Termination of pregnancy: a review of psychological effects on women

This study reviews the evidence on the psychological effects of induced abortion

INTRODUCTION
Termination of pregnancy is a relatively minor, safe procedure that has minimal physical impact. Following a literature search and appraisal, this article explores some of the main themes arising from studies on the psychological impact. The results demonstrate that negative psychological effects are more likely in certain high-risk women. A table of indicators has been developed which could assist nurses in recognising whether a woman is at risk of negative psychological effects after termination.

COMPLEX NATURE OF THE EVIDENCE
Owing to the diverse nature of the topic, in addition to accessing major policy documents, the main electronic databases were searched for English language articles. These included Medline, CINAHL, PsychLit and Science Direct. Keywords used were:

- Abortion;
- Termination of pregnancy;
- Psychological effects;
- Emotion;
- Anxiety;
- Depression.

This review does not claim to be systematic in the strict sense (Greenhalgh, 1997). The quality of the studies accessed varied, as did sample size and validity measures.

Randomised controlled trials are the least biased form of research (Gray, 1997) but women cannot be ‘randomised’ into termination. Quantitative evidence, therefore, centres on observational studies that may inadvertently under-report events where medication is administered orally. This is followed by a 5–6 hour stay 24–48 hours later, when further abortifacient medication is administered and the termination occurs. Surgical termination is a one-stage, day-case procedure usually performed under general anaesthetic. Women may be given the choice of a medical or surgical termination depending on their preference, stage of pregnancy and local availability of services (Lipp, in press; Royal College of Obstetricians and Gynaecologists, 2004).

IMPLICATIONS FOR PRACTICE

- Some women would benefit from psychological support after a termination of pregnancy, and this support should be targeted towards those who are most at risk of experiencing negative psychological consequences.
- Nurses should establish the presence of risk factors for adverse psychological impact before termination to determine whether support is likely to be necessary.
- It is important to target assistance to ensure that those who need it receive it in a timely manner while allowing those who do not to move on.

FACTORS INFLUENCING NEGATIVE PSYCHOLOGICAL CONSEQUENCES
According to the evidence, some women are at greater risk of psychological disturbances than others and certain factors influence this.
A Norwegian mixed-method study of 80 women followed them up for two years with an interview, the Impact of Event Scale and a questionnaire about their feelings associated with the termination (Broen et al, 2005a). In Norway, as in some other European countries, a woman has an unconditional right to a termination before 12 weeks’ gestation. The authors found that pressure from a male partner to have a termination had a negative psychological effect on the woman and was the strongest predictor of emotional distress at six months’ and two years’ follow-up.

In a study comparing mental health following termination with mental health following miscarriage, the authors found the mental health of women undergoing termination was poorer before the event (Broen et al, 2005b). They argue this could account for elevated anxiety of the termination group compared with the miscarriage group, which continued until the end of the five-year follow-up period.

Cozzarelli et al (1998) performed a study based on 615 women undergoing first-trimester surgical termination in the US. They found that women with a positive self-regard were better able to mobilise their social networks, which allowed them to cope more effectively post termination. Those with low self-esteem tended to be ineffective in seeking support from their partners and thus were left to cope after the procedure.

Low self-esteem, late-gestation termination, prior psychiatric illness and conflict with religious or cultural beliefs were all issues found to influence negative psychological outcomes following termination, in an Australian review. This summarised the international literature from a 30-year period between 1970 and 2000 (Bonevski and Adams, 2001).

PSYCHIATRIC DISTURBANCES
In an early study, Ashton (1980) interviewed 111 women before a surgical termination with eight-week and eight-month follow-up. There was a large drop-out rate, with only 22 women interviewed at eight months. Of these, six reported persistent disturbances and all six were married and had been ambivalent about having the termination. GP records were accessed for 86 women at eight months and about 10% were found to experience serious psychiatric problems. However, these were short-lived and mainly resolved by eight or nine months after the termination.

This finding is echoed in a review, published a decade after Ashton’s study, of the preceding 20 years’ studies. The reviewers found that severe or persistent psychological disturbances were reported to occur in about 10% of women (Zolese and Blacker, 1992).

A comprehensive review by Thorp et al (2002) examining multiple effects following termination included 10 studies on subsequent mental health. The studies spanned 25 years from 1974 to 2000. Three large studies in the review examined almost 600,000 records and found an increase in the risk of suicide after termination. Three studies followed women up for 30 days and one (173,279 records) followed them up for 1–8 years. Thorp et al (2002) asserted that women contemplating a termination should be cautioned about an increased risk of self-harm or suicide. However, it could be argued that such a direct approach may be counterproductive at such a sensitive time.

Hess’ (2004) US phenomenological study found that some women who found the experience negative sought help and healing. This indicates that help should be made easily accessible to women at the time of their termination. The risk factors affecting psychological consequences are outlined to assist nurses in assessing those at risk undergoing a termination (Table 1, p28).

