INFLUENCE HEALTH BEHAVIOUR?

WHAT IS THE PSYCHOPHYSIOLOGICAL BASIS OF HEALTH, STRESS AND COPING?

CAN THE STUDY OF PSYCHOLOGY HELP US TO DEAL WITH DIFFICULT HEALTH ISSUES SUCH AS AIDS, AND CONTRACEPTION AND ABORTION?

This up-to-date and comprehensive introduction to health psychology explores the role of psychology in understanding health and the treatment of illness. Written by a team of expert teachers and researchers, it discusses the application of psychological studies to the experience of illness, and looks at the psychological aspects of specific health issues of current concern, including living with chronic disease and the role of the family in promoting health.

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which allow us accurately to predict, early in pregnancy, what complications might arise in childbirth or how happy or unhappy any particular woman might be with her situation in a few years' time, as compared to her state had the termination decision been different.

Radcliffe Richards has pointed out a further complication of this form of legislation: it is that it conflates two types of decision which ought to be clearly separated. The first is a *descriptive* statement that, if abortion is granted or refused, certain consequences are likely. The second is a *prescriptive* statement as to whether these consequences justify the sacrifice of a child. Radcliffe Richards suggests that, even if we assume that the first type of decision lies within the competence of a medical practitioner, there is no good reason to suppose that the second type does also.

It is not clear to what extent beliefs about the harmful effects of abortion have been influential in framing this legislation. Adler (1982) suggests that research on abortion, or, at least, the conclusions drawn from it, have mirrored historical and social trends in attitudes and legislation. From the 1940s to the 1960s, when legislation was generally restrictive, it was often concluded that abortion was likely to result in psychological disturbance. It may be, however, that some subjects in this research had undergone illegal abortions in sub-standard facilities and that their reactions to the termination were confounded by this. More recently, it has proved extremely difficult to find data to support the idea of abortion as a harmful experience (Adler 1982; Brewer 1977; Greer *et al.* 1976; Lask 1975; WHO 1978). This is not to suggest that some women do not suffer afterwards. It has, however, been found that a negative outcome tends to be associated with, among other variables, lack of social support and negative attitudes of family, and also with terminations carried out for medical reasons. These negative consequences, however, must be considered in relation to the possible negative results of having the termination refused.

Decision making by the woman

Allen (1981) reported that 73 per cent of her sample of women who had had abortions had visited their general practitioners before the eighth week of pregnancy, and over 90 per cent before the eleventh week. The majority of these women had already made a definite decision before the consultation. Both Allen (1981) and Braken *et al.* (1978) emphasize the importance of discussions with friends, relatives and partners, rather than with medical professionals, in the decision to have an abortion. Braken *et al.* suggest that, having reached a tentative decision, the woman then seeks support by discussing the decision with people who might agree with her. Particular importance may be attached to role models – for example, to other women who have had abortions without apparent ill-effect. Although a decision may be reached early in the pregnancy, the woman may still be ambivalent. Braken *et al.* found that about 40 per cent of each of their samples of young women

who terminated or continued their pregnancies, changed their minds at least once in the early stages. Allen reported that, although more than half of her sample never had any doubts about wanting a termination, there was greater ambivalence among very young women and divorced and separated women. Among the young women, this seemed to be associated with what Allen calls 'romantic notions' of what it would be like to have a child. The ambivalence may also be reflected in the greater contraceptive risk-taking which Allen noted in both of these groups. This could, however, be related to unplanned sexual activity.

Smetana and Adler (1979) studied the decision-making process using Fishbein's model of behavioural intention (Fishbein 1972). This model predicts that the intention to perform an act, and its actual performance, are a multiplicative function of the attitude towards performing the behaviour in a particular situation, of beliefs about what others expect to be done and of the person's motivation to comply with these expectations. Smetana and Adler found that the intention to have, or not to have, an abortion, stated before the results of a pregnancy test were available, correlated very highly with actual behaviour. In line with the model's predictions, the intention to have an abortion was significantly related to beliefs about the expectations of significant others (mother, partner, clergyman) and to beliefs about the consequences of having a child. Thus, women choosing either action claimed that others wanted them to follow their chosen alternative. The women choosing or rejecting abortion, however, did not differ in their stated motivation to comply with these expectations, with the exception that women choosing an abortion claimed to be more strongly motivated to comply with the expectations of female friends. The two groups also saw the consequences of having a child in very different terms: those who chose abortion stressed the burden and long-term commitment of child rearing, while those who continued their pregnancies stressed their emotional well-being and fulfilment. The groups did not differ in their moral attitudes to abortion.

