POSTABORTION GRIEF: PSYCHOLOGICAL SEQUELAE OF INDUCED ABORTION

L.L. DE VEBER, MD, FRCPC
JANET AJZENSTAT, PHD
DOROTHY CHISHOLM, BA, BJ

In this paper the authors challenge the assumption, widely held among the general public and among some members of the medical profession, that induced abortion has no adverse consequences for women. It argues that current studies support the conclusion that abortion entails for women a burden of psychological distress, which is greater than that borne by unwilling mothers who go to term.

Authorities on bereavement have long remarked on the grief that follows neonatal deaths and stillbirths and, recently, many observers have described a sense of bereavement that follows spontaneous abortion. In this paper we survey reasons for believing that a similar grieving process may occur after induced abortion. Many reports have addressed women's reactions to the abortion experience, and in the first section of this paper we review studies intended to determine whether some women suffer adverse psychological consequences as a result of the abortion experience. In the second section we examine attempts to describe the factors that may dispose to postabortion distress. We conclude that some women do suffer adverse consequences, that abortion is more traumatic than childbirth, and that some individuals are incapacitated by postabortion stress. We find considerable agreement that some groups, for example women with a history of psychiatric disorders, are more vulnerable to such stress, but we find no consensus concerning the number of women who suffer adverse consequences and little agreement about how to study the issue further.

Although most studies to date are flawed, much can be learned from the difficulties experienced by research workers in this field. For the most part, observers have tended to focus on the woman's immediate circumstances and reactions, although, recently, physicians and counsellors have begun to test the idea that reactions to early pregnancy loss may be deeply buried, surfacing months or years after the event, perhaps when the woman gets married, carries another child to term, or seeks counseling for apparently unrelated matters, such as drug abuse or marriage difficulties. In the last section we propose a long-term study to test the hypothesis of delayed reactions and to provide the data that would enable us to evaluate the magnitude of the psychological sequelae of induced abortion.

ADVERSE SEQUELAE OF ABORTION: Several studies have compared the responses of postabortion and postpartum women to estimate the relative stress of the abortion experience. Using the Danish system of computerized health records, David, Rasmussen and Holst compared, for the 3 months after abortion or birth, the rates of admission to psychiatric hospitals for 27,234 women who had abortions and 71,378 women who carried their pregnancies to term. The postabortion group had 18.4 admissions per 10,000 and the postpartum group had 12 per 10,000; thus, the risk of psychiatric admission was substantially higher for women who had had abortion. After reviewing some 300 reports on the psychological after-effects of abortion, Rogers, Nelson and Phifer found that David's study comprised the largest samples and was the best conducted. The Danish results stand in sharp contrast to Brewer's study in
Britain, which reported 1 instance of postabortion psychosis in 3550 abortions (0.03 per 1000) and 7 puerperal psychoses in 4110 deliveries (1.7 per 1000). The difference between the two studies may be that David, Rasmussen and Holst relied on the Danish system, which records all contacts an individual has with social and medical agencies and service providers, whereas Brewer compiled medical histories of the women admitted to psychiatric hospitals from the reports of psychiatric consultants. Brewer cannot be as certain as David, Rasmussen and Holst that he has each woman’s complete abortion history.

A Canadian interview-based study of postpartum and postabortion women found that, immediately after the procedure and at a 4-week follow-up, those in the abortion group exhibited “poorer psychological adjustment” than the maternity patients. Although the data in this study indicate that women who have an abortion are more likely to suffer adverse reactions than those who carry their pregnancies to term, the authors sought to reassure women as to the safety of abortion, asserting that “abortion does not cause psychological damage to the majority of women who have had an abortion.”

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Other Canadian studies support the view that for some women, induced abortion has adverse psychological consequences. A Saskatchewan review of the use of health services including deliveries, spontaneous abortions, induced abortions and sterilization 1 year before and 1 year after pregnancy related events, found that postabortion women had “mental disorders” 40.8% more often than did postpartum women and that the former were treated 25% more often for accidents or conditions resulting from violence. Subsequently women in the postabortion sample consulted physicians for reasons related to mental health twice as often as did the postpartum women. In Alberta, a 5-year study, which compared women who had had abortions with women in general, showed that, of the women who had had abortions, 25% made visits to psychiatrists, compared to 3% in the general population.

