REVIEW ARTICLE

Eastern Journal of Medicine
East J Med 25(3): 477-483, 2020
DOI: 10.5505/ejm.2020.82246

Psychological Effects of Abortion. An Updated Narrative Review

Kornelia Zareba[1], Valentina Lucia La Rosa[2*], Michal Ciebiera[3], Marta Makara-Studzińska[4], Elena Commodari[2], Jacek Gierus[1]

[1]*Department of Obstetrics and Gynecology, Center of Postgraduate Medical Education, Warsaw, Poland*
[2]*Department of Educational Sciences, University of Catania, Catania, Italy*
[3]*Department of Obstetrics and Gynecology, Center of Postgraduate Medical Education, Warsaw, Poland*
[4]*Faculty of Clinical Health Psychology Jagiellonian University Medical College, Krakow, Poland*

ABSTRACT

The results of studies on the psychological consequences experienced by women after termination are inconclusive. Some of the studies do not confirm an increased prevalence of psychological complications. However, the experience of abortion can lead to the development of post-traumatic stress disorder, depression and problems with interpersonal relations. The main factors which influence psychological effects include the reason for abortion, the type of medical procedure, the term of pregnancy as well as personal, social, economic, religious and cultural factors that shape the woman's attitude towards abortion. Often women while terminating pregnancy are not aware that they will require psychological support later due to subsequent psychological effects they experience. Usually, the first symptoms appear within four months up to a year from the procedure. Therefore, it is important to identify the high-risk women susceptible to subsequent psychological complications.

Key Words: Pregnancy termination, abortion, psychology, mental health, stress, post-traumatic stress disorder, post-abortion syndrome

Introduction

Abortion is perceived as a traumatic experience affecting an individual in contact with the healthcare service. According to the most recent statistics, it has been estimated that during 2010–2014, about 56 million induced abortions occurred each year worldwide. The estimated global abortion rate in the same period is 35 per 1,000 for married women and 26 per 1,000 for unmarried women (1).

Apart from medical complications, more and more attention is being paid to psychological consequences associated with abortion, which sometimes occur a long time after the procedure (2). Termination of pregnancy for medical reasons is a complex decision, which may lead to long-term complications, both for the woman and for the whole family. The results of studies on psychological consequences experienced by women after termination are inconclusive. Part of the studies does not confirm an increased prevalence of psychological consequences (3, 4). A review of the study from 2014 assessing fourteen studies on termination for medical reasons mainly conducted in the US and the UK indicated that termination shakes up the woman's fundamental views, which later need to be reconstructed (5). For many years, there have been discussions on the subject of medical, social and psychological consequences of deciding to undergo an abortion. There is talk about post-abortion stress syndrome and medical complications linked to the procedure. Sometimes loss of fertility for psychological reasons is also observed (6). Many women see the experience of termination as abuse, which leads to a decreased sense of security. According to studies, 17% of women who have experienced termination due to fetal defects report signs of post-traumatic stress disorder even two to seven years after the procedure (7). A survey conducted until the third week, three months after and a year after the procedure on a small group of nineteen patients showed that women see termination as a stigma and loss similar to natural miscarriage (8). Some

***Corresponding Author:** Valentina Lucia La Rosa, Department of Educational Sciences, University of Catania, Via Biblioteca 4, 95124 Catania, Italy
E-mail: valarosa@unict.it, Phone: (+39) 3345390030
ORCID ID: Kornelia Zareba: 0000-0002-8262-4380, **Valentina Lucia La Rosa:** 0000-0002-6619-6777, **Michal Ciebiera:** 0000-0001-5780-5983, **Marta Makara-Studzińska:** 0000-0001-7374-528X, **Elena Commodari:** 0000-0002-7647-8743, **Jacek Gierus:** 0000-0003-2532-3327
Received: 10.03.2020, **Accepted:** 07.05.2020

women put themselves in the position of a survivor, saying that "they have survived the worst thing in their life" (9). Whereas others say that this experience has made them stronger. They find the strength to rebuild family relations and inner empathy (9-11).

