

Women's grief in induced abortion (IA) and later loss of pregnancy

Themes from a narrative literature review with implications for counselling

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Abstract

This article is based on a review of literature on pregnancy losses at later gestational dates. The author, the head of counselling of a counselling team housed within an induced abortion (IA) clinic, undertook the review with the aim of compiling a fact sheet for clients to assist in their grief and loss associated specifically with IA. The research question was specifically exploring whether women's experience of IA during the first trimester of pregnancy differed from women's experiences during the second trimester of pregnancy, and therefore whether services and a resource needed to reflect this. A key theme in the literature reviewed was that loss by a later elective IA increased the likelihood of the parents' experiences of disenfranchised grief. Findings also showed that there were negative impacts to the women's health if grief and loss counselling was not offered. The experiences highlighted in the research literature were identifiable from other losses related to pregnancy caused by premature delivery, neonatal death, spontaneous abortion (miscarriage), and stillbirth. Recommendations for dealing with disenfranchised grief in the context of counselling in a women's IA clinic are explored with implications for assisting women and their partners post IA.

Keywords

Induced abortion, pregnancy, women's health, public health

This article is based on a literature review undertaken as an initial step to developing an information sheet for patients of a regional New Zealand public health clinic who might be contemplating later pregnancy loss (considered as 12 weeks onwards) by IA. Abortion is a form of pregnancy loss that requires a grieving process that is for the most part unacknowledged by the general public (Hayes et al., 2020).

Abortion in the second trimester of pregnancy is understood as being in the 12–24 weeks period after conception (Mukkavaara et al., 2012). In Aotearoa New Zealand, recent amendments (23 March 2020) to the Contraception, Sterilisation and Abortion Act 1977 provide for termination of pregnancy through IA for those women who have pregnancies greater than 20 weeks, and do not wish to continue the pregnancy. This is a new development in the provision of eligibility for IA, and not just for those women and/or their partners who have a diagnosed abnormality in their pregnancy. In the second trimester of pregnancy, women may now self-refer to our clinic to terminate a pregnancy without needing to give a reason. According to the 2020 amendments to the legislation, counselling is no longer compulsory in either first- or second-trimester pregnancies. Counselling is recommended, however, for women who have risks identified at the point of referral, as discussed below.

Although the medical procedures surrounding IA are regarded as relatively low risk medically, particularly if a general anaesthetic is not necessary (Mukkavaara et al., 2012), this belies the complex emotional and psychological issues that are evident before, during, and after the procedure. The choice to have an IA is acknowledged to be a complex one (Kerns et al., 2018), and involves a pregnancy loss that requires a grieving process just like any other pregnancy loss (including those that are spontaneous and/or not induced, such as miscarriage). The distinction often drawn between a “wanted pregnancy” and an “unwanted pregnancy” creates a false dichotomy as many women and/or their partners who seek an IA are ambivalent about the pregnancy, partly wishing to continue the pregnancy if the relationship, finances, or psychosocial circumstances had been different (Kerns et al., 2018). Creating typologies for women who have an IA and those who have a spontaneous loss of pregnancy are found to be universally shaming and unhelpful in supporting women at a critical decision making time in their life (Hayes et al., 2020). Disenfranchised grief (Doka, 1989) is a concept that is useful for counsellors and clients in making sense of the grieving process when it is disrupted by societal attitudes that evoke shame, social stigma, and blame. Consequently, the needs of those who seek an IA in a second trimester, beyond those women and couples with diagnosed abnormality, may often go unacknowledged. Hayes et al. (2020) poignantly highlight that the experience is virtually undocumented and is a marginalised narrative thought to be almost unspeakable to the point of invisibility. Later loss of pregnancy is acknowledged to be as traumatic as that of a loss of a significant adult in a person’s life (Robson, 2002). Regret, depression, doubt, and loss all feature routinely, particularly in the higher gestations (Robson, 2002).

The topic of supporting women through the abortion decision in the second trimester is, therefore, a critical one nationally and internationally (Hayes et al., 2020). Approximately one in four women have an abortion over the course of their lifetime and, as such, it is a topic that is likely to come up in more generally based counselling sessions to do with other life concerns. It is therefore preferable that common issues pertaining to women’s sexual and reproductive health are not treated by counsellors as a specialist issue but rather one that requires a reflective process within a safe and trusting therapeutic relationship that can explore client options in a supportive and non-judgemental space (Mukkavaara et al., 2012). Counsellors have a significant role in facilitating healing, especially when there is disenfranchised grief and the person/couple have limited places where they can properly discuss their experiences without encountering negative judgements that might cause them further psychological harm.

