Grief reactions from induced abortion have not been precisely described nor well documented. For example, one of the leading studies on emotional reactions to abortion had possible responses ranging from much crying to much smiling. In addition, women have often been asked a very general question such as how they “feel” after abortion. In other research adverse psychological reactions are combined into a category of “negative reactions” but without providing any specific description of the nature of these reactions. It is very seldom that any standardized tests are used which might provide the basis for objective evaluation.

Two studies on grief reactions relating to induced abortion are summarized in this Newsletter. One study describes pre-abortion and short-term post-abortion reactions. The other study describes long term reactions. These studies did attempt to use objective test methods and criteria to measure the multi-faceted aspects of grief. This factor alone separates them from the vast majority of psychological studies reported in the literature. The use of a multi-faceted grief evaluation is important as it can identify specific kinds of harm or injury to women in connection with grief reactions from abortion.

Pre-abortion and Short-term Post-abortion Grief Responses

Grief reactions have been found in women both in the precounseling period shortly prior to abortion and following the abortion. Researcher Larry Peppers of Clemson University studied 80 women volunteers whose pregnancies were terminated at Midtown Hospital in Atlanta during 1982. During the counseling session prior to abortion women completed a questionnaire to determine sociodemographic information and responded to questions on a grief scale. The grief scale consisted of 13 items representing selected symptoms of grief. These are sadness, loss of appetite, irritability, sleeping problems, difficulty concentrating, preoccupation of thoughts, depression, anger, guilt, problems returning to usual activity, repetitive dreams, exhaustion, and lack of strength. Respon-
Dents were asked to rate themselves on a scale from 1 (no problem) to 9 (extreme difficulty) on each of these variables. Scores ranging from 13 to 117 were possible. The overall grief score was determined by summation of the responses of each of the items. Preabortion grief scores ranged from 19 to 104. The mean grief score was 60.98 (s.d. 20.24).

Approximately 6 weeks after the abortion the same women again completed the grief test. Postabortion grief scores ranged from 14 to 77 with a mean of 35.45 (s.d. 16.52).

Commentary:

These generally lower post-abortion grief responses may be due to no longer being pregnant, represent repression or denial of feelings, may include women who project their feelings onto another, or represent a form of relief after eliminating a "bad" part of themselves by destroying their unborn offspring. Women who had low pre-abortion or post-abortion scores may be narcissistic self-absorbed individuals who express little emotion generally. They also may be women who have attempted to trivialize the experience as a coping mechanism in a crisis situation, and therefore may be at risk for long term grief reactions.

The study included three types of abortion procedures. Vacuum aspiration (VA) or suction (7-12 weeks LMP*), dilation and evacuation (D&E) (13-16 weeks LMP), and intrauterine induction (17-24 weeks LMP). Grief scores indicated that the intensity of the grief reaction was dependent upon the length of the pregnancy. Women were also asked the number of weeks that had passed since they had their pregnancy confirmed. Statistically significant correlations were found between weeks since confirmation and pre- and post-abortion grief scores. The longer the pregnancy continued, the more emotionally traumatic the abortion experience and the more difficult it was for grief resolution to occur.

High pre-abortion grief scores were found among women having D&E abortion, those indicating frequent church attendance, those indicating infrequent sexual activity, those who had discussed their decision with a minister, those who had a family member who opposed the abortion, those whose relationship with their partner had ended, those who were seeking abortion for financial reasons, those who had several weeks to consider the abortion, black women, and those with less than a high school education.

Those women who scored high on the post-abortion grief scores approximately 6 weeks thereafter included Catholics, those with less than a high school education, those with a prior live birth, those with multiple abortions, those with previous miscarriages, those whose reason for seeking abortion was either financial or because of age, and those who had no one to talk to prior to the abortion. The conclusions from the study were:

• There is a grief reaction to elective abortion.
• The grief reaction is most likely initiated when the decision to terminate the pregnancy is made.
• Some women experience a minimally dysfunctional grief reaction, while others suffer greatly.
• The intensity of the grief reaction is associated with the length of the pregnancy.
• Grief associated with elective abortion is symptomatically similar to that experienced following involuntary infant/fetal loss.


