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Psychology & reproductive choice

Abortion Psychological Sequelae: the debate and the research

By Ellie Lee and Dr Anne Gilchrist

Introduction

What follows is the text of a paper given at a conference organised by Pro-Choice Forum called 'Issues in Pregnancy Counselling: What do Women Need and Want?' The conference was held at Ruskin College, Oxford in May 1997. It's aim was to give students, academics, service providers and others interested in ensuring pregnancy services meet women's needs, the opportunity for a critical discussion of the provision of counselling as part of these services.

Ellie Lee

The term 'Post-Abortion Syndrome' (PAS) has become a reference point in the debate about women's psychological response to abortion. Literature which deals with abortion psychological sequelae which has been written over the past few years, is likely to make reference to PAS as a theory of the way women respond psychologically to abortion. Although most commentators approach the term with scepticism because of the association between the theory of PAS and the anti-abortion movement, little has been written which provides clear criticism of the approach to abortion psychological sequelae which informs the PAS theory. I attempt to do so in my comments.

The term PAS was first developed in America. Key proponents of this theory of abortion psychological sequelae are the American anti-abortionists, Vincent Rue and Anne Speckhard. In discussing what the theory of PAS says about the way women respond psychologically to abortion, I am going to refer mainly to their writings.(1) Although this theory has its origins in the American debate about abortion, it has subsequently entered the British discussion. In particular, organisations opposed to abortion in this country, such as LIFE and the Society for the Protection of Unborn Children (SPUC) suggest that PAS explains most accurately how women respond psychologically to abortion. Both of these organisations run their own post-abortion counselling services. SPUC has a sister organisation, British Victims of Abortion (BVA), specifically dedicated to counselling women who have undergone abortion. LIFE and BVA both use PAS as the theory of abortion psychological sequelae to underpin the counselling that they offer to women.

I am going to first explain the argument that the theory of PAS puts forward about abortion psychological sequelae; second explain why the theory is wrong; and third explain why I think the theory needs to be vigorously opposed by anyone who believes it to be important to uphold an accurate picture of the experience of abortion.

The theory of Post Abortion Syndrome

The main contentions of PAS as a description and theory of abortion psychological

sequelae are as follows. First that there is evidence of women post-abortion exhibiting an extreme negative psychological response.
The symptoms are defined as long-lasting and recurring. The symptoms that are said to characterise this response are:

'..sadness/sorrow, depression, anger or guilt, surprise at the intensity of their emotional reaction, preoccupation with the aborted child, a low self-image, repression and discomfort at being around babies or young children, flashbacks of the abortion experience, feelings of 'craziness', thoughts of suicide, nightmares related to the abortion, perceived visitations from the aborted child, hallucinations related to the abortion. The date upon which the child would have been born and anniversaries of both the operation and the 'would-have-been' birthday become focal points for Post Abortion Trauma Syndrome symptoms.'(2)

The second is that this response to abortion should be categorised as a form of Post-Traumatic Stress Disorder (PTSD). Society should perceive PAS as a definable, severe, psychological condition. It should be borne in mind that what is being suggested here is that there is evidence of something akin to psychosis, exhibited by women, which is attributable to termination of pregnancy.

Thirdly that this recognition of the extreme, negative psychological effects of abortion should lead to a refutation of the argument that legal abortion is justified on the grounds of benefit to women's health. In fact, advocates of the theory of PAS argue that the advent of legal abortion has been a set-back for women. They suggest that it has created a situation where thousands women suffer negative psychological consequences as result being able to terminate pregnancy. In Britain, under the 1967 Abortion Act, abortion can be provided legally if two doctors agree 'that the pregnancy has not exceeded its twenty-fourth week, and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children'.(3) The proponents of PAS argue that this ground cannot be met, because abortion damages women psychologically. Hence abortion should not be legal on these grounds.

