

PSYCHOLOGICAL ASPECTS OF LEGAL ABORTION - A REVIEW

KITTY K.C. CHAN

SUMMARY

This paper attempts to review some of the literature on the psychological sequelae of abortion, and to draw some working principles for the medical profession when faced with a request for legal termination of pregnancy. Ambivalence during the early stages of pregnancy is as common among expectant mothers as among applicants for abortion. The conflict of wanting or not wanting to interrupt a pregnancy must be resolved, preferably in a well-informed decision-making process. The psychological reactions involved during this process and after the abortion procedure are discussed. The at risk factors are also described, and pre/post abortion counselling is suggested.

Keywords: abortion, termination of pregnancy, psychological aspects, counselling, at risk factors,

INTRODUCTION

Since the passing of the Abortion Law, the number of legal abortions done in Hong Kong has been rising while the number of child births has been decreasing. In recent years, about 20,000 legal abortions were done, i.e. 263 per 1,000 live births (Department of Health, 1991). This figure closely follows that of the States with 346 per 1,000 for 1989 (Anonymous, 1991). The essence of the Abortion Law in Hong Kong is that termination of pregnancy can be performed legally if two registered medical practitioners are of the opinion, formed in good faith that: a) continuance of the pregnancy would involve risk to the life of the pregnant woman or of injury to the physical or mental health of the pregnant woman, greater than if the pregnancy were terminated; or b) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormality as to be seriously handicapped (Hong Kong Government, 1973). Late in 1992, the medical profession has been criticised for not giving adequate counselling before TOP (termination of pregnancy), which may lead to extreme guilt in women after abortion (South China Morning Post, 1992). This paper attempts to review some of the literature on the psychological sequelae of abortion and to draw some principles for reference by the medical professions when faced with a request for legal TOP.

EMOTIONAL REACTIONS TO PREGNANCY

The first few months of pregnancy are often described as a period of heightened emotional sensitivity, of elation and depression, of irritability and aggression (Baker, 1967; Caplan, 1961; Horobin et al, 1973; Kaig & Nilsson, 1972). Caplan (1957) reported that 80% of women expecting their first baby admitted conscious feelings of marked disappointment and anxiety when they found out they were pregnant. Bone (1973) reviewed that one-third of pregnancies of married women or women living in a stable cohabitation was unplanned. When faced with an unplanned pregnancy, a woman has to face the following stresses:

1. Financial problems and the arrangements for care of the new-born;
2. Readjustment of role to motherhood;
3. Fear for the unknown future of the unborn child;
4. Re-examination of her close relationships; and
5. To choose between career/study and baby care at home.

Nevertheless many who are initially horrified by their pregnancies eventually accept them willingly and cope successfully with motherhood (Breen, 1975).

PSYCHOLOGICAL REACTION & FACTORS INVOLVED IN DECIDING OF TERMINATION OF PREGNANCY

If totally unprepared for an undesired pregnancy, a woman has to face the option of either continuing or terminating the pregnancy. During this decision making process, she may feel lost, confused, fearful, guilty, angry, agitated, depressed, helpless and hopeless. Such depressive symptoms during this period are often associated with poor family relationships, communicating difficulties with male partners, adverse pregnancy symptoms, contraceptive use and denial of the pregnancy (Bluestein & Rutledge, 1993).

In fact, two types of factors may influence a woman's decision on abortion (Osofsky & Osofsky, 1973):

A. Attitudinal factors

These include a combination of cultural and social experiences such as religious belief, ethnic and cultural background, education and social class. Evidence suggested that Catholic women may be less likely to prevent pregnancy and less likely to define it as unwanted when it occurs. Yet when the pregnancy is defined as unwanted, they appear to be just as ready to choose abortion as non-Catholic women are (Leon & Steinhoff, 1972). Recent studies showed that a higher percentage of lower social class and low education amongst women who had applied for TOP (D'Avanzo, 1992; Soderberg et al, 1993).

