



Unwanted Pregnancy, Forced Continuation of Pregnancy and Effects on Mental Health

POSITION PAPER

**Grupo
Médico**
POR EL DERECHO
A DECIDIR
GDC COLOMBIA

**Global
Doctors**
FOR CHOICE
NETWORK

Unwanted Pregnancy, Forced Continuation of Pregnancy and Effects on Mental Health

P O S I T I O N P A P E R

Grupo Médico por el Derecho a Decidir - Colombia
Global Doctors for Choice (GDC) Network

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Grupo Médico por el Derecho a Decidir is a network of doctors from different specialty areas that advocates for women's timely, comprehensive access to sexual and reproductive healthcare services, grounded in respect for their freedom to make choices. It is part of the Global Doctors for Choice (GDC) network.

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Introduction

Grupo Médico por el Derecho a Decidir is part of the Global Doctors for Choice network, which has members in almost every region of the world (Africa, North America, Latin America and Europe). On the occasion of the network's launch in Colombia, the group wishes to voice their position as MD's belonging to different specialties, regarding the consequences of unwanted pregnancy on women. Daily experience with this reality through our medical practice has made us aware of the tragedy suffered by women who are compelled to face sometimes insurmountable barriers in order to voluntarily terminate a pregnancy, including, at times, the forced continuation of the pregnancy.

The purpose of *Grupo Medico por el Derecho a Decidir* is to defend every woman's prerogative to take free and informed decisions in the field of sexual and reproductive health. We emphasize on the importance of finding a legitimate voice that will allow us to relate our day to day experiences with women seeking sexual and reproductive health services including legal, voluntary termination or pregnancy (or VTOP), making it possible to *speak up* for the protection and respect of women's decisions and rights.

Stemming from our commitment to promoting women's healthcare according to the highest quality standards of care, and based on evidence, we assert that unwanted pregnancy and its forced continuation affect women's mental health.

There is ample evidence to support the argument that the continuation of an unwanted pregnancy increases the risk of mental health problems; thus, from this standpoint, any woman who is forced to carry an unwanted pregnancy to term faces a health risk that she should not have to face under current legislation in Colombia¹ and has the right to terminate her pregnancy.

¹ Ruling C-355/2006. Colombian Constitutional Court.

Summary of the evidence

As doctors, the ethical practice of our profession demands that we ask ourselves whether the continuation of an unwanted pregnancy involves a health risk to the patient. In accordance with the principles of evidence-based medicine, the answer must be comprehensive, based on our experience and expertise and supported by the best existing evidence in scientific literature.

Types of studies and methodological challenges

Despite our observations on a daily basis of the profound and evident effects that unwanted pregnancy has on women's mental and social health, it is worth attempting to demonstrate and measure the existence of this impact from a scientific standpoint, in an effort to search for an epidemiological response that allows us to:

1. Infer population-level risk.

2. Establish more reliable correlations by controlling confounding variables.
3. Establish intensity correlation measurements that may provide useful elements of judgment at the individual level helping women to make informed decisions and allowing healthcare professionals to assess the existence of risk; or to understand the concept of unwanted pregnancy as a health risk. This data is also a source, at the collective or public level, of useful elements for formulating public policy in relation to the protection of women's health.

The search for an answer based on epidemiological data poses interesting methodological challenges in the area of health research that have been resolved in medical literature basically through two approaches: The most frequent, because it does not require prolonged follow-up periods or very select populations, is to try to demonstrate a statistical correlation between depression or its symptoms and unwanted pregnancy, during pregnancy and postpartum.

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The second approach –which is much more demanding due to the need for prolonged periods of observation and identification of more specific sub-groups of women–, is to search for a correlation between long-term effects on mental health and how an unwanted pregnancy is resolved. In other words, a comparison is made between women who voluntarily terminate their pregnancy and others who carry it to term due to factors beyond their control.

These measurements are especially viable in scenarios where due to the legislation, some women's requests for abortion are denied because they are not considered to be exposed to any health risks.

This allows for a comparison of the true effects of the birth of an unwanted child among a group of women who were forced to continue their pregnancies against their will.

Based on the previous analysis, we can conclude that, although both types of studies provide useful evidence, those that assess the impact of the forced continuation of an unwanted pregnancy provide a much stronger degree of inference. The latter encompass a subgroup of women that represent the situation of thousands of Colombian women

experiencing unwanted pregnancies, whose right to legal abortion is not acknowledged because their pregnancy is not considered a health risk.

