Clinical psychological research on women with experience of abortion early in pregnancy

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CLINICAL PSYCHOLOGICAL RESEARCH ON WOMEN
WITH EXPERIENCE OF ABORTION EARLY IN PREGNANCY

SHOKO SUGAO*

Abstract

Understanding of the psychological aspects of women who experienced miscarriage or stillbirth has been expanding in recent years. However, psychological research pertaining to women who have had a termination of pregnancy (hereinafter “abortion”) also during the perinatal period are very few in number.

In order to examine what kind of support is available to these women, this paper attempted to depict the internal thoughts of five women who have experienced early termination of pregnancy through semi-structured interviewing and questionnaires filled out by the individuals themselves (IES-R).

The result was not fully consistent with the concept of PTSD shown in past research, but it has revealed that the research participants showed signs of abortion-related psychological problems, which prominently appeared one month after the operation, when physical conditions start to stabilize. On the other hand, these individuals also spoke of their attachment to the lost baby. Based on these facts, it can be considered necessary to know in advance what psychological conditions are likely to occur after abortion, and for the people close to the individuals and for the individual herself to delicately handle distress or strong feelings of guilt, and accept the individuals’ feelings towards the lost child.

However, there are still future challenges facing this research, such as biased subjects or paucity of cases. Based on these facts, it is considered necessary to continue conducting case studies and examine what kind of support will be helpful.

Key words: abortion, psychological influence, attachment
1. Problem and Purpose

Understanding of the psychological aspects of women who experienced miscarriage or stillbirth has been expanding in recent years. However, psychological research pertaining to abortion, also during the perinatal period, are very few in number despite being oft-discussed in medical, legal, and religious fields (Sugao, 2006). It is assumed that the reason for this is due to the fact that abortion cases vary greatly between individual cases, which are affected by social background and personal values. Furthermore, the fact that abortions are considered to be taboo is also one of the major reasons.

According to the report by the Ministry of Health, Labor and Welfare, the number of abortions has gradually been declining after peaking at 1,170,143 cases in 1955. However, in 2009, there were still as many as 223,405 cases: still more than 200,000 cases overall. When looking at 2009’s data by age brackets, the largest bracket was ages 20 to 24 with 50,627 cases, followed by ages 25 to 29 with 47,952, followed by ages 30 to 34 with 45,152, ages 35 to 39 with 40,917, and finally ages under 20 with 21,192.

The experience of having an abortion “often causes a lasting conflict over choices made by the woman or the people around her, and such stress may easily drive the individual into isolation” (Sugao, 2008). Abortion has a considerable influence on women, both physically and psychologically, and “a feeling of guilt or remorse tends to put women into negative mental states for short or long-term periods” (Tokiwa et al., 2003). Furthermore, abortion is said to possibly be traumatic, in some cases (Miyaji, 2004). There were studies in Europe and the United States in which psychological conditions before and after abortion were attempted to be analyzed as a problem centered around PTSD and depression (Pope et al., 2001). In the nursing field, the need for continued counseling before and after abortion, and the importance of psychoeducational intervention in both mental and physical respects have been pointed out (Suzuki et al., 2001) (Kinebuchi, 2008). However, it is not uncommon for nurses to take care of delivery and abortion at the same time. This results in psychological burdens for the nurses as a result of difficulty in changing emotional gears or feeling apologetic for failing to provide sufficient care. Cases of secondary stress or substitute injury have arisen as a problem, and are often suffered by nurses at sites of midterm abortion care. There are reports that these problems result in heightened defensiveness of nurses, who are the ones providing care (Shimoyama, 2010). Considering that the same things would happen in early abortion, and also taking into account the care that is needed not only for the individual undergoing abortion but also for her nurse, it can be said that the presence of experts in psychology, such as a clinical phycologist, is necessary.