B. Situational factors

A woman's desire to terminate the pregnancy reflects her assessment of the impact of that particular pregnancy on her life in addition to her attitude towards abortion. Factors such as a woman's age, marital status, and the number of living children all may influence her response to a particular pregnancy. These factors are interrelated, and two general types of abortion patients emerge: the young, unmarried woman who has not yet begun a family; and the older, previously or presently married woman who has already completed her family.

The situational factors appear to be more important than the attitudinal ones. However, the latter do play an important part in determining how the former elements are perceived. A survey conducted in 1987 showed 75% gave interference with work, school or other responsibilities as reasons for seeking abortion, two-thirds said they could not afford to have a child and half said they did not want to be a single parent or had any relationship problems (Torres & Forrest, 1988).

The question of why women desire abortion must not be confused with the issue of why they become pregnant. Abortion represents the end point of a series of personal decisions about intercourse, contraception and pregnancy. There may be some unrealistic motives for becoming pregnant such as a neurotic bid for power, a way of purchasing reassurance or affection, especially in the adolescents (Priest, 1976). Some psychoanalysts even suggested that some unconscious reasons in the form of unresolved conflicts and anxieties belonging to earlier stages of a woman's

psychic development may lead to conscious planned abortion (Pines, 1990). Studies on repeat aborters showed that they are more likely to have persistent ambivalence and unresolved conflicts about pregnancy, unstable personal relationships and social situations, motivational problems and poor self-image (Lazarus & Stern, 1986).

PSYCHOLOGICAL COMPLICATIONS OF TERMINATION OF PREGNANCY

Studies showed that the psychological distress is experienced mostly by women before the abortion (Rizzardo et al, 1991; Slonim-Nevo, 1991). On the contrary, there is usually significant psychiatric improvement after the procedure, in terms of guilt feelings and adjustment in sexual and interpersonal relationships (but no change in marital adjustment) (Greer et al, 1976; Romans-Clarkson, 1989). One study showed that 50% had shortlived psychosocial disturbances after 8 weeks, but only about 5% had enduring, severe psychiatric disturbances after 8 months (Ashton, 1980). In fact, long-term follow-up studies tend to document more positive reaction and fewer undesirable feelings (Doane & Quigley, 1981). In a review of 250 abortion articles, Doane & Quigley (1981) found that the most commonly reported post-abortion symptoms are related to depression and are mostly within a short post-abortive period.

Nevertheless, many of these studies showed the following pitfalls (Romans-Clarkson, 1989):

1. Most mentioned guilt a significant symptom, but there was no valid instrument for measuring its intensity which often relied on subjective rating by the patient.
2. Most studies were clinic based and their samples were biased by the referral trends.
3. The follow-up period were usually short-lived, ranging from 1 to 18 months. However, long-term tracings were difficult and the percentage of response was usually low.
4. The initial psychological assessment was usually made at a time when the woman was in a psychological crisis in reaction to unwanted pregnancy and was not a true baseline measure of her normal mental state. It was more an estimate of her coping competence under severe psychosocial stress.
5. The absence of a control group such as non-pregnant women or women with wanted pregnancies.

However, a recent study (Zabin et al, 1989) comparing three groups of women - those with negative pregnancy test, those with positive pregnancy test ending in TOP and those that carried to term - showed that the abortion group scored significantly lower on trait anxiety than did the negative pregnancy or the childbearing group at two-year follow-up. In addition, the abortion group showed more positive responses in self-esteem than did the negative pregnancy group; and a more internal orientation than did the childbearing group. This is consistent with an U.S. research on a national sample of 5295 women which demonstrated no negative effects on self-esteem eight years after an abortion (Russo & Zierk, 1992).

AT RISK GROUPS

Several studies have identified particular risk factors in women susceptible to psychological sequelae of TOP (Iles, 1989). The more obvious are:

1. A history of psychiatric illness before pregnancy: evidence indicated that emotional sequelae are more common, more prolonged and more serious in patients with a past history of psychiatric problems, and that the symptoms reported after an abortion are consistent with those described in their previous history (Doane & Quigley, 1981; Lask, 1975; Margolis, et al, 1971). It was commented by Ekblad (1955) that "the greater the psychiatric indications for a legal abortion, the greater is also the risk of unfavourable psychic sequelae after the operation". Depression is the most common post-abortion symptom, and is apparently more apt to occur if depression already pre-exists (Ney & Wickett, 1989).