Impact of an unwanted pregnancy on women's mental health

An unwanted pregnancy or birth has an effect on the woman, the couple, the child and the rest of the family. Various studies have specifically shown that women are at a greater risk for suffering negative health consequences during and after an unwanted pregnancy.¹

Unwanted pregnancy has consistently proven in several studies to be one of the main risk factors associated with the development of depression during pregnancy^{2, 3} and postpartum,^{4, 5, 6} and with lower levels of psychological well-being during pregnancy, postpartum and in the long term.^{7, 8, 9}

In general, as shown in Table 1, women who say their pregnancy is unwanted during prenatal checkups are, on average, twice as likely to develop symptoms of depression or anxiety and/or for having higher stress levels.

Table 1. Summary of studies that show correlation between unwanted pregnancies and mental health effects		
Author/Year	Description of study	Findings
Eastwood 2011	Cross-section of 29405 women, Australia	Greater incidence of postpartum depression symptoms among women with an unwanted pregnancy
Bunevicius 2009	Cohort study, 230 women, Lithuania	Greater risk of depression during each trimester of pregnancy among women with an unwanted pregnancy
Lau keung 2007	Cross-section of 2178 women, China	40% greater incidence of high levels of psychological stress and three times greater incidence of high levels of depressive symptoms among those with an unwanted pregnancy.
Rich-Edwards 2006	Cohort study, 1662 women, USA	Twice the risk of postpartum depression among women with an unwanted pregnancy compared to women who wanted pregnancy.
Iramfar 2005	Cohort study, 163 women, Iran	Twice as much postpartum depression among women with an unwanted pregnancy compared to women who wanted pregnancy.
Najman 1991	Cohort study of 6642 women, Australia	Five times greater risk during pregnancy and three times greater risk postpartum of suffering depression among women with an unwanted pregnancy—and who also had a negative reaction toward the pregnancy from the beginning.
Laukaran 1980	Cohort study of 8000 pregnant women, USA	2.6 times greater incidence of psychosocial problems in women with an unwanted pregnancy and negative attitude in regard thereto.

In assessing these findings, there may be some question as to whether the mental health effects are the result of factors which are associated, but not directly related to pregnancy, such as low socioeconomic status, absence of a partner, low educational level, drug abuse or the presence of violence, in which case the termination or continuation of a pregnancy would not factor in as a health risk.

This potential bias is resolved by analyzing each of these variables separately to assess their impact on mental health. Stratified analyses consistently show that, while some adverse psychosocial situations can be more frequent among women who experience an unwanted pregnancy, the sole presence of an unwanted pregnancy correlates independently with an increased incidence of mental health effects.

A study published by Najman provides the best evidence in terms of proper methodology and use of a strict definition of unwanted pregnancy. This study carried out a prospective analysis of 6642 women in Australia starting at prenatal checkups through to 6 months postpartum. Among the participants, very strict criteria were used to identify women who did not want their pregnancy, pinpointing 277 who not only had not planned their pregnancies but also showed an emotionally negative reaction to them during the first prenatal checkup.

This study only included women who carried their pregnancy to term, so it is possible that the group might include women who wanted to have an abortion but faced a variety of barriers, as well as women who grew to accept the pregnancy over time. It is to be expected that the consequences of an unwanted pregnancy on the mental health of women who decide to continue with the pregnancy are mitigated to some extent by acceptance; however, measurements obtained using standardized and validated psychometric tools in the study of this heterogeneous group of women who had in general initially rejected their pregnancy showed a clear increase in the risk of anxiety and depression both during the pregnancy, as well as at one and six months postpartum.

The risk of depression observed during pregnancy in these women can be up to five times greater than that of their peers with wanted pregnancies. Even though risk decreases postpartum, it remains twice as high in comparison to the control group. The same trend is observed in regards to the risk of developing anxiety.

It is important to note that this study did not include women who chose to give their child up for adoption. It is therefore possible that these correlation measures may have been even stronger had this subgroup been included, given that they are undeniably, among those who carried a definitely unwanted pregnancy to term and, therefore, the most likely to suffer its consequences on their mental health.

Barber⁹ provides a more long-term look at how an unwanted pregnancy affects the mental health of women through a 31-year study performed on 1113 women in the United States. This study showed greater scores of depressive symptoms and lower indicators of happiness among women who reported giving birth to and raising an unwanted child in the 1960s, when abortion was illegal.

