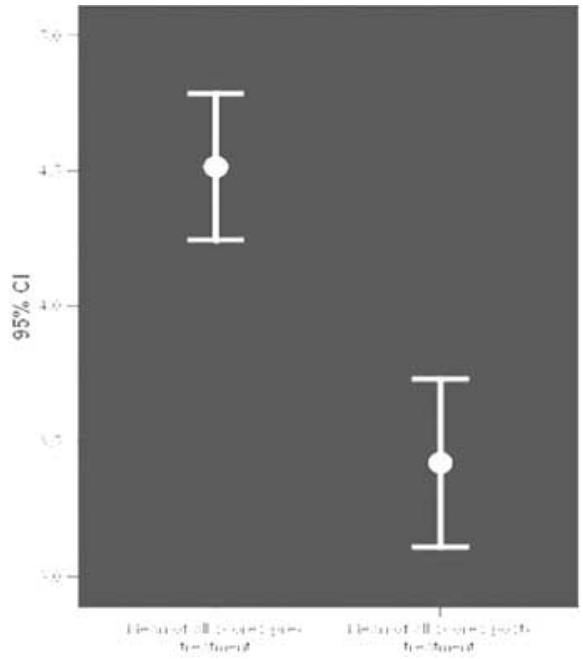

Fig. (1). Over all changes.

Table **4** indicates those components of the treatment program most closely associated with a decrease in feelings of sadness. One of the authors' clinical impressions (PGN) supports the correlation between discovering and asserting a sense of one's authentic self and decreased severity of depression.

Table **5** indicates that component of the treatment program which is most closely associated with the decreased chance that the patient will want to hurt somebody close to them is the patient's understanding how being a survivor of a pregnancy loss in their family affected them, it was closely related to less desire to hurt others.

Table **6** indicates that when a stepwise regression is done on components of the program, it appears that those factors that most closely associate with a sense of better functioning are: the ability to celebrate life, humanize losses, forgive the person's self, know why they can't resist, threats and understanding the "Universal Ethic of Mutual Benefit". Each component is represented in a question answered by each patient on whether or not they had understood or completed this aspect of treatment. The variables that were excluded in the first model, but are still relevant, include (not a comprehensive list): I recognize my resistance to knowing and growing; I learned to push through my resistance to

Table 3. Results

	Z	p
Decreased desire to hurt self	-3.162	<0.01
Decreased desire to hurt others	-2.971	<0.01
Decreased frequency of obsessive thinking	-2.217	=0.022
Decreased pessimistic thinking	4.128	<0.01
Decreased uncontrollable fears	-3.251	<0.01
Decreased frequency of bad choices	-3.289	<0.01
Decreased feelings of fearfulness	-3.987	<0.01
Decreased anger	-4.152	<0.01
Decreased sadness	-5.067	<0.01
Decreased loneliness	-4.250	<0.01
Decreased hopelessness	-4.250	<0.01
Decreased feelings of being alone	-3.257	<0.01
Decreased feelings of being trapped	-3.775	<0.01
Increased self-respect	-5.056	<0.01
Increased enjoyment of life	-3.298	<0.01
Improved memory	-2.929	<0.01
Improved ability to sleep	-2.432	=0.015
Improved physical health	-2.030	=0.042
Improved relationships with father	-2.537	=0.011
Improved relationships with siblings	-3.136	<0.01
Improved relationships with partner	-4.107	<0.01

Wilcoxon Signed Rank.

Table 4. Factors Most Closely Associated with Decreased Feelings of Sadness

	Standardized Coefficients Beta	t	Sig.
Constant		10.599	.000
Told trusted friend to remind me about my authentic self	.971	14.100	.000
Shared re: pregnancy losses	.578	8.496	.000
Repudiated my part in death of someone	.392	7.363	.000
Welcomed and accepted welcome	.509	6.509	.000
Understand my difficulties to celebrate	.303	3.130	.011
Resolved to use my life for benefit of others	.474	6.041	.000
Remembered earlier pain and fear	.311	4.110	.002
Said a good good-bye to the group counsellor	.176	2.408	.037

Stepwise linear regression.