2. When abortion is indicated for medical reasons or foetal abnormality: these are originally wanted pregnancies and many have already established some sort of bonding with the foetus. A study found 80% of women who had TOP for foetal abnormality showed acute grief reaction, and 25% had not resolved their grief six months after the termination (Elder & Laurence, 1991). Another study found a greater incidence of short term regrets in women aborting for medical indications compared with those aborting for psychological indications, but long-term regrets occurred in approximately equal frequency in both groups (Lazarus & Stern, 1986). Another retrospective study showed that about 20% still complained of regular bouts of crying, sadness and irritability for up to a year after the TOP. Within the same period, there was increased marital disharmony (White-van Maurick, et al, 1992).

3. Abortions performed in the second trimester: these abortions generally produce more difficulty, not only for medical reasons but also for psychiatric ones (Kaltreider et al, 1979). Most women who obtain second-trimester abortions do not do so out of lack of awareness of their pregnancies, but due instead to their ambivalence and procrastination in seeking help. These late presenters are more likely to have accepted the foetus and to regard it as a potential child (Lazarus & Stern, 1986).

4. Ambivalence in decision making: women who initially want to be pregnant react more negatively to abortion (Major et al, 1985). Ambivalence in decision making was shown to be more common among those who abort in the second trimester (Bracken, 1978; Olsosky et al, 1972). Those who feel uncertain or reluctant (when coerced by friends or relatives) for TOP are more likely to show guilt and depressive reactions following the procedure (Friedman et al, 1974).

5. Adolescents: teenagers are at higher risk than older women in suffering from the short-term psychological sequelae after induced abortion (Bracken et al, 1974). There is a greater percentage of anxiety, depression, sadness, guilt and regret. They tend to have abortions later in

the gestational period, to feel forced by circumstances and to report greater severity of psychological stress (Franz & Reardon, 1992). However, continuing an unplanned pregnancy to term is associated with an even higher risk of psychological sequelae than TOP.

6. Poor social support: studies have shown that women who perceived good support from their family, friends and partners and higher self-efficacy for coping predicted better adjustment on the psychological measures (Cozzarelli et al, 1990). Those with poor social support or belonging to socio-cultural groups antagonistic to abortion were especially at risk from adverse psychological sequelae (Zolse & Blacker, 1992).

The identification of these risk factors does not necessarily constitute a contraindication to abortion nor the carrying of pregnancy to term can resolve the problems. However, such identification is useful so that adequate support, social assistance and follow-up are available to these women to ensure their return to normal health. Since abortion in these cases may be followed by intense grief reaction, guilt and anger persisting for months, careful pre-abortion counselling and follow-up and support are important.

MANAGEMENT OF PSYCHOLOGICAL COMPLICATIONS

Since there is no way one can predict for sure what will happen whether abortion is granted or denied, and since considerations of mental health should not be separated from social issues, the professional arbiter is to assist the woman in taking a responsible and carefully weighed decision, and to help her return to her normal life whatever her decision is (Hodgson, 1981).

Induced abortion should be a matter of discussion between the woman concerned and her family physician. The need for involvement of psychiatrists before therapeutic abortion has been debated often. The American Psychiatric Association statement on abortion, published in 1970, recognized that abortion was a 'medical decision and a medical responsibility', and that psychiatric consultation could help clarify motives for the procedure. However, others suggested that there should be no routine psychiatric consultations, but psychiatric evaluation should be requested if the patient exhibits signs and symptoms of major psychiatric illness, has a history of postpartum psychosis, exhibits ambivalence over the decision, or is passively compliant with the wishes of parents or spouse but does not wish to have an abortion. There should also be follow-up treatment for those women who respond with adverse emotional reactions to therapeutic abortion (Pasnau, 1971). Moreover, psychiatrists dislike being used as an authority who can grant dispensation from restrictive laws (Levene & Rigney, 1970).