These results support Allen's finding that the decision to have an abortion is made relatively quickly; indeed, in Smetana and Adler's study, the women did not yet know for certain if they were pregnant. The results also emphasize the perceived role of partners, family and friends in the decision-making process. The results do not, however, offer direct evidence about the nature of this role, as no data were collected from these people.

Decision making by professionals

The majority of abortions in England and Wales are carried out because it is claimed that continuation of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated. It appears that it is the mental health of the mother which is thought to be at risk in the vast majority of these cases, because 'neurotic

form of contraception and five had been sterilized. It is not clear, however, how many of the women were sexually active, nor whether any were trying to become pregnant.

These figures present similar problems of interpretation as those mentioned earlier: they are based on self-reports and give little indication of the pattern of use. Some researchers, however, have reported figures for requests for subsequent abortions. In Abrams's study, these were 7 per cent in the first year of follow-up and 11 per cent in the second. Rovinsky (1972) reported a rate of 5 per cent even with intensive advice about contraception though some requests for repeat abortions would be expected simply from rates of contraceptive failure.

Allen (1981) has noted that advice about contraception has apparently become standard practice following, or even prior to, abortion. As she points out, promises to use contraception may be used as part of a 'bargaining procedure' before the termination is carried out. There is, however, little evidence that this advice is based on an analysis of the factors which may influence a woman's – or her partner's – decision to use contraception. Rather, some of Allen's professional respondents appeared not to acknowledge the difficulties women might experience in obtaining and using contraception. One gynaecologist claimed that it was necessary to 'put the squeeze' on women before the termination because afterwards they 'don't give a damn'. One general practitioner spoke of a 'hard core' who 'like to live with the risk', while another claimed that women didn't experience two unwanted pregnancies 'unless they're hopeless'. This last comment was said by Allen to sum up the feelings of many respondents.

CONCLUSIONS

Psychological research on abortion has tended to emphasize the outcome of the procedure, in terms of 'psychiatric complications', or the psychological characteristics of women seeking abortions. It is, of course, important to know about the outcome of abortion and about the factors which influence it, provided that this research is matched by research on the outcome of refusals to grant terminations. But this implicitly pathological bias could lead to a relative neglect of other important aspects of the subject, particularly of the relationship between social attitudes and abortion legislation, of professional decision making and of the application of research on contraception use to post-abortion counselling. And the neglect of male subjects is notable: their attitudes and reactions to their partners' experiences are often unknown, while they do not appear to be expected to take any responsibility for contraception immediately after a termination. Future research needs to redress the balance and to place abortion in the wider social context in which it belongs.

Chapter 12

Essential hypertension

Keith Phillips

INTRODUCTION

Hypertension is a chronic disorder characterized by sustained elevation of blood pressure level (BPL). It may result from a specific physical cause such as renal failure, adrenal tumour or aortic disease, in which case the disorder is termed secondary hypertension. The treatment of secondary hypertension involves purely medical interventions. Temporary BPL elevations may be caused by the actions of some drugs or may occur during pregnancy. Chronic elevation of BPL is commonly not associated with any identifiable physical cause and in this instance the condition is termed primary or essential (meaning 'of unknown origin') hypertension. This chapter will be concerned solely with essential hypertension, whose treatment may involve pharmacological or behavioural methods, or both. (Further references to 'hypertension' should be understood as meaning essential hypertension.)

Hypertension is said to be asymptomatic, and although a variety of symptoms are reported by hypertensive patients such as headache, dizziness, fatigue and breathlessness, these are neither consistently reported nor exclusive to hypertension. It is reported that 20–25 per cent of the adult populations of the UK and USA exhibit hypertension to some degree. It represents a major threat to health since although itself asymptomatic, hypertension is a risk factor for other diseases including kidney failure and cardiovascular disorders such as myocardial infarction, congestive heart failure and cerebrovascular stroke (see Chapter 13). The objective of treating hypertension is to reduce the morbidity and mortality associated with renal and cardiovascular diseases of these types.

