

Is counselling necessary? Making the decision to have an abortion.

A qualitative interview study.

Sally Brown

School of Medicine and Health, Durham University, Queen's Campus,
Thornaby on Tees, United Kingdom.

Short title: Is pre-abortion counselling necessary?

Key words: Abortion, Counselling, Young women, Qualitative

Correspondence: Dr. Sally Brown, School of Medicine and Health, Durham University, Queen's Campus, Thornaby on Tees, TS17 6BH, United Kingdom.

Tel: +44 (0)191 334 0517. Fax: +44 (0)191 334 0374. E-mail:

s.r.brown@durham.ac.uk

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 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 abortion. 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 these young women had decided that they wanted an abortion before accessing health services to request one. They had discussed their decision with someone close to them and did 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. At present, counselling is voluntary in the UK. 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, Isle of Man) or making it unavailable resulting in women travelling abroad to have one (Ireland), whilst others allow it on certain grounds (e.g., Great Britain, Finland). Most European countries allow abortion on request but under certain conditions, generally concerning duration of gestation (e.g., Italy, Albania, France, Norway), counselling (mandatory in Germany and Belgium), and where an abortion can take place^{1,2}. In Poland, a ban on abortion in 1993 has led to a huge increase in clandestine abortions and “abortion tourism”;³ in other Eastern European countries (e.g., Hungary, Slovenia) access to abortion has been increasingly limited due to the influence of the Roman Catholic church during and after periods of political transition.² Post reunification, abortion law reform in Germany in 1995 introduced mandatory counselling aimed at discouraging women from seeking an abortion and classifying abortion as “unlawful but nonpunishable”.⁴ 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, reflecting a trend by conservative politicians and religious groups in many countries to attempt to restrict or remove women’s access to safe, legal abortions. UK Members of Parliament Frank Field and Nadine Dorries proposed amendments to the NHS and Social Care Bill 2011 which would have barred abortion providers,

mainly charities, from providing advice and counselling, and to require women to receive counselling from 'independent' bodies before an abortion. This caused concern that by 'independent', they meant organisations such as LIFE and Care, who are opposed to abortion in all circumstances. As Lee points out,⁴ 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.^{5,6} Although ultimately Field's and Dorries' proposals failed to be accepted as an amendment, the issue remains politically contentious with the current Minister of Health (Jeremy Hunt) advocating a reduction in time limit to 12 weeks, whilst the Prime Minister (David Cameron) has said there are no plans to change the law.

The 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 women⁷; 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.⁸

A further problem with making counselling obligatory is the fundamental change in the nature of counselling if it becomes a legal requirement rather than a voluntary process to aid decision making. If it is a legal requirement, questions are then raised about the role of the counsellor (to give permission for an abortion?) and the position of the woman being counselled (to merely be present? to justify her decision?). To give power to the counsellor would mean a fundamental change in the relationship between the two parties. In such circumstances, the concern of the woman may be more about giving “correct” answers than engaging in a free and open discussion.

The Royal College of Obstetricians and Gynaecologists (RCOG)'s guidelines⁹ 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)¹⁰ 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 the latter across the sector, Field suggests that it would be better if counselling was provided by general practitioners (GPs)¹¹ although 'better' is not defined, and GPs themselves do not appear to be in favour of the change.¹²

Studies with women seeking an abortion have shown that they want information and an uncomplicated referral process.¹³ Women think that it should be easier and quicker to get an abortion and counselling should be available for those who wanted it.¹⁴ In addition, most women make their decision prior to consulting a medical professional¹⁵ or having counselling.¹⁶ The concept of mandatory counselling, which is required in 32 states in the USA, does not have a robust scientific basis.¹⁷

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 contraception, and attitudes towards 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 she 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 one 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 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.

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 method¹⁸ 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 mother 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 [because] 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 [the University] 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 anymore and be on benefits and that. I'd rather wait til [until] I'm a bit older. (R9, age16)

For two respondents, the pregnancy had led to the end of the relationship, which had then led to the decision to have an abortion.

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 some young women in this study were not using contraception reliably, they were not resorting to abortion as a birth control method. 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.

Strengths and weaknesses

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 focused 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 to a good end¹⁹ so the successful completion of this study with young women should be regarded as a strength.

The young women in this study had made their decision quickly, which contrasts with a study²⁰ that found that young women make their decision to have an abortion later than older women, which then leads to later abortions. These findings are consistent with those of other investigators who assessed abortion decision making in older women.

