

**INFORME SOBRE LA EVIDENCIA CIENTÍFICA DEL RIESGO  
PSICOLÓGICO DEL ABORTO PROVOCADO POR DIAGNÓSTICO DE  
MALFORMACIONES**

**Beatriz Mariscal Díaz**

**Psicóloga Presidenta de la Asociación de Víctimas del Aborto (AVA)**

[www.vozvictimas.org](http://www.vozvictimas.org)

[equipomedico@vozvictimas.org](mailto:equipomedico@vozvictimas.org)

Dadas las nuevas evidencias y estudios recientes sobre el trauma tras el aborto, se ha realizado este Informe sobre la evidencia científica actualizada del riesgo psicológico que pueden sufrir las madres y padres que abortan a un hijo por habersele diagnosticado durante el embarazo un riesgo más o menos elevado de malformación. Sólo se han empleado artículos científicos publicados en revistas de alto índice de impacto con revisión doble e indexadas en la U.S. National Library of Medicine (Pubmed.gov)<sup>1</sup>.

En estudios realizados hace ya 8 o más años se demostraba que el aborto provocado por malformación fetal tiene riesgos psicológicos que es preciso conocer y a los que había que dar respuesta.

De hecho, cuatro estudios, dos de 1993, y otros de 1997 y 2001 demostraron que las mujeres que abortaban a un hijo por un diagnóstico prenatal positivo presentaban secuelas **igual de graves que la pérdida de un hijo sano** durante el embarazo o parto, y que la interrupción voluntaria del embarazo en este supuesto causa aislamiento social y depresión (Iles and Gath 1993; Zeanah, Dailey et al. 1993; Salvesen, Oyen et al. 1997; Schutt, Kersting et al. 2001).

En dichos estudios se comparaba el estado psicológico posterior de dos grupos de mujeres: el primer grupo que abortó por malformación y el segundo que perdió un hijo por aborto espontáneo, ambas pérdidas en el segundo trimestre de gestación. Los investigadores de estos cuatro trabajos internacionales alertan de que el aborto supuso en casi todos los casos un trauma. Los resultados mostraron que la sintomatología no difería entre ambos grupos y que entre las mujeres cuyo aborto era provocado por malformación – no espontáneo - **un 17% fueron diagnosticadas de depresión mayor y un 23% precisaron tratamiento psiquiátrico** (Zeanah, Dailey et al. 1993).

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<sup>1</sup> Accesible online en: <http://www.ncbi.nlm.nih.gov/sites/entrez/>

Además, hubo en la década de los 90 otros estudios indicaron el estrés grave que podía llevar el aborto por malformación y sus graves efectos en la madre y padre (Di Giusto, Lazzari et al. 1991; White-van Mourik, Connor et al. 1992; White-Van Mourik, Connor et al. 1992; Kolker and Burke 1993; Lilford, Stratton et al. 1994).

En los dos estudios de los investigadores de Glasgow se demostró que después de 2 años tras el aborto por malformación, todavía un **20% de madres del estudio de 68 matrimonios tenían brotes de llanto, tristeza e irritabilidad tras el aborto** (White-Van Mourik, Connor et al. 1992). Los maridos también relataron en un porcentaje elevado falta de concentración e irritabilidad durante el primer año. Además, un **12% de los matrimonios sufrieron crisis temporales durante este primer año** e incluso algún matrimonio llegó a romperse durante este breve periodo.

Por su parte, otro estudio de Leeds en Reino Unido examinó a 57 parejas que habían abortado de forma espontánea o provocada por malformación, ofreciéndoles asesoramiento psicológico de forma aleatoria tras abortar y no presentar problemas psicológicos graves tras éste (Lilford, Stratton et al. 1994). Querían evaluar si resultaría clínicamente útil ofrecer el asesoramiento psicológico a todas las parejas, incluso aquellas que parecían no tener problemas psicológicos tras el aborto por anomalía fetal. Entre los resultados cabe destacar que, aunque no pudo demostrarse de forma rotunda que la intervención del psicólogo que se empleó fuera eficaz, sí resultó de interés contar con esta asistencia **ya que las parejas del grupo con psicoterapia que la recibieron adecuadamente integraron mejor la pérdida que las que faltaron a la misma**. Además, se encontró sintomatología ligeramente más grave en las parejas cuyo aborto fue provocado y no espontáneo.