Nevertheless induced abortion is still widely regarded as having no significant adverse psychological sequelae. Observers seem to have little confidence even in well-conducted studies like that of David, Rasmussen and Holst. The former Surgeon General of the United States, Dr. Koop, concluded that the evidence to date is too weak to support conclusions of any kind about the psychological consequences of abortion. In the view of Rogers, Nelson and Phifer, many studies are marred by poor selection of subjects, high numbers of drop-outs, inadequate controls and failure to use reliable assessment measures. They believe that drop-outs are more likely to be women suffering acute distress. Adler and associates believe that women who find the abortion experience stressful are underrepresented in volunteer samples but have concluded that the degree of bias so introduced is likely to be minimal.

The study by Gold, Berger and Andres was weakened by noncompliance in the postabortion group. At the 4-month interview, the postabortion sample was reduced from 580 to 95 women, 16% of its original size. As Parthun and Kiss pointed out, there is no reason to suppose that the remaining abortion subjects were representative of the original group, let alone “the majority of women who have had abortion.”

Gibbons asserted that, typically, studies of the adverse psychological effects of abortion are deficient because they ignore the possibility that reactions will surface years later. Lazarus and Stern criticized especially the reliance on questionnaires and single interviews because these methods do not reveal deep-seated psychological or psychiatric problems. Similarly Kent saw no merit in short-term studies and survey techniques. Spaulding and Caven pointed to another possible source of bias: that physicians may be reluctant to acknowledge that a “therapeutic” process will produce morbidity.

In the search for evidence of deep-seated, long-term adverse reactions to the abortion experience, the small-scale studies provide what the large projects lack: they examine reactions over years and probe for reactions in a variety...
of behavioural and symptom areas. Studying 50 postabortive women in psychotherapy, Kent and colleagues17 found that, although none had entered therapy because of adverse emotional reactions to abortion, they expressed deep feelings of pain and bereavement about the procedure as treatment continued. Typically the bereavement response emerged during the period when the patient was recovering from the presenting problem.

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From a questionnaire on their abortion experience, administered to 72 women who were not in psychotherapy, Kent15 found that, in contrast to the 50 women in his therapy sample, they showed a marked absence of affect. From this, he concluded that the initial reaction to abortion is likely to be one of numbness or relief and that only therapy uncovers the underlying pain and sense of loss.

Rue18 described reaction to abortion in terms of the post-traumatic distress disorder, a delayed reaction to stress first described in veterans of the Vietnam War. Warden19 asserted that “abortion is one of those unspeakable losses that people would rather forget” and suggested that although “the surface experience after an abortion is generally one of relief . . . a woman who does not mourn the loss may experience the grief in some subsequent loss.” Others concur: Horowitz20 found that a typical immediate response was emotional numbing. From counselling experiences, Joy21 deduced that distress may surface only after months or years. Cavenar, Maltbie and Sullivan22 described a woman whose bizarre behaviour, crying spells, inability to sleep and bulimia were, at least in part, a response to an abortion 21 years earlier. At that time she was approaching the end of her childbearing years.

Parthun and Kiss12 believe that studies conducted by physicians who perform abortions may be unsatisfactory because they must concern themselves with the immediate crisis; their observations about women’s reactions are necessarily short-term. When distress surfaces, the woman is likely to seek help from another agency, thus obscuring the connection between trauma and symptoms. In any event, a woman unhappy about her abortion is not likely to be forthcoming in interviews with the performing physicians.12

Speckhard23 argues that women may attempt to keep the abortion secret, suggesting another reason why short-term interviews may not turn up evidence of subsequent distress. In her study of 30 women identified as having long-term, high-stress reactions to their abortion experience, 85% tried to conceal the abortion or to minimize it. Former Surgeon General Koop10 believes that “50% of women who have had an abortion apparently deny having had one.” Zimmerman24 noted that, among the Western nations, abortion is still viewed as a deviant act and thus is not freely discussed.

According to Cavenar and colleagues,25 Wallerstein, Kurtz and Bar-Din26 and Gilligan,27 after abortion women may exhibit symptoms of distress on the anniversary of the abortion or of the expected delivery date. Speckhard23 noted that the women she interviewed expressed surprise at the intensity of the grief uncovered by therapy.