Table 5. Factors Most Closely Associated with a Lessened Chance to Hurt Those Close to Me

	Beta	t	Sig.
Constant		4.966	.000
Understood how being a survivor or pregnancy loss in my family affects me now	.74	4.037	.001
Shared the events and emotions surrounding my pregnancy losses	.453	2.483	.025
Having received no responses, I decided to say good-bye to those with whom I tried to reconcile	.353	2.181	.046

Stepwise linear regression.

Table 6. How are you Feeling and Functioning Now?

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	2.588	.153		16.964	.000
I understand why it is difficult for me to celebrate life	.211	.024	.872	8.801	.000
I humanized and individualized all my losses	.355	.038	1.510	9.238	.000
I wrote a letter of reconciliation to myself and forgave myself	.155	.034	.656	4.540	.000
I found out why I couldn't say, "Stop it."	.122	.029	.517	4.191	.000
I recognised how the Universal Ethics of Mutual Benefit could operate in my life	8.269E-02	.027	.350	3.082	.004

Dependent Variable: POST, Feeling and Functioning Now
Stepwise regression on 28 components of Hope Alive group therapy.

change; I understand how my defences operate; I understand the patterns and themes from my time line; I understand how triggers now operate in my life; I remembered and felt the early experience of pain and fear; I evaluated the damage done to me by childhood mistreatment and unborn pregnancy losses. From the 135 factors in this program, the group members selected, as most influential in their overall improvement, gaining insight (Table **7**).

A sample of histograms show the distribution of the some variables in question Figs (**2** to **5**). They show results analyzed by Wilcoxon ranks for significance. It appears the "before and after" treatment measures of self-respect, sadness, relationship with partner and hopelessness improved particularly. Others also show significant, sometimes marked improvement.

DISCUSSION

Clinical observation and intuition supports the belief that group psychotherapy works well to improve communication, social behaviour and insight, but this is difficult to demonstrate. Using pre- and post-subjective impressions of the group patients represented on visual analogue scales, that data we present supports the use of the Hope Alive method of conducting group therapy for a reasonably representative clinical sample of patients. They suffered from various combinations of depression, anxiety, obsessive thinking, phobias, anorexia and other neurotic disorders that have arisen from the conflicts associated with childhood mistreatment and pregnancy losses. Their improvement appears to be most closely related to a better understanding of the roots to the turmoil in their thinking. Is it possible that humans are programmed with a need to understand and resolve the residual turmoil of their confusion engendered by life threatening experiences?

Hope Alive has some distinctive features that may contribute to its usefulness with these patients. "Homework" which requires 6 to 8 hours of thinking and writing between sessions, introduces each task and optimizes the time spent in the group. To the patients, the phases appear to form a natural sequence that helps them make sense of their painful trauma in the order they experienced them. The most difficult phase is reconciling with those who have hurt them and those whom they have hurt. However, they find that once they forgive: they forget, their thinking is clearer and they more often experience joy.

There appears to be a correlation between childhood trauma and later pregnancy losses, particularly miscarriage and abortion. The combined experiences may result in intense conflicts that are often impossible to resolve without assistance. Those affected may attempt to resolve the persistent turmoil by repeatedly re-enacting them, only to deepen the distress and extend the confusion [20].

The natural progression in the Hope Alive program has one phase readily following the other. Not infrequently, patients anticipate the next phase. Group members express appreciation for the home assignments, and many useful insights occur outside the group session. They recognize that a major direction of the program is to teach new skills in analyzing confusing experience. They can use these and other newly acquired abilities for the rest of their lives. Patients often report that following the termination of the group process there is a short honeymoon period followed by

Table 7. Factors Most Influential in Overall Improvement During Treatment

Post Treatment	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95% Confidence Interval for B	
One of the best features of group	B	Std. Error	Beta			Lower Bound	Upper Bound
INSIGHT INTO ROOTS OF BEHAVIOUR	1.420	.362	.475	3.919	**.001**	.652	2.189
EMPATHETIC UNDERSTANDING	1.251	.417	.312	3.001	**.008**	.367	2.136
THEORETICAL BASIS OF CONFLICTS	1.117	.419	.292	2.665	**.017**	.228	2.006

Logistic regression. Dependent variable, "How are you feeling and functioning now".