En 1995, el Servicio de Genética del Centro Médico de Investigación Pediátrica de la Universidad de Montreal, en Québec, Canadá, realizó un estudio comparativo de las reacciones psicológicas de dos grupos de padres que abortaron tras el diagnóstico prenatal (Dallaire, Lortie et al. 1995). El primer grupo de 76 pacientes tenían riesgo familiar de tener un hijo con malformación y el segundo grupo, de 124, no lo tenían. El **sentimiento de culpabilidad** tras el aborto estuvo presente en ambos grupos (29 y 79%, primer y segundo grupo respectivamente), así como la **necesidad de recibir asistencia psiquiátrica** (19 y 7%, respectivamente). La Universidad concluye la necesidad del apoyo psicológico durante el diagnóstico prenatal dado la gravedad del duelo que puede presentarse tras el aborto por malformación.

## ¿Cuál es la evidencia científica más relevante y novedosa sobre el tema?

Los siguientes estudios poseen una metodología más adecuada para el estudio del trauma postaborto por malformación. Por ello se explicarán brevemente con sus principales resultados.

Un estudio del Centro Universitario Médico de Utrecht en Holanda publicado en el 2005 examinó a los 2-7 años de la intervención a 151 parejas – madres y padres - que había abortado por malformación (Korenromp, Page-Christiaens et al. 2005). Usaron cuestionarios estandarizados de duelo, estrés postraumático, ansiedad y depresión. Entre los resultados citaban que había todavía parejas que presentaban **puntuaciones patológicas en estas escalas**. Alertaron de que los hombres también presentan estrés postraumático tras el aborto. Los factores que se asociaron a una mayor sintomatología fueron el bajo nivel educacional, tiempo de embarazo o edad gestacional mayor y que la malformación fuera compatible con la vida, entre otros.

En el mismo centro y ese mismo año, dicho equipo publicó otro trabajo, esta vez examinando a 254 mujeres entre 2 y 7 años del aborto por malformación (Korenromp, Christiaens et al. 2005). En este caso, **un 17,3% de mujeres presentaron puntuaciones patológicas de estrés postraumático**, con lo cual los investigadores concluyeron alertando que el aborto provocado por malformación se asocia fuertemente a secuelas de larga duración para un número elevado de mujeres. De nuevo se asociaron las mismas características enumeradas arriba para presentar mayor sintomatología.

El estudio más reciente de este equipo experto del Centro Universitario Médico de Utrecht ha sido publicado en el 2007, y ha examinado 217 mujeres y 169 varones a los 4 meses del aborto de sus hijos con malformación (Korenromp, Page-Christiaens et al. 2007). Se han demostrado **altos niveles de síntomas de estrés postraumático** (44 y 22% para mujeres y hombres, respectivamente) y de **depresión** (28 y 16%, respectivamente)(Korenromp, Page-Christiaens et al. 2007). Se señaló en el estudio que eran factores de riesgo para presentar mayores problemas psicológicos, entre otros, haber dudado en su toma de decisión, la edad gestacional elevada y la baja autoconfianza. Además, **tan sólo a los 4 meses del aborto por malformación, ya un 2% de las madres estaban arrepentidas de haber abortado**.

En España cada año se encuentran en riesgo de sufrir este trauma más de 6.000 personas sumando madres y padres.

Con todos estos datos de estudios internacionales, **AVA** indica que resulta relevante e imprescindible la inclusión de estas secuelas demostradas en los consentimientos informados que firman las madres y padres previamente a la intervención en los centros acreditados para el aborto provocado. Estos documentos son obligatorios por la Ley 14/1986 y la Ley 41/2002 y entregar con la suficiente antelación para comprender las consecuencias posibles, con lo que debería proporcionarse al menos con 24 horas de antelación a la intervención (tal y como se recomienda en otras intervenciones quirúrgicas).

