ABORTION AND WOMEN'S HEALTH

An evidence-based review for medical professionals of the impact of abortion on women's physical and mental health.

By

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ABOUT THE AUTHOR

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INTRODUCTION

Women considering an abortion must be provided with accurate information about the procedure and its possible effects on their health – not least because it is most often carried out on healthy women.[1] Additionally, there are complex legal, social, ethical and personal questions relating to abortion that do not pertain to other procedures. Moreover, because ambivalence about an abortion decision is common,[2] and ambivalence is related to post-abortion distress,[3,4,5] the requirement to provide information is made even more acute.

Abortions have been conducted legally in many countries over the past few decades and considerable international research has been undertaken on the physical and psychological impact on women, and also on the circumstances surrounding the decision-making process.

The information that follows comes from this large body of research.

It should be noted that abortion research suffers from particular obstacles, one of which is reporting bias. In a prospective study of women aged 15 to 27, for example, the reported rate of abortion was 74% of what would be expected from national data sets.[6] In a Dutch cohort study, abortion history was clearly underreported, mentioned by only 1.2% of all women giving birth.[7] Underreporting of abortion leads to an underestimation of its effects.[8] Other sources of bias, expanded upon in the section on psychological effects below, include the fact that distressed women are often excluded from studies,[9] or refuse to participate. Moreover, many studies of the physical risks of abortion include only healthy women,[10] specifically excluding women who are at higher risk of complications.

A significant amount of research begins and ends with the simple assertion that abortion, both medical and surgical, is 'safe'. This is particularly the case for politically driven research - for example to prove that abortion facilities do not need hospital admitting privileges[11] or ambulatory surgical standards,[12] or to prove that women do not benefit from pre-abortion counselling.[13,14] However, risk and safety have subjective elements, and with regard to an abortion procedure, it is the woman herself who will interpret what the risks are and whether she considers abortion 'safe' or not, based on the information provided to her.[15]

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[1] "In 2019, 98% of abortions (202,975) were performed under ground C. A further 2% were carried out under ground E (3,183 abortions, a decrease of 86 since 2018), with 1% (1,045 abortions) under ground D. The remaining grounds account for very few abortions; 181 in total across grounds A, B, F and G. (Table 2). Most of the overall increase in the number of abortions is the result of ground C abortions increasing." Abortion Statistics for England and Wales: 2019, *Department of Health and Social Care*, 11 June 2020 https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2019

[2] Kero A *et al.* (2001) Legal abortion: a painful necessity. *Social Science and Medicine* 53:1481-1490.

[3] Kero A *et al.* (2004) Wellbeing and mental growth – long-term effects of legal abortion. *Social Science and Medicine* 58:2559-2569.

[4] Coleman PK *et al.* (2005) The psychology of abortion: a review and suggestions for future research. *Psychology and Health* 20(2):237-271.

[5] Coleman PK *et al.* (2017) Women who suffered emotionally from abortion: A qualitative synthesis of their experiences. *J American Physicians & Surgeons* 22(4):113-118.

[6] Pedersen W (2008) Abortion and depression: a population-based longitudinal study of young women, *Scand J Public Health* 36:424-428.

[7] Scholten BL *et al.* (2013) The influence of pregnancy termination on the outcome of subsequent pregnancies: a retrospective cohort study. *BMJ Open* 3:e002803.

[8] *Ibid.*

[9] Purcell C *et al.* (2014) Access to and experience of later abortion: accounts from women in Scotland. *Perspectives on Sexual and Reproductive Health* 46(2):101-108.

[10] White K *et al.* (2015) Complications from first-trimester aspiration abortion: a systematic review of the literature. *Contraception* 92:422-438.

[11] A hospital admitting privilege is a requirement for a doctor to have a formal agreement, usually by being a staff member, with a nearby hospital to ensure they can admit a patient for treatment. In the context of abortion, admitting privileges are a legislated requirement in some US States to ensure appropriate care.

[12] White K *et al.* (2015) *Op. Cit.*

[13] Baron C, Cameron S & Johnstone A (2015) Do women seeking termination of pregnancy need pre-abortion counselling? *J Fam Plann Reprod Health Care* 41:181-185.

[14] Brown S (2013) Is counselling necessary? Making the decision to have an abortion. A qualitative interview study. *Eur J Contraception and Reprod Health Care* 18:44-48.

