

Prevalence of Elevated Post Traumatic Stress Symptom Scores Among Women Receiving Postabortion Care at Nakuru Level Five Referral Hospital Kenya

Eunice Kanini Mitheu¹ and Daniel A. Otwor²

¹ Great Lakes University of Kisumu, Kenya; ² Great Lakes University of Kisumu, Kenya

Corresponding author: Eunice Kanini Mitheu | mitheueunice@gmail.com

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ABSTRACT

Background: Psychological support may be relevant during postabortion care, but self-report symptom scores should not be equated with a clinical diagnosis. **Objective:** To estimate the distribution of post-traumatic stress symptom scores among women receiving postabortion services at Nakuru Level Five Referral Hospital. **Methods:** This secondary manuscript reports Objective One of a 2020 cross-sectional thesis. The thesis sampled 192 women and used a modified 17-item, five-response symptom scale. Frequencies across five thesis-defined score bands and mean scores for three symptom domains were extracted. A Wilson 95% interval was calculated for scores at or above 38. **Results:** Of 192 respondents, 25 (13.0%) were classified as little or no symptoms, 17 (8.9%) mild, 6 (3.1%) moderate, 13 (6.8%) high, and 131 (68.2%) severe. Thus 150/192 (78.1%; Wilson 95% CI 71.8–83.4%) scored at least 38 under the thesis threshold. Mean domain scores were 2.82 for intrusion, 3.02 for avoidance and 3.06 for arousal. **Conclusion:** Elevated symptom scores were common in this facility sample. Modified scale scoring, selection, timing and lack of diagnostic interview preclude a clinical PTSD prevalence estimate or causal inference about the preceding pregnancy event.

Keywords: Kenya, Nakuru, postabortion care, prevalence, screening, trauma symptoms

1. INTRODUCTION

Patient-centred postabortion services can include an opportunity to identify distress and offer appropriate support. A self-report symptom scale is useful for describing needs in a service population, but diagnosis requires clinical assessment and consideration of context. The American Psychiatric Association advises that assessment measures should enhance clinical decision-making rather than serve as the sole basis for diagnosis (APA, 2022). WHO guidance places postabortion care within a wider framework of respectful, evidence-based services (WHO, 2022).

Evidence from a prospective cohort of women seeking abortion in the United States found no higher subsequent PTSD risk among those who received care than among those denied care, illustrating the importance of baseline experience, comparison groups and follow-up in causal questions (Biggs et al., 2016). That study is not directly comparable with the Nakuru sample. The present article asks only what proportion of the surveyed Nakuru patients crossed the thesis-defined symptom threshold and how scores were distributed.

2. METHODS

The source was Eunice Kanini Mitheu's 2020 Great Lakes University of Kisumu thesis on determinants of post-traumatic stress symptoms among women after abortion at Nakuru Level Five Referral Hospital. Its first objective assessed prevalence. The study used a cross-sectional descriptive design with a target sample of 192 women seeking abortion-related treatment in the gynaecology department. The thesis describes an estimated monthly service population of 376 and a systematic selection interval of about two. The analytic table contains 192 respondents; recruitment dates and a screened-to-enrolled flow are not reported clearly enough to reconstruct a response rate.

A modified 17-item five-response scale adapted from Bride and colleagues was used to measure intrusion, avoidance and arousal. The thesis lists a score threshold of 38 for its elevated symptom category. Its displayed bands are 17–28, 28–37, 38–43, 44–48 and 49 or more. Because 28 appears in two displayed bands, the underlying assignment at that boundary cannot be verified without individual scores. Internal consistency in the pilot was reported as $\alpha = .91$. Modifications and validation in this clinical population were not fully documented. The thesis reports consent, confidentiality, hospital permission and referral for distress; the manuscript should retain exact approval identifiers only after checking the original appendices.

Counts and means were taken from thesis Tables 4.9 and 4.10. The 95% confidence interval for 150/192 was calculated with the Wilson method and is descriptive of the sample under the stated threshold, without correcting selection or measurement error. No comparison group or diagnostic interview was available.

3. RESULTS

Table 1. Thesis-defined symptom score distribution (n = 192)

Score band	n	%
Little or no symptoms, 17–28	25	13.0
Mild, 28–37	17	8.9
Moderate, 38–43	6	3.1
High, 44–48	13	6.8
Severe, 49 or higher	131	68.2
Total	192	100.0

Combining the three bands beginning at 38 yields 150 respondents, or 78.1% of the 192. This is the proportion above the thesis-defined screening threshold; it is not a confirmed diagnosis of PTSD. The overlapping boundary at 28 does not change the displayed count at or above 38, but prevents an independent audit of the lower category allocation.

Table 2. Reported symptom-domain mean item scores (n = 192)

Domain	Mean	SD
Intrusion	2.8219	0.72944
Avoidance	3.0171	0.77106
Arousal	3.0573	0.96116

The arousal domain had the highest reported mean and intrusion the lowest. Because domain composition and scoring details are incomplete, differences among means are descriptive and have not been tested statistically.

4. DISCUSSION

The thesis table shows a high proportion above its chosen score threshold in one referral-hospital sample. This finding supports offering a confidential route to assessment and support for patients who want it. It does not show that the preceding abortion caused symptoms, and its denominator does not represent all women in Nakuru or Kenya. Referral populations may differ from community samples in medical circumstances, pre-existing stress, socioeconomic resources and reasons for seeking care.

The thesis describes the instrument as modified, yet does not present item-level scoring, local cut-off validation, timing for every participant or independent diagnostic confirmation. A threshold imported from another context can misclassify respondents. The source also uses diagnostic labels for scale bands; this article deliberately describes them as symptom-score categories. Biggs et al. (2016) demonstrate why prospective comparison and accounting for other experiences are needed before attributing later symptoms to a particular event.

5. CONCLUSION

In the thesis sample, 150 of 192 respondents (78.1%) scored at least 38 on the modified symptom scale. The estimate is a facility-specific screening proportion. Clinical assessment, validated local scoring and clearer recruitment documentation would be required to establish diagnostic prevalence. Postabortion services should provide voluntary, respectful assessment and referral when a patient reports distress.

REPORTING LIMITATIONS

The article is derived from a 2020 thesis, rather than new 2026 data. The displayed score bands overlap at 28, the scale modification is incompletely documented, and no clinical diagnostic interview, population-based sampling or comparison group is reported. The original approval details and consent records should be verified against the appendices before journal publication.

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