There are also what may appear to be conflicting results. In a longitudinal study that followed 1247 women for 13 years after a first unplanned pregnancy, no difference was found in the incidence of depression between those who chose to terminate and those who gave birth. This data, however, should be interpreted with caution for two reasons: The first is that the study group was defined based on the question of whether the pregnancy was planned, and not on whether it was wanted. The range of possibilities within this group is very broad since many unplanned pregnancies are wanted from the beginning. The second reason is that this study was undertaken in the context of a liberal law within which, in theory, women had the option of choosing to terminate their pregnancy; therefore, it can be presumed that those who chose to have an abortion mitigated the effects on their mental health in doing so. It is possible that, had they not had the choice, a higher degree of depression would be observed in women who carried their pregnancy to term.

Furthermore, this study showed a higher educational level and long-term income in the group that opted for an abortion: Two fundamental social determinants in regards to mental as well as social health.

Impact of forced continuation of pregnancy on women's mental health

The first studies that attempted to prove the effects of unwanted pregnancy and its forced continuation on women's health took place in Europe. These studies were carried out during periods of transition in abortion legislation when exceptions were established; therefore, there were instances when abortion requests could be denied.

Despite their lack of rigorous methodology, including shortcomings in the application of standardized tools for measuring mental health or selecting a proper control group, the initial approaches to this issue are valuable. They are represented by the classic, long-term studies of Hook¹¹ and Forssman¹² in the 1960s, which followed women whose abortion requests were denied. In these groups of women, lower rates of mental health and socioeconomic well-being were observed in comparison to women who were not facing the same situation.

In a study that applied a more rigorous methodology with appropriate comparison groups and a sample of 6410 British women, Gilchrist¹³ found that carrying an unwanted pregnancy to term, for any reason, is associated with a tendency almost three times higher than the average of developing self-destructive behavior in the future; this includes suicidal tendencies. Moreover, when the continuation of the pregnancy had occurred as a result of the denial of an abortion, this risk increased twofold in comparison to women who terminated their pregnancy.

In a retrospective study¹⁴ in Brazil, where the law is restrictive, the presence of common mental disorders (depression and anxiety) was assessed among 1121 pregnant women, finding a very high incidence (63%) among those who wanted to have an abortion or had tried but failed to have one.

Dagg¹⁵, in a review of the consequences of being denied an abortion, found a variety of responses to unwanted birth. Invariably, across all studies, there were widespread negative long-term effects varying from resentment toward the child to symptoms of mental illness, anxiety and poor psychosocial adaptation.

In conclusion, the aforementioned studies showed that the forced continuation of an unwanted pregnancy increases health risks for women, in addition to the immediate and long-term effects on mental health, exposing women to depression, anxiety and unhappiness as a result of the unwanted pregnancy. Therefore, denying abortion, despite the existing health risks associated, puts women at great risk.¹⁶

Our experience in clinical practice as part of the evidence

An unwanted pregnancy can cause severe anxiety and depressive reactions in a woman who does not feel emotionally or socially prepared to be a mother. Our daily clinical practice puts us in direct contact with women going through this situation and provides us with an up-close perspective of their suffering. The simple notion of carrying an unwanted pregnancy to term becomes a kind of psychological torture for many women. Those of us who interview and help them, often witness a painful emotional situation that is relieved by an abortion.

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Mental health consequences of terminating a pregnancy

In 2008 the American Psychological Association published a very thorough report that provides an analysis of medical literature published in scientific journals since 1989 on the possible effects of abortion on women's mental health (APA Task Force on Mental Health and Abortion).¹⁷ The general conclusion drawn from this systematic review is that terminating an unwanted pregnancy in the first trimester does not pose a greater mental health risk than the continuation of the pregnancy. They also found that losing or terminating a wanted pregnancy due to fetal malformation, for example, might indeed have more consequences on the woman's mental health.

The determining factor then is not the abortion itself but rather the woman's wishes regarding the abortion.

An abortion can, in many cases, relieve the stress associated with an unwanted pregnancy as many studies have shown.¹⁷ However, in some instances the decision to have an abortion is accompanied by social/religious stigma, the woman may be forced to keep her decision a secret or she may not have a support network to rely on. This can cause additional stress that is not directly related to the abortion but rather to the unfavorable circumstances surrounding it.

These authors find that many studies contain evidence of bias against women's right to choose. This is manifested in the interventionist fallacy, which poses, with little methodological clarity that abortion causes increased depression in women and that therefore reducing the number of abortions will reduce the rate of depression among women. Those who defend this fallacy have not taken depression rates and rates of other psychosocial disorders in women who have been denied abortions into account.