[15] The standard for informed consent in the UK was redefined in 2015 by *Montgomery v Lanarkshire*. Deciding about risk disclosure shifted from the "reasonable doctor" to the "reasonable patient". (See https://www.medicalprotection.org/uk/articles/new-judgment-on-patient-consent Accessed 28 Nov 2019).

Importantly, given the ongoing nature of much abortion research, definitive statements about safety are inappropriate.

This review of the evidence informs medical professionals of the issues that need to be raised with patients considering abortion.

MOTIVES UNDERLYING AN ABORTION DECISION

General

Medical practitioners need to be aware of the motivating factors that underlie an abortion decision, because there may be a need for referral to support services. For example, since intimate partner violence (IPV) is strongly correlated with abortion, practitioners need to ascertain whether a woman is at risk of physical, emotional or psychological harm.[16] Or a woman may wish to proceed with pregnancy but does not have material support, necessitating referral to social services.

Some motivating factors may have implications for post-abortion effects, specifically mental health effects. For example, if a woman is motivated to have an abortion because of foetal disability, her risk for psychological harm is higher than if motivated by other reasons, like not being able to cope or fear of jeopardising her future.[17]

Deciding to have an abortion is far more complex than simply not intending to become pregnant.[18] The concepts of pregnancy wantedness and intendedness are often used by researchers to understand why women might seek abortions. Yet women are ambivalent about pregnancy and abortion in ways that do not fall neatly into the categories some social scientists use for understanding ambivalence.[19] Women rarely see babies themselves as a threat, and instead feel positively towards them. However, it is the related experiences, like the future stress and difficulty of parenthood, financial stress, loss of freedom, ongoing violence or deprivation that women may be hoping to avoid by seeking abortion.[20]

In most cases, no single factor motivates women to seek abortion. Rather, a variety of factors are involved. These include relationship problems, pressure from partners and family members, study and career aspirations, financial difficulties, lack of confidence as a mother, and lack of community support.[21,22] Furthermore, reasons differ by country because of cultural context. In Eastern European countries, it is mostly married women with children who have abortions to space or limit births[23]; that is, as a means of family planning, whereas in countries like the US and Sweden, predominantly unmarried women have abortions for socioeconomic reasons or because a child would interfere with future opportunities.[24,25] By far the majority of women cite multiple reasons for their abortion that work together to inform decision making. In addition, some women report multiple disruptive events in their lives at the time of the abortion, including unemployment, separation from a partner, falling behind on rent or mortgage payments, and moving house.[26]

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[16] Pallitto CC et al. (2013) Intimate partner violence, abortion, and unintended pregnancy: results from the WHO Multi-country Study on Women's Health and Domestic Violence. *Int J Gynecology Obstetrics* 120:3-9.

[17] White-Van Mourik MCA *et al.* (1992) The psychosocial sequelae of a second-trimester termination of pregnancy for fetal abnormality. *Prenatal Diagnosis* 12:189-204.

[18] Bankole A *et al.* (1998) Reasons why women have induced abortions: evidence from 27 countries. *Int Family Planning Perspectives* 24(3):117-152.

[19] Askelson NM *et al.* (2015), "Baby? Baby not?" Exploring women's narratives about ambivalence towards an unintended pregnancy, *Women & Health* 55(7):842-858.

[20] *Ibid.*

[21] Allanson S & Astbury J (1995) The abortion decision: reasons and ambivalence. *J Psychosomatic Obstetrics & Gynecology* 16:123-136.

[22] Kirkman M *et al.* (2011) Abortion is a difficult solution to a problem: A discursive analysis of interviews with women considering or undergoing abortion in Australia. *Women's Studies International Forum* 34: 121-129.

[23] Pestvenidze E & Stray-Pedersen B (2018) Who obtains abortion in Georgia and why? *Int J Women's Health* 10:733-743.

[24] Bankole A *et al.* (1999) Characteristics of Women Who Obtain Induced Abortion: A Worldwide Review. *Int Family Planning Perspect* 25(2):68-77.

[25] Chae S *et al.* (2017) Reasons why women have induced abortions: a synthesis of findings from 14 countries. *Contraception* 96:233–241.

[26] Jones RK *et al.* (2013) More than poverty: disruptive events among women having abortions in the USA. *J Fam Plan Repr Health Care* 39(1):36-43.