In the light of these considerations, this review aims to propose a general and updated overview of the literature about the psychological implications of abortion to underline the importance of a multidisciplinary approach in the clinical and psychological management of women who interrupt their pregnancy.

Materials and methods

A review of the articles about the psychological implications of abortion is presented. Authors conducted their search in PubMed of the National Library of Medicine and Google Scholar. Databases were extensively searched for all original and review articles/book chapters using keywords (one or in combinations): abortion, pregnancy termination, psychology, post-traumatic stress disorder published in English until December 2019. Moreover, additional articles in the bibliographies of reviewed articles were searched. Overall, most relevant articles were reviewed and included as appropriate.

Results

Psychological Consequences of Pregnancy Termination: All pregnancies, even healthy ones, may cause an existential and emotional crisis in a woman, which reinforces pre-existing internal conflicts (12). Indeed, pregnancy is a unique experience in a woman's life which is influenced by several factors, particularly cultural, social, emotional and psychological ones (13). For most women, pregnancy is a happy experience associated with positive expectations. In this regard, for example, a particular case is that of women who survive cancer for which the possibility of becoming a mother has a particular value. For these women, a child is a symbol of life that defeats death (14). On the contrary, pregnancy can be the cause of particular emotional stress for women with consequent development, in some cases, of psychopathological disorders such as maternity blues and postpartum depression (10, 13, 15). Mood disorders during and after pregnancy have a detrimental effect on the mother-child relationship and family life (16). Finally, pregnancy may be unwanted or there may be particular conditions such as fetal abnormalities or pregnancy complications that make abortion necessary (5, 17, 18).

Studies about the psychological consequences of termination provide contradictory results. The experience of abortion can lead to the development of post-traumatic stress disorder, depression and problems with interpersonal relations (19).

The American Psychiatric Society distinguishes between two types of disorders concerning post-abortion complications: PAD (post-abortion distress) and PAS (post-abortion syndrome).

PAD is defined as a disorder that involves experiencing strong post-abortion stress. It appears in the first three months after abortion and may persist for about a year. Its signs are experiencing a sense of loss or guilt, a feeling that life is pointless, sleep disorders and psychological pain. In terms of sex, it involves the fear of becoming pregnant again and fear of sexual intercourse. PAS instead is a chronic disorder that sometimes develops a long time after abortion or reappears periodically. It is characterized by the following symptoms: reliving the trauma (insomnia, nightmares, retrospection, anniversary reactions), use of defense mechanisms (repression, denial, rationalization), avoidance of places and situations which remind the individual about the event, excitation, chronic anxiety, a sense of threat, mood swings and outbursts of anger, sleep disorders, concentration problems), additional symptoms (depression, neurosis, obsessive-compulsive disorder, a sense of harm and injustice, a sense of shame and guilt, suicidal thoughts, lowered self-esteem, psychosomatic disorders, no interest in sex, addictions) (20, 21). The most common symptoms are nightmares relating to abortion, repetitive persistent dreams, a strong sense of guilt and the need to fix it. It should be added that, according to some experts, PAS is a social diagnosis that bypassed professional dissent and diffused into public policy, especially due to the anti-abortion think tanks (22).