Given these well-established effects of IA, the aim of the literature review was to specifically determine if there were any differences between counselling and grief and loss work with women who have first-trimester loss of pregnancy (up to 12 weeks) through elective IA procedures, compared with those who present with second-trimester pregnancies of 12 weeks or greater. The former group comprise 90 per cent of the clinic patients seeking IA, with the latter a much smaller population. Identifying if there was any difference in the need for counselling could be used to inform clinic policies and procedures and better meet the identified needs of our clients.

Context of the study

The regional abortion clinic in which our team works is an outpatient clinic with a 10-bed day ward staffed by a counselling and multidisciplinary team and co-located within the Regional Maternal Fetal Medicine Service and Maternity and Gynaecology Outpatient Service. The clinic provides a pregnancy counselling and IA service within the framework of the new amendments set by the above-mentioned Contraception, Sterilisation and Abortion Act 1977 that came into effect in March 2020. At the time of this research the clinic operated according to mid-Level 4 Covid-19 lockdown restrictions.

The clinic's services include pre- and post-abortion counselling, contraception, and sexual health services. As the amended Contraception, Sterilisation and Abortion Act 1977 no longer requires two doctors from the clinic to review the physiological and psychosocial circumstances of each woman, there is no longer any independent agreement between two professionals that the woman meets the legal criteria to have an IA. Consequently, pre-decision counselling is offered as an option to women at the first point of contact. Under the amendments the counsellor's role is now to assess if the woman is clear in making her own decision and has had access to information about the process and procedure, including the request for return of the "products of conception" (Harvard Medical School, 2019). The counsellor's role is to provide clear and comprehensive information about the abortion process, future contraception, and the likely recovery process. Therefore, the focus of the clinic is on the decision making of the individual woman and is underpinned by a rights and social justice paradigm.

The staff of the clinic believe that women should have access to legal, safe, and non-judgmental counselling to inform their decision making. A clinical nurse manager, who provides clinical supervision and direction, leads the team of nurses and midwives and related healthcare professionals, and a clinical director provides leadership of a team of medical doctors. The counselling team of five counsellors/social workers undertakes the initial assessment of women in the context of their life circumstances and provides post-loss counselling to women from the Regional Maternal Fetal Medicine Service and Maternity and Gynaecology Outpatient Service. The author of this paper leads the counselling team and provides coordination of pre-decision/pregnancy loss counselling services for all clients using our services.

All clinic staff have training in women's health, and some have over 20–30 years of clinical experience of working in the field of pregnancy, grief, bereavement, and IA counselling. The three senior clinicians across the disciplines provide strategic direction and develop and maintain policy and practices.

The clinic operates within the context of the regional hospital, which is underpinned by the guiding principles of Te Tiriti o Waitangi, the partnership between Māori, the indigenous people of Aotearoa New Zealand, and the Crown (Orange, 2011). These partnership principles include the sharing of resources (lands, forests, and fisheries), and knowledge, between Māori and Pākehā (non-Māori), including those aspects of spiritual and health knowledge considered to be tapu (sacred) to Māori (Reid & Cram, 2005). These understandings of wellbeing are required to be embedded in modern healthcare practices and systems in Aotearoa New Zealand (Reid & Cram, 2005). Thus, an understanding of the bicultural nature of New Zealand society is embedded in the healthcare system through operationalising and applying Te Tiriti o Waitangi¹ partnership principles to the work of the clinic. One of the ways our clinic is aligning with the need for embedding bicultural practices in our work is to offer every woman the option of having Whānau Care (a service for families within the hospital, underpinned by indigenous Māori principles and practices) providing cultural support, karakia, and accommodation for supporting patients and their whānau. Similarly, when Pacific women self-refer to our clinic, we offer the option of referral to Pacific Health Services for culturally appropriate support throughout the patient journey with their whānau.

The literature review

Cargill (2015) describes literature reviews that are undertaken by practitioners in order to “evidence” their ways of working through comprehensive searches of available research and literature in their field. The literature review informing the basis of this article was undertaken with similar intent to Cargill’s (2015) work in order to inform practice, specifically the development of an in-clinic client information sheet. As Cargill (2015) advocates, literature reviews of this nature aim to synthesise the findings of the literature retrieved from a variety of sources including manual searches, electronic database searches, and seminal works in the field under study. For rigour it is considered important to report the specific search strategy used, the range of journals searched, the extent of coverage of the topic, and level of representation of those sources (Cargill, 2015).