Definition of hypertension

The diagnosis of hypertension depends upon measurement of BPL within the arterial blood system. Blood circulates within a closed circulatory system and has to be forced around the system under pressure. Its movement within this system is determined by several haemodynamic factors, and the BPL within

disorders' or 'personality disorders' are the conditions most frequently given as justification for the termination (OPCS 1987). This means that the majority of abortions (and, presumably, the majority of refusals) involve doctors' judgements about the woman's likely psychological state, taking into account her 'actual or foreseeable environment'. It was pointed out earlier, however, that there is no set of rules by which these judgements might be made, nor have representative data been provided on their reliability. This places those who must make the judgements in a very difficult position. As Radcliffe Richards (1982) has pointed out, it also leaves the way open for the operation of personal beliefs.

Qualitative data presented by Allen (1981) emphasize this problem. Although she found that many of the general practitioners in her sample referred for consultation all women who requested a termination, some did not. One commented that:

> They're entitled to the benefit of the law. I've given up moral judgement. If it's for a reason like they have a heavy mortgage etc., I forget to write sometimes. I say, 'Too late, love, sorry. It's the hospital appointment system. You'll have to have the baby.'
>
> (Allen 1981: 71)

Most of the consultants interviewed claimed that they very rarely refused to perform abortions, but it was clear from Allen's interviews with general practitioners that certain consultants were avoided when referrals were made, presumably because they were less likely to agree to perform abortions.

In a more systematic study of the variables which influence the decision to allow or refuse termination, Hamill and Ingram (1974) examined the decisions reached in 132 referrals for psychiatric opinion on termination. A questionnaire covering general information, clinical and social findings, and contraceptive history was completed by each consultant at the time of examination. Some 64 per cent of the women were granted a termination and 36 per cent were refused. The questionnaire data for these two groups were then compared. Members of the group granted terminations were significantly more likely to be older, married, already to have children, to have claimed to use contraception regularly, and to be rated as showing psychiatric symptoms. There was no significant difference in the overall number of social problems rated in the two groups, but the women refused terminations were significantly more likely to have been deserted by their partners. Some 52 per cent of the women who were granted abortions agreed to be sterilized. The finding here that women who claimed to use contraception regularly were more likely to be granted an abortion is in line with Allen's (1981) report that women who had been 'unlucky' because of contraceptive failure were usually granted a termination without difficulty, and were sympathetically treated by their doctors.

In introducing their research, Hamill and Ingram (1974: 119) noted that

> The assessing doctor tends to show bias by labelling psychiatric disorder in those he recommends and vice versa. We hoped to diminish this by avoiding formal diagnoses on the questionnaire and asking instead about the presence or absence of specific symptoms.

There is, however, no reason to suppose that any biases in psychiatric diagnoses would not equally apply to judgements about the presence of the 'specific symptoms' rated on the questionnaire which included 'emotional immaturity' and 'personality disorder'. Hamill and Ingram's results do raise the question of whether those women who were granted termination were somehow seen as more 'deserving' and of whether this judgement might have biased judgements of symptoms. It is, however, very difficult to research this question because the details of doctors' decision making are not officially recorded, nor are the numbers or characteristics of those refused terminations. The high proportion of women who had terminations and were also sterilized is particularly striking. This figure can be compared with the report of the Lane Committee (1974) which found that almost half of all married women granted National Health Service abortions had also been sterilized, although the overall figure for all women granted terminations was 15 per cent. This proportion is now considerably lower: in 1986, for example, it was 4.5 per cent for all women granted termination. A higher proportion of National Health Service abortions, however, were accompanied by sterilization than were non-NHS abortions: 7.8 per cent versus 1.9 per cent (OPCS 1986). It is not clear whether this reflects a different population structure for the two sectors, or a different professional decision-making process.

Contraception following abortion

It seems reasonable to suppose that the values assigned to various elements in contraceptive decision making would alter following the termination of a pregnancy, although we cannot assume that this will always lead to efficient use of contraception. A number of studies have examined the extent of women's use of contraception after abortion. Beard *et al.* (1974) found that 81 per cent of their sample reported using some form of contraception one to two years after a termination, and that some of the remainder wished to become pregnant. This figure compares favourably with that of 41 per cent who claimed to be using contraception previously. Using a sample of 10–18 year olds, Abrams (1985) reported that 79 per cent of those followed up for two years after a termination were using reliable methods of contraception. Lask's (1975) figures are much lower: of a sample of forty-one women followed up six months after the abortions, sixteen were regularly using some

Decision making for contraception and abortion

Mary Boyle

for something like three-quarters of that part of the professional abortionist's business that derives from urban American married women, he can thank the birth controllers and the current imperfections in the technique of their art.