2

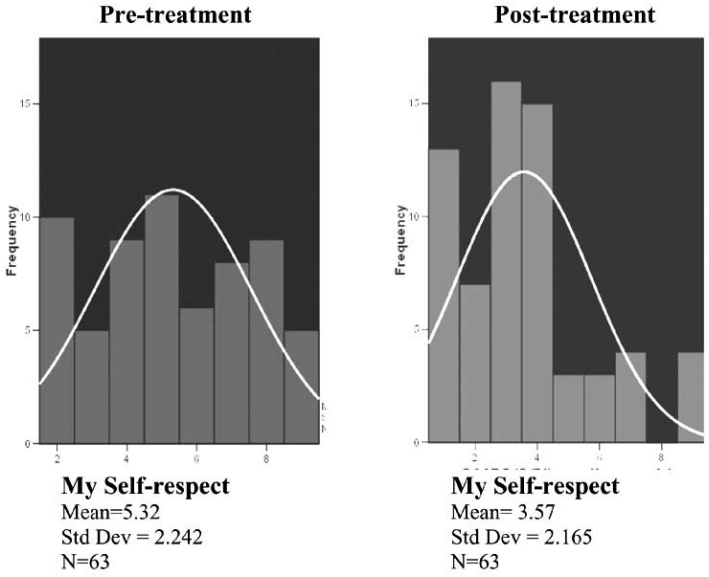

Fig. 2 to 5 contd….

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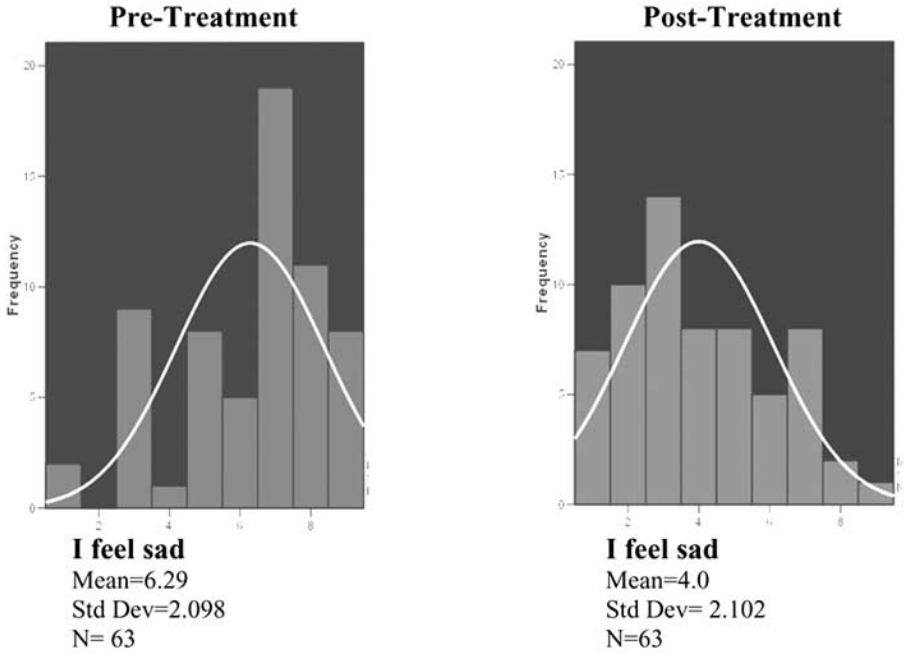