Además es un deber sanitario facilitar la asistencia psicológica y psiquiátrica a todos los padres tras un aborto por malformación durante la elaboración del duelo.

**Vistos** los porcentajes de sintomatología de estrés postraumático y depresión demostrados (al menos en un 44 y 28%, respectivamente, en mujeres a los 4 meses del aborto; y al menos en un 17,3% para el estrés postraumático de los 2 a 7 años tras el aborto), **resulta gravemente contrario al beneficio de la salud de los padres** no alertar previamente de estos riesgos y ocultar la posibilidad de que se precise elaborar el duelo por la pérdida fetal.

## **BIBLIOGRAFÍA EMPLEADA CON LOS RESÚMENES DE LAS PUBLICACIONES**

Dallaire, L., G. Lortie, et al. (1995). "Parental reaction and adaptability to the prenatal diagnosis of fetal defect or genetic disease leading to pregnancy interruption." *Prenat Diagn* **15**(3): 249-59.

The objective of the study was to evaluate the psychological reaction of two groups of parents to a pregnancy termination after they had undergone a prenatal diagnostic procedure. The analysis involved interviews with a study group of 76 patients who were at risk of giving birth to a child with a genetic disease or defect and a comparison group of 124 who had a pregnancy termination after a major anomaly had been detected by routine ultrasound and who were not at known risk for a genetic disease. Only patients in the study group had received counselling before the prenatal diagnosis and were aware that the fetus could be affected. The overall reaction of the comparison group was one of shock, denial of fetal abnormality, and guilt over 'abandoning the fetus'. A feeling of guilt was expressed by patients in the comparison group (73 per cent versus 29 per cent) in the period immediately following the interruption. One-third of patients in both groups felt obliged to undergo a therapeutic abortion. More patients in the study group than in the comparison group expressed the need to see a psychiatrist at the time of the study (19 per cent versus 7 per cent) and viewed future pregnancies as a replacement for the lost pregnancy (63 per cent versus 19 per cent). The recommendations of the study focus on information sessions to personnel, nursing support, analgesia during the expulsion period, an atmosphere of respect that should be present at the time that the fetus is viewed, the anticipation of mourning, and the long-term follow-up of the couple to ensure that counselling for future pregnancies and psychological support are provided when needed.

Di Giusto, M., R. Lazzari, et al. (1991). "Psychological aspects of therapeutic abortion after early prenatal diagnosis." *Clin Exp Obstet Gynecol* **18**(3): 169-73.

The early discovery of a fetal pathology creates a "crisis" situation fraught with psychic problems for the couple who must live through it. The Authors observed a group of patients in the second trimester of pregnancy. They had all requested therapeutic abortion since serious malformation of the fetus had been confirmed. By means of a questionnaire constructed for the purpose, certain characteristics of fetal malformation and of pregnancy were evidenced, as well as the way these were experienced by the patients. The immediate and delayed reactions to the diagnosis of malformation were also studied, as was the experience lived when faced with the choice of abortion.

Iles, S. and D. Gath (1993). "Psychiatric outcome of termination of pregnancy for foetal abnormality." *Psychol Med* **23**(2): 407-13.

Termination of pregnancy for foetal abnormality has become frequent with the increasing sophistication of techniques of antenatal diagnosis. The aim of this study was to obtain quantitative and qualitative information about psychiatric morbidity in women after termination of pregnancy for foetal abnormality. Two samples of women were compared. The first consisted of 71 women who had had a termination of pregnancy for foetal abnormality (FA group). The second consisted of 26 women who had experienced so-called missed abortion (MA group). Both groups had lost a pregnancy in the mid-trimester of pregnancy, but the MA group had no element of choice. Standardized psychiatric and social measures were used to assess both groups on three occasions after the termination. In both groups, 4 weeks after the termination psychiatric morbidity was high (four to five times higher than in the general population of women), and social adjustment was impaired. Six months and 12 months after the abortion, levels of psychiatric morbidity were near normal. Semi-structured interviewing was used to obtain information about the experience of grief after mid-trimester termination. For many women, symptoms of grief persisted throughout the year. These symptoms included typical features of grief as well as grief symptoms specific to pregnancy loss. The findings have implications for the counselling of women after termination for foetal abnormality or after missed abortion.