In an interview of 72 women who were about to face abortion, they expressed a need for professional advice, information and support (Slonim-Nevo, 1991). Pre-abortion Counselling is based on the assumption that there is value in

the free expression of both painful and anxious feelings and in the honest examination of conflicts. Rather than being an invasion of women's rights, it is a means of identifying and disentangling the numerous choices confronting a woman with an unwanted pregnancy (Illsley & Hall, 1975). These processes are positively related to less damaging behaviour in the future (Cheetham, 1977). Counselling at the point of crisis also seems to make it more likely that people will return more readily for other help they may need (Lewis, 1971). During the counselling, the woman is given an opportunity to clarify her feelings about the pregnancy and its termination, and to verbalize her doubts and fears. Deciding on abortion is often an occasion for the woman to reconsider her needs for personal growth and re-evaluate her future activities and goals. Through counselling, other family problems and conflicts may come to the surface.

The role of the health professional is to assist the woman to evaluate her life situation as objectively as possible (Franz & Reardon, 1992). Before making the decision, she should have fully understood the following issues (Mace, 1975):

1. the procedures involved in abortion and its complications;
2. her own personal wish which should not be under the pressure of her husband/partner, her parents or friends;
3. how this decision would affect her own value system and her conscience;
4. how this decision would affect her life and those people who are important to her;
5. the possibility of keeping this pregnancy; and
6. the methods and use of effective contraception.

No matter whether the patient has or has not had the TOP, follow up counselling is indicated in order to assist the woman to come to terms with the reality. She should be encouraged to ventilate any positive and negative feelings, to solve any problems that had occurred and then make realistic plans for her future. The counsellor can also render appropriate therapy were there any feature of physical or psychological morbidity after the abortion. In all circumstances recidivism should be prevented by giving the most appropriate contraception advice.

CONCLUSION

Ambivalence during the early stages of pregnancy is a known phenomenon, among expectant mothers as well as among applicants for abortion. The conflict of wanting or not wanting to interrupt a pregnancy must be solved in the decision-making process that precedes the choice. No one but the pregnant woman herself can arrive at a well-informed decision about the future of her pregnancy. Every pregnant woman should be offered the opportunity to talk about her situation, her thoughts and feelings to a neutral listener, in order to make that decision (Holmgren & Uddenberg, 1993).

Family practitioners are usually the first professionals of contact when a woman is faced with an unexpected pregnancy. They should be educated and trained through the means of talks, discussions and workshops in pregnancy

counselling and the detection of at risk cases. For those special groups mentioned above that need more intensive counselling and support, they are better handled by the specialists.

Whenever possible, prevention is always better than cure. Contraceptive advice should be more vigorously practised at the primary and community care level to ensure that women who do not want children are using an effective contraceptive method.

The above is just a preliminary discussion on some psychological aspects related to abortion. Further research on the issue especially at the local level should be encouraged. e.g. doctors' attitude on abortion; the patients' reasons for seeking abortion; the characteristics of patients who choose abortion; the number of patients who initially ask for abortion have changed their mind after counselling and the reasons why; the short-term and long-term follow-up of those patients who had abortion in comparison to those who had continued the pregnancy (and kept the baby) and those who gave up their baby for adoption after delivery.

