Late Psychological Sequelae of Abortion: Questions from a Primary Care Perspective

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Research strongly supports the view that pregnancy termination is seldom associated with adverse psychological sequelae in the short to medium term, but experience shows that there is a small group of women who experience long and intense suffering. This is a report of the cases of two women who presented with psychological problems associated with a termination 19 and 5 years earlier.

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The scientific literature overwhelmingly supports the view that for the majority of women, unwanted pregnancy is a time of crisis that is quickly resolved by termination.[1-7] Former US Surgeon General C. Everett Koop concluded that although negative responses may be severe in individual cases, the problem is "minuscule from a public health perspective."[8]

It has been suggested, however, that while termination is undoubtedly an effective short-term coping mechanism for most women, it can be a significant long-term stressor.[9-11] This paper reports two cases of women presenting to their primary care physicians with psychological problems that they blamed on termination of a pregnancy some years before.

Case Reports

Case 1

A 38-year-old woman called a physician to her home for the problem of perineal bleeding. She was an infrequent consulter, having been seen mainly for backache and ear problems, and had never previously presented with psychological problems. She had an excellent record as a care assistant in a home for the elderly. She was not particularly well known to any individual physician in the practice, although the doctor who came to see her on this occasion knew her from her place of work, where she always appeared friendly, helpful, and cheerful. Her apartment was remarkable for the large number of cuddly toys that occupied almost every available space. A fluffy bear lay on her pillow with the words "love me" on its vest.

The consultation focused on the presenting problem until a few routine gynecological questions were asked. The patient began to lose her normally sunny affect, burst into tears, and told the physician how unhappy she had been ever since "I lost my son." She was 19 years old at the time, unemployed, still living with her parents, and had fallen in love with a boy who lived in a housing project. When she realized that she was pregnant, she told her parents, who insisted that there be no further contact with this young man. They insisted that she terminate the pregnancy to avoid jeopardizing her chances of making a "good marriage." Her general practitioner at that time had referred her out of the area for termination apparently after only the briefest of chats. The patient volunteered that her physician had never asked her what she really wanted.

She had vivid recollections of the actual procedure, saying that a "pro-life" nurse told her afterward that she had just killed a perfectly formed little boy. For a few years following the procedure, she had had a loveless marriage and now lived with a kindly man, with whom she appeared to share more a friendship than a love relationship. She had never had children. She said that not a single day goes by in which she does not cry for "my son" and for what might have been had she never terminated the pregnancy. Her younger sister had two children, and she wept inwardly each time she saw them. She resented her par-

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ents' relationship with these children and was angry at them for their part in the termination decision, but she had never been able to express this directly. Although she spent a great deal of energy caring for her parents, she commented, "If they weren't so narrow-minded, they could have had a lovely grandson long before those other grandchildren were born."

This was the first time she had told anyone, apart from her partner, about her suffering. The family physician visiting her spent some time allowing her to vent her feelings. After talking about the termination at that time and in a few later consultations, and after a taking a brief period off work, she reports feeling happier and able to enjoy being with her partner more.

Case 2

A 24-year-old woman presented to her family physician with difficulties with intimate relationships, depressed mood, and a sense of general unhappiness of several months' duration. The only other time she had consulted a physician for psychological problems was during a crisis in her relationship about 1 year earlier. At the very end of the consultation, she revealed she was feeling guilty and unhappy about a pregnancy that she had terminated at 10 weeks when she was 19 years old. In the patient's medical record, her reasons for wanting termination were listed as financial and lack of readiness to take responsibility for a child.

She now told her physician that a crisis at the time in the relationship with her boyfriend was the real reason for requesting the termination. She had learned that he had been unfaithful to her at about the same time she discovered she was pregnant. This led to her decision to have a termination. She told her boyfriend about it only after the procedure. Their relationship, however, had grown since then, and he had recently told her that he would have liked the pregnancy to continue. Although she was living with her parents at the time, the patient has never discussed the matter with them. Until this moment, she had told only her partner and one other person about this termination. Her family physician referred her to a community psychiatric nurse for counseling, and after four sessions in which she discussed the termination, her mood improved and she is now employed as a child care worker.