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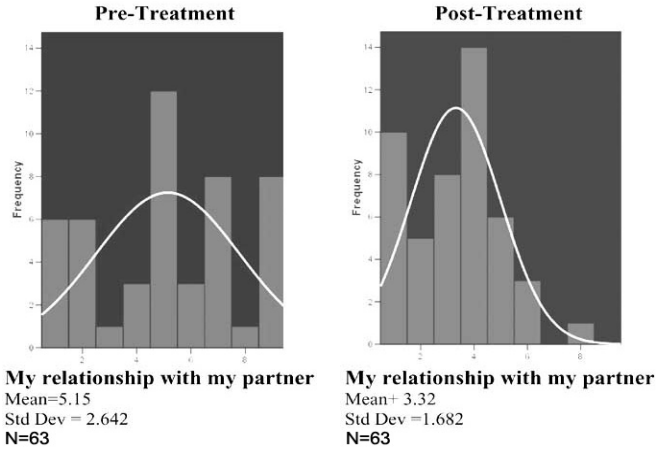

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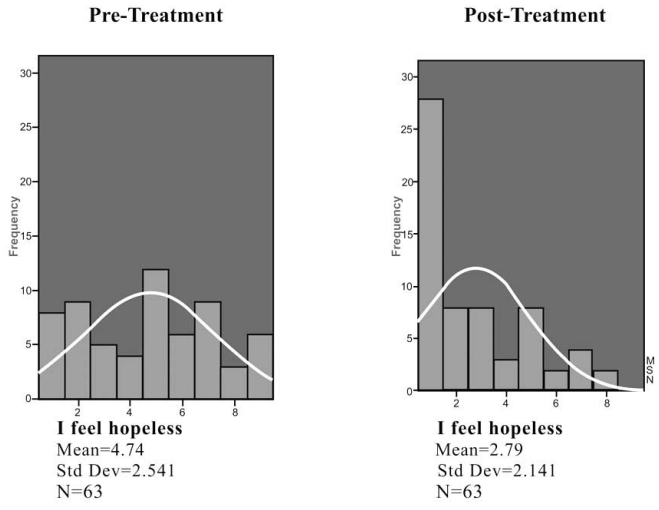

Figs. (2 to 5). Examples of the distribution of measures showing changes from pre to post treatment.

a familiar crisis. If they review their homework and apply their new skills, they are able to use the crisis to further build their confidence and self esteem.

From doing both individual and group psychotherapy, it appears that groups are both more effective and efficient. For any psychiatrist in a busy consulting practice with a never-ending waiting list this is vitally important. Doing extensive homework means the patients are almost continually and effectively working on their problems so that the time in-group is better used because it is more often focused. Patients appreciate knowing when the groups start and finish so they can plan their work and lives accordingly. It also puts reasonable pressure on them to use their opportunity well.

There is no study where patients have been randomly assigned to either individual or to this type of group therapy Kent and Nicholls [21] found that women in group therapy for post-abortion women appeared to have had a termination sometimes in revenge for abortions their mothers had. Gordon [22] found that one two-hour counselling session with men after fetal loss decreased their anxiety.

Tourigny *et al*. [23] at the University of Sherbrooke found their psycho-educational group therapy of 20 weekly two-hour sessions for sexually abused adolescent girls was effective on measures of post-traumatic stress, coping strategies, relationship with the mother and empowerment compared to a control group. Ryan, Fisher, Gilbert *et al.* [24] in London compared the effectiveness of 12 group or individual sessions for childhood sexual abuse (CSA) to a waiting list control. Measures before, after and at 4 then 8 months follow-up showed significant improvement for both treatments. The gains were maintained except on one measure for the group psychotherapy patients. Reay *et al*. in Canberra found that interpersonal group psychotherapy for mothers with post-natal depression "may improve symptom severity" [25]. The use of "homework" for groups has not been reported.

To the authors' knowledge, the use of group psycho-therapy designed for women or men affected by a combination of early childhood mistreatment and later pregnancy losses has not been reported else-where. The results of Hope Alive group therapy have been presented at the annual meetings of the American Group Psychotherapy Association in Los Angeles, May 2000 and the Canadian Psychiatric Association in Vancouver, November 2005. Since the Hope Alive technique has been taught in over 30 countries, there are other reports of outcome data for this technique that originated in Canada [26].