With regard to psychological care, there is very little research of systematic and specific therapy methodology or detailed reports of accounts regarding mental states and emotions of women who have had abortions. To evaluate what kind of support can be available to these women, it is necessary for an interviewer to listen to each account by each individual, and
consider how the individual feels at that specific moment while listening to her stories. These considerations will be the foundation for support. This research aims to depict the internal thoughts of women who had an abortion by listening to their accounts.

2. Method

2.1. Participants

Five women in their 20s who have experienced early abortion due to social/personal reasons such as economic reasons, etc. (under 12 weeks of pregnancy) were recruited from obstetrics and gynecology hospitals, and via the Internet. Reasons for selecting women in their 20s as interviewees were because many abortions are conducted for social or personal reasons, this age group makes up the largest percentage of abortions, and because it is difficult for them to request proactive nursing care or psychological support because nurses often regard them as “selfish,” “have no idea how to provide appropriate care,” or “think these women should be left alone” (Okubo, 2003). As a result, one of the participants did not have an abortion, but rather her pregnancy was terminated as a result of miscarriage. However, the case has been included as is because it was not inappropriate for this study.

2.2. Research Period and Method

The research was conducted during the period from May to October of 2005. Participants who understood and agreed to the purpose of the research were given, in advance, oral and written explanations stating that the results of the research would strictly be used for academic purposes only, that strict attention will be paid to protect privacy, that the interview would be conducted on a voluntary basis so as to allow participants to end it at any time, and that participating in the interview may cause emotional instability. Permission was granted to use these result in this paper.

Since this study’s relationship with PTSD has been pointed out in past studies, I started the research by issuing an Impact of Event Scale-Revised (IES-R) questionnaire (Asukai, 1999) to measure the level of distress the abortion had caused in the individual within the past week, using a five-point scale. Additionally, in consideration of difficulties of controlling complicated factors such as the participant’s personality or sense of values, her relationship with her partner, friends or families, I decided that qualitative research was also appropriate and conducted a 90 to 150 minute semi-structured interview. These interviews were recorded with permission from the participants, and conducted in accordance with the interview guide with questions that included inquiring about when the individual received their abortion, the reason, their feelings, their status, and their participation in the interview. The participants were encouraged to talk as freely and as much as possible.
3. Results and Observations

3.1. IES-R Results and Observations

IES-R scores of all the participants in the interview, except A, exceeded the cutoff value (24/25), which suggested the possibility of PTSD (see Table 1). States of mind which are believed to be symptoms of PTSD—intrusion, avoidance, and hyperarousal—were recounted in a variety of expressions. Abortion means experiencing a loss of life, which may be a traumatic event. However, we should not ignore that there are cases in which IES-R scores are low, as can be seen from individual A. In A’s case, more than three and a half years had passed since the operation, which may have contributed to the low score. However, C, who had an abortion more than two years ago, had an IES-R score that was similarly high as the others. This indicates that time is not the only factor that affects a decline in score. During the interview, participants including A talked of their love and affection towards their baby. Therefore, considerations must be made not only from the perspective of PTSD but also from the aspect of grief reaction. Furthermore, biased subjects and paucity of cases in this research must also be taken into account. Based on the above, it seems dangerous to suggest the possibility of trauma only from scores acquired by questionnaire. Careful consideration will be needed to decide whether or not each case falls under the concept of PTSD.

3.2. Interviews and Analysis

Next, the paper will discuss sections in the interviews that shared commonalities, as well as subjects that were deemed important. All recorded interviews were transcribed to better understand the whole picture. Additionally, I noted the mood and affect during the interview to get a better understanding. In this paper, participant stories that seemed particularly important are collectively presented in Table 2. In order to protect privacy, information which could identify the individual was slightly modified.

