

No regrets

Decisions about access to abortion are often argued on grounds of safety. But abortion, for good reasons, is a highly emotional issue and therefore information on safety can be bent by the biases of those looking at the topic. After so much public, religious, and political debate, perhaps no-one can approach the analysis of the clinical outcome of abortion with an entirely open mind and a few people unashamedly look for the data they "want" to buttress their preconceptions.

Initially, the debate tended to revolve around the physical safety of abortion. The low mortality rates from central and eastern Europe in the 1960s were said to be politically adjusted and western leaders in obstetrics claimed it was impossible to conduct abortions with a death rate of less than 1 in 10 000 operations. However, in the 1970s statistics from the USA and the UK unequivocally showed that first-trimester vacuum aspiration abortion could be carried out with a mortality as low as 1 in 100 000 operations.¹

On July 30, 1987, then President Ronald Reagan, in remarks at a briefing for the Right to Life leaders, directed then Surgeon General C. Everett Koop to prepare a comprehensive report on the medical and psychological impact of abortion on women. The Surgeon General "met privately with 27 different groups which had philosophical, social, medical, or other professional, interests in the abortion issue".² After extensive staff consultations with a range of specialists, Koop, a former paediatric surgeon who is personally opposed to abortion, declined to issue a report. He wrote a letter to the President on Jan 9, 1989, stating that "despite a diligent review . . . , the scientific studies do not provide conclusive data on the health effects of abortion on women".³ Koop's scientific integrity had prevailed over an administration prepared to dissemble.

On March 16, 1989, a congressional hearing³ was held to review the Surgeon General's draft report, subsequently published in the *Congressional Record*.⁴ In view of the impasse regarding the psychological impact of abortion, the American Psychological Association appointed an expert review panel whose report was published last month in *Science*.⁵ Clearly, the psychological responses after abortion are intrinsically more difficult to evaluate than mortality and morbidity statistics. Thus, the researchers limited their analysis to those papers with the most rigorous designs from the USA, supplemented by a major study from Denmark which used a uniform population registration system not available in any other country.⁶

Overall, the panel found "legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard for most women." Perhaps even more important, from a clinical perspective, their review noted that there is "little evidence of psychopathology" after abortion.

The data permit some generalisations. Women who never wanted to become pregnant were less likely to report regret than women for whom pregnancy was "highly meaningful." Those who had negative feelings towards their partner, experienced opposition from their parents, or were highly ambivalent also experienced increased distress. If a woman mentioned a subsequent good relationship with her partner, she was more likely to experience regret a year after

abortion. Women were more likely to have problems if they had attended a clinic accompanied by a male partner rather than on their own.

Existing protocols have been based on the voluntary participation of study subjects and may have excluded those experiencing most stress. An ideal study would assess a women's psychological status before pregnancy and follow her reactions afterwards. Koop has called for such a prospective study based on a national sample of women. Only two studies have attempted to compare the psychological responses after abortion and after birth. Athanasiou and colleagues, using the Minnesota Multiphasic Personality Inventory, found the two groups "startlingly similar".⁷ Zabin et al found that adolescents who chose to abort an unintended pregnancy had somewhat greater self-esteem than those who carried the pregnancy to term.⁸

The proven surgical safety of early abortion and the apparent lack of psychological sequelae cannot decide the ethics of terminating a pregnancy, but studies of the type reported in *Science* help remove illegitimate weapons from the political battlefield. There is one last category of data that, like the psychological consequences of abortion, is especially difficult to evaluate—the outcome of births to women who seek abortion but fail to obtain one and are compelled to carry the baby to term. The only comprehensive pair-matched study of "unwanted" and "wanted" children has now been followed for 24 years in Prague, Czechoslovakia.⁹ In the aggregate, the 220 children born to women twice denied abortion for the same pregnancy experienced a far more detrimental psychosocial development than did the 220 children born to women who had stopped taking contraception to conceive or had accepted an unplanned pregnancy. As young adults, they reported more psychological disorders and more difficulties in partner relations, and also appeared more often in the alcohol, drug, and criminal registers.

Any clinical procedure that is adopted on a large scale will be associated with some side-effects, occasionally severe. Just as therapeutic abortion has a measurable, if very small, mortality, so some women will be severely damaged psychologically. As Koop noted, these cases, whilst tragic, are "minuscule from a public health perspective".¹⁰

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