The data on 65 patients representing 8 groups indicates that overall, Hope Alive is a useful program in the treatment of those who have been injured by a combination of childhood mistreatment and pregnancy losses, but replication by other therapists using the same method is necessary. It appears that some components of the program are more useful than others. These observations are supported by clinical evidence at 3 months, 6 months and long-term follow-up. Most patients are able to discontinue, and others reduce, the use of medication for anxiety and depression. Off medication, they are often very grateful that, "Now my mind is no longer in a fog. I get down at times but I have real feelings and understand where they come from".

Following the analysis of data for the phases, we have a better understanding of which component of the program is best suited for which type of problems from the patients post treatment responses. On the follow-up questionnaire they are asked how well they are doing symptomatically and on a different segment how well they feel they completed the tasks and for each phase of the treatment. The underlying mechanisms are more fully described elsewhere [27]. They include the following: a) Being able to connect childhood traumatic experience with conflicts that they attempt to resolve by obsessively searching for reasons and meanings to them and by re-enacting them with subconsciously picked and coached partners, work mates and friends. This understanding of their "key conflicts" helps them to more quickly realize what is transpiring when they are about to act out the same painful psychological conflict once again. This makes it possible to choose a different direction, b) Mourning the loss of the Person I Should Have Become makes it possible to welcome the person the are and so become kinder to themselves and others. They have a more respectful appreciation of their authentic though still damaged self. c) Humanized and individualized their pregnancy losses, welcomed them into their family, symbolically buried them and committed their spirits into the hands of their "Creator", d) Understood their contribution to the painful experiences of life, e) Written Letters of Reconciliation to those who have injured them and who they have injured, forgiven them and been forgiven and consequently forgotten the experiences of fear, pain, guilt and shame associated with those people. It appears that the mind no longer retains painful and confusing memories once it can make sense of painful experiences, when people have been able to grieve the loss of the Person I Should Have Become and forgiven those who harmed them and whom they hurt, including themselves. f) Once their thinking is not so absorbed in futile self-analysis, they seem better able to make more accurate perceptions and rational decisions. Not being so self-absorbed, they can see and appreciate the small joy and wonder filling moments of their life. g) As they rid themselves of the interminable and futile self analysis, they are more available to understand their children who respond with better appreciated delight in having a mother and fathers who can laugh and cry again.

This study needs a longer period to follow-up, a larger sample, and the inclusion of some variables that now appear to be relevant. The best design is using the patient as his or her own controls but that would entail delaying treatment for some very unwell people.

CONCLUSION

Intensive, time-limited group therapy with pre-determined phases appears to be effective in treating the difficult problems arising in people who have experienced a combination of childhood mistreatment and pregnancy loss. The results from this study indicate sufficiently good outcomes to warrant further use of the Hope Alive method, but further study of its underlying mechanisms is necessary. There are a plethora of variables that might help explain the

results. It is not possible to control for all of them in one study. Since we now have evidence of benefit, it becomes difficult to have a no treatment control group. Instead we will use patients as their own control. We are currently extending this research and will report on data more concisely isolating which type of psychological symptoms and psychiatric diagnosis respond best to Hope Alive group psychotherapy.

REFERENCES

[1] Lewis E. Mourning by the family after a stillbirth or neonatal death. Arch Dis Child 1979; 54: 303-6

[2] Franche RL. Psychologic and obstetric predictors of couples' grief during pregnancy after miscarriage or perinatal death. Obstet Gynecol 2001; 97(4): 597-602.

[3] Conway K, Russell G. Couples' grief and experience of support in the aftermath of miscarriage. Br J Med Psychol 2000; 73: 532-45.

[4] Buchegger P. Couple treatment following abortion in prenatal diagnosis. An interdisciplinary and interprofessional cooperation. Schweiz Med Wochenschr 1997; 127(3): 69-72.