The initial parameters of this review included peer-reviewed articles published in English, and within the past five years. Due to the lack of publications, however, this timeframe was later expanded to include publications from within the last 20 years. This change of delimiter to encompass a wider timeframe greatly expanded the range, cultural diversity, and volume of material accessed. A combination of the phrases and keywords given below were used within the electronic databases Medline, Medline Pending, AMED, Ovid Nursing, Psy Info, Embase, Scopus, and Web of Science. Search terms included: “late termination of pregnancy” or “late stage termination of pregnancy;” “late abortion” or “late stage abortion;” “grief” or “grief*” or “bereave;” “counseling” or “counselling;” and “counselor” or “counsellor.”

Twenty-four articles were found across a range of journals, including medical, obstetric, gynaecological, women’s mental health, religion, and health psychology. The journals were representative of a variety of contexts including Australasian, Chinese, Indian, Scandinavian, and European and Middle Eastern countries. The majority of articles were based in original empirical research, including one longitudinal study; an ethnography from an anthropological perspective, and several outcome studies written with a mental health focus.

Findings: Themes in the literature

There were four main themes across the literature reviewed: the importance of assessing the impact of social stigma and disenfranchised grief; post-trauma and mental health issues post IA; other impacts of IA; and factors buffering negative impacts of IA and protective factors building resilience post IA.

1. Stigma and disenfranchised grief

While 20 per cent of women worldwide elect to have an IA, the social stigma surrounding the procedure and women’s decision persists (Kotta et al., 2018). Some researchers differentiate between abortion that is elective and abortion conducted upon medical recommendation, yet stigma seems to pervade all decisions to have an IA (Kotta et al., 2018).

Disenfranchised grief (Doka, 1989), mentioned previously, describes grieving in situations in which it is too difficult to acknowledge the loss by virtue of social beliefs, attitudes, or trauma. This attitude or worldview often perpetuates a belief that grieving under situations of IA is not legitimate, so it is as though the loss never happened. This lack of acknowledgement can make the loss of pregnancy invisible, or considered unreal, as it is not socially acknowledged as a legitimate circumstance in which to grieve. This disenfranchised grief has been found to be particularly disabling when an IA is involved (Mukkavaara et al., 2012; Nazaré et al., 2012).

Reflective of this stigma, literature also suggests that women's and their partners' experiences around loss of pregnancy at greater than 12 weeks are often left untold. This is particularly so when the pregnancy is ended by choice. The complex nature of contexts leading to IA can be hidden or unappreciated in societal discourses relating to IA, rendering the narrative and the experience as invisible or relegated to the periphery. Andersson et al. (2014) advocate that the experience can also be so painful as to be unspeakable, but this does not mean that women regret their decision to have an IA.

In situations of IA following a diagnosis of foetal abnormality, recent research highlights that for women and their partners impacted by societal stigma there can be long-term impacts on the mental health of the woman having the procedure (Hanschmidt et al., 2018). The sophistication of modern screening techniques facilitates early detection of abnormality, and with such advances an increasing number of women opt to terminate once the diagnosis is confirmed (Hanschmidt et al., 2018).

Depression, post-traumatic stress responses and negative self-worth, therefore, are noted in those grieving following IA, often leading to long-term negative outcomes years after the IA (Hanschmidt et al., 2018). For women where there is an internalisation of negative societal attitudes towards IA, feelings triggered by this internalised stigma include guilt, self-blame, shame leading to depression, and other impacts on psychological health and wellbeing (Kotta et al., 2018). For example, one study aiming to identify the prevalence of longer term psychological reactions to IA following a diagnosis of foetal abnormality found that 18.9 per cent of a sample of 395 women surveyed between 2008 and 2015 expressed post-traumatic stress and high levels of grief and depression seven years after the procedure (Hanschmidt et al., 2018). This finding corroborates the findings of earlier studies about elective IA and responses post IA (Kersting et al., 2007). In the Hanschmidt et al. (2018) study, women's internalised stigma pertained to their perceptions about judgement from others and self-judgement about their decision to terminate a pregnancy with abnormality diagnoses. Comparison of the extent to which pervasive sociocultural norms influenced or reinforced this internalised stigma as opposed to women's own internalised shame pathologies were noted as largely missing in such studies, which were conducted in a European context. Regardless, such findings suggest the need for interventions targeting the feelings of blame, guilt, shame, self-judgment, and internalised stigma that can arise post IA regardless of the origins (Hanschmidt et al., 2018).