In a review of several studies, one theme that emerged was concern for the welfare of the child, that the desire to be a good parent constituted a reason to abort. The researchers argued "women take seriously the responsibilities of motherhood in seeking abortion".[27] Framing the desire for abortion in this way presents an opportunity for a clinician to address a woman's desire to be a good parent as being more consistent with giving birth and raising her child.

Health professionals do not always recognise the complexities of women's lives and are at risk of presuming in favour of abortion. In a study of young pregnant black refugee/migrant women in the care of the UK government, all women (even those pregnant as a result of rape) chose motherhood instead of abortion despite the difficulties they faced and despite the negative assumptions of healthcare professionals.[28] This study highlights the power held by individual healthcare professionals to create a caring environment that is woman-centred and culturally sensitive. Similarly, in a population of formerly homeless young women whose lives stabilised when they became mothers, the researchers concluded that "having a baby can serve as an asset to street exit for some homeless youth including motivating discontinuation of substance abuse; parenthood can activate hope and motivation; salience is high while the challenges are many; however, social service agencies have an essential and ongoing role to foster and support development for mothers and their children and to assist with avoidance of repetitive cycles of family trauma."[29]

In addition to the notion of pregnancy wantedness, pregnancy intention is likewise a blurry concept. Women do not always formulate pregnancy intentions, and many become pregnant without reference to intention. Pregnancy planning is an unattainable ideal for many women, and seems to be more within the province of privileged women, and/or those with stable relationships and financial security.[30] Millions of women around the world will never achieve this, but will have children regardless. Borrero and colleagues show that pregnancy intendedness, happiness about pregnancy, and acceptability of pregnancy are all separate constructs. Many women are happy about pregnancy regardless of their intentions. And some women terminate wanted pregnancies because of financial, relationship or other personal problems. These authors recommend abandoning the term "planning" and instead propose assisting women to prepare for whatever might happen.[31] Themes from the stories of women aged 18-24 who underwent abortions were described by researchers as follows: "There is more often than not a story of a boyfriend who was not supportive, or a pregnancy with a person they did not know well involving a 'poor decision', and alcohol seemed to be involved quite often. Parents are often not involved. … to give future children a good life, they had to 'get through school' so 'gave up this one' … Some noted that they didn't want a child brought up in their family or current living situation. Often described was the pain and anguish of being pregnant and very few knowing … wondering if 'the right decision was made'…"[32]

The primary reasons change somewhat when an abortion is sought in the second trimester, and include delay due to indecision, poor or absent relationship with a partner,[33] late diagnosis of pregnancy, and lack of certainty about being pregnant.[34,35] The reasons why women find the decision

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[27] Kirkman M *et al.* (2009) Reasons women give for abortion: a review of the literature *Arch Womens Ment Health* 12:365–378.

[28] Mantovani N & Thomas H (2014) Choosing motherhood: the complexities of pregnancy decision-making among young black women 'looked after' by the State. *Midwifery* 30:e72-e78.

[29] Ruttan L *et al.* (2012) Does a baby help young women transition out of homelessness? Motivation, coping, and parenting. *J Family Social Work* 15(1):34-49.

[30] Stern J *et al.* (2015) Is pregnancy planning associated with background characteristics and pregnancy-planning behaviour? *Acta Obstetricia et Gynecologica Scandinavica* 95:182-189.

[31] Borrero S *et al.* (2015) "It just happens": a qualitative study exploring low-income women's perspectives on pregnancy intention and planning. *Contraception* 91:150-156.

[32] Gray JB (2015) "It has been a long journey from first knowing": Narratives of unplanned pregnancy. *J Health Comm* 20:736-742.

[33] Loeber O & Wijsen C (2008) Factors influencing the percentage of second trimester abortions in the Netherlands. *Reproductive Health Matters* 16 Supplement 31:30-36.

[34] Ingham R *et al.* (2008) Reasons for second trimester abortions in England and Wales, *Reproductive Health Matters* 16(31) Supplement 18-29.

