The after-care of abortion patients

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SUMMARY. I report the findings of a follow-up study of abortion patients from one health district. While patients generally prefer to rely on friends and relatives for emotional support after they have had an abortion, a small number would have welcomed the opportunity of talking to somebody outside their personal situation if this had been possible. This group included some patients with quite severe psychiatric disturbance.

I suggest that the present provision of after-care for abortion patients is haphazard and that free access to a suitably qualified counsellor after abortion might fulfil some of this unmet need. General practitioners should be aware of the emotional sequelae to abortion so that they can identify them when they occur and offer appropriate support to patients who are having emotional difficulties.

Introduction

THE development of abortion services within the National Health Service has been an *ad hoc* affair. Additional resources were not made available following the 1967 Abortion Act and the development of the service has depended on the interest and goodwill of consultant gynaecologists. The result has been a service which is not rationally organized. One of the major deficiencies which has been identified is the failure to develop abortion counselling for those women who need it (Lane, 1974).

A systematic series of studies into the provision of induced abortion in the Wessex Health Authority Region (Ashton *et al.*, 1980 a, b; Ashton, 1980 a, b, c, d, e, f, g) has made it possible to examine counselling and decision making in abortion and to assess psychosocial outcome. One of these studies (Ashton, 1980i) has provided information about the use of lay and professional services after abortion and it is this information which forms the basis of the present paper.

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Method

The study sample consisted of each patient having a National Health Service induced abortion in the Southampton Health District during an eight-week period. During this time 118 patients had this operation; 102 consented to postabortion follow-up (87 per cent).

Follow-up data

There were three principal sources of follow-up data:

1. *Follow-up interview*
This was carried out eight weeks after the operation by an interviewer using a semi-structured questionnaire. It included questions designed to establish the incidence of lay discussion and professional consultation, the use of contraception following abortion and the incidence of 'nervous' symptoms (as defined by the patients themselves) and whether such symptoms led to medical consultation. It also included items based on the Eysenck Personality Inventory.

2. *Follow-up data from general practitioners*
A single-page questionnaire was sent to the general practitioners of those patients who had agreed to follow-up. This questionnaire was sent out eight months after the abortion and contained questions about the occurrence and purpose of consultations with the general practitioner since the operation.

3. *Hospital and social work record search*
A search of the hospital records was carried out for all those patients who had agreed to follow-up. This search was carried out eight to nine months after the operation and was intended to produce information about secondary care contacts. Additional information was available about those patients who had seen a social worker.

Response and quality of follow-up data

1. *The follow-up interview*
Questionnaires were completed for 64 (63 per cent) of the 102 patients who had been willing to be seen for a follow-up interview. Sixty-one of these were completed through a personal interview; three were completed by telephone at the patient's suggestion. One interviewer

carried out 56 of the interviews; the remainder were done by a second interviewer. The patients were interviewed within eight and 12 weeks of the operation.

There were no differences between the interviewed and the non-interviewed patients with regard to age, religion, marital status, social class, previous psychiatric or physical history and the three parameters of the Eysenck Personality Inventory (intraversion, extraversion and neuroticism).

2. *The general practitioner questionnaire*

Ninety-four (91 per cent) of the 103 general practitioners involved completed their questionnaires. No data were available for eight of their patients because they had either moved away, changed their doctor, or their notes were missing.

Results

Discussion with other patients at the time of operation

Of the 64 patients, 23 (36 per cent) had discussed their operation with other patients. For 13 of these patients this had been a helpful thing, but for eight it had not been helpful.

Helpfulness of staff

In general, the medical and nursing staff were found to have been helpful or very helpful. Only six patients (nine per cent) felt that the staff had been at all unhelpful.

Preference for doctors of stated sex

A majority of patients said that they had no preference as to the sex of the doctors whom they had consulted, either general practitioner or gynaecologist.

Lay discussion and professional consultation

Sixty-one patients (95 per cent) had discussed their operation with somebody by the time of the follow-up interview, usually with friends (17 per cent of all discussions), family doctors (17 per cent), boyfriends (14 per cent), mothers (12 per cent) or husbands (nine per cent). Seventy per cent of all discussions (128 out of 182) had been at least some help; 51 per cent had been moderately or very helpful; 30 per cent were unhelpful. Seven discussions (four per cent) were moderately or very unhelpful. The most helpful discussions had been those with husbands, boyfriends and girlfriends. Approximately two out of every three such discussions were described as moderately or very helpful. Only 39 per cent of discussions with family doctors were described as moderately or very helpful. Fifty-one per cent of discussions with general practitioners were described as not helpful.

Opinion was divided on the value of talking after the operation to somebody outside the family or friendship network. Fourteen patients felt that this would have been helpful (22 per cent) but 46 (72 per cent) felt that it would not. The main reasons given for the latter view were that patients did not wish or need to talk about the operation once it was over or that they had enough close friends in whom they could confide to make this unnecessary. However, those who would have welcomed the opportunity to talk to somebody included a number of patients who had persistent emotional problems after their operations.

Consultations with general practitioners

Of the 86 patients for whom general practitioner data were available, 80 (93 per cent) had consulted their doctor since their operation. The majority of these consultations concerned matters not directly related to the abortion (Table 1). Fourteen women had consulted their doctor for a physical problem related to their operation (16 per cent) and nine for an emotional problem related to the operation (11 per cent).