The myth of Post Abortion Syndrome

I want to dispute the argument that evidence exists to sustain the notion that women experience this 'condition' in response to termination of pregnancy. The psychological effects of abortion have been extensively surveyed since the advent of legal abortion in the USA, Britain and Europe. Literally hundreds of studies have been carried out, to assess the extent of the risk of psychological complications of termination of pregnancy. The very fact that so much research has been commissioned and carried out indicates that those involved with abortion are very sensitive to the claim that abortion can be psychologically damaging, and feel the need to investigate whether this is the case. Yet regardless of which country the research has been conducted in, where abortion is legal, and carried out safely, there is no evidence that abortion leads to psychological damage.

In fact the results generated by survey after survey are remarkably uniform and each survey simply acts to reaffirm what has been already found out. The overall result is that the number of women exhibiting severe, negative psychological sequelae is small, and that where a negative response is indicated, it results from the particular circumstances of the woman, rather than the abortion itself.

There are numerous studies that can be referred to to confirm this observation. Characteristic are the studies carried out by Greer et al (1976) and Frank et al (1985). The first study followed up 326 aborted women and found that 6.5 per cent

were undergoing psychiatric treatment post-abortion. The second assessed 6105 women post-abortion, using the criteria of psychiatric morbidity to measure psychological state. It found that 2.5 per cent of women could be classified as exhibiting this response. Both these studies, like others, indicate that a small minority of women indicate severe psychological problems after termination. However crucially, where this is the case, it does not follow that this psychological state is attributable to the abortion itself. Most commonly, women with psychiatric complications post-abortion exhibited those conditions prior to the operation, so their difficulties cannot be linked to termination. Other groups of women that are found in the minority exhibiting negative reactions are very young women; women with a wanted pregnancy who aborted for foetal abnormality; women with strong religious convictions. It is the particular situation of these women that creates their unusual response to abortion. The survey which Anne Gilchrist was involved with, which she will talk about shortly, confirms the salient points of these prior surveys.

Where a severe, negative psychological response is indicated, this does not mean we can draw any conclusions from it about abortion. Even where a woman does find, because of her circumstances, termination of pregnancy to be psychologically problematic, this still does not mean that the other alternative, giving birth, would have been less so.

The evidence given by those who argue that there is such a condition-which they then label PAS-if anything confirms the findings of other research. Analysed properly, it suggests that small numbers of women, because of particular circumstances, experience severe psychological complications post-abortion. One such piece of research, which was never actually published, but was used by Speckhard and Rue to justify the term PAS, was a doctoral thesis written by Speckhard. The research for this thesis was 45-90 minute interviews with 30 women. This is a small sample size to begin with, but the women were also self-selected. They were chosen because they themselves defined abortion as 'highly stressful'.

The sample included women who had undergone both legal and illegal abortions. Undoubtedly illegal abortion can be psychologically problematic because of the need of secrecy and the stigma associated with being involved with something society deems illegal. Additionally 46 per cent of trimester abortions.(4) The nature of the medical procedure involved in these instances could explain why these women found abortion psychologically difficult. Speckhard's research provides no grounds to sustain the PAS theory. Rather it indicates that these particular women experienced psychological difficulties post-abortion, for particular reasons.

Beyond this research, the evidence I have seen to sustain the case for PAS comes from accounts in letters or interviews with women who describe their abortion as a traumatic experience. Undoubtedly these women found abortion difficult to cope with. Many women who write these accounts regretted having terminated pregnancy. This does not, however, constitute evidence to suggest that abortion leads to a specific psychological or psychiatric condition.

Further, these women are not typical. Their cases cannot be used to make general comments on reactions to abortion, or to predict which reactions are most likely to follow from the procedure. In contrast there is a large body of evidence that provides a more objective account. It indicates that the majority of women experience no major negative sequelae and that severe psychological reactions are rare.

Abortion psychological sequelae

Author	Sample size	Criteria	Negative outcome (%)
Niswander & Paterson (1967)	161	Emotional Health	6.9
Clark et al (1968)	111	Worse	0.9
Pare & Raven (1970)	169	Guilt, depression	17.2
Meyerowitz et al (1971)	77	Adaptation	9.1
Ewing & Rouse (1973)	126	Emotional reaction	6.3
Ashton (1980)	64	Guilt	7.8
Lazarus (1985)	292	Depression	15

PSYCHOLOGICAL EFFECTS OF THERAPEUTIC ABORTION

These surveys assess not psychiatric disorder, but what is commonly called 'post-abortion feelings'. The most obvious point to make it that even negative feelings, never mind psychiatric disturbance post-abortion, are exhibited by only a minority of women.

