Is counselling necessary? Making the decision to have an abortion. A qualitative interview study.

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Short title: Is counselling necessary?

Key words: abortion, counselling, young women, qualitative

Abstract

Objectives: To explore young women’s decision-making about having an abortion, in particular, how they reached the decision and with whom they discussed it.

Methods: This was a qualitative study comprising semi-structured one-to-one interviews with 24 women aged between 16 and 20 who were waiting for, or had recently had, a surgical termination of pregnancy. Interviews were recorded with the consent of the interviewees, fully transcribed, and analysed using a grounded theory approach.

Results: All but one of the women had been offered counselling; one could not remember. Only two had accepted the offer of counselling, most feeling that it was unnecessary. The majority of young women have decided that they want an abortion before accessing health services to request one. They have discussed their decision with someone close to them and do not feel the need to have further discussions with counsellors.

Conclusions: Most young women have already made the decision to have an abortion before they approach their GP or a family planning clinic to request one. Requiring women to undergo counselling would delay the process and for most women would be an unnecessary burden, whilst also diverting resources from those women who require counselling.

Introduction

Access to abortion varies widely between European countries, with some prohibiting it completely (Malta) or making it unavailable (Ireland) whilst others allow it on certain grounds (eg. Great Britain, Finland); most European countries allow abortion on request but under certain conditions, generally concerning gestation, counselling, and where an abortion can take place1. Despite termination of pregnancy being legal in the UK (except Northern Ireland) since 1967 and in the USA since 1973, abortion remains a contentious and politically “live” issue in both countries. Many states in the USA have increased restrictions on access to abortion in recent years, and whilst there has been no legislative change in the UK, several attempts to introduce more restrictive legislation have been made. Most recently, attempts to bar abortion providers, mainly charities, from providing advice and counselling, and to require women to receive counselling from “independent” bodies before an abortion, failed to be accepted as an amendment to the NHS and Social Care Bill 2011. This reflects a trend by conservative politicians and religious groups in many countries to attempt to restrict or remove women’s access to safe, legal abortions.

In the UK, proposals by Frank Field MP and Nadine Dorries MP have caused concern that by “independent”, they mean organisations such as LIFE and Care, who are opposed to abortion. As Lee points out,2 the supporters of such organisations often promote their counselling services on the basis of the psychological trauma preceding and following abortion, despite there being no evidence that abortion itself causes trauma.3,4The relationship between abortion and mental health has become highly contentious, and many of those opposed to abortion insist that it results in massive and long term mental and emotional distress. There is no evidence of this for the vast majority of women5; where there is emotional distress after abortion it is in women who had previous mental health problems, which suggests that the underlying problem causes the ongoing mental health issue. Other misinformation, such as risk to life, risk of breast cancer, risk of future infertility and fetal pain, is also widely promulgated by anti-abortion organisations in the UK and even more so in the USA, usually based on distorted interpretations of scientific literature.6

The Royal College of Obstetricians and Gynaecologists (RCOG)'s guidelines7 state that all women should be offered the opportunity to discuss their decision with a non-directive counsellor, and/or clinician. The concern about involving organisations such as LIFE, who have a very clear aim of preventing abortions, is that any counselling they provide would not be non-directive. The Department of Health’s (DH) Required Standard Operating Principles (RSOPs)8 regulate provision in the NHS and in independent providers, ensuring that counselling following recommended guidelines is provided across the whole sector. Despite the existence of clear and robust guidelines to ensure the provision of counselling, and the regulation of that counselling across the sector, Field suggests that it would be better if counselling was provided by GPs9 although “better” is not defined, and GPs themselves do not appear to be in favour of the change.10

Studies with women seeking an abortion have shown that they want information and an uncomplicated referral process,11 think that it should be easier and quicker to get an abortion and counselling should be available for those who wanted it12 and that most women make their decision prior to consulting a medical professional13 or having counselling.14 The concept of mandatory counselling, which is required in 32 states in the USA, does not have a robust scientific basis.15

Methods

The study was designed as an exploratory qualitative study using semi-structured interviews. In this way, selected topics could be addressed, but the interviews had the flexibility to allow the participants to talk at length about topics that were of concern to them, and also to introduce relevant issues to the interview. The study explored young women’s knowledge of and attitudes to use of contraception, and decisions about contraceptive use and abortion. Findings relating to use of contraception are reported elsewhere.

Interviewees were recruited from day patients on a surgical termination of pregnancy list at a Women and Children’s Unit in the north of England. It was initially intended to talk to women post-operatively, once they had left hospital, having obtained their consent pre-operatively. However, although 18 women had agreed whilst on the ward that the researcher could contact them a week later, the response to the telephone call was almost entirely negative. All but two respondents said they had changed their minds about being interviewed, mainly because they regarded the hospital stay as the end of the process and had no wish to think about the termination. As a result of these difficulties in recruiting, an amendment to the protocol was obtained from the local Research Ethics Committee to allow interviews to take place once the patient had been admitted but before they went to theatre. Although initially the concern was that this might cause distress, in fact the young women were keen to talk on the day, and it was felt that it actually causes more distress to bring up a subject that women consider “closed” after the event. In total, 23 face to face interviews took place, 22 on the ward and 1 post-procedure in the young woman’s home. One short telephone interview was carried out, also post-procedure. The face to face interviews lasted between 9 and 35 minutes. One interview was cut short because the interviewee was called for theatre. The interviewees were aged between 16 and 20 years old. Five of the interviewees already had a baby, two of them having given birth at the age of 15.