[35] Purcell C *et al.* (2014) Access to and experience of later abortion: accounts from women in Scotland. *Persp Sexual & Reprod Health* 46(2):101-108.

to abort difficult include the humanity of the foetus, their perception of themselves and the impact of their decision upon others.[36,37]

As noted, ambivalence about an abortion decision is common.[38,39] And what is of particular concern is the relationship between ambivalence and the potential development of long-term post-abortion psychological distress,[40] exacerbated by "impulsive and not fully internalized decisions".[41]

There are two other risk factors for later psychological distress of which medical professionals need to be aware. The first of these is moral opposition to abortion. Women sometimes have abortions despite being morally opposed to them,[42,43] which might indicate the presence of coercive influences in favour of abortion.[44] Studies have identified more negative post-abortion effects when women are morally opposed to abortion.[45]

The second risk factor is abortion for foetal disability or disease. Abortions of this type lead to more severe consequences not only for the woman but also for her partner. Numerous studies have identified a high incidence of negative emotions,[46] psychological distress,[47] post-traumatic symptoms[48] and somatic complaints.[49] Furthermore, women may not be fully aware of the role and consequences of screening for foetal disability. For example, in relation to screening for Down's syndrome, researchers found that only 37% of decisions were informed, 31% did not know that miscarriage was a potential consequence of amniocentesis, and only 62% knew that abortion would be offered if Down's syndrome was identified.[50]

Social support is of vital importance in the context of unexpected pregnancy or when a pregnant woman is unsure if she can cope. In these circumstances, women want nurturing and social network support, emotional support, and direct advice to provide some form of certainty in a difficult, frightening situation.[51]

Finally, in a recent study that examined the reasons why women who had considered an abortion then chose not to have one, the majority involved internal personal reasons rather than external ones. These included a desire for the child as well as moral opposition to abortion or past bad experiences of one.[52]

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[36] Kirkman M *et al.* (2011) *Op. Cit.*

[37] Coleman PK *et al.* (2017) *Op. Cit.*

[38] Törnbom M *et al.* (1999) Decision-making about unwanted pregnancy. *Acta Obstetricia et Gynecologica Scandinavica* 78:636-641.

[39] Kirkman M *et al.* (2010) Reasons women give for contemplating or undergoing abortion: A qualitative investigation in Victoria, Australia. *Sexual and Reproductive Healthcare* 1:149-155.

[40] Söderberg H *et al.* (1998) Emotional distress following induced abortion. A study of its incidence and determinants among abortees in Malmö, Sweden. *Eur J Obstet & Gynecol & Reprod Biol* 79:173-8.

[41] Korenromp MJ *et al.* (2005) Long-term psychological consequences of pregnancy termination for fetal abnormality: a cross-sectional study. *Prenatal Diagnosis* 25:253-260.

[42] Allanson S & Astbury J (1995) *Op. Cit.*

[43] van Ditzhuijzen J *et al.* (2019) Dimensions of decision difficulty in women's decision-making about abortion: A mixed methods longitudinal study. *PLOS ONE* 14(2):e0212611.

[44] Adamczyk A (2008) The effects of religious contextual norms, structural constraints, and personal religiosity on abortion decisions. *Social Science Research* 37:657-672.

[45] Rue VM *et al.* (2004) Induced abortion and traumatic stress: a preliminary comparison of American and Russian women. *Medical Science Monitor* 10(10):SR5-16.

[46] White-Van Mourik MCA *et al.* (1992) *Op. Cit.*

[47] Davies V *et al.* (2005) Psychological outcome in women undergoing termination of pregnancy for ultrasound-detected fetal anomaly in the first and second trimesters: a pilot study. *Ultrasound in Obstet & Gynecol* 25:389-392.

[48] Korenromp MJ *et al.* (2005) *Op. Cit.*

[49] White-Van Mourik MCA *et al.* (1992) *Op. Cit.*

[50] Rowe HJ *et al.* (2006) Are pregnant Australian women well informed about prenatal genetic screening? A systematic investigation using the Multidimensional Measure of Informed Choice. *Aust & NZ J Obstet & Gynaecol* 46:433-439.

[51] Gray J (2014) Social support communication in unplanned pregnancy: Support types, messages, sources, and timing. *J Health Comm* 19:1196-1211.

[52] Roberts SCM *et al.* (2019) Consideration of and Reasons for Not Obtaining Abortion Among Women Entering Prenatal Care in Southern Louisiana and Baltimore, Maryland. *Sexuality Res & Social Policy* 16:476–487.