Whereas the DSM-V classification includes abortion as one of the risk factors for post-traumatic stress disorder, according to the American Psychological Society, a legal abortion performed in the first trimester does not cause further psychiatric disorders in women. In 1992, the Planned Parenthood Federation of America (PPFA) issued an official statement denying the existence of the term "post-abortion stress

syndrome" and informing that the majority of emotional reactions are positive (23). It should be noted that the hypothesis was based on an analysis of studies that mainly concerned the termination of unwanted pregnancies. Some studies show that the risk of psychiatric disorders after termination is lower than after birth (24-26). Whereas other researchers support the post-abortion stress syndrome theory despite that the disease has been officially removed from the classification of psychiatric disorders (20). Another study from 2011 by Coleman, which analyzed later studies from 1995-2009 suggests a higher risk of certain psychiatric disorders after termination (27). According to Horvath and Schreiber (2017), depression rate is almost the same between women obtaining an abortion and those who denied an abortion and the rates of anxiety symptoms are higher in women in whom abortion care has been denied (28). As stated by Reardon, abortion is consistently associated with elevated rates of mental problems in comparison with women who did not have this problem. Reardon highlights pre-existing mental illness, as one of the main risk factors of mental health problems after an abortion and the very important fact that it is impossible to identify the extent to which mental problems following an abortion can be reliably attributed to it (19).

Risk and Protective Factors: The main factors influencing psychological complications after an abortion include the reason for undergoing the abortion, type of medical procedure, the term of pregnancy as well as personal, social, economic, religious and cultural factors that shape the woman's attitude towards abortion (4). In particular, the factors associated with the most negative consequences are previous psychiatric diseases, planned and wanted pregnancy, pressure from people in the surroundings, no social support, personality with a higher tendency to react negatively to stress (low self-esteem, pessimism, low sense of control). The same factors may cause mental disorders in women who decide to continue their pregnancy (20). Risk factors for short-term complications–occurring within a few months after termination–are support from the partner, religiousness, advanced term of pregnancy and a disease diagnosed in the fetus (29); in case of long-term complications, the risk factors include little support from the partner, advanced term of pregnancy, level of education and chances for the child's survival (7). Women who have terminated their first pregnancy were more at risk of developing anxiety disorders than women who have given birth to their first child. A strong predictor of developing anxiety disorders after abortion is earlier mental health problems. Exposure to violence and anxiety disorders experienced before pregnancy also have a correlation with anxiety disorders after abortion. In a dynamic study that commenced four months after termination, it was demonstrated that, initially, a low psychological response was the strongest predictor of long-term complications (29). At this point, we should also mention stigmatization by professionals as a possible risk factor (30, 31). The conscientious objection appears to constitute a barrier to care, especially for selected groups (32). In this regard, some professionals who object to abortion stigmatize women that their decision is wrong and they should not perform it. Gynecologists frequently invoke the conscience clause not only when refusing to terminate a pregnancy but also when prescribing contraceptives. There are two sides in this field: professionals who accept to help women and those who neglect help (33). This might cause a problem with timely access or access in general to elective abortion what might have direct psychical, organizational and ethical implications (34).

Literature also talks about protective factors, such as support from the partner and close family, no past mental illnesses, higher education, no medical doubts and young age (35, 36). In Lowenstein's study comparing the level of stress experienced by patients who underwent abortion performed with the use of surgical or pharmaceutical methods, the patient group who underwent pharmaceutically-induced miscarriage showed a higher tendency to develop obsessive-compulsive reactions, had a stronger sense of guilt and showed more sensitivity. In that group, more women did not have children, which is probably why they chose the safer but more time-consuming method, which also causes more pain (37). However, the authors suggest that the respondents who chose pharmacologically-induced miscarriage probably felt less comfortable with their decision and chose a method which bears a smaller psychological load and is less definitive, leaving the course of events to fate (37). When comparing acceptance and selection of the abortion method, Slade indicated that women who had chosen a surgical method did not want to be aware of the whole procedure and did not want to participate in it in any way. They were very focused on pain and emotional issues (38).