CONCLUSION

Across most of Europe, with some exceptions, abortion is generally accessible, with some variations mainly around gestational age and requirements for counselling. The legal position is relatively stable, although in many Eastern European countries in the early 1990s, laws governing access to abortion became more restricted as the Roman Catholic Church became more influential. As far as the latter point is concerned, the situation in the UK is more akin to that of the USA, where challenges to the legality of abortion and increasing restrictions on access to services are growing. In a UK political context where LIFE (a charity opposed to abortion in all circumstances) but not BPAS (British Pregnancy Advisory Service) are invited to be part of a sexual health forum advising the government which replaces the Independent Advisory Group on Sexual Health,²¹ 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. A key challenge is to find ways to support women

experiencing an unwanted pregnancy, rather than to add even more restrictions to accessing safe legal abortions.

Declaration of interest: The author reports no conflicts of interest. The author alone is responsible for the content and writing of the paper.

Source of funding: Kingston upon Hull City Council Teenage Pregnancy Unit.

REFERENCES

1. Pinter B, Aubeny E, Bartfai G, *et al.* Accessibility and availability of abortion in six European countries. *Eur J Contracept Reprod Health Care* 2005;10:51-8.
2. Arisi E. Changing attitudes towards abortion in Europe. *Eur J Contracept Reprod Health Care* 2003;8:109-21.
3. Mishtal J. Neoliberal reforms and privatisation of reproductive health services in post-socialist Poland. *Reprod Health Matters* 2010;18:56-66.
4. Funk N. Abortion counselling and the 1995 German abortion law. *Conn J Int Law* 1996;12:33-65.

5. Lee E. Pregnancy counselling in Britain: a review of the literature. *Psychol Reprod Choice* July 2011. Accessed 20 August 2012 from:
http://www.prochoiceforum.org.uk/psy_ocr13.php
6. Stotland NL. The myth of the abortion trauma syndrome. *JAMA* 1992;268:2078–9.
7. Major B, Appelbaum M, Beckman L, *et al.* Abortion and mental health: evaluating the evidence. *Am Psychol* 2009;64:863–90.
8. National Collaborating Centre for Mental Health. *Induced abortion and mental health: a systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors*. London: Academy of Royal Medical Colleges 2011.
9. Rowlands S. Misinformation on abortion. *Eur J Contracept Reprod Health Care* 2011;16:233-40.
10. Royal College of Obstetricians and Gynaecologists. *The care of women requesting induced abortion: Evidence-based Clinical Guideline Number 7*. London: RCOG Press 2011.
11. Department of Health. Procedures for the approval of independent sector places for the termination of pregnancy. Accessed 20 August 2012 from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008741

12. Merrick, R. MP Frank Field set to tighten up abortion law without Parliament vote. *Liverpool Daily Post*, 24 June 2011. Accessed 20 August 2012 from: <http://www.liverpooldailypost.co.uk/liverpool-news/regional-news/2011/06/24/mp-frank-field-set-to-tighten-up-abortion-law-without-parliament-vote-92534-28932936/2/>

13. News. GPs criticise “unnecessary” abortion law changes. *Pulse* 2011;71:6.

14. Harden A, Ogden J. Young women’s experiences of arranging and having an abortion. *Sociol Health Illn* 1999;21:426-44.

15. Allen I. *Counselling services for sterilisation, vasectomy and termination of pregnancy*. London: Policy Studies Institute 1985.

16. Kumar U, Baraitser P, Morton S, Massil H. Decision-making and referral prior to abortion: a qualitative study of women's experiences. *J Fam Plann Reprod Health Care* 2004;30:51-4.

17. Rowlands S. The decision to opt for abortion. *J Fam Plann Reprod Health Care* 2008;34:175-80

18. Green J. Grounded theory and the constant comparative method. *Br Med J* 1998;316:1064-5.

19. Hunton RB, Spicer J. An evaluation of the counselling given to patients having a therapeutic abortion. *Aust N Z J Obstet Gynaecol* 1979;19:169-73.

20. Holmgren K. Time of decision to undergo an abortion. *Gynecol Obstet Invest* 1988;26:289–95.

21. Quinn B. Anti-abortion group drafted in as sexual health advisor to government. *The Guardian* 24 May 2011. Accessed 20 August 2012 from: <http://www.guardian.co.uk/society/2011/may/24/abortion-sexual-health-coalition>