[5] Davies V, Gledhill J, McFadyen A, *et al.* Psychological outcome in women undergoing termination of pregnancy for ultrasound-detected fetal anomaly n the first and second trimesters: a pilot study. Ultrasound Obstet Gynecol 2005; 25(4): 389-99.

[6] Broen AN, Moum T, Bodtker AS, *et al.* Psychological impact on women of miscarriage versus induced abortion: a 2-year follow-up study. Psychosom Med 2004; 66(5): 795-6.

[7] Kirsting A, Ohrmann P, Pedersen A, *et al.* Neural activation underlying acute grief in women after the loss of an unborn child. Am J Psychiatry 2009; 166(12): 1402-10.

[8] Khan RA, Drudy L, Sheehan J, *et al*. Early pregnancy loss: how do men feel? Ir Med J 2004; 97(7): 217-8.

[9] Fergusson DM, Horwood LJ, Ridder EM. Abortion in young women and subsequent mental health. J Child Psychol Psychiatry 2006; 47(1): 16-24.

[10] Reardon DC, Cougle JR, Rue VM, *et al.* Psychiatric admissions of low-income women following abortion and childbirth. Can Med Assoc J 2003; 168(10): 1253-6.

[11] Kumar R, Robson K. Previous induced abortion and antenatal depression in primiparae: A preliminary report of a survey of mental health in pregnancy. Psychol Med 1978; 8: 711-5.

[12] Benedict MI, White RB, Connely DA. Maternal perinatal risk factors and child abuse. Child Abuse Negl 1985; 9(2): 217-24.

[13] Coleman PK, Maxey CD, Rue VM, *et al.* Associations between voluntary and involuntary forms of perinatal loss and child maltreatment among low income mothers. Acta Paediatr 2005; 94(10): 1476-83.

[14] Ney PG, Fung T, Wickett AR, Beaman-Dodd C. The effects of pregnancy loss on women's health. Soc Sci Med 1994; 38(9): 1193-1200

[15] Ney PG, Fung T, Wickett AR Relationships between induced abortion and child abuse and neglect: Four studies. Pre Perinatal Psychol J 1993; 8:43-63

[16] Reardon DC, Ney PG, Cougle J, *et al.* Deaths associated with delivery and abortion - a record linked study. South Med J 2002; 95(8): 834-41.

[17] Ney PG. Fung T. Wickett AR. The worst combinations of child abuse and neglect. Child Abuse Negl 1994; 18(9): 705-14.

[18] Ney PG. Fung T. Wickett AR. Child neglect: the precursor to child abuse. Pre Perinatal Psychol J 1993; 8(2): 95-112.

[19] Ney PG. Transgenerational Child Abuse. Child Psychiatry Hum Dev 1998; 18: 151-168.

[20] Ney PG. Child mistreatment: possible reasons for its trans-generational transmission. Can J Psychiatry 1989; 34: 594-601.

[21] Kent I, Greenwood RD, Nicholls W. Emotional sequelae of elective abortion. Br Columbia Med J 1978; 20: 118-9.

[22] Gordon RH. Efficacy of a group crisis-counseling program for men who accompany women seeking abortions. Am J Commun Psychol 1978; 6(3): 239-46.

[23] Tourigny M, Hebert M, Daigneault I, *et al.* Efficacy of a group therapy for sexually abused adolescent girls. J Child Sex Abuse 2005; 14(4): 71-93.

[24] Ryan M, Nitsun M, Gilbert L, *et al.* A prospective study of the effectiveness of group and individual psychotherapy for women CSA survivors. Psychol Psychother 2005; 78(4): 465-79.

[25] Reay R, Fisher Y, Robertson M, *et al.* Group interpersonal psychotherapy for postnatal depression: a pilot study. Arch Women Ment Health 2006; 9(1): 31-9.

[26] Gajowy M, Simon W. Group therapy for people damaged by child abuse, neglect and pregnancy loss combination. Psychiatr Pol 2002; 36: 929-44.

[27] Ney PG. Deeply Damaged, 3rd ed. Victoria, Pioneer Publishing, 1998.

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