In exploring the theme of self-blame, in one study a distinction was made conceptually between "behavioural" and "characterological" self-blame among parents adjusting to later IA, stillbirth, and infant death (Jind, 2003). The major hypothesis of this Danish study was that blaming one's essential character in the process of grieving was thought to result in slower adjustment to the loss than behavioural self-blame. The 110 participants researched in this study were parents who had a late abortion or had lost an infant, with the survey occurring between one and 20 weeks after the loss. The Trauma Symptom Checklist (Briere & Runtz, 1989) was adapted to assess the issue of attribution in the loss (Jind, 2003). The attribution scale underpinning the study was derived from social psychology theories which assume that when people are confronted by unexpected events they will try to find an explanation for what has happened, including an explanation about why it took place and to clarify who was responsible for what has occurred (Jind, 2003). Interestingly, the findings indicated that women experienced more self-blame than men and felt greater responsibility for the loss of pregnancy than men, and there were more characterological aspects to their self-blame (Jind, 2003). Women felt more responsible for the loss of the pregnancy and had more frequent thoughts about the loss being related to them or something that they did or did not do (Jind, 2003).

A further aspect appearing in the literature related to viewing or spending time with the foetus or what is referred to in the literature as "remains" (Mitchell, 2016). Many women have thoughts and feelings about their pregnancies but may be ambivalent about viewing or spending time with the "remains"

after an IA due to the social taboos that exist (Mitchell, 2016). Similarly, there can be fears of what will be seen (Andersson et al., 2014). In my clinical experience, for some women it is important to keep the image of the pregnancy alive through ultrasound images. For others, taking the remains with them for burial or cremation with a ceremony is important. This need for ceremony is particularly strong for Māori and Pacific clients referred to our clinic. Some clients may wish to have no contact nor to see the products of conception, though the option is offered to all women, as it is required by the New Zealand Ministry of Health's Revised Standards for Abortion Care (Ministry of Health, 2020). Handprints and photography are offered but may be avoided as women and partners struggle to deal with the loss they feel. Literature also highlights that the attitudes of the clinical staff have been found to influence the woman's desire to see or take home the products of conception. If coercive attitudes are felt, the woman and/or partner find it difficult to refuse the offer to view (Mitchell, 2016). Others describe positive experiences of viewing or taking home the products of conception (Andersson et al., 2014). How to honour and say goodbye to a pregnancy which is surrounded by these responses is at the core of much of our work as clinic counsellors.

2. Trauma and impacts to mental health

Post-traumatic stress (PTS) and post-traumatic stress disorder (PTSD) after the loss of a pregnancy has been reported in a systematic review of 48 studies (Daugirdaite et al., 2015). IA was seen as differing from other reproductive losses in that it involved the choice of the woman to terminate the pregnancy or not. The authors concluded that it was important to distinguish those IA which are because of foetal abnormality from IA for reasons of social or economic circumstances (poverty). Having a medical as opposed to a surgical IA was found to be associated with a diagnosis of PTSD and a range of sociocultural variables such as lower education, being a younger age, poorer housing, a history of sexual trauma, and depression (Daugirdaite et al., 2015).

There were particular groups of participants for whom PTS was recorded as being more frequent—for instance, women pregnant with a traumatic late loss and IA due to a chromosomal abnormality. In a qualitative study (Cowchock et al., 2011) of 15 women it was discovered that high levels of grief and PTS symptoms were significant for this group both during the pregnancy and following the IA. Various tools such as a depression inventory, perinatal grief scale, and anxiety scale were administered at various stages pre and post IA, after all genetic and medical diagnostic testing was completed, to minimise the risk of causing psychological harm to participants (Cowchock et al., 2011).

In a comparative study of women post stillbirth (Navidian et al., 2017) who had access to psychological intervention compared with a control group who did not, it was found that the severity of post-traumatic stress symptoms was significantly decreased after an intensive psychological intervention through counselling. This was compared to the control group who were not offered counselling. The counselling for grief and loss was offered to the women in the intervention group, and involved some elements of cognitive behavioural therapy in terms of challenging negative cognitions about the loss, as well as encouragement to return to physical exercise and yoga which were specific interventions recommended to buffer the impact of negative ruminations post procedure.