Discussion

About 3 million women per year in the United States have an unplanned or unwanted pregnancy,[12] and approximately 1.5 million of these pregnancies end in elective abortion.[5,13] One in five women in the United States has an abortion during her lifetime,[14] and roughly 20% of all pregnancies in England and Wales end in legal abortion.[15]

Several studies report that decisions about unwanted pregnancy are difficult for many women, even if they do make an unwavering decision about abortion.[2,14,16,17] Many who initially request termination change their minds.[2,16] In the United States, primary care physicians are the first professionals many women with unwanted pregnancy consult about their difficult decision,[18] and studies have found that approximately 80% of the physicians consulted are willing to refer women for abortion.[18,19] The majority of British women requesting termination do so through their general practitioners, and each year the average general practitioner in New Zealand is likely to see between 5 and 10 women with an unplanned or unwanted pregnancy.[17] Thus, the consultation for "crisis" pregnancy is a common event. It provides medical professionals with a unique opportunity, when appropriate, to enhance a woman's understanding of the far-reaching implications of a decision for abortion, help her make a choice for which she feels responsible, and find mechanisms for coping with the consequences.[1,20]

Because most research has failed to identify long-term sequelae of this common procedure, primary care physicians may undervalue their potential contribution to the consultation for unwanted pregnancy.

Does current research adequately identify the long-term psychological sequelae of abortion?

Scientific investigation in this area faces many challenges.[3,6,10,21-23] Social class, family support, the pregnancy itself, and cultural values are some of the many variables possibly confounding comparisons between control subjects and women undergoing termination. Adequately matching controls and cases for psychological characteristics is problematic, since pregnancy influences psychological state, and the psychological evaluation of women

before they actually become pregnant is not practical for large numbers.

Because complications are generally rare, the lack of statistically significant differences between groups does not rule out clinically important sequelae of termination in some individuals. While follow-up periods of studies are adequate to identify short-term sequelae, they are usually insufficient to identify the effects of termination on some women in the longer term. Only three of the studies in the oft-quoted review by Zolesc and Blacker[6] had a follow-up of more than 2 years, and only one study reported by Adler and colleagues[3] assessed response at 2 years.

A recent British study, however, observed 13,261 women prospectively for up to 10 years and found no excess psychiatric morbidity reported to family practitioners among woman who terminated their pregnancies compared with those who did not interrupt their unplanned pregnancies.[16] If, as some studies suggest, abortion leads to a lowering of stress in the short term, this study would fail to identify a small but important cluster of long-term adverse events.[3,5,22] Furthermore, Goldberg and Bridges[24] have shown that about one half of all psychiatric illness is "hidden" from the family physician.

Research is limited by the unavailability of information about women who do not consent to participate in studies. Loss to follow-up is often high in studies on termination.[1,6,14] Subjects are frequently recruited from selected clusters, limiting generalizability.[1] Women with greater distress about unwanted pregnancy may be less willing to share problems with researchers than subjects in trials examining less sensitive matters would be. They also may be more reluctant to answer questions about painful experiences in the distant past.[1,3,4,6]

It is difficult to say how the women presented here would have responded at different times to questions about their abortions, or whether their problems would ever have been identified by a questionnaire or other interview techniques. Imperfect assessment methods could mean a failure to identify deep-seated conflict that emerges only years after the event.[6,10,25]

Definitions of morbidity abound.[1,6] The cases presented in this report illustrate that significant suffering can be present in women who have functioned well for long periods. Important qualitative aspects concerning women's experiences and perceptions of abortion and the broader circumstances that shape their reproductive decisions do not form a large part of controlled or observational studies. The "voices of women" are missing.[26]

Thus, some researchers studying long-term adverse events have relied on more unusual methods: a case-controlled study identifying its subjects by calling for volunteers through women's organizations and posted notices[21]; a descriptive study asking women at a church meeting to submit their experiences in writing[27]; and another study identifying adverse reactions during psychotherapy for other problems.[28] Personal accounts by counselors[9,29] and reports of individual cases[30-32] have also described severe morbidity that was partly related to abortion and emerged many years after the event.

While nonrandom sampling gives no information about incidence, such reports suggest that many individuals are suffering as a result of regretted terminations, and that as clinicians, we should be alert to this possibility, despite reassuring general information about groups or populations.

Are there structural barriers that prevent primary care physicians from providing an optimal structure for autonomous decision-making?

It is possible that primary care physicians face important structural barriers to the full utilization of opportunities in the consultation to assist the process of considered, autonomous decision-making. For example, time considerations may exert pressure on clinicians to focus more or less exclusively on the presenting problem and its quick solution rather than deliberately broadening the consultation to explore relevant psychosocial aspects of decisions.[33,34] Because the procedure is so common, some clinicians may regard termination as fairly routine and thus underestimate its impact for some women.

The timing of the consultation in relation to the pregnancy bears on the urgency of referral.[35] As the pregnancy approaches certain cutoff points, physicians may be more concerned about avoiding delay than encouraging women to carefully consider the decision. This is a particular problem when waiting times for the procedure are longer.

Family physicians also may feel that since they

are not performing the termination, full responsibility for the implications of true informed consent rightfully lies with the physician who obtains consent.