Kolker, A. and B. M. Burke (1993). "Grieving the wanted child: ramifications of abortion after prenatal diagnosis of abnormality." Health Care Women Int **14**(6): 513-26.

Prenatal diagnosis is increasingly common. Whereas amniocentesis is typically performed in the second trimester, chorionic villus sampling (CVS) is a first-trimester procedure, which makes an earlier, safer abortion possible. However, CVS carries a slightly higher risk of miscarriage and other complications. In choosing a procedure, couples (with the aid of genetic counseling) must weigh the risks of miscarriage against the odds and implications of an abnormal diagnosis. Interviews with women who decided on abortions after amniocentesis or CVS and meetings with genetic counselors indicate that both types of abortion are more traumatic than is commonly realized. Both dash dreams and hopes. Termination after amniocentesis also forces the mother to take an active part in the life and death of a nearly viable fetus. Yet, because abortions for fetal abnormality are statistically rare, there is little societal understanding and minimal support for those who experience them. This is true of health care workers as well as for the couple's primary support group.

Korenromp, M. J., G. C. Christiaens, et al. (2005). "Long-term psychological consequences of pregnancy termination for fetal abnormality: a cross-sectional study." Prenat Diagn **25**(3): 253-60.

OBJECTIVE: We examined women's long-term psychological well-being after termination of pregnancy (TOP) for fetal anomaly in order to identify risk factors for psychological morbidity. METHODS: A cross-sectional study was performed in 254 women, 2 to 7 years after TOP for fetal anomaly before 24 weeks of gestation. We used standardised questionnaires to investigate grief, posttraumatic symptoms, and psychological and somatic complaints. RESULTS: Women generally adapted well to grief. However, a substantial number of the participants (17.3%) showed pathological scores for posttraumatic stress. Low-educated women and women who had experienced little support from their partners had the most unfavourable psychological outcome. Advanced gestational age at TOP was associated with higher levels of grief, and posttraumatic stress symptoms and long-term psychological morbidity was rare in TOP before 14 completed weeks of gestation. Higher levels of grief and doubt were found if the fetal anomaly was presumably compatible with life. CONCLUSION: Termination of pregnancy for fetal anomaly is associated with long-lasting consequences for a substantial number of women. Clinically relevant determinants are gestational age, perceived partner support, and educational level.

Korenromp, M. J., G. C. Page-Christiaens, et al. (2005). "Psychological consequences of termination of pregnancy for fetal anomaly: similarities and differences between partners." Prenat Diagn **25**(13): 1226-33.

OBJECTIVE: We examined the psychological responses to termination of pregnancy (TOP) for fetal anomaly from both men and women. The aim was to find risk factors for poor psychological outcome both for the individuals and for the couple. METHODS: A cross-sectional study was performed in 151 couples 2-7 years after TOP. We used standardized and validated questionnaires to investigate grief, symptoms of posttraumatic stress, somatic complaints, anxiety, and depression. RESULTS: Most couples adapted well to their loss, although several patients had pathological scores on posttraumatic stress symptoms and depression. Differences between men and women were slight. Higher education, good partner support, earlier gestational age, and life-incompatibility of the disorder positively influenced the outcomes, more for women than for men. Men and women with pathological scores rarely had such scores simultaneously. CONCLUSION: We emphasize the importance of equally involving both parents in the counselling because the outcomes of grief and posttraumatic stress symptoms between men and women only moderately differ and post-TOP psychopathology occurs in men as well. Good adjustment to TOP in women seems dependent on the level of support that they perceive from their partners. The intracouple results of the study suggest a mutual influence in the process of grieving between the partners.

Korenromp, M. J., G. C. Page-Christiaens, et al. (2007). "A prospective study on parental coping 4 months after termination of pregnancy for fetal anomalies." Prenat Diagn **27**(8): 709-16.