Figure 1. Recruitment process

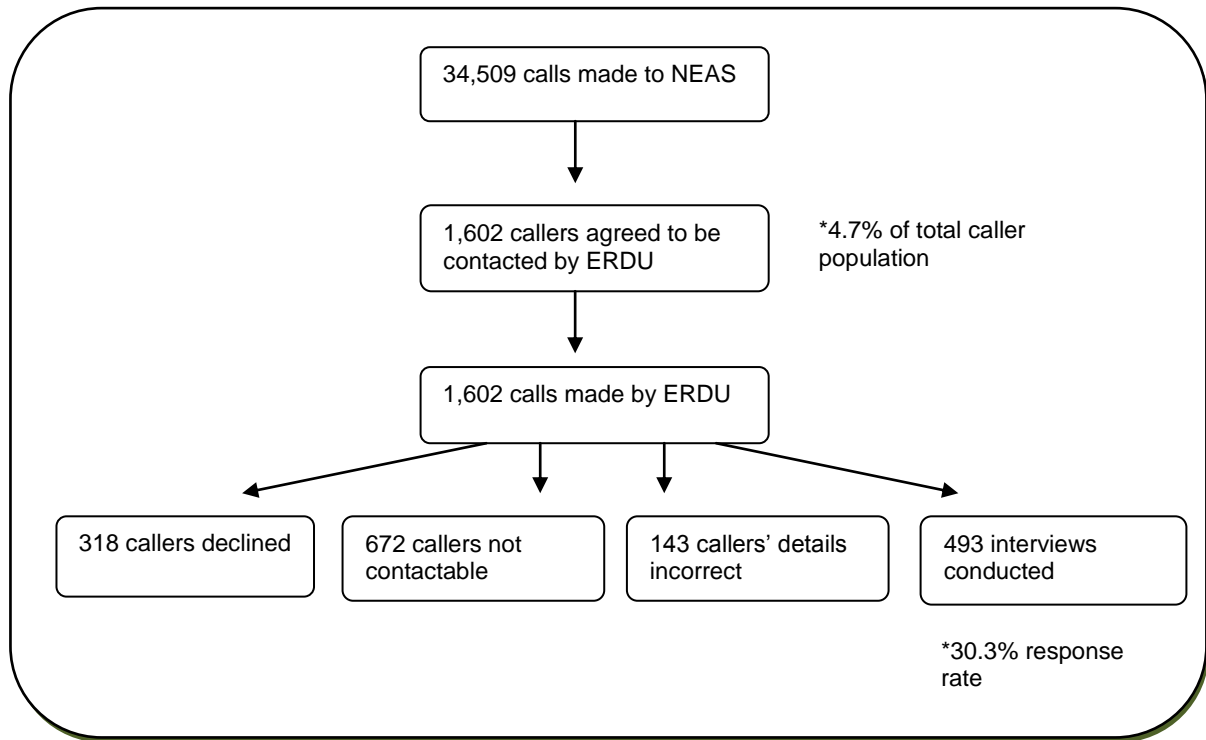


Table 1. Comparison of the study sample to the NEAS caller sample by age and gender

		Study sample n (%)	NEAS sample (N) %
Calls made for an adult (≥ 20 years)		324 (65.8)	23,811 (69.0)
Gender *	Male	104 (21.1)	13,597 (39.4)
	Female	389 (78.9)	19,532 (56.6)

*For 1,380 (4.0%) callers gender was unknown

Table 2. Distribution of what callers were advised to do

	n (%)
Got to an UCC	319 (64.7)
Other (not advised to go somewhere)	56 (11.4)
Wait for an ambulance	39 (7.9)
Wait for a home visit	39 (7.9)
Got to a GP	13 (2.6)
Go to A&E	11 (2.2)
Collect a prescription	10 (2.0)
Got to the pharmacy	4 (0.8)
Other (advised to go somewhere)	2 (0.4)
Total	493 (100%)

Table 3 Satisfaction of callers

	n (%)	
	Agree	Disagree
1. It was difficult to get through on the telephone	17 (3.4)	475 (96.3)
2. The person who answered the phone gave all the necessary advice	459 (93.1)	31 (6.3)
3. The person who took the message seemed to understand the problem	446 (90.5)	38 (7.7)
4. I thought the call handler was right to give me guidance on the telephone	451 (91.5)	22 (4.5)
5. I was unhappy with the telephone guidance I received	26 (5.3)	461 (93.5)
6. I thought the call handler made me feel guilty about contacting him/her	11 (2.2)	481 (97.6)
7. The call handler made me feel that I was wasting his/her time	12 (2.4)	479 (97.2)
8. I think the call handler was a little rushed	10 (2.0)	482 (97.8)
9. I would have preferred it if a doctor or nurse had spoken to me.	82 (16.6)	317 (64.3)
10. If possible, I would have preferred to have had a visit from a doctor or nurse	83 (16.8)	368 (74.6)
11. The arrangements for contacting a doctor when the surgery is closed could be improved	167 (33.9)	302 (61.3)