In fact research has consistently indicated that the most stressful and emotionally difficult time for women is immediately before the abortion, when they are making the decision to terminate. This is not surprising, given the stigma involved with abortion. Women are often concerned at how others will react to their decision, increasing stress; there may be worry about 'getting it over with', where women are concerned about whether the procedure will hurt and how long it will last; also the fact that unplanned pregnancy will for large numbers of women create a confused response needs to be taken into account here. Many women are unsure about what they want to do. They want a child at some point in their lives, but are concerned about whether this point, given their financial situation, career plans, relationship with their partner and a range of other issues, is the right one. Making the decision therefore inevitably involves ambivalence and emotion.

In contrast post-abortion, the most common response exhibited by women is relief. The decision has been made, the procedure is over, and the woman can re-establish her pre-pregnant state. She experiences relief (and in some cases euphoria) because she is back in control of her circumstances. She is more able to predict what will happen to her, in contrast to her experience of unplanned, unwanted pregnancy.

Negative post-abortion emotions, where they are indicated, are short-lived and understandable. Guilt for example is to be expected given that society has stigmatised abortion. Those women who feel guilty do so because discourse on abortion consistently suggests that opting for abortion is at best a very serious decision, at worst the taking of a life.

Feelings of depression are best understood as a continuation of pre-abortion ambivalence. The woman may want a child, and wish she had been able to carry the pregnancy through, but knew that circumstances did not allow for it. This should not, however, be taken as grounds to assume that she feels she made the wrong decision. A woman can certainly know what she did was right, but at the same time feel depressed, wishing the situation of her pregnancy had been different.

This account of post-abortion feelings emphasises further the importance of understanding psychological response contextually. Both the broad context of abortion as a stigmatised procedure and the narrow context of the woman's individual circumstance shape her response. These factors, not abortion itself, explain post-abortion feelings.

Undoubtedly there are some women who terminate pregnancy and deeply regret having done so. However, this should be viewed in the same way in which we view other decisions we might make in life that we can deeply regret and feel bad about afterwards. Getting divorced or never having children can generate similar psychological responses. These events, like a regretted abortion are simply a part of life. The fact that we make wrong decisions on occasion does not mean that the ability to make that decision should be taken away from us.

The surveys referred to above are criticised by advocates of the theory of PAS on the grounds that their sample size is too small, the drop-out rate of respondents in follow-up is sometimes high and that they use different criteria to assess psychological state. All research can be criticised for not conforming to the ideal.(5) However, there is an indisputable, consistent body of evidence that indicates that PAS does not exist.

This fact is something that PAS advocates are aware of. In response they employ the psychological category of 'repression' to explain the lack of evidence for their theory. This category describes the phenomenon where negative psychological responses to events are repressed in the subconscious, but may emerge at a later date. The person subject to repression can then be described as exhibiting 'denial'.6 They deny their true psycho-logical response, by refusing to make it conscious. This thesis is useful for those who want to sustain the idea of PAS, but lack the evidence to do so. Women who indicate no negative symptoms post-abortion can be classified as exhibiting 'repression' and 'denial'.

As a preferable alternative to this approach, we can chose to simply believe women who say that abortion was the right decision for them to make, that they feel content with the decision, and are experiencing no emotional difficulties.

PAS and Post-Traumatic Stress Disorder (PTSD)

Those who support the theory of PAS utilise the same psychological concepts to argue that PAS should be defined as a form of PTSD. The term PTSD was first employed to define the psychological condition apparent in veterans of the Vietnam War. These veterans exhibited severe psychological disorders, which appeared to have no immediate explanation. The PTSD thesis contends that such severe reactions resulted from the experience of Vietnam, but the meaning of that experience was repressed in the minds of the veterans, generating no conscious connection between their behaviour and psychological state, and the Vietnam War. The psychological disturbance could emerge at varying times after the return from the war. Subsequently, PTSD has been applied to describe the delayed psychological response to a number of other experiences, including child abuse, rape and the Hillsborough football stadium disaster.