(Pearl 1939)

it appears to be common practice that women will resort to abortion (whether legal or illegal) if the contraceptive method they are using fails.

(Potts *et al.* 1977)

If these statements conveyed a full picture of the relationship between contraceptive use and unwanted pregnancy, psychologists would have little to contribute to the area. For the statements imply that, if an unwanted pregnancy occurs, attention should be directed to the method of contraception and not to the method of use. There is, however, abundant evidence that this picture is incomplete. In spite of the availability of reliable contraception, often at little or no financial cost, the rate of legal termination of pregnancy amongst women aged 15–44 in England and Wales has risen each year since 1983 (OPCS 1987). Ryan and Sweeney (1980) reported that 63 per cent of a sample of pregnant teenagers claimed to have made a conscious decision not to use contraceptives, although less than a third of the sample intended to become pregnant. Similarly, Braken *et al.* (1978) found that 68 per cent of young, unmarried women having abortions had not used any contraceptive around the time of conception. Using a wider age range, Allen (1981) found that 39 per cent of a sample of women granted terminations reported either never having used contraception or not having used it at the time of conception. There are, moreover, several reasons for supposing that these figures may overestimate the relationship between the desire to avoid pregnancy and efficient contraceptive use. First, some of the figures are based on the self-reports of women seeking or granted abortions. If abortion is not available on demand, then it would be surprising if some women did not report using contraception when they had not, in the hope that this might increase their chances of obtaining a termination. They might then maintain this report if questioned afterwards by researchers. Second, figures for use or non-use of contraceptives tell us little about the *pattern* of use: was the pill taken every day? Was the cap used with a spermicide? Was the condom put on before any contact was made? And, third, Ryan and Sweeney's report that around 30 per cent of pregnant teenagers wished to become pregnant seems rather high in comparison with a figure of 10 per cent from a national sample of sexually active teenagers (Zelnick and Kantner 1977). It is possible that some of Ryan and Sweeney's sample, having not used contraception and then found themselves pregnant, decided in retrospect that the pregnancy was intended.

What is clear from these figures is that the relationship between contraceptive use and the desire to achieve or avoid pregnancy is not straightforward. This chapter will consider some of the factors which are related to the decision to use, or not use, contraception. It will also examine the processes surrounding decisions about the termination of pregnancy. Finally, the chapter will look at patterns of contraceptive use following abortion.

Before this is done, however, there is a feature of the literature which is worth noting, and that is that the majority of research subjects are female. Indeed, an alien reading some of the research would have to conclude that men had nothing to do with either contraception or conception. One possible reason for this bias is that women are more likely than men to form a 'captive' subject pool at family-planning clinics, pregnancy advisory services and termination clinics, or at mother and baby homes. As Chilman (1985) has pointed out, however, another plausible reason is that contraception and the avoidance of pregnancy are, in our society, seen as the responsibility of women and that the structure of research is a reflection of this view. She suggests that this selective attention to women places an unfair burden on them and makes it more difficult for men to share the responsibility for contraception, even if they wished to do so. Similarly, Schinke (1984) has suggested that, because males are less victimized by pregnancy, they are forgotten in most research directed at the prevention of unwanted pregnancy. It is perhaps not quite as bad as this, but of fourteen studies aimed at encouraging teenagers to use contraception, and reviewed by Beck and Davies (1987), seven were aimed exclusively at females and only one exclusively at males.

DECISION MAKING AND CONTRACEPTION

Much of the research into contraceptive decision making has proceeded outside any particular theoretical framework. This is not necessarily a disadvantage, as valuable descriptive data may be gathered and can form the basis of theoretical models. Some of the models which have been suggested have not been subjected to rigorous evaluation. Some, too, such as the health belief model (Becker 1974; Rosenstock 1974), were developed in other health areas, and their applicability to contraceptive decision making is debatable