*LMP means the elapsed time since the last menstrual period to the abortion.
Commentary:

The most important finding from this study is the presence of anticipatory grief in women prior to abortion. For some women there are highly intense feelings of grief as if the loss has already occurred. The existence of anticipated loss indicates that the grief is due to the anticipated abortion and not from the pregnancy itself. This heavy emotional loading prior to abortion will likely result in a decrease in the intensity of grief reactions in the period following abortion. This may lead an observer, especially if women express relief following abortion, to the false conclusion that abortion is therapeutic. While abortion may eliminate the crisis created by the pregnancy, it also appears to frequently bring about a new set of psychological reactions, including grief reactions, arising out of the abortion experience itself. This is evidenced in this study by the fact that different groups of women showed high grief scores at each time period.

The intensity of preabortion grief varied widely indicating that women approach abortion in various ways. This is supported by observations of abortion counselors who have identified at least four approaches to decision-making in crisis. These are: (1) the spontaneous approach i.e., a quick decision without thinking much about it, (2) the rational-analytical approach i.e., careful analysis of options but without taking emotions into account, (3) the denying - procrastinating approach, (4) the no-decision approach where the woman permits others to make the decision for her and refuses to take any responsibility herself. (Uta Landy, Abortion Counselling - A New Component of Medical Care, Clinics in Obstetrics and Gynecology, 13(1):33, March, 1986). Researchers at Duke University also found a generalized stress response syndrome when women arrived for abortions at a Raleigh, North Carolina clinic. Four distinct coping styles were also identified in the Duke University study. Women tended to be either “approachers” or “avoiders” and were marked by anxiety, depression, denial and intrusion. It was concluded that the responses were similar between abortion patients and other bereaved populations. (L Cohen and S Ross, Coping with Abortion, Journal of Human Stress, Fall, 1984, pp.140-145).

Based upon this study, a large number of women are at risk for at least short term intensive postabortion grief reactions. For example, Catholics were reported to have high short term grief reactions. In a 1987 survey by Alan Guttmacher Institute (AGI) of 9,480 woman at 103 clinics, doctors offices, and hospitals across the U.S., 31.5% of the women reported they were Catholic. Another risk factor for at least high short term grief reactions was multiple abortions or prior miscarriages. The same AGI study found that 42.9% of the women obtaining abortions were having multiple abortions. (SK Henshaw, J. Silverman, The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients, Family Planning Perspectives, 20(4):158, July/Aug, 1988). It is possible that women with multiple abortions or prior miscarriages had not adequately mourned or grieved the earlier losses and that the effects of these prior losses were re-awakened by the abortion experience.

Those groups with high short-term, post-abortion grief included women whose reasons for seeking abortion were financial or were age related. In another 1987 study by AGI of 1,900 women at 38 abortion facilities across the U.S. with high numbers of abortions, 21% of the women having an abortion said the most important reason for the abortion was that "she can’t afford a baby now" and 68% said not being able to afford a child was a contributing reason; 11% of the women in the same study said the most important reason for the abortion was that "she was not mature enough or is too young to have a child". (A Torres, JD Forrest, Why Do Women Have Abortions?, Family Planning Perspectives, 20(4):169, July/August,
The Grief Experience Inventory (GEI)

The GEI was developed to meet the need for an objective multidimensional measure of grief. It consists of 135 True-False items concerning somatic and emotional aspects which are frequently associated with the process of bereavement. There are three validity scales and nine symptoms scales. The nine symptoms scales are despair, guilt, somatization, death anxiety, anger/hostility, social isolation, loss of control, depersonalization, rumination.

There is also a Form B version of the GEI which consists of 104 items. This version has three validity scales and twelve bereavement/research scales. The three validity scales are denial, atypical response, and social desirability. The twelve bereavement/research scales are despair, anger/hostility, social isolation, loss of control, somatization, death anxiety, sleep disturbances, loss of appetite, loss of vigor, physical symptoms, optimism/depression and dependency. Since grief is thought to be multidimensional, the GEI examines the various components of grief rather than yielding a single, composite, unidimensional score.