In another study of family interventions post IA for abnormality, the focus of its efforts was to educate partners and family members on how to support the woman who experienced the pregnancy, diagnosis of abnormality, and decision making for IA (Sun et al., 2018). The shame experienced by its participants, Asian mothers, around abnormality during pregnancy and IA was highlighted by this study which found that visits to the women from extended family made them feel exposed and was likely to trigger negative responses such as grief, anxiety, and depression (Sun et al., 2018). It was therefore recommended that nurses assess patients' social networks and the extent of family support, and the

psychological state of women who are pregnant and face IA. A second recommendation was that families be educated about responding appropriately to the woman's needs, which change over time. By overcoming feelings of loneliness and helplessness and promoting a return to usual life, well-timed contact with family members has the potential to help women facing loss post IA for abnormality (Sun et al., 2018).

3. Other impacts of IA

An increase in women's gestational age of pregnancy and medical advances in enhanced prenatal testing are two factors identified as contributing to the increased incidence of abnormality during pregnancy. Coupled with this increased incidence is the ability of clinicians to detect abnormality in pregnancy earlier and to give decision making to the woman and partner on what they wish to do next (Nazaré et al., 2013).

Depending on the age of the woman and her partner, a pregnancy may have no narrative coherence in the context of the woman or couple's life. Kotzé and Crocket (2011) advocate that working with ambivalence and decision making from a counselling perspective involves identifying points of transition in the woman's life as well as the implications for the contexts of family, career, community, and one's dreams for the future. In such decision making it was important for women and their partners to explore the circumstances in which the pregnancy occurred and how it fitted, or not, the personal narrative of the individual and his or her family (Kotzé & Crocket, 2011).

Men as well as their female partners require opportunities to share their difficulties coping with loss and grief in pregnancy to avoid the internalising of more negative feelings such as guilt and self-blame which, if unaddressed, can lead to depression and anxiety (Nazaré et al., 2013). Couple counselling may assist in assessing how each person in the couple is coping and influencing the other, as men often use the coping strategies of denial and avoidance, positivity and humour, in an effort to indicate that they have moved on in their grief when this may not be so (Nazaré et al., 2013). The use of humour and the flight into everyday activities, which is noted predominantly among male partners, is needing careful assessment as recommended across the reviewed literature (Nazaré et al., 2013; Sun et al., 2018). This flight into everyday life by partners is seen as often representing an attempt to avoid the emotional pain associated with a later loss of pregnancy, and so requires careful assessment. The coping strategy of one partner may be causing the other distress, so a systemic approach could be needed alongside individual grief and loss counselling (Robson, 2002). Having a focus on the extended family is also considered important in dealing with loss post IA, particularly in some cultures which have a collectivist philosophy underpinning them (Sun et al., 2018).

4. Buffering factors—building resilience

Early intervention to prevent complicated grief and longer-term psychological consequences was a recurring theme in the literature. Navidan et al. 2017 proposed using a comprehensive grief and loss model of intervention which combined psychological with other kinds of interventions, such as screening for past medical and psychiatric history pre-IA. Similarly, Kotzé and Crocket (2011) advocated follow-up grief and loss counselling; involvement in physical exercise programmes, couple/family counselling, and contraceptive options counselling; and psychoeducation on grief and loss and how the issues might need to be revisited when triggered by normal life transitions. Assessment of social networks and family support is also recommended pre-IA by Sun et al. (2018).

Interestingly, spirituality and/or involvement in religion is seen both as a protective factor and as an obstacle to the grieving process post IA in the reviewed literature. Some women who identify abortion as a “sin” may struggle to consider abortion as an option and may be forced to see the pregnancy to term. Religiosity, on the other hand, has been identified as a protective influence in grieving for a later loss of pregnancy in that it has been found to provide a means of adjusting to loss by giving meaning to experience from a spiritual viewpoint. Cowchock et al. (2011) undertook a pilot study with 15 women experiencing a traumatic late-pregnancy loss—“traumatic” defined as a foetal death or serious abnormality leading to death. These researchers found that religiosity plays an important part in maternal coping during the stress surrounding these pregnancies. The positive effects of spiritual or religious beliefs in dealing with the aftermath of bereavement during pregnancy were found when various anxiety and depression scales were administered to women in the sample, at the point of having all genetic testing completed, and where the loss had been impending.