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Interviews were recorded and transcribed. Themes and concepts were identified through reading and rereading the transcripts in order to build an analytical framework, with emerging thematic categories being refined and saturated as the interviews proceeded. Using the constant comparative method16 ensured that the categories developed were robust. A second researcher read the transcripts to ensure that the analysis had been thorough and rigorous.

Results

Interviewees were asked about the decision-making process leading to the abortion, including with whom they had discussed it, and the consultation process. They had all discussed it with at least one person they trusted (mother =10, boyfriend =13, friends = 4, other family =2, other person =1) and by the time they consulted a health professional (usually the GP) they had decided that they wanted an abortion.

All but one of the interviewees had been offered counselling once they reached their first hospital appointment; one thought she might have been but was not sure. Only two accepted counselling and both felt that they had been given enough opportunities to talk things through; one of these interviewees had also talked to her mum and her boyfriend, the other did not report having spoken to anyone else. The majority who declined counselling did so because they were already certain about their decision:

*Yeah, but I didn’t take it because I knew straight away as soon as I found out. I already knew that I didn’t want it. (R3, aged 17)*

*Cos I just don’t think I need it. Cos I know it’s what I want. (R1, age 16)*

Most of them had already discussed it with people they knew:

*I’ve had other people that I’ve been able to speak to, and I feel confident that I’ve made the decision that’s right for me (R5, age 20)*

*Because I didn’t feel I needed to, because I’ve talked a lot about it with my Mum, I talked about it with my boyfriend, I talked about it with my friend. (R22, age 18)*

The importance of having known and trusted people to talk to was brought out by one interviewee who already had a counsellor due to other issues in her life, and felt that she did not want to talk to someone unknown:

*I’ve already got a counsellor. So I’d rather have someone else have that counsellor and me keep my own. Cos I know her. (R10, age 17)*

One interviewee explained that she did not need counselling because:

*After this it’ll just be back to normal (R21, age 18)*

The decision to have an abortion was made for a clear reason, mostly to do with not being able to offer a child a secure upbringing or the interviewee and her partner being too young, although in two cases it was because the relationship had ended.

Several interviewees who did not already have a child said that they felt they were not in a position to have a baby, although often said they felt that they would want children one day:

*Because I can’t support it financially. He can’t, my Mum can’t. I’m hoping to go to Uni in September, and I want to get my career sorted out first, get some money, give it a life. Cos I know that I can’t now. (R2, age18)*

*I can’t give it anything, like I want to be able to have a kid when I’ve got money to bring it up (R17, age 18)*

As well as not being in a position to raise a family in a way they thought “right”, the other main reason was they were too young to have a baby:

*I’m too young. I’ve messed up a bit at school, I don’t want to mess up any more and be on benefits and that. I’d rather wait til I’m a bit older (R9, age16)*

For two respondents, the pregnancy had let to the end of the relationship, which had then led to the decision to have a termination.

*As soon as I told him I was pregnant, he didn’t want to know. Haven’t seen him since (R16, age18)*

For those who already had a small child, the deciding factor centred on whether they could cope with another baby:

*I’m just not ready for another one yet (R14, age18)*

*I just knew I couldn’t go through with it again, not having already got one. Two babies, with two different fathers, at my age? Don’t think so. I knew I just couldn’t cope with it. (R23, age18)*

Discussion

The young women interviewed for this study were already certain about their decision to request an abortion and had already discussed it with people they trusted before consulting a medical professional, usually their GP. They had clear reasons for their decision. Counselling had been offered to all but one, but was seen as unnecessary by most and therefore declined.

Although one study17 found that young women make their decision to have an abortion later than older women, which then leads to later abortions, the young women in this study had made their decision quickly. Although some of the young women in this study were not using contraception reliably, they were not using abortion as a method of contraception. It was not something entered into lightly. In almost all cases, they had discussed their decision with one or more trusted people who were close to them. The findings of this study are consistent with other studies which have looked at abortion decision making in older women.

Qualitative interviews are a good method of data collection allowing insight into people’s views and experiences, particularly on a sensitive topic such as this. As the interviews were on a sensitive topic, some young women may not have wished to talk; in addition, this was a focussed study, looking at reasons for unintended conceptions amongst young women having a termination. Therefore the young women interviewed may not have been typical of the wider population, and caution should be exercised as far as potential transferability of findings is concerned. However, studies on emotional issues, especially abortion, are difficult to carry out successfully15 so the successful completion of this study with young women should be regarded as a strength.

Conclusion

In a UK political context where LIFE but not BPAS are invited to be part of a sexual health forum advising the government which replaces the Independent Advisory Group on Sexual Health,18 and politicians engage in continued attempts to alter regulations without parliamentary debate, it is vital that robust and ethical studies take place showing how women make decisions about abortion.

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