Each scale has a number of true and false items. A scoring key specifies which of the items are given a value of 1 or 0. In this manner a numerical composite is calculated for each scale. These raw scores are then converted to T-scores using a conversion table. A T-score is a standard score with a mean of 50 and a standard deviation of 10. Each scale represents a distinct aspect of grief. The larger the T-score the greater is the intensity of the behavior measured by the scale. A T-score of less than 50 may occur in the general population in response to the conditions of everyday living. A T-score of over 50 indicates a likelihood of at least minimal grief. A T-score of 60 or greater indicates a likelihood of at least moderate grief, and a T-score of 70 or more may indicate acute grief.

A Grief Experience Inventory Newsletter called the GEI Review has been developed and is circulated to interested people as a forum of exchange of information from various researchers. It is published by Catherine M. Sanders, the GEI test developer. She is located at the Center for the Study of Separation and Loss, PO Box 2087, Blowing Rock, NC 28605 (704) 295-9501. The GEI can be purchased together with a manual for the grief experience inventory from the Center for the Study of Separation and Loss.

The fact that women who said they aborted for financial reasons and suffered high grief reactions afterward, indicates that such women would have preferred another pregnancy outcome. This underscores the importance of financial assistance programs to make sure the costs of childbirth as well as many other essential financial needs are made available to the woman, particularly at the time of decision-making.

Women who said they aborted because of age (presumably being too young) also had high postabortion grief reactions. An earlier study found that women with immature object relations who had abortions had elevated postabortion anxiety, anger, and depression. (Payne et al. Outcome Following Therapeutic Abortion, Archives of General Psychiatry, 33:725, June, 1976). Women who had abortions as adolescents have also reported a greater severity of post-abortion psychological distress compared to older women. (WFranz, D Readon, Differential Impact of Abortion on Adolescents and Adults, Adolescence, 27(105):161, Spring 1992).

Women who had completed less than a high school education were at high risk for both pre- and post-abortion high grief reactions.

Social isolation had been previously identified as a risk factor for adverse psychological effects from abortion. Women who are socially isolated withdraw from social contacts and responsibilities. A study of young California women who kept their pregnancy and abortion a secret from their families had continuing guilt and difficulty following their abortion. (J. Wallerstein, Psychological Sequelae of Therapeutic Abortion, Archives of General Psychiatry, 27:828-832, Dec, 1972). A Danish study of psychiatric hospital admissions among postabortion women found that separated or divorced women had higher hospital admission rates than married women. (H David, et al, Postpartum and Post-abortion Psychotic Reactions, Family Planning Perspectives, 13(2):88-92, March/April, 1981).

**Long Term Grief Responses**

Participants in a long term grief study by researcher Gail B. Williams consisted of 83 women who voluntarily agreed to participate, having been recruited from outpatient clinics, family planning agencies, women’s health services and individual providers in Florida, Alabama, Georgia, Mississippi, Tennessee, Texas and Vermont during 1990. Only women who had reported one prior induced abortion, had no self-reported history of prenatal losses within the last five years and had no documented psychiatric history were included. The reason for these exclusions was to attempt to measure the effect of a single induced abortion.

The mean time since their abortion was 11.0 years and ranged from less than 1 year to 26 years with 92.8% of the women having first trimester abortions. Ninety-eight percent of the women were white, 68.7% were single at the time of their abortion. 8.4% were married, 15.6% were separated or divorced, 2.4% widowed and 4.8% cohabitating. At the time of their abortion 59% reported some college preparation or held an undergraduate or advanced college degree. The average gestation at the time of abortion was 8.7 weeks.

The mean age of women at the time of the study was 31.9 years. In regard to religious affiliation, 8.4% of the women reported they were Catholics, 41% identified themselves as Protestant and 47% Christian and 72.3% reported weekly attendance at religious services. At the time of the study, 91.2% reported some college preparation or held an undergraduate or advanced college degree and 55.4% of the women were employed. Also, 25.9% reported annual household income of $50,000 or greater, 12% reported $40,000-49,000, 16.9% reported $30,000-39,000, 20.5% reported $20,000-29,000, 16.9% reported $10,000-19,999 and 6.0% reported $9999 or less household income. The women also reported that 58.5% of their husbands were the major wage earners. Although 72.3% reported being married, only 49.4% were living with their husbands and children at the time of the study. Only 19.3% were currently living with the father of the aborted baby. Thirty-five percent had no living children at the time of the study. Sixty percent reported no formal counseling after their abortion.