In summary, our review of the studies described in this section permits no firm views about the numbers of women who experience psychological distress after abortion but suggests that those who have an abortion are more likely to suffer adverse reactions than women who carry a child to term. Buckles,28 Jones29 and Rue18 maintained that no woman comes through the abortion experience unscathed. Some women appear to suffer a disabling reaction after abortion.30-33 Among the sequela recorded (some mild, some incapacitating) are guilt, depression, grief, anxiety, sadness, shame, feelings of hopelessness, lowered self-esteem, distrust, hostility, insomnia, suicidal feelings, drug dependency and difficulties in family and sexual relationships.

Researchers like David, Rasmussen and Holst,4 and Gold, Berger and Andres,7 emphasized that only a minority of women experience adverse reactions. Adler and associates11 asserted that “the weight of the evidence from scientific studies indicates that legal abortion of an unwanted pregnancy in the first trimester
does not pose a psychological hazard for most women." However, the minority who do suffer adverse reactions are an important group of patients because induced abortion is so common in Western society. We may expect an increase in postabortion psychological problems in the future because the number of abortions is not decreasing. Also, the profile of the fetus is becoming more visible to the public through advances in the science of fetology, such as ultrasonography.

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ADVERSE ABORTION SEQUELAE: WHO IS AT RISK? Research on psychological sequelae has moved from the general question of whether abortion is psychologically damaging to the specific task of identifying persons or groups at risk. In the literature the groups considered most at risk are those whom the public regards as most in need of abortion as therapy: women in their teens, women with a previous history of psychiatric disorders and women who abort because the fetus has been diagnosed as defective.

Clearly, women with a history of psychiatric disorders are at risk. An editorial in the British Medical Journal asserts that seriously disturbed patients, "who may appear to have prima facie grounds for abortion for psychiatric reasons," are more likely to show serious psychiatric sequelae. According to Heath, Sim and Neisser and Sclare and Garaghty, women with a psychiatric history have a poorer prognosis after induced abortion. In 1970, a World Health Organization report noted this effect. In 64 women, assessed 8 weeks after induced abortion, Ashton found that 5% had "enduring" psychiatric symptoms and concluded that women with a previous psychiatric or abnormal obstetric history, those with physical grounds

for abortion and those expressing ambivalence toward the abortion are especially at risk. Fifty-five percent of his group experienced at least short-term adverse reactions. Unfortunately, the study of postpartum and postabortion psychosis by David, Rasmussen and Holst excluded women with a psychiatric history; they eliminated from the sample those who had been admitted to a psychiatric hospital in the 15 months before abortion or delivery.

Women who undergo abortion for medical reasons appear to be more vulnerable to adverse sequelae, perhaps because their pregnancies were planned or desired. In one sample of 13 families who had elected induced abortion following a diagnosis of genetic defects in the fetus, 12 of the women and 10 of the men were found to be suffering depression. Borg and Lasker asserted that parents who have decided to abort a potentially defective child grieve in the same way as other bereaved parents. Rayburn and Laferla found markedly more grief among women who had aborted for medical or genetic reasons than among aborted women in general. Lloyd and Laurence found support services inadequate for women who abort after a diagnosis of fetal malformation.

Abortion appears to be especially stressful for adolescents perhaps because it affects their fragile self-esteem. Wallerstein, Kurtz and Bardin, who studied 22 aborted women ranging in age from 14 to 22 years, found that in the 14- to 17-year-old group symptoms were more dramatic and more severe. The symptoms included "withdrawal from social relationships, preoccupation with feelings of 'ugliness,' severe crying spells upon seeing children or pregnant women, increased dependency on parents (radical changes in relationship patterns), one suicide attempt and several acute anniversary reactions." Four of these very young women had pervasive long-range adverse effects including sex-role oscillation (these young women "entered into masculine role engagements" followed by "promiscuous feminine sexuality"), self-reproach, social regression and obsession with the need to become pregnant again. Margolis and colleagues, who found considerably more evidence of ambivalence and guilt among women under 18 years of age, advise great caution when recommending abortion for women in this age group. In very young teens Perez-Reyes and Falk found negative feelings to be most acute immediately after the abortion.
It is difficult to demonstrate that the presence of social support decreases the likelihood of adverse reactions, although many assert that women who receive support from family and counsellors will suffer less distress. In the Danish study, David, Rasmussen and Holst\textsuperscript{4} found that separated, divorced and widowed women are more disposed to severe adverse reactions. Indeed this was perhaps their most striking finding. The rate of admission to psychiatric hospitals for separated, divorced or widowed postabortion women was 63.8 per 10,000; the rate for the comparable group of postpartum women was 16.9. They conclude that postabortion stress is greatly magnified by the absence of the woman’s male partner. However others,\textsuperscript{47} including Gold, Berger and Andres,\textsuperscript{7} found that women accompanied by male partners at the time of the abortion suffered more distress than unaccompanied women. Greenglass\textsuperscript{48} found a similar pattern of increased distress among married women. It is difficult to explain this difference although perhaps the experience of a stable sexual relationship disposes women to increased distress because it heightens their ambivalence about the abortion.