1) Initiative regarding decision

When deciding upon getting an abortion, every participant of this research was in a situation

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**Table 1.**

<table>
<thead>
<tr>
<th>Age, Marital status</th>
<th>Occupation</th>
<th>Time since abortion</th>
<th>Total IES-R (I: intrusion, A: avoidance, H: hyperarousal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 20s, married</td>
<td>student</td>
<td>3yrs 8m ago</td>
<td>6 (I: 5, A: 0, H: 1)</td>
</tr>
<tr>
<td>B 20s, unmarried</td>
<td>office worker</td>
<td>3m ago</td>
<td>43 (I: 19, A: 9, H: 15)</td>
</tr>
<tr>
<td>C 20s, unmarried</td>
<td>office worker</td>
<td>2yrs 2m ago</td>
<td>48 (I: 24, A: 7, H: 17)</td>
</tr>
<tr>
<td>D* 20s, unmarried</td>
<td>student</td>
<td>3m ago</td>
<td>55 (I: 21, A: 16, H: 18)</td>
</tr>
<tr>
<td>E 20s, unmarried</td>
<td>student</td>
<td>7m ago</td>
<td>54 (I: 19, A: 19, H: 16)</td>
</tr>
</tbody>
</table>

*: D bled one week before the scheduled abortion. (She considered it a miscarriage but details are unknown)
Their partner after a week after the abortion. Their feelings of guilt, attachment.

I wanted to have a baby. I felt betrayed. He didn’t understand the feelings that I wasn’t able to articulate. I felt as if he’d turned his back on me.

Table 2. Interview contents

<table>
<thead>
<tr>
<th>Conditions and symptoms post-abortion</th>
<th>Their feelings of guilt, self-punishment</th>
<th>Regard to talk about the experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>I was in a stupor. I felt dizzy….</td>
<td>I’m still wondering about whether taking the life of my baby was the right decision. I was hardly able to talk with my relatives’ babies, as I had an inherent dislike of children and felt unsure about my baby. I was able to calm down a bit.</td>
</tr>
<tr>
<td>B</td>
<td>Around one week post-abortion, when physical conditions had almost recovered, the emotional anxiety and pain became more intense. Suicidal tendency was very strong. Suicide ideas. After two years since the operation, the urge towards self-inflicted suicide was reduced, but suicidal thoughts are still continual. I felt empty, and kept crying all the time. I felt so lonely.</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>I was glad that morning sickness disappeared, so at first I didn’t feel anything special….</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Thought she had to force a smile when she was with people so that they wouldn’t worry. One month after the operation, there were times when she could think more positively, but around two months after the operation the times of the greatest instability, and she had very strong feelings of loneliness, went through hyperventilation, flashbacks, and restlessness. Writing-cutting started, as well as anxiety. I couldn’t express any dissatisfaction or anger because I thought that I was to blame. I ended up thinking that I’m not entitled to getting a job that I want, and that I shouldn’t be here, because I killed my baby.</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Felt this was her decision and that she had to get well again soon. Tried not to think about it. Around one month after the operation, when physical conditions began to recover, experienced intense emotional distress which led to suicidal thoughts. About two or three months after the operation, several symptoms appeared such as insomnia, sickness, flashbacks with a sudden crying, and significant decline in concentration. Currently (at seven months after abortion), still receiving medication for insomnia. Hard to hear about people around her giving birth or seeing a pregnant woman or person with a baby.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eating seemed like a form of being alive, so I kept on immediately vomiting whatever I ate from a feeling of guilt.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When I saw an ultrasound image of my baby, I really started feeling empathy. For a while after the operation, I still felt like the baby was still in my body and I unconsciously acted in such a way as to protect it. The morning sickness disappeared and the sense of loss really hit me, as if I had lost a part of my body. Through ultrasoundography at the checkup post-operation, I confirmed that I lost my baby and it hurt me emotionally. I was able to talk to my professor. At first, I was uneasy if I had the baby. It really made me believe that I was incapable of having my baby.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>After receiving the explanation of the operation, I felt that I didn’t want my baby to undergo such suffering. I should have talked more to my baby. Even a brief counseling, I didn’t go to the hospital immediately because I wanted to keep it for as long as possible. I bought toys for the baby and I still always carry it as a charm. A nurse told me that I would be free from my pain when the surgery was finished. Being told this, I felt as if the baby was regarded by others as a nuisance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I’m still wondering about whether taking the life of my baby was the right decision. The way the hospital treated the procedure like an assembly-line system was harmful to me because I felt an attachment to my baby. When I see other children growing up, it hurts because I know that if my baby had been born, it would have gone through the same sort of process. On the anniversary of my child and its due date, I take time to think about the baby. I kept a journal of my experience as evidence that the baby existed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I’m glad that I was able to talk about my baby so much today by taking this interview.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I’m glad that I had someone to listen to me talk. I still often think back to the time of abortion. I realized that I haven’t recovered from that time at all. I hope I can be of some help to others who are going through similar situations.</td>
<td></td>
</tr>
</tbody>
</table>