The Grief Experience Inventory (GEI, Form B) was used as an objective measure of grief. It was found that the mean average T-score for the 83 women exceeded 50 (repre-
senting at least minimal grief) on 7 of the 12 bereavement/research scales. Overall T-scores ranged from 27-82. The bereavement/research scales exceeding a mean average of 50 were anger/hostility (51.93, range 33-70, s.d. 11.52), social isolation (51.96, range 33-74, s.d. 13.58), loss of control (54.74, range 30-73, s.d. 10.03), death anxiety (50.35, range 29-71, s.d. 11.25), loss of vigor (52.0, range 36-74, s.d. 13.30), physical symptoms (50.13, range 36-80, s.d. 11.21), and dependency (51.03, range 27-68, s.d. 11.05).

Other scales which had a mean average T-score of less than 50 but still had a substantial number of women exceeding 50 were despair (49.32, range 34-74, s.d. 13.97), somatization (49.38, range 33-77, s.d. 10.63), sleep disturbance (45.89, range 36-82, s.d. 11.32), loss of appetite (43.25, range 37-72, s.d. 9.61), optimism/despair (48.20, range 41-74, s.d. 10.90).

T-scores varied widely on each of the validity scales as well as the bereavement/research scales. These were denial (45.66 mean, 37-69 range, s.d. 7.69); atypical response (50.85 mean, 37-77 range, s.d. 10.66); social desirability (51.41 mean, 29-60 range, s.d. 8.05).

Women who had counseling scored higher on somatization, loss of vigor and dependency scales compared to women without counseling. Two scales, loss of vigor and loss of control, were significantly associated with the lessening of the intensity of grief over time. Other bereavement/research scales were negatively (weakly) correlated with the time since abortion. Women who had living children at the time of their abortion experienced significantly higher intensities of grief compared to women without living children at the time of their abortion. The areas in which there were significant differences were somatic complaints, death anxiety, sleep disturbances and physical symptoms.

Four women who exhibited evidence of acute grief as measured by T-scores of 70 or over on the atypical response validity scale were separately studied. Mean T-scores for these four women were 70 or above for despair, social isolation, and optimism/despair. Mean T-scores were 60 or above for anger/hostility, loss of control, somatization, death anxiety, sleep disturbances, loss of vigor and physical symptoms. The ages of these four women ranged from 28-50 and the time since their abortion ranged from 4 to 20 years. All four women had their abortion at 2-4 months gestation and all had living children at the time the study was conducted. Two women reported being "very pressured" to have the abortion. One reported being "moderately pressured". None had experienced prenatal losses or other significant losses in the last five years. Two had participated in counseling following their abortion.

It was concluded that some women experienced persistence of various aspects of grief for long periods of time following induced abortion. It was also concluded that there is a need for funeral rites with a religious orientation to validate the loss and that, to date, professionals have attempted to minimize the grief and sadness associated with abortion.


Commentary:

The sample of women studied differs from U.S. women who obtain abortions generally. There were fewer minority women, fewer Catholics, had better educational levels, had a higher social status, and had fewer second trimester abortions. Because the study attempted to measure the grief effect from a single abortion, it excluded women having multiple abortions or those with a previous psychiatric history. These types of women would be expected to have more intense psy-
chological reactions following abortion than the study sample.

Similar to short term grief reactions, a wide range of intensity of long term grief reactions was demonstrated ranging from no evident grief to acute grief. Acute grief reactions were found in women 4-20 years post-abortion indicating that these grief reactions may be severe, longlasting, and persistent. These long term acute reactions may occur despite counseling following abortion, in women aborting during gestational ages ranging from 2-4 months, in women without previous adverse psychiatric history, and under conditions where there was no coercion to abort.