\textbf{Ambivalence about abortion disposes a woman to adverse reactions.}

Certainly it appears that ambivalence about abortion disposes a woman to adverse reactions. Women who delay seeking an abortion are at greater risk\textsuperscript{11,49} and Friedman, Greenspan and Mittleman\textsuperscript{50} and Senay\textsuperscript{51} have concluded that women who have been coerced into the decision experience more distress. Even in planned pregnancies there may be ambivalence because, as Hager and Owens\textsuperscript{2} pointed out, at the beginning of a pregnancy as many as 50% of women may say that they do not want to carry to term.

Adler and associates\textsuperscript{11} asserted that “women who report little difficulty in making their decision, who are more satisfied with their choice, and who are terminating pregnancies that were unintended and hold little personal meaning for them show more positive responses after abortion.” This observation raises a larger question: Is postabortion distress a cultural phenomenon? If the Western nations had no inhibitions about abortion would postabortion distress be less common? There is nothing in the record of the past 20 years, years of relatively free access to abortion in the Western world, to suggest that women are becoming less vulnerable to this form of psychological distress.\textsuperscript{52}

Crisis pregnancy counselling agencies and family service organizations now provide postabortion counselling, often by women who have had abortions. The names of such groups suggest considerable anger and resentment: Women Exploited by Abortion, American Victims of Abortion, Victims of Choice.\textsuperscript{53}

In summary, we believe that some women suffer adverse emotional and psychological effects following abortion and that this experience is more likely to be traumatic than carrying the child to term. Those most at risk are women in their teens, women with a previous history of psychiatric disorders, and women seeking abortion because the fetus has been diagnosed as defective. In our opinion it is important that adverse reactions to abortion may appear months or years after the event. Even when the woman appears to suffer no immediate ill effects, she may have undergone a severe emotional trauma, which only comes to light months or years later.

\textbf{PROPOSAL FOR FURTHER STUDY:} To ascertain the true extent of postabortion psychological sequelae, something more is required than studies based on questionnaires or interviews conducted shortly after the abortion.

A satisfactory study would provide follow-up for at least 5 years after the abortion and would include those who have never been pregnant and those who have carried one or more pregnancies to term as well as those who have had abortions. This study would record all events in the lives of the women and their families that required professional attention or counselling, whether or not these were related to pregnancy. It would establish special categories for women who have aborted spontaneously or suffered stillbirth and for the groups believed most at risk: women in their mid-teens, those with a history of emotional distress and women who have aborted defective fetuses.
The study would record whether the women had preabortion or postabortion counseling and what agencies were involved. The interviewers should not be associated with institutions identified with only one perspective on the abortion issue, for example, hospitals and other facilities that provide abortions.

Finally, because most of the previous studies concentrate on North American and European experiences, this research should be extended to non-Western societies, especially the Soviet Union and Japan, where induced abortion is socially acceptable.

**CONCLUSIONS:** Contrary to widely held assumptions, an undetermined but significant number of women suffer postabortion grief. Current knowledge about a woman’s grief following neonatal death, stillbirth or spontaneous abortion supports this conclusion. The inadequacy of studies to date and the large numbers of women potentially at risk make necessary a long-term study of abortion’s psychological aftermaths. Such a study would determine the magnitude of the problem and would enable us to identify the groups of women most likely to require special advice and treatment.

L.L. De Veber, MD, FRCP
Professor of Pediatrics
University of Western Ontario
800 Commissioners Rd. E
London, ON
N6A 4G5

Janet Ajzenstat, PhD
Department of Political Science
McMaster University
Hamilton, ON
L8S 4M4

Dorothy Chisholm, BA, BJ
108 - 101 Hafton Blvd.
Toronto, ON
M4V 1Z6

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