I’m still wondering about whether taking the life of my baby was the right decision. The way the hospital treated the procedure like an assembly-line system was harmful to me because I felt an attachment to my baby. When I see other children growing up, it hurts because I know that if my baby had been born, it would have gone through the same sort of process. On the anniversary of my child and its due date, I take time to think about the baby. I kept a journal of my experience as evidence that the baby existed.

Through this interview, I realized that there are still many feelings that I had not acknowledged or resolved. I’m glad that I was able to talk about this.

I had two or three discussions with my partner, but we never talked to each other about what we wanted to do. As a result, I felt empty, and kept crying all the time. I felt so lonely. Suggested that I was incapable of having my baby. I didn’t want to converse with others or go to college. I was able to calm down a bit thanks to talking to the professor. At first, I was uneasy because I didn’t have much information about my feelings after abortion, but I was slightly released from my anxiety by talking in the interview. I’m glad that I had this opportunity to cooperate with this research.

I’m surprised that I was able to talk about this more calmly than I expected, but sometimes I still cry... This was a good opportunity to organize my own feelings, I think.
where carefully reflecting upon their inner conflict was difficult. Though they had feelings for the small life that they carried in their body, these individuals were not able to have much dialogue regarding this new life with their partner in the limited amount of time that they had before deciding upon abortion, or decided upon abortion without being able to reconcile differences in opinion. The unmarried status of the woman may be an influential factor, but whether or not they can talk about the decision or make an effort to share their thoughts depends on what kind of relationship they have already established. This kind of problem would occur even to married people.

Whether or not the individual consciously approached her decision towards abortion and the process of undergoing surgery greatly affects the subsequent psychological process and quality of her relationships. Because having an abortion is a grave decision, leaving the decision to the partner without taking any initiative causes persisting negative feelings such as hatred, resentment, and conflict toward the individual’s partner, such as feeling that they were “betrayed”, feeling “malice”, feeling that her partner did not “accept her”, or feeling “discontent”. Furthermore, participants presented the possibility that feelings of self-punishment, helplessness or guilt may be enhanced; for example, by thinking “I’m not worth living,” “I killed my baby,” “I should be punished,” or “why am I still alive?”

2) Status post-abortion

Cases within this research reported that psychological instability manifested in individual B one week after her operation, and one month after operation in other participants. It is said that in order to protect themselves against overwhelming emotional states of being, humans try to limit or attempt to avoid or limit sensations in their day to day lives (Herman, 1992/1999). Even in this research, the participants recounted that they “tried not to think about it,” avoided contact with other people, or had difficulties in making plans for the future. Furthermore, feelings of guilt regarding killing their child and doing so by their own decision, as well as a damaged sense of self-esteem, seems to affect the shrinking of these individuals’ outlook of the future. They repeatedly ask themselves if they are “worth living” or “worth being happy”, which has sometimes led to suicide attempts or suicidal ideations. These individuals also stated that they felt a strong sense of loneliness, as well as emotional aversions and pain upon seeing a baby stroller or a pregnant woman. Intrusion symptoms such as “having nightmares” or “suddenly crying and remembering the abortion,” hyperarousal symptoms such as being “prone to overreaction,” and other symptoms including sleeping or eating disorders, depression, and frustration were also reported.