The Impact on Couple Relationship and Sexuality: A study examining changes in the quality of life of people deciding to terminate the pregnancy–which involved 658 males and 906 females–showed that the experience of termination in a previous relationship hurts the next one. Termination in a current relationship increases the frequency of arguments about children by 116% in women and by 196% in men. Besides, it increases the number of sexual dysfunctions in women by 122-182% and the number of conflicts with family members by 80%. Women who have experienced abortion in their current relationship also reported an increase in abuse between the partners. Researchers claim that people deciding to abort a pregnancy are more predisposed to have an unstable relationship for psychological reasons, such as egocentrism and emotional instability (39). According to Breslau et al., women who have experienced abortion, later on, reported numerous sexual dysfunctions about desire, frequency of intercourse, ability to reach an orgasm and sexual satisfaction (40). Whereas couples who have experienced the death of a child or fetus did not report sexual dysfunctions, women confirmed a drop in their interest in sex saying that it reminded them of how their dead child was conceived (41). In a study from 2003 conducted among 10,847 women, Sullins showed that twice as many women who underwent abortion were not married. He also showed that, if they were married, the likelihood of divorce was 37% higher (42). Conklin and Lydon showed that being married was a protective factor for the individual's wellbeing after abortion. In this regard, married women did not react with negative emotions (43, 44).

A survey by Desrochers conducted among seven males who had experienced a termination in the previous four months showed that the termination had no negative impact on the relationship. Four out of the seven respondents even claimed that their relationship got stronger after this experience (45).

The Role of Counseling Before and After Pregnancy Termination: According to available data, most of the women are seeking an uncomplicated referral process. The main opinion is that this process should be easy and quick as possible and the counseling should be available for those who need it (46). As stated by Brown et al., most women make their decision before counseling visit and they discuss their decision with someone close to them. Many women undergoing pregnancy termination think that counseling prolongs the whole process and causes additional stress (46). In the study by Baron et al., only 9% of patients reported pre-termination counseling. The authors concluded that counseling is not necessary in every case and should be targeted at women with risk factors for psychological complications (47). According to another recent study, women do not expect systemic support, as they believe it is marginal (48). A different voice about counseling comes from an interesting study by Vandamme et al., according to which most women were distressed before the counseling session, but after it, they felt very satisfied and experienced less distress and greater decisiveness (49). Additional data about the real needs and new methods of counseling and decision-making process in the topic of pregnancy termination is still needed to make it less stressful or harmful and more patient-tailored.

While terminating pregnancy, women are often not aware that they will require psychological support later due to a delayed sense of sadness that they experience. Usually, the first symptoms appear within four months up to a year from the procedure (29). According to a study by Fisher conducted by an organization that helps 500 people a year (who have experienced termination), parents usually seek support and contact with others two or three months after the procedure. This correlates in time with the anniversary of the child's death and with the family's and friends' wish to go back to normal (50). There is a lot of new studies trying to help women who require psychological support, however data are still limited and it is necessary to better investigate the characteristics of these women (51).

Most of the studies presented herein are limited to small groups of patients and show significant differences in results–depending on the country where the study is conducted. The first issue is the lack of control groups. People are unable to predict how they would act in an extreme situation. Control groups in such studies usually consist of women who have never been pregnant, have given birth to planned children or have miscarried planned pregnancies. Results also vary due to the place where the study is conducted. From private clinics in America only accessible to the more affluent part of society to countries with different socio-political circumstances (law, religion, family model). Women from countries with restrictive laws and religion are less willing to talk about abortion, which leads to a low response ratio sometime after the procedure (52). They are also unwilling to talk about mental health and

emotional problems, which are a stigmatized subject in many countries.

Results are also influenced by the nature of pregnancy and the grounds for performing the procedure. Most studies examine abortions without medical grounds, mainly performed due to the pregnancy being unwanted, financial problems and young age (26, 53) Different results are obtained for women who have terminated a wanted pregnancy due to fetal defects and for young women deciding to abort an unwanted pregnancy. Such terminations are performed at a later time, which leads to a more painful and aggravating procedure and more attachment of the mother to the fetus. The procedure is comparable to miscarrying a wanted pregnancy, stillbirth, death of a newborn or giving birth to a child with severe physical defects.