REFERENCES

- Anonymous (1991) Abortion surveillance: preliminary analysis -- United States, 1989. **Morbidity & Mortality Weekly Report**, **40**(47): 817-8.
- Anonymous (1992) **South China Morning Post** November 8, 1992. p.11
- Ashton, J.R. (1980) The Psychological Outcome of Induced Abortion. **British Journal of Obstetrics & Gynaecology**, **87**:1115-1122
- Baker, A. (1967) **Psychiatric Disorders in Obstetrics**. Blackwells, Oxford.
- Bluestein, D.; Rutledge, C.M. (1993) Family relationships and depressive symptoms preceding induced abortion. **Family Practice Research Journal**, **13**(2):149-156
- Bone, M. (1973) **Family Planning Services in England and Wales**. HMSO, London.
- Bracken, M.B., Hachamovitch, M. & Grossman, G. (1974) The Decision to Abort and Psychological Sequelae. **Journal of Nervous & Mental Diseases**, **158**: 154-162.
- Breen, D. (1975) **The Birth of a First Child**. Tavistock, London.
- Caplan, G. (1957) Psychiatric Aspects of Maternal Care. **American Journal of Public Health**, **47**:26.
- Caplan, G. (1961) **An Approach to Community Mental Health**. Tavistock, London.
- Cheetham, J. (1977) **Unwanted Pregnancy and Counselling**. Routledge & Kegan Paul. London.
- Cozzarelli, C., Sciacchitano, A.M., Cooper, M.L., et al. (1990) Perceived social support, self-efficacy, and adjustment to abortion. **Journal of Personality & Social Psychology**, **59**(3): 452-463.
- D'Avanzo, B., Luchini, ., Parazzini, F., Negri, E.,; La-Vecchia, C. (1992) Descriptive epidemiology of induced abortion in Italy 1979-1990. **Contraception**, **46**(6): 549 - 559.
- Department of Health (1991) **Annual Report. 1990/91**.