As an aside it is worth noting that the thesis that attempts to link psychosis directly to a past event is currently disputed. Some literature suggests that psychological response cannot be linked in a linear way to a particular event. Rather the prevailing discourse in society that constructs that event in a particular way links psychological disturbance to an event.(7) This argument means that the argument about PTSD in general is far from straightforward.

However, accepting the definition and diagnosis of PTSD as given for the sake of argument, it is worth noting the definition of abortion, as an event capable of inducing PTSD, that including PAS as an example of PTSD would entail. The type of stressor severe enough to generate the kind of psychological response characteristic of PTSD would have to be, as American Psychiatric Association (APA):

..an event that is outside the range of usual human experience...e.g. serious threat to one's life or physical integrity; serious threat or harm to one's children..or seeing another person who has been or is being seriously injured or killed as the result of physical violence.(8)

Suggested stressors include military combat, violent personal assault and being held hostage. In this definition, induced abortion would have to be defined as a violent, threatening act, which is hardly sensible given that women opt for the procedure voluntarily, and no violence is involved. Abortion is certainly not 'outside the range of usual human experience'. It is the most commonly carried out operation in the UK, with one in four women undergoing it at some point in their lives. Abortion is a common fact of life for sexually active women, not an unusual event that cannot be easily integrated into a woman's life. Unsurprisingly, the APA has rejected the suggestion that induced abortion be defined as a PTSD stressor.

Conclusion-PAS and the politics of the anti-abortion movement There is no evidence that women experience abortion in the way that the theory of PAS suggests. Therefore I can confidently argue that there is no such thing as PAS. In fact it is no more than a term that has been invented by opponents of abortion to discredit abortion.

PAS bears no relation to the extent or nature of abortion psychological sequelae. Rather it is best understood in political terms. The reason why PAS has emerged as a theory is as an attempt by those opposed to abortion to generate an argument that can give them a hearing in the contemporary context. This is a context where the traditional arguments against abortion, based on the idea that abortion is 'sinful' carry less weight than in the past. As a result anti-abortion argument is expressed, through the PAS theory, in the terms of more popular discourse-the language of feminism (concern for women's best interests) expressed through apparent concern for their psychological well-being.(9)

The idea that the theory of PAS represents an exposition of concern for women should be strongly disputed. The opposite is the case. It presents women as 'victims' of abortion, who are incapable of making and living with the decision to end an unwanted pregnancy. Its consequence is to suggest that legal abortion is bad for women, where to the contrary, the advent of legal abortion has given women the freedom to decide when and by whom they become pregnant.

Dr Anne Gilchrist

Questions about the psychological sequelae of abortion arise both in clinical practice and in public debate. Psychological difficulties or disorders are in fact rarely attributable to any one single factor, and in relation to abortion, as in any other life circumstances, multiple adverse and protective factors interact for any individual. Two (disguised) case examples illustrate this clinical complexity, as well as the variety of beliefs which are held about psychological effects of abortion.

A 16 year old admitted to hospital for an abortion is referred for counselling. She feels an abortion is the best option for her, expects she will feel some guilt and upset, but balances that against what she expects to feel if she continues the pregnancy. Her mother, however, is extremely worried about psychological 'damage' after an abortion. In the second case, a 14 year old is referred by her GP for 'post abortion counselling'. Her mother feels the abortion caused all the problems, but the girl herself feels the main problem is that she was persuaded to have an abortion and now has no-one to whom she can talk about her mixed feelings. In contrast to the complexity of clinical situations, public debates sometimes appear to incorporate polarised and oversimplified views about any

psychological aspects of abortion. For example, from a psychiatric perspective, the term 'post abortion syndrome', implies there is one unique and specific pattern of difficulties after abortion, a view inconsistent with clinical experience. Individual accounts of abortion, whether of psychological upset or of psychological benefit, can be powerful, but do not allow any predictions about other women, each in their own unique circumstances.