Women in a worse mental state withdraw from further stages of studies more often than women without such disorders. Similarly, studies on subsequent psychiatric disorders were often conducted on support groups and similar organizations for people seeking assistance rather than on women undergoing abortions as a whole. Moreover, it is difficult to choose the right time for subsequent interviews, as there are no clear indications of when such an interview should be carried out.

Previous research indicates that the main factors influencing the physical consequences of miscarriage are the term of the pregnancy at the time of termination, the woman's age and health as well as the experience of the person performing the procedure. Whereas easy access to the procedure minimizes medical complications. Complications mainly involve trauma which may occur after the surgery. Emotional complications depend mainly on the own resources of patients, e.g. support from loved ones and society, reasons for terminating the pregnancy and the degree of reconciliation with the decision. Often women while terminating pregnancy are not aware that they will require psychological support later due to subsequent psychological effects they experience. Therefore, it is important to identify the high-risk group susceptible to subsequent psychological complications.

Despite numerous limitations, such studies provide a lot of useful information and the issue undoubtedly requires further research.

Acknowledgment: This material was not presented elsewhere.

This study was funded by the Center of Postgraduate Medical Education.

Grant number 501-1-21-27-17, 501-1-21-27-18 and 501-1-21-27-19.

Disclosure Statement: All authors declare no conflict of interest.

References

1. Sedgh G, Bearak J, Singh S, et al. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. Lancet 2016; 388: 258-267.
2. Coleman PK. Negative abortion experiences: predictors and development of post-abortion psychological and relational adjustment scale. Issues Law Med 33: 133-162.
3. Charles VE, Polis CB, Sridhara SK, Blum RW. Abortion and long-term mental health outcomes: a systematic review of the evidence. Contraception 2008; 78: 436-450.
4. Major B, Appelbaum M, Beckman L, Dutton MA, Russo NF, West C. Abortion and mental health: Evaluating the evidence. Am Psychol 2009; 64: 863-890.
5. Lafarge C, Mitchell K, Fox P. Termination of pregnancy for fetal abnormality: a meta-ethnography of women's experiences. Reprod Health Matters 2014; 22: 191-201.
6. Gammeltoft T, Tran MH, Nguyen TH, Nguyen TT. Late-term abortion for fetal anomaly: Vietnamese women's experiences. Reprod Health Matters 2008; 16: 46-56.
7. Korenromp MJ, Page-Christiaens GC, van den Bout J, et al. Psychological consequences of termination of pregnancy for fetal anomaly: similarities and differences between partners. Prenat Diagn 2005; 25: 1226-1233.
8. Maguire M, Light A, Kuppermann M, Dalton VK, Steinauer JE, Kerns JL. Grief after second-trimester termination for fetal anomaly: a qualitative study. Contraception 2015; 91: 234-239.
9. Bryar SH. One day you're pregnant and one day you're not: pregnancy interruption for fetal anomalies. J Obstet Gynecol Neonatal Nurs 1997; 26: 559-566.
10. Kotta S, Molangur U, Bipeta R, Ganesh R. A Cross-Sectional Study of the Psychosocial Problems Following Abortion. Indian journal of psychiatry 2018; 60: 217-223.
11. Sharma R, Radhakrishnan G, Bhatia MS, Gupta R, Mehdiratta A. Satisfaction and psychological after effects of legal abortion at a tertiary care teaching hospital of North India. J Obstet Gynaecol 2018; 38: 836-841.