Polls on both sides of the Atlantic show that the vast majority of the general public agree that women should have the right to choose abortion in the first few months of pregnancy.[18,36,37] Despite the necessity to satisfy certain criteria before a pregnancy is legally terminated, some patients, families, and physicians may consider that primary care physicians' efforts at providing a structure within which the pregnant woman can explore ambivalence and alternatives constitute meddling in the exercise of a personal right. Patients can bypass their primary care physician, however, and go directly to an abortion provider without the primary care physician's knowledge.

A physician's personal experience of psychological complications may be limited because, as these cases illustrate, women are sometimes unable to talk about their feelings for several years. When problems do emerge, they may not be presented to the physician who made the referral for termination.

What clinical method could enhance the process of making effective choices?

It is quite possible that both the women described in this report would have presented with psychological problems later in life even if they had not had an abortion. Neither had a history of psychiatric problems before the termination, however, and they both identified regret about their decision to terminate as the source of their distress. Neither felt that the decision was the best for them at the time, and the first patient volunteered that her physician had made no attempt to ascertain her true feelings on the issue. The clinicians involved were unaware of important pressures influencing their patients. Both women's psychological distress, presented years after the event, appears to have improved after an opportunity to vent their feelings about the termination. It is possible that a fuller exploration of these women's decisions at the time each was considering abortion might have led to better psychological adjustment, whatever decision they eventually reached. It has been estimated that if important psychological problems occurred in only 1% of women who have abortions, the annual incidence in the United States would be 15,000 new cases.[27]

The decision-making process itself has been found to be the single variable that best differentiates the small group of women who have emotional difficulties following termination of a pregnancy from the majority who do not.[1]

While recognizing that it is never the place of clinicians to impose abortion counseling on any woman,[38] it is suggested that primary care physicians have an important role "in creating an atmosphere that allows the client to consider all facets of her own situation [without the clinician's] imposing values on her."[23] Focusing beyond the immediate reduction of stress broadens the base of decisions and clarifies ambiguity that could reduce the potential for postabortion regret.[35,39] This is particularly true for women with high stress and those at high risk for psychological complications after abortion. The literature clearly identifies the main risk factors as termination on medical grounds, termination later in pregnancy, ambivalence about the decision, poor social support, being a teenager, having a history of previous psychiatric problems, being subject to undue influence of partners and parents, and belonging to sociocultural groups antagonistic to abortion.[1,4,6,7,20,21,30,35,40]

The first woman in this case report was clearly subject to parental pressure, and the second was influenced by the behavior of her partner. Neither woman appears to have been left with the feeling that the decision to undergo termination was really her own. Both were in their teens and later reported that they were ambivalent at the time of the procedure.

While both women were living with their families, the first was unable to communicate her true feelings to her parents, and the second never discussed the abortion with her family. The negative treatment experience of the first patient is another factor previously identified with poor outcome.[21] Regarding the symptoms described by the first woman, experiencing similar intense emotions in relation to children, referring to the aborted fetus as "my baby,"[27] difficulty expressing anger toward parents,[30] and "masking" unhappiness[21,27] have all been previously reported.

Clinicians who use a patient-centered clinical method are most likely to overcome the structural

barriers in primary care to ensure that risk factors are considered and to provide a structure for the effective consideration of difficult decisions.[41,42] The routine use of a complete evaluation focuses attention not only on the physical problem (pregnancy), but also on relevant personal and contextual influences.[41,43] A three-stage assessment—biological, personal, contextual—may be useful. This clinical tool has its origins in a biopsychosocial model of medicine[44] and systems theory.[45] Factors at all three levels interact and influence each other in causing and maintaining disease. A formal biological, personal, and contextual assessment ensures that problems presented in purely physical terms are not dealt with solely at a biological level.

Abortion counseling has been criticized for offering support and explaining the procedure to the exclusion of helping with the decision-making process when appropriate.[39,46] A personal assessment in the cases presented here would have broadened the consultation to consider the women's ambivalence and emotional vulnerability. A contextual assessment would have included factors such as relatively young age, poor social support, and economic insecurity. In the case of the first woman in this report, the class prejudices of the parents and their overt pressure to influence her decision would also have formed part of the contextual diagnosis, while in the second case, the boyfriend's unfaithfulness would have been part of the contextual diagnosis. The patient's possible desire to punish her boyfriend would have formed part of the personal diagnosis.

The "retrospectoscope" is a powerful instrument, and it is easy for others, post hoc, to suggest improvements in the way physicians handled difficult situations. While it is not suggested that these reports prove the benefits of the three-stage assessment, a more comprehensive diagnostic approach might have led to a fuller exploitation of the potential in these consultations. By considering a wider range of relevant factors, women may be more likely to feel that they made the best possible decision under the circumstances. For the clinician, providing a structure for considering influences beyond the immediate biological problem enhances his or her facilitation of effective, autonomous decision-making.

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