OBJECTIVE: To identify short-term factors influencing psychological outcome of termination of pregnancy for fetal anomaly, in order to define those patients most vulnerable to psychopathology. STUDY DESIGN: A prospective cohort of 217 women and 169 men completed standardized questionnaires 4 months after termination. Psychological adjustment was measured by the Inventory of Complicated Grief (ICG), the Impact of Event Scale (IES), the Edinburgh Postnatal Depression Scale (EPDS), and the Symptom Checklist-90 (SCL-90). RESULTS: Women and men showed high levels of posttraumatic stress (PTS) symptoms (44 and 22%, respectively) and symptoms of depression (28 and 16%, respectively). Determinants of adverse psychological outcome were the following: high level of doubt in the decision period, inadequate partner support, low self-efficacy, lower parental age, being religious, and advanced gestational age. Whether the condition was Down syndrome or another disability was irrelevant to the outcome. Termination did not have an important effect on future reproductive intentions. Only 2% of women and less than 1% of men regretted the decision to terminate. CONCLUSION: Termination of pregnancy (TOP) for fetal anomaly affects parents deeply. Four months after termination a considerable part still suffers from posttraumatic stress symptoms and depressive feelings. Patients who are at high risk could benefit from intensified support.

Lilford, R. J., P. Stratton, et al. (1994). "A randomised trial of routine versus selective counselling in perinatal bereavement from congenital disease." Br J Obstet Gynaecol **101**(4): 291-6.

OBJECTIVE: To find out whether routine counselling improves psychological wellbeing after bereavement for fetal abnormality. DESIGN: A randomised trial among bereaved couples who did not demonstrate any unexpected strain or psychopathology after bereavement. SETTING: St. James's University Hospital, Leeds. SUBJECTS: Fifty-seven couples. INTERVENTIONS: Independent counselling by an experienced psychotherapist. MAIN OUTCOME MEASURES: Self-administered questionnaires measuring grief, anxiety and depression and a structured psychological interview 16 to 20 months after the loss. Anniversaries of a death or expected birth date were avoided. RESULTS: There were no differences in outcome between women randomised to the study group or randomised to the control group with respect to grief, anxiety, depression or the results of the structured overview. Among those in the randomised study group, women who attended for counselling had a much better outcome than women who defaulted from counselling. Overall, women who underwent termination of pregnancy did slightly worse than those who had experienced stillbirth or neonatal death. On an informal basis, the clinician concerned believes that he was better able to help bereaved couples as a result of feedback and criticism from the independent counsellor. CONCLUSIONS: (1) The hypothesis that all couples should have independent counselling after prenatal loss for congenital abnormality is unproven, but it is likely that clinicians can benefit from feedback from a counsellor; (2) it is possible that termination of pregnancy is more psychopathogenic than other forms of fetal loss; (3) people who attend for their counselling sessions are probably inherently better able to adjust to bereavement; (4) trials of psychological intervention are feasible, but follow up is either difficult to achieve or expensive.

Salvesen, K. A., L. Oyen, et al. (1997). "Comparison of long-term psychological responses of women after pregnancy termination due to fetal anomalies and after perinatal loss." Ultrasound Obstet Gynecol **9**(2): 80-5.

The objective of the study was to compare psychological responses of women following a pregnancy termination due to ultrasound-detected fetal anomalies (ultrasound group) with the psychological responses of women following a late spontaneous abortion or a perinatal death (perinatal loss group). The assessments, which were performed on four occasions in the year after the life event, included Montgomery and Asberg Depression Rating Scale, Goldberg General Health Questionnaire, Impact of Event Scale, State-Trait Anxiety Inventory and Schedule for Recent Life Events. In the acute phase, a few days after the life event, the women in the ultrasound group reported statistically

significantly less depressive symptoms and less intrusion and avoidance symptoms than the perinatal loss group. No differences in psychological responses in the two groups were found at the examinations at approximately 7 weeks, 5 months or 1 year. A statistically significantly higher proportion of women in the ultrasound group reported that they had tried to become pregnant in the following year. A few subjects in each group reported persisting high psychological distress throughout the year, but only one woman fulfilled the criteria of a post-traumatic stress disorder. It is concluded that the long-term psychological stress response in women to pregnancy termination following ultrasonographic detection of fetal anomalies does not differ from the stress responses seen in women experiencing a perinatal loss.