12. Sharapova A, Goguikian Ratcliff B. Psychosocial and Sociocultural Factors Influencing Antenatal Anxiety and Depression in Non-precarious Migrant Women. Front Psychol 2018; 9: 1200.
13. Yim IS, Tanner Stapleton LR, Guardino CM, Hahn-Holbrook J, Dunkel Schetter C. Biological and psychosocial predictors of postpartum depression: systematic review and call for integration. Annu Rev Clin Psychol 2015; 11: 99-137.
14. Lagana AS, La Rosa VL, Rapisarda AM, Platania A, Vitale SG. Psychological impact of fertility preservation techniques in women with gynaecological cancer. Ecancermedicalscience 2017; 11: ed62.
15. Vitale SG, Lagana AS, Muscatello MR, et al. Psychopharmacotherapy in Pregnancy and Breastfeeding. Obstet Gynecol Surv 2016; 71: 721-733.
16. Bruno A, Lagana AS, Leonardi V, et al. Inside-out: the role of anger experience and expression in the development of postpartum mood disorders. J Matern Fetal Neonatal Med 2018; 31: 3033-3038.
17. Jones K, Baird K, Fenwick J. Women's experiences of labour and birth when having a termination of pregnancy for fetal abnormality in the second trimester of pregnancy: A qualitative meta-synthesis. Midwifery 2017; 50: 42-54.
18. Padula F, Lagana AS, Vitale SG, et al. The introduction of the absolute risk for the detection of fetal aneuploidies in the first-trimester screening. J Matern Fetal Neonatal Med 2017; 30: 1249-1253.
19. Reardon DC. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. SAGE Open Med 2018; 6: 2050312118807624.
20. Speckhard AM, N.;. Uniwersalne reakcje na aborcję? In: Chazan BS, W.;, editor. Aborcja – przyczyny, następstwa, terapia. Wroclaw: Wektory; 2009.
21. Simon W. Konsekwencje aborcji u kobiet. In: Meder J, editor. Problemy zdrowia psychicznego kobiet. Kraków: Biblioteka Psychiatrii Polskiej; 2003.
22. Kelly K. The spread of 'Post Abortion Syndrome' as social diagnosis. Soc Sci Med 2014; 102: 18-25.
23. Stotland NL. The myth of the abortion trauma syndrome. JAMA 1992; 268: 2078-2079.
24. Grimes DA, Creinin MD. Induced abortion: an overview for internists. Ann Intern Med 2004; 140: 620-626.
25. Russo NF, Dabul AJ. The relationship of abortion to well-being: do race and religion make a difference? Prof Psychol Res Pr 1997; 28: 23-31.
26. Adler NE, David HP, Major BN, Roth SH, Russo NF, Wyatt GE. Psychological responses after abortion. Science 1990; 248: 41-44.
27. Coleman PK. Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009. Br J Psychiatry 2011; 199: 180-186.
28. Horvath S, Schreiber CA. Unintended Pregnancy, Induced Abortion, and Mental Health. Curr Psychiatry Rep 2017; 19: 77.
29. Korenromp MJ, Page-Christiaens GC, van den Bout J, Mulder EJ, Visser GH. Adjustment to termination of pregnancy for fetal anomaly: a longitudinal study in women at 4, 8, and 16 months. Am J Obstet Gynecol 2009; 201: 160 e1-7.
30. Cardenas R, Labandera A, Baum SE, et al. "It's something that marks you": Abortion stigma after decriminalization in Uruguay. Reprod Health 2018; 15: 150.
31. Studnicki J, Longbons T, Fisher JW, Harrison DJ, Skop I, MacKinnon SJ. Doctors Who Perform Abortions: Their Characteristics and Patterns of Holding and Using Hospital Privileges. Health Serv Res Manag Epidemiol 2019; 6: 2333392819841211.
32. Keogh LA, Gillam L, Bismark M, et al. Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers. BMC medical ethics 2019; 20: 11.
33. De Zordo S. From women's 'irresponsibility' to foetal 'patienthood': Obstetricians-gynaecologists' perspectives on abortion and its stigmatisation in Italy and Cataluna. Glob Public Health 2018; 13: 711-723.
34. Bo M, Zotti CM, Charrier L. Conscientious objection and waiting time for voluntary abortion in Italy. Eur J Contracept Reprod Health Care 2015; 20: 272-282.
35. Lafarge C, Mitchell K, Fox P. Women's experiences of coping with pregnancy termination for fetal abnormality. Qual Health Res 2013; 23: 924-936.
36. Kamranpour B, Noroozi M, Bahrami M. Supportive needs of women who have experienced pregnancy termination due to fetal abnormalities: a qualitative study from the perspective of women, men and healthcare providers in Iran. BMC Public Health 2019; 19(1): 507.
37. Lowenstein L, Deutcsh M, Gruberg R, et al. Psychological distress symptoms in women undergoing medical vs. surgical termination of