- Doane, B.K. & Quigley, B.G. (1981) Psychiatric Aspects of Therapeutic Abortion. **Canadian Medical Association Journal**, **125**: 427 - 432.
- Ekblad, N. (1955) Induced abortion on psychiatric grounds--- A follow up study of 479 women. **Acta Psychiatrica and Neurologica Scandinavica, Supplement 99**: 1 - 238.
- Elder, S.H. & Laurence, K.M. (1991) The impact of supportive intervention after second trimester termination of pregnancy for fetal abnormality. **Prenatal Diagnosis**, **11**(1): 47 - 54.
- Franz, W. & Reardon, D. (1992) Differential impact of abortion on adolescents and adults. **Adolescence**, **27**(105): 161 - 172.
- Friedman, C.M., Greenspan, R. & Mittleman, F. (1974) The decision-making Process and the outcome of therapeutic abortion. **Journal of Nervous & Mental Diseases**, **158**:154 - 162.
- Greer, H.S., Shirley, L.A.L., Lewis, S.C., Belsey, E.M. & Beard, R.W. (1976) Psychosocial consequences of Therapeutic Abortion. King's Termination Study III. **British Journal of Psychiatry** **128**:74 - 79.
- Hodgson, J.E. (1981) **Abortion and Sterilisation: Medical and Social Aspects**. Academic Press Inc. Ltd., London. p.194.
- Holmgren, K. & Uddenberg, N. (1993) Ambivalence during early pregnancy among expectant mothers. **Gynaecology and Obstetrics Investigations**.**36**(1):15 - 20.
- Hong Kong Government (1973) **Offences against the Person Ordinance, Chapter 212**.
- Horobin, G.W. et al (1973). **Experience with Abortion: A Case Study in North-East Scotland**. Cambridge University Press.
- Iles, S. (1989) The loss of early pregnancy. **Baillieres Clinical Obstetrics & Gynaecology** **3**(4): 769 - 90.
- Illsley, R. & Hall, M.H. (1975) Psycho-social Aspects of abortion: A Review of Issues and Needed research. **WHO Bulletin**. Nov.
- Kaig, L. & Nilsson, A. (1972) Emotional and Psychotic Illness following Childbirth. in J.E. Howells (ed.), **Modern Perspectives in Psycho-Obstetrics**. Oliver & Boyd, Edinburgh.
- Kaltreider, N.B., Goldsmith, S. & Margolis, A. (1979) The Impact of mid-trimester abortion techniques on patients and staff. **American J. of Obstetrics and Gynecology** **135**: 235 - 238.
- Lask, B. (1975) Short-term psychiatric sequelae to therapeutic termination of pregnancy. **British Journal of Psychiatry** **126**: 173 - 177.
- Lazarus, A. & Stern, R. (1986) Psychiatric Aspects of Pregnancy Termination. **Clinics in Obstetrics and Gynaecology** **13**(1): 125 -134.
- Leon, J., Steinhoff, P.G. (1972) **Catholics use of abortion: A Conception Cohort Analysis**. Unpublished paper, Univ. of Hawaii.
- Levene, H.I. & Rigney, F.J. (1970) The law, preventive psychiatry and therapeutic abortion. **Journal of Nervous and Mental Diseases**, **151**: 51-59
- Lewis, S.C. (1971) Out Patient Termination of Pregnancy. **British Medical Journal**, 4 Dec. 1971.
- Mace, D.R. (1975). **Abortion --- The Agonizing Decision**. Chinese Christian Literature Council.
- Major, B., Mueller, P. & Hildebrandt, K. (1985) Attributions, expectations and coping with abortion. **Journal of Personality and Social Psychology**, **48**: 585-599.
- Margolis, A.J., Davidson, L.A., Hanson, K.H., Loos, S.A. & Mikkelsen, C.M. (1971) Therapeutic abortion follow-up study. **American Journal of Obstetrics and Gynaecology**, **110**: 243-249.
- Ney, P.G. & Wickett, A.R.E. (1989) Mental Health and Abortion: Review and Analysis. **Psychiatric Journal of University of Ottawa**. **14**(4): 506-516
- Osofsky, H.J. & Osofsky, J.D. (1973) **The Abortion Experience : psychological and medical impact**. Medical Department, Harper and Row, Publishers, Maryland. 206-225.
- Pasnau, R.O. (1971) Contemporary psychiatric consultation: evaluation or rehabilitation? **Clinical Obstetrics and Gynaecology**, **14**: 1258-1262
- Pines, D. (1990) Pregnancy, miscarriage and abortion---a psychoanalytic perspective. **International Journal of Psychoanalysis**, **71**(Pt 2): 301-307
- Priest, R.G. (1974) Psychiatric indications for terminations of pregnancy. In RN Gaird & BL Hudson (eds.) **Current Themes in Psychiatry**. Macmillan Press Ltd. London. pp 8-9
- Rizzardo, R., Novarin, S., Forza, G. & Cosentino, M. (1991) Personality and psychological distress in legal abortion, threatened miscarriage and normal pregnancy. **Psychotherapy & Psychosomatics**, **56**(4): 227-234
- Romans-Clarkson, S.E. (1989) Psychological Sequelae of Induced Abortion. **Australian and New Zealand Journal of Psychiatry**, **23**: 555-565
- Russo, N.F. & Zierk, K.L. (1992) Abortion, childbearing and women's well-being. **Professional Psychology**, **23**: 269-280
- Slonim-Nevo, V. (1991) The experience of women who face abortions. **Health Care for women International**,**12**(3): 283-292
- Soderberg, H., Anderson, C., Janzon, L. & Sjoberg, N.O. (1993) Socio-demographic characteristics of women requesting induced abortion. a cross-sectional study from the municipality of Malmo, Sweden. **Acta-Obstet-Gynecol-Scand.**, **72**(5): 365-368
- Torres, A. & Forrest, J.D. (1988) Why do women have abortions? **Family Planning Perspectives**, **20**(4): 169-76
- White-van Mourik, M.C., Connor, J.M. & Ferguson-Smith, M.A. (1992) The psychosocial sequelae of a second-trimester termination of pregnancy for fetal abnormality. **Prenatal Diagnosis**, **12**(3): 189-204
- Zabin, L., Hirsch, M.B. & Emerson, M.R. (1989) When urban adolescents choose abortion: Effects on education, psychological state and subsequent pregnancy. **Family Planning Perspectives**, **21**: 248-255
- Zolose, G. & Blacker, C.V. (1992) The psychological complications of therapeutic abortion. **British Journal of Psychological Medicine**, **160**: 742-749