Twenty-eight of the 64 patients who had been seen for follow-up interview had felt that they had had "trouble with their nerves" postoperatively, and 23 of these had consulted their general practitioner. However, only 11 patients had specifically consulted their general practitioner about their nerves or a sleep problem. (This is reported more fully in Ashton, 1980a.)

Four of the six patients who had reported a lot of regrets or said that they felt it had been a mistake to have the abortion, had seen their general practitioner. The general practitioner recorded an awareness of emotional disturbance in none of these women. The two remaining patients who had regrets about the operation had both changed their doctor (Ashton, 1980a).

Hospital consultations

Of the 102 patients for whom a record search was possible, 20 had had a gynaecological outpatient appointment in the eight months following their operation. One failed to attend. Three of these 20 appoint-

Table 1. Consultations with general practitioners within eight months of the operation.

Reason for consultation	Number of consultations by 86 women	Proportion of women consulting (percentage)
Routine	17	*19.8*
Family planning	39	*45.3*
Physical problem related to abortion	14	*16.3*
Emotional problem related to abortion	9	*10.5*
Miscellaneous other	41	*47.7*
Total	120	*100*

Table 2. Method of contraception at eight weeks after abortion.

Method of contraception	Number	Percentage
Female sterilization	12	*19.0*
Male sterilization	3	*4.8*
Oral contraception	27	*42.9*
Intra-uterine device	7	*11.1*
Sheath	2	*3.2*
Other	2	*3.2*
No method	10	*15.9*
Total	*63	*100*

*No data for one patient.

ments had been made as a matter of routine at the time of the operation.

Among the 16 patients who attended and whose consultations were not of a routine nature, six had physical problems related to abortion. Four of these were patients with heavy periods, two of whom required further dilatation and curettage; one patient was re-admitted for evacuation of the remaining products of conception and another had pelvic inflammatory disease. Two patients requested further terminations, one requested a reversal of sterilization, one patient believed herself to be still pregnant and another had abdominal pain and constipation.

Of the 10 patients consulting non-gynaecological specialists, only two had problems related to their abortion. Both consultations were with psychiatrists. One followed an overdose; the other was a patient with severe depression who had requested reversal of sterilization. One other patient saw a psychiatrist following an overdose but the reasons for the overdose were not thought to be related to the abortion.

Contact with social workers

Of the 103 patients who consented to follow-up, three had seen a hospital social worker and three had seen a community social worker within eight months of their operation. Of the six patients who were known to have persistent psychiatric disturbance following their operations, one had made contact with a community social worker before the operation but not afterwards. Two patients known to have been emotionally disturbed for a short time after their abortions were among the six patients seeing a social worker after the operation.

Contraception

At the time of follow-up, 53 patients (83 per cent) of the 64 for whom a questionnaire was completed, claimed to be using some form of contraception. Almost all of these patients were using the most reliable methods and 12 of the follow-up patients had had sterilization operations at the time of their abortions (Table 2).

Information was available for 10 patients who were not using contraception. Their reasons for not using contraception were diverse. Three regarded themselves as currently unlikely to have intercourse and one patient said that she was abstaining until her husband had had a vasectomy. Two patients expressed anxiety about consulting a doctor for contraceptive advice and one said that she did not like to use contraceptives. One patient had stopped taking her oral contraceptives because she had amenorrhoea and one said that she had forgotten to take her pills. One patient said that nobody had offered her contraceptive advice during her hospital admission. Three of the patients who were at risk of pregnancy had seen their general practitioner since their operation.

Discussion

Legal abortion under modern conditions is not without physical and psychological morbidity, but neither is pregnancy (Ashton, 1980a). However, most of the problems related to abortion in this study seem to be short-lived and do not require specialist intervention.

The findings reported here suggest that at least in one health district the after-care of abortion patients is rather haphazard. The patients were not routinely followed up by a gynaecologist or a general practitioner and, although the overwhelming majority did see a general practitioner within three months of their operation, consultation was not necessarily related to the severity of medical need. In most cases general practitioners did not notice emotional disturbances where these were present after abortion and where the patient had seen her doctor. Very little use was made of social workers for after-care.

Overall, the picture is one of patients depending heavily on their lay network for emotional support. To a large extent this appears to be what they want. However, a minority of patients, who included some of those who were quite severely disturbed after abortion, would have welcomed the opportunity of talking with somebody who was outside their normal situation. Although the general practitioner is well placed to fulfil this role, many of these patients did not obtain from him the sort of help which they apparently needed.

It may be that if general practitioners become more aware of the sort of emotional problems which can follow abortion, they will identify them more quickly and come to manage them adequately. However, there may be a case for offering open access to a counsellor or social worker with special responsibility for abortion patients so that the small numbers who need help of this kind will be able to find it.

The great majority of patients were using reliable methods of contraception when they were seen for follow-up. However, we cannot be complacent about this as it still seems possible for abortion patients to pass through the system without being advised about contraception.

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Prevention of spinal osteoporosis in oöphorectomized women

One hundred women who had taken part in a prospective controlled trial of oestrogen therapy for prevention of post-oöphorectomy bone loss were reviewed after a median follow-up period of nine years. A significant reduction in height occurred among the placebo-treated group, but not in the group treated with mestranol. Oestrogen treatment helps prevent central, as well as peripheral, bone loss, and reduces the incidence of vertebral compression.

Source: Lindsay, R., Hart, D. M., Forrest, C. & Baird, C. (1980). Prevention of spinal osteoporosis in oöphorectomized women. *Lancet*, **2**, 1151-1153.