pregnancy. Gen Hosp Psychiatry 2006; 28: 43-47.

38. Slade P, Heke S, Fletcher J, Stewart P. A comparison of medical and surgical termination of pregnancy: choice, emotional impact and satisfaction with care. Br J Obstet Gynaecol 1998; 105: 1288-1295.
39. Coleman PK, Rue VM, Coyle CT. Induced abortion and intimate relationship quality in the Chicago Health and Social Life Survey. Public Health 2009; 123: 331-338.
40. Breslau N, Schultz L, Peterson E. Sex differences in depression: a role for preexisting anxiety. Psychiatry Res 1995; 58: 1-12.
41. Hagemeister AK, Rosenblatt PC. Grief and the sexual relationship of couples who have experienced a child's death. Death Stud 1997; 21: 231-252.
42. Sullins D. Abortion and family formation: Circumstance of culture? In: Koterski JW, editor. Life and Learning XIII Proceedings of the Thirteen University Faculty for Life Conference. Georgetown University 2003.
43. Conklin MOC, B.; Beliefs about the Fetus as a Moderator of Post-Abortion Psychological Well-Being. J Soc Clin Psychol 1995; 14: 76-95.
44. Lydon J, Dunkel-Schetter C, Cohan CL, Pierce T. Pregnancy decision making as a significant life event: a commitment approach. J Pers Soc Psychol 1996; 71: 141-151.
45. Desrochers J. The Psychological Impact of Termination of Pregnancy for Fetal Anomaly of the Male Partner 2011 [Available from: https://bir.brandeis.edu/bitstream/handle/10192/24389/Desrochers.PsychosocialImpactOfTOP.pdf?sequence=1.
46. Brown S. Is counselling necessary? Making the decision to have an abortion. A qualitative interview study. Eur J Contracept Reprod Health Care 2013; 18: 44-48.
47. Baron C, Cameron S, Johnstone A. Do women seeking termination of pregnancy need pre-abortion counselling? J Fam Plann Reprod Health Care 2015; 41: 181-185.
48. Zareba K, Makara-Studzinska M, Ciebiera M, Gierus J, Jakiel G. Role of Social and Informational Support while Deciding on Pregnancy Termination for Medical Reasons. Int J Environ Res Public Health 2018; 15 (12).
49. Vandamme J, Wyverkens E, Buysse A, Vrancken C, Brondeel R. Pre-abortion counselling from women's point of view. Eur J Contracept Reprod Health Care 2013; 18: 309-318.
50. Fisher J. Termination of pregnancy for fetal abnormality: the perspective of a parent support organisation. Reprod Health Matters 2008; 16: 57-65.
51. Qin C, Chen WT, Deng Y, Li Y, Mi C, Sun L, et al. Cognition, emotion, and behaviour in women undergoing pregnancy termination for foetal anomaly: A grounded theory analysis. Midwifery 2019; 68: 84-90.
52. Berer M. Abortion Law and Policy Around the World: In Search of Decriminalization. Health Hum Rights 2017; 19: 13-27.
53. McKay HE, Rogo KO, Dixon DB. FIGO society survey: acceptance and use of new ethical guidelines regarding induced abortion for non-medical reasons. Int J Gynaecol Obstet 2001; 75: 327-336.