ANXIETY AND DEPRESSION
The psychiatric disturbance in the 10% of women who underwent termination in Zolese and Blacker’s (1992) review was mainly in the form of anxiety and depression.

Bradshaw and Slade (2003) performed a critical review of the literature regarding emotional experiences following termination. Their review accessed post-1990 literature as they recognised that, culturally, attitudes have become more liberal over the past two decades. They found that levels of anxiety, depression and general distress decreased in the month following termination but the results of studies differed on the degree of the reduction. The better-quality studies suggested that 8–23% of women were experiencing high levels of general distress one month after their termination (Bradshaw and Slade, 2003).

Bonevski and Adams (2001) found no

REFERENCES


REFERENCES


COPING WITH TERMINATION

The ways in which women cope psychologically with termination vary and, although qualitative studies cannot normally be generalised, a number have been included to add another dimension to the evidence.

A phenomenological study of 17 women found five themes that described the women’s journey from making the decision, coping with the memories, gaining perspective, seeking help and recognising its worth (Hess, 2004). Within these themes, there were negative and positive ways in which women coped following termination. These included acknowledging forgiveness, which hastened healing. ‘Making the foetus a person’ helped some work through their grief as well as appreciating that intense emotions continued years later.

Interestingly, another phenomenological study appears to contradict these findings as it found that persistent emotional upset was connected with a more human view of the foetus (Goodwin and Ogden, 2007). In a further phenomenological study involving women 15 years or more after their termination, ‘embodiment: giving form to the child’ was a theme raised by some women. Most women were able to recall the age the child would have been at the time of the study. This highlights the individual nature of qualitative findings and the fact such studies are not generally applicable. The hypothesis regarding the foetus as a person in these studies would benefit from testing in future quantitative research.

To enable coping, sensitive follow-up would be required during future gynaecological and obstetric care. First, it would be important to enable women to disclose their past termination by providing the right environment. Concealing their previous history within a healthcare setting
could be detrimental to patients’ current care. However, many women conceal their circumstances from friends and family because of the shame associated with termination of pregnancy (Major and Gramzow, 1999). It is part of nurses’ and midwives’ roles to give women opportunities to work through any unresolved feelings, be it immediately after termination or during future pregnancies, smear tests or even menopausal care.

**POSITIVE OUTCOMES**

Although most research studies explore the negative psychological consequences of termination, it is worth noting that positive outcomes have been found to outweigh the harm, with women feeling more relief than negative or positive emotions after two years (Major et al, 2000). This echoes the findings of Shusterman’s (1979) study of 393 women undergoing termination, which found that women experienced favourable psychological consequences that outweighed negative ones.

A large prospective longitudinal study followed 13,000 UK women over 8–11 years (Gilchrist et al, 1995). The authors found that previous psychiatric history was controlled for, psychiatric disorders were no higher following termination than previous psychiatric illness and those at risk of psychological difficulties.

In the long term, Bradshaw and Slade’s (2003) review found that, over 10 years, women who had terminations did no worse psychologically than women who gave birth to wanted or unwanted children.

Supportive partners or parents have been found to improve psychological outcomes for women (Bonevski and Adams, 2001). A rather dated US prospective study (Jacobs et al, 1974), a sample of unmarried, predominantly black women of lower socioeconomic status showed a significant reduction in distress in most outcome measures four weeks following termination.

This study, along with others in this section, point to the conclusion that, while there is a risk of negative psychological consequences, such consequences could be minimal and transitory.

The Royal College of Obstetricians and Gynaecologists (2004) noted there is no causal link between termination and negative psychological consequences and that pre-existing conditions need to have been ruled out in making such assumptions. The recent RCN (2008) guidance on termination care reiterates RCOG (2004) guidelines in advocating post-termination counselling for those at risk of psychological difficulties.

**CONCLUSION**

The evidence found in this literature review suggests that a proportion of women would benefit from psychological support after termination. Based on the above findings, it would be reasonable to target assistance, in the first instance, towards those women who fit the criteria set out in Table 1.

If psychiatric disturbance occurs, it is likely to affect those at risk such as those with a history of psychiatric illness and depression. Having a termination for medical reasons, such as foetal abnormality or being unduly influenced in making the decision to abort, also seems to increase the risk of psychiatric disturbance, although such disturbances are often transitory in nature.

Eliciting the presence of these factors in a sensitive manner, preferably before the procedure, will help nurses to target women appropriately, ensuring that their post-termination care meets their needs in both the short and long term. Targeting assistance would ensure that help is offered in a timely manner and at the appropriate level, while minimising the risk of prolonging the experience for those women who do not need psychological support and wish to move on.

**REFERENCES**


**PRACTICE COMMENT**

Share your views and thoughts with the nursing world. Has new research, a change in policy or a news article made you think about how nursing practice will be affected? Our new Practice Comment section gives you the opportunity to speak up on a current issue and how it relates to nursing. So if you want to air your view, please contact the Nursing Times practice team at NT@emap.com, putting ‘Practice comment’ in the subject box.