Schutt, K., A. Kersting, et al. (2001). "[Termination of pregnancy for fetal abnormality--a traumatic experience?]." Zentralbl Gynakol **123**(1): 37-41.

The diagnosis of a lethal anomaly of the fetus can affect a pregnant woman in a traumatic way. Almost immediately she has to decide whether she wishes the pregnancy to be terminated or not. Literature shows that such a loss is very difficult to cope with, and can lead to social isolation and depression. Contrary to popular belief the loss felt by the woman is at least the same to that following a stillbirth. Problems arise when the woman has difficulties in expressing her feelings, has a lack of self-esteem or receives very little social support. The prenatal diagnosis evokes an acute grief reaction. Only few studies are available regarding length, course and severity of grief in this case. Although an abortion through a fetal anomaly is a traumatic experience, research is vague on the trauma caused. Present day research of the psychological sequelae after the termination will be summarized. In respect to the current trauma-research lies the question of which psychiatric conditions arise from such a traumatic experience.

White-van Mourik, M. C., J. M. Connor, et al. (1992). "The psychosocial sequelae of a second-trimester termination of pregnancy for fetal abnormality." Prenat Diagn **12**(3): 189-204.

A retrospective study to investigate the psychosocial sequelae of a second-trimester termination of pregnancy (TOP) for fetal abnormality (FA) is described. After appropriate consent was obtained, 84 women and 68 spouses were visited 2 years after the event and asked to complete an extensive questionnaire. Most couples reported a state of emotional turmoil after the TOP. There were differences in the way couples coped with this confusion of feelings. After 2 years about 20 per cent of the women still complained of regular bouts of crying, sadness, and irritability. Husbands reported increased listlessness, loss of concentration, and irritability for up to 12 months after the TOP. In the same period, there was increased marital disharmony in which 12 per cent of the couples separated for a while and one couple obtained a divorce. These problems could be attributed to a lack of synchrony in the grieving process. Confusing and conflicting feelings led to social isolation and lack of communication. Difficulties in coming to terms with the fetal loss were not found to be linked to the type of fetal abnormality or religious beliefs but were related to parental immaturity, inability to communicate needs, a deep-rooted lack of self-esteem before the pregnancy, lack of supporting relationships, and secondary infertility. Suggestions for improved management are given.

White-Van Mourik, M. C., J. M. Connor, et al. (1992). "The psychosocial sequelae of a second trimester termination of pregnancy for fetal abnormality over a two year period." Birth Defects Orig Artic Ser **28**(1): 61-74.

Zeanah, C. H., J. V. Dailey, et al. (1993). "Do women grieve after terminating pregnancies because of fetal anomalies? A controlled investigation." Obstet Gynecol **82**(2): 270-5.

OBJECTIVE: To test the hypothesis that grief responses do not differ between women who terminate their pregnancies for fetal anomalies and women who experience spontaneous perinatal losses. METHODS: A case-control study was conducted. Twenty-three women who underwent terminations through the genetics service of a tertiary referral obstetric hospital from January 1991 to April 1992 were assessed psychiatrically 2 months after the termination. The grief responses of these women on the Perinatal Grief Scale and the Beck Depression Inventory were compared to a

demographically similar group of women assessed 2 months after they experienced spontaneous perinatal loss. Differences between the groups were assessed through one-way analysis of covariance. RESULTS: After matching women in the two groups, it became clear that women who terminated for fetal anomalies were significantly older than women in the comparison group, and age was inversely correlated with intensity of grief. Therefore, age was covaried in comparing the grief responses of women in the two groups. Neither statistically significant nor clinically meaningful differences were found in symptomatology between the groups. By the time of assessment, four of 23 women (17%) who terminated their pregnancies were diagnosed with a major depression, and five of 23 (22%) had sought psychiatric treatment. CONCLUSIONS: Women who terminate pregnancies for fetal anomalies experience grief as intense as those who experience spontaneous perinatal loss, and they may require similar clinical management. Diagnosis of a fetal anomaly and subsequent termination may be associated with psychological morbidity.