A large number of women in the study reported that they attend Christian churches weekly. Many of these women are still suffering grief from abortion. This strongly suggests that (1) churches should be actively defending and protecting the unborn child, at least by offering alternatives to abortion, since the legalization of abortion is, to some degree, an attack upon their own members, (2) churches should provide an opportunity for ritualizing and recognizing the loss of a child due to abortion and thus help to effect a healing in the process. For examples of the role of religion in healing from abortion see especially Postabortion Dysphoria and Religion, MB Tamburrino et al, Southern Medical Journal, 83(7): 736, July 1990, Ritual Mourning for Unresolved Grief After Abortion, K. McAll, W. P. Wilson, Southern Medical Journal, 80(7): 817-821, July 1987.

The study identified a large number of women who appeared to be very independent as well as a large number of women who were excessively dependent. Both these effects may be present to a greater degree as a result of the abortion experience. For example 72.3% of the study sample were married, but only 49.4% were living with their husbands and children. The study sample also had a relatively high number of women exhibiting dependency which is an excessive need to depend on others. Independence may be dominant for the women who feel that others have coerced them into abortion or been given bad advice to do so. These women may conclude that no one else is going to tell them what to do - ever! These women are reported to have particular problems in marriage because of their insistence on control. The dependent woman may say that she was primarily responsible for a very bad decision. She may conclude that she is incapable of making good decisions and may subsequently rely upon others' advice even in small matters. (L. Gsellman, Physical and Psychological Injury in Women Following Abortion: Akron Pregnancy Services Survey, Association for Interdisciplinary Research Newsletter, 5(4):1-8, Sept/Oct, 1993).

The vast majority of the women who had abortions appeared to have terminated the relationship with the father of the aborted baby since only 19.3% were living with the father of the aborted baby at the time of the study.

The highest mean T-score was found in the area of loss of control. Loss of control is an inability to control overt emotional experiences. An example of this is found where a woman described a postabortion dream: "I was passing shops with an urgency to get somewhere. I walked down steps into a grocery store, I came to a shelf of small jars of baby food. I put loads into the basket. Someone said 'you can't have those'. I left them and had a feeling of panic and ran out of the store." (Barbara L. Blum, Psychological Aspects of Pregnancy, Birthing and Bonding, New York: Human Sciences Press (1980), p. 60).

Although a majority of the women appeared to no longer utilize denial following their abortion, a sizeable minority appeared to be continuing to do so even after several years following their abortion. Therefore the full intensity of grief reactions may not yet have been realized in these women.

There were many women who were in a state of despair, even many years after their
abortion. This scale measures the mood state of the individual. Another scale identified as the optimism/despair scale measures the degree of despair and loss of meaning. This scale was also elevated for many women.

Death anxiety was also an aspect of long term grief among many women. Death anxiety measures the intensity of concern about one's personal death. A previous study of short term grief reactions of postabortion women who obtained abortions in Virginia found that the death anxiety scale on the Grief Experience Inventory consistently received elevated scores. (L. M. Butterfield, Incidence of Complicated Grief and Post-traumatic Stress in a Postabortion Population, PhD Thesis, Virginia Commonwealth University (1988), Dissertation Abstracts Int'l, 49(8), p3431B, Feb, 1989. Order No. DA8813540). The current long term study indicates that this apprehension of death may persist for many years.

Written by Thomas W. Strahan, Editor

Suggested Reading

Books:

Good Grief, Granger Westberg, Fortress Press; Philadelphia, PA, (1962)
Life is Goodbye, Life is Hello, Grieving Well Through All Kinds of Loss, Alla Bozarth-Campbell, CompCare Publishers; Minneapolis, MN, (1982, 1986)
Surviving Grief and Learning to Live Again, Catherine M. Sanders, John Wiley & Sons; New York, (1992)
Parental Loss of a Child, ed. Therese A. Rando, Research Press; Champaign, IL, (1986), esp. Chapter on Induced Abortion, Betty Harris, pp. 241-256
Abortion's Second Victim, Pam Koerbel, Victor Books; Wheaton, IL, (1986)

Articles:


Complicated Mourning: Dynamics of Impacted Post-Abortion Grief, Anne Speckhard, Vincent Ruc, Pre and Perinatal Psychology Journal, 8(1):5-32, Fall, 1993