This literature review also highlighted that the emotional availability of partners to one another is another protective factor in buffering the aftermath of a later loss of pregnancy. In couple counselling in situations of abnormality or issue during pregnancy, it is often the strength of the couple relationship that can navigate the grieving process. In the Portuguese study conducted by Nazaré et al. (2013), 73 couples were contacted who had experienced a loss of pregnancy one to six months earlier. Various perinatal grief scales were administered to each couple to discover the active grieving process of each partner and the coping strategies used by each. The availability of emotional support to ventilate feelings were found to be more commonly used coping strategies for women than for men. The reasons behind men’s less frequent use of emotional support stemmed from suppression of feelings due to societal norms and trying not to add to their partners’ distress (Nazaré et al., 2013). As grieving is an interactive process, the authors surmise that male partners endeavour to use humour and to remain more positive to buoy the morale of women partners. There were also indications that women are more likely to use self-blame, which is an indicator of less favourable grieving outcomes and likely to negatively influence the grieving process (Nazaré et al., 2013).

Moving forward—some concluding thoughts

These are some significant ways in which this literature review is informing the development of a comprehensive grief and loss service within our clinic and which to date has had a flow-on effect on women’s health more broadly.

Psychoeducation about the psychological and emotional impact of grief involving IA in later pregnancy has become an even greater consideration in our provision of a comprehensive range of services. Disenfranchised grief is a theme across all of our client groups, therefore educating clients about some of the barriers to grieving is as important as informing them about the grieving process itself.

Ways of validating mourning processes, in the midst of a busy, active life, are critical to promoting positive health and good outcomes when there is a later loss of pregnancy. Honouring the pregnancy, coupled with creating memories, ceremony/ritual around the products of conception, and encouraging couples to discuss their experiences individually and together, is recommended in the evidence-based literature (Navidian et al., 2017). Exploring the dynamic impact of one partner’s grieving on another and the gender differences impacting grieving processes also require exploration and, in some cases, explanation (Robson, 2002). Family support involving the extended family (whānau) is recommended.

Furthermore, among first nations people and where partnership principles guide our ways of working under the founding document of our nation, Te Tiriti o Waitangi, the extended family (whānau/hapū) and tribal affiliations (iwi) need to be acknowledged and respected by a broader perspective of the

spiritual and emotional components of health and wellbeing in relation to IA understandings and post-IA care and counsel. As a comprehensive grief and loss counselling service in Aotearoa New Zealand, cultural responsiveness when working with Māori and Pacifica is crucial. This identified need has meant that our clinic is beginning to work in a closer partnership with Māori and Pacifica health units within our hospital. Asking Māori and Pacific women what they want in terms of counselling services in abortion care, employing culturally appropriate researchers, is a direction identified for further research.

At our clinic we have found that having our counsellors and practice rooms located in an IA clinic separate from the rest of women's health leads to an ideological separation within the service that has at times seemed unhelpful. To avoid the shaming and social stigma that surrounds an IA, particularly in later pregnancy, which in turn can contribute to the experience of disenfranchised grief, it is important that the specific reason for a loss of pregnancy is not differentiated but instead, that all form a part of the clinic's work in a women's health service. At our clinic, the counsellors have recently grown our service from referrals for pre-decision/post-abortion counselling to encompass Maternal Fetal Medicine referrals due to genetic abnormality, and we are seeing these groups of clients along with referrals for later/recurrent miscarriage and stillbirth. Offering face-to-face grief and loss counselling pre and post IA, particularly for those women who are under the age of 20; those women who often lack social support and/or have pre-existing mental health issues, as these are risk factors suggested in the literature, are also now a major focus of our approach. Developing educational materials on disenfranchised grief and how it can affect the grieving process for our client groups has been a significant priority. Weblinks to sites and blogs that support a woman's right to choose IA are now included in our information to clients about post-IA support and the grieving process.

Making sense of one's experience in a transformed world after IA can be assisted by engagement of individual women, their partners and families using quality psychoeducational material about disenfranchised grief and loss in IA in addition to a service that is receptive to the complexities facing those affected. This literature review has achieved its aim of informing us in this regard.

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Endnote

1. “The Treaty of Waitangi is an agreement made in 1840 between representatives of the British Crown and more than 500 Māori chiefs. It resulted in the declaration of British sovereignty over New Zealand by Lieutenant-Governor William Hobson in May 1840. Most chiefs signed a Māori-language version of the treaty [Te Tiriti o Waitangi]. The English- and Māori-language versions held different meanings, and Māori and Europeans therefore had different expectations of the treaty’s terms. Ever since, resolution of these differences has presented New Zealand with challenges.” (Claudia Orange, “Treaty of Waitangi.” <https://teara.govt.nz/en/treaty-of-waitangi/print>)