Coleman et al.¹⁸ recently published a meta-analysis in the British Journal of Psychiatry in October 2011 in which they found a high rate of mental disorders in women as a direct consequence of an abortion. However, this study has been highly criticized due to the vast number of methodological and ethical errors made by its authors, who are notorious anti-choice activists.

Some reflections by Grupo Médico por el Derecho a Decidir

The voluntary termination of pregnancy (VTOP) is a basic, legal procedure when it involves preventing a risk to the woman's mental health, particularly in the case of an unwanted pregnancy. It is therefore closely linked to the healthcare professional's duty and commitment to medical ethics and patients' rights. This statement incites the following reflections:

On the role of doctors when it comes to women's decisions

- In cases when a woman requests the termination of a pregnancy, doctors do not participate in this decision making. It is not our duty to do so, because it is not a medical decision. It is an autonomous decision by a woman who sees the continuation of the pregnancy as something that risks her health and well-being.
- Safeguarding the possibility of making autonomous decisions is part of protecting women's mental health. The greatest health effects on women

occur when they are denied access to a legal service and are thus denied the possibility of making autonomous decisions about their lives and bodies. Ruling T-009 of 2009 (Colombian Constitutional Court) makes it clear that no one other than a woman can make the decision to terminate her own pregnancy, this is encompassed within her right to the free development of her own personality and must be respected.

- Legal termination of pregnancy is a health service rendered through a medical procedure that has indications that are not necessarily medical in nature. For example, when a woman with an unwanted pregnancy comes to request a service, she does so in exercise of her constitutional right to the free development of her personality, i.e., her right to make autonomous decisions. Doctors are bound to respect the autonomy of all their patients, including women with unwanted pregnancies who request abortions. .
- Constitutional Court Ruling C-355 of 2006 does not require doctors to express their agreement with a woman's decision to terminate her pregnancy; it only asks them to acknowledge and certify the existence of a health risk when there is one. . A doctor may disagree with a woman's decision, but this cannot affect his or her ability to acknowledge the risk. In the case of conscientious objection for moral or religious reasons, the doctor must see to it that his/her conscientious objection does not become a barrier to access; he/she must refer the patient to a non-objecting colleague.
- Denial of abortion services based on dissent with the woman's decision, is inappropriate and cannot be understood as conscientious objection, it is rather an unjustified denial of health services and, therefore, a violation of a woman's rights.
- The certificate that we, as medical professionals, issue to the patient who requests a VTOP should merely address the existence of a health risk from a broad perspective (bio-psycho-social), including the life project in its social and even economic dimensions. On this point, it is worth mentioning that it would not make sense to use a narrow definition of health for the purpose of abortions when we use a broad one for other health issues.

On health and an unwanted pregnancy:

- Maternity is a situation that must be assumed (mentally and emotionally); an unwanted pregnancy therefore impedes women from taking ownership of their situation.
- The existence of a mental health risks and consequently, its certification, does not require the presence of a mental disorder or illness such as schizophrenia. Nor does it depend on any set degree of risk; it is up to the woman to decide the degree of risk she is willing to take since she is under no obligation to take any at all. Our recommendation is to make a judicious assessment of the existence of risk without limiting the certification thereof to the presence of any illness or set degree of risk. This assessment must be comprehensive, i.e., it must consider health as a complete physical, mental and social state of well-being as it is defined by the World Health Organization.
- The effect on a woman's mental health does not mean that she loses the capacity to make decisions about her health and her life. We have often seen how healthcare service providers confuse "mental health disorder" with "mental disability." Mental health disorders, such as depression, anxiety... etc. do not affect the patient's ability to make decisions about her life, health or personal affairs. A distinction must be made between mental health disorder and diminished autonomy (mental disability). Most mental disorders refer to a type of emotional or psychological suffering and not to alterations in cognitive functions.²
- None of the doctors of *Grupo Médico por el derecho a decidir* considers voluntary termination of pregnancy (VTOP) to be the treatment for an illness or the effects of an unwanted pregnancy, either in the physical or psychological

² Only when cognitive functions are seriously altered (orientation, memory, attention, language comprehension, abstract thinking, among others) can it be said that there is a "mental disability" or loss of autonomy. An example of this is dementia or very severe mental disorders like schizophrenia that, in certain circumstances, can alter an individual's autonomy.

sense. However, VTOP can alleviate and restore a woman's well-being and prevent the pregnancy from becoming a risk to her health.