The cases in this research showed that psychological problems became especially apparent after some time had passed from the operation. This is believed to be the case due to the fact that immediately after the operation, individuals felt relieved or liberated from the completion of the surgery, or believed that they should or have to hurry and return to their former life, or felt that they did not want to worry the people around them. This is consistent with the findings of Suzui
et al (2001) that state that feelings of anxiety decline and stress is relieved just after operation, but these feelings get stronger on the 3 and 6 month marks. Generally, follow-up aftercare is provided for one month after the operation, before it ends. Thus it is likely that the individual’s contact with her medical institution will have ended just as psychological problems become evident. There is a study in nursing science that reports that women who have had abortions and who seemed calm would pour forth their repressed feelings when others took the time to speak with them (Hase, 2003). This study indicates that healthcare professionals directly involved with women who undergo abortions also need to have an understanding of these complicated feelings. These professionals should know that even though individuals undergoing abortions seem fine just after abortion or at the one-month checkup mark, they may develop psychological or mental problems later.

3) Attachment towards the baby and grief of loss

During the interview, attachment towards the lost baby was discussed, along with strong feelings of guilt, anger, and PTSD symptoms. For an expectant mother, “the baby” is a “part of her body”, while also being a “part of her soul”. In other words, undergoing an abortion is analogous to the experience of losing a part of one’s own soul. After abortion, women tend to feel guilt and regret, or go through avoidance by attempting not to think of it or trying to pretend that it didn’t happen. This leads to feeling shame towards the fact that they feel affection and love towards the child. The woman feels reluctant to express these feelings of love and affection for the baby, and these feelings progress into trepidation and guilt about holding such feelings. As stated in Okonogi’s study (1979), in order to follow the psychological grief process, one needs to accept sadness or pain as it is and must experience feelings of regret, hatred, and guilt without avoiding them. Furthermore, how well the individual and the people around her accept affection and attachment towards the lost baby, and how much they lament the loss also become important. Grief is a mental process which progresses automatically, but the “need to adapt to the external world, as well as internal self-defensive mechanisms, may block the process of grief” (Okonogi, 1979). It is considered necessary to remove these obstacles in order to recover the natural workings of the mind.

4) Talking about the experience of abortion

It was revealed that the interviews, despite merely being cooperative research, encouraged the women to express their feelings, organize their experiences, and realize their true feelings and state of mind. For women who have had abortions, speaking about her own experience to others in a safe environment, even in a single interview, seems to work to a certain extent. As Kluge-Bell states (2000), miscarriages, stillbirths, and abortions are likely to be kept to the individual as an experience of unspeakable loss. Speaking about abortions is particularly susceptible to the dangers of becoming emotionally damaging experiences due to the nature of the experience. However, if the individual is given warm support from others, she can speak about her experiences, which will help stabilize her day to day life. Listening to these women
without making one-sided judgments or interpretations regarding their own story is crucial to their process of orienting their experience of loss as well as their guilt into their lives upon choosing the option of abortion. I aim to suggest the possibility that re-experience through recounting various feelings regarding what was lost can become a step towards following the psychological process necessary for recovery.

3.3. Future challenges

This research’s interview portion was conducted via voluntary participation, who expressed that they “wanted to have their story heard”. Therefore, there were problem points that included biased subjects and a lack of control in the time elapsed from abortion to this research among participants, as well as an insufficient number of cases. It is difficult to say that all women who have had abortions undergo such states of mind. Furthermore, this research is based on the interviews of women and did not cover subjects of their male partners in detail. Because data regarding male partners is also important, future tasks should involve making a survey pertaining to male partners while also continuing case studies of women. It seems to be a future challenge to consider psychological states and discuss how to support those involved in abortion with a broad view that includes aspects of the decision-making process and reactions to grief.

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