- While VTOP does not resolve the conflict of an unwanted pregnancy, it does allow the resolution of other conflicts: ambivalence regarding one's life project, personal commitments, etc. The psychological and emotional development of a woman –or of any human beings for that matter– is about taking absolute control of one's own life. This is part of mental health. In the area of mental health, a pregnancy termination can be an act of enormous social.

Finally, both the State and the medical community should guarantee the existence of friendly specialized clinics and services staffed with sensitive personnel and providers supportive of access to legal abortion services, where women who seek this service are not subjected to illegal barriers or disproportionate burdens.

References

- 1 Logan C., Holcombe E., Manlove J., Ryan S. "The consequences of unintended childbearing." The National Campaign to Prevent Teen and Unplanned Pregnancy. *Child Trends*, INC, May 2007.
- 2 Bunevicius R., Kusminskas L., Bunevicius A., Nadisauskiene R.J., Jureniene K., PopVJ. "Psychosocial risk factors for depression during pregnancy." *Acta Obstet Gynecol Scand*. 2009;88(5):599-605.
- 3 Najman J.M., Morrison J., Williams G., Andersen M., Keeping J.D. "The mental health of women 6 months after they give birth to an unwanted baby: a longitudinal study." *Soc Sci Med*. 1991;32(3):241-7.
- 4 Rich-Edwards J.W., Kleinman K., Abrams A., Harlow B.L., McLaughlin T.J., Joffe H., Gillman M.W. "Sociodemographic predictors of antenatal and postpartum depressive symptoms among women in a medical group practice." *J Epidemiol Community Health*. 2006 Mar; 60(3):221-7.
- 5 Iranfar S., Shakeri J., Ranjbar M., Nazhad Jafar P., Razaie M. "Is unintended pregnancy a risk factor for depression in Iranian women?" *East Mediterr Health J*. 2005 Jul; 11(4):618-24.
- 6 Eastwood J.G., Phung H., Barnett B. "Postnatal depression and socio-demographic risk: factors associated with Edinburgh Depression Scale scores in a metropolitan area of New South Wales, Australia." *Aust N Z J Psychiatry*. 2011 Oct 22.

- 7 Laukaran V.H., van den Berg B.J. "The relationship of maternal attitude to pregnancy outcomes and obstetric complications. A cohort study of unwanted pregnancy." *Am J Obstet Gynecol*. 1980 Feb 1; 136(3):374-9.
- 8 Lau Y., Keung D.W. "Correlates of depressive symptomatology during the second trimester of pregnancy among Hong Kong Chinese." *Soc Sci Med*. 2007 May; 64(9):1802-11.
- 9 Barber J.S., Axinn W.G., Thornton A. "Unwanted childbearing, health, and mother-child relationships." *J Health Soc Behav*. 1999 Sep; 40(3):231-57.
- 10 Schmiede S., Russo N.F. "Depression and unwanted first pregnancy: longitudinal cohort study." *BMJ*. 2005 Dec 3; 331(7528):1303.
- 11 Hook K. "Refused abortion. A follow-up study of 249 women whose applications were refused by the National Board of Health in Sweden." *Acta Psychiatr Scand Suppl*. 1963;39(168):1-156.
- 12 Forssman H., Thuwe I. "One hundred and twenty children born after application for therapeutic abortion refused. Their mental health, social adjustment and educational level up to the age of 21." *Acta Psychiatr Scand*. 1966;42(1):71-88.
- 13 Gilchrist A.C., Hannaford P.C., Frank P., Kay C.R. "Termination of pregnancy and psychiatric morbidity." *Br J Psychiatry*. 1995 Aug; 167(2):243-8
- 14 Ludermir A.B., Araya R, de Araújo T.V., Valongueiro S.A., Lewis G. "Postnatal depression in women after unsuccessful attempted abortion." *Br J Psychiatry*. 2011 Mar; 198(3):237-8.
- 15 Dagg P.K. "The psychological sequelae of therapeutic abortion—denied and completed." *Am J Psychiatry*. 1991 May; 148(5):578-85.
- 16 Watter W.W. "Mental health consequences of abortion and refused abortion." *Can J Psychiatry*. 1980 Feb; 25(1):68-73.
- 17 *American Psychological Association*, Task Force on Mental Health and Abortion. (2008). "Report of the Task Force on Mental Health and Abortion." Washington, D.C.: Author. Consulted in: <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>
- 18 Priscilla K. Coleman. Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009. *BJP* September 2011. 199:180-186.

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