Research findings, based on studies of groups of women, are therefore essential to inform patients, families and professionals. Follow up studies of women who have had an abortion consistently find that 10-20 per cent experience psychological problems, most commonly short lived guilt and depression. Those ambivalent about the abortion are at risk, as are those with previous psychological problems(10). Psychological disturbance after abortion is evidently not universal, and there are some clues as to who is vulnerable.

However, this kind of study clearly cannot show whether women feel better or worse after the procedure, compared with before it. Where pre and post abortion assessments have been included in the research design, up to 20 per cent of women show problems before an abortion, and later improvement in psychological state. Thus research on women who have an abortion shows both that some women experience psychological disturbance, and that many do not. It can give no information on whether abortion itself is linked with an increased risk of psychological disorder, since women who did not have an abortion are not included.

To investigate that question, it is essential to start from the idea that abortion becomes potentially relevant when a women experiences a particular life crisis-a pregnancy which is unwanted or associated with problems. This kind of experience in itself is psychologically difficult. So to find out whether there is a psychological effect of abortion it is crucial to compare women who choose that option with women who continue their pregnancy. The largest and most recent study of this type in the UK is the collaborative study of induced abortion by the Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists.(11) The study aimed to answer two main questions about psychological disorders and abortion. First, is the risk of psychological disorder after abortion increased? Second, is the risk of psychological disorder greater in women with a past history of psychological or psychiatric problems?

The study was based on data collected from general practitioners and obstetricians. Between 1976 and 1979 volunteer general practitioners in England and Wales recruited to the study women who requested an abortion and a similar sized group of women who had not planned their pregnancy, but intended to continue it. Of the women who requested abortion, some were refused and some changed their minds before the procedure so that there were ultimately four 'comparison groups' of women : 6151 who had an abortion, 6410 who did not request an abortion, 379 who were refused an abortion and 321 who changed their mind. A study of this size was important since it was unlikely that any rare complications of abortion, or a small increase in risk would be detected unless the number of women included was of this order. Women who agreed to participate in the study were not identified; all details were sent anonymously to the study centre. Data were collected by the GP when women were recruited (age, marital status, age at completing full time education, past medical, obstetric and psychiatric history etc.), information about women who had an abortion was supplied by gynaecologists, and follow up data for all women was provided by GPs from their records, up to 1987 where possible.

There are obvious disadvantages in this type of follow up in that the clinical information is not detailed, and the diagnoses made are relatively imprecise. However, while the data are relatively crude, the key point is that they are equally

crude for all women. The study did not rely on interviews, questionnaires or any other form of self reports, partly to allow for the large number of women involved, but more importantly to reduce the risk of biased responding. If attempts are made to directly assess women after the end of their pregnancy, particularly if they have an abortion, there is a risk that women who take part will be different in some way from those who are not willing or able to participate. In this case, over 50 per cent of women in a pilot sample indicated they would refuse to be interviewed and the likelihood is that they would have differed in important respects from the group who agreed.

It was expected that there would be some imprecision in the diagnoses recorded by GP's, so psychological or psychiatric disorders were grouped into three categories- major mental illness (diagnoses including puerperal psychosis, schizophrenia and manic depressive psychoses), minor mental illness (diagnoses of depression, anxiety or other emotional disorders) and deliberate self harm (drug overdoses, self cutting etc.).

In order to isolate the effect of abortion as far as possible, each comparison group (continued pregnancy, abortion, refused abortion, changed mind) was divided into four subgroups according to their history of psychological or psychiatric disorder before the study pregnancy. This meant that women with equivalent previous histories of psychological or psychiatric problems but different outcomes to their pregnancies could be compared. In addition, the results were statistically adjusted, to allow for differences between the groups at recruitment, for example in age and marital status, which might explain any findings. It is, however, important to recognise that observational research of this type is always subject to difficulty in fully adjusting for alternative explanations. Women who choose to seek an abortion may well be different from those who do not, and these differences may influence the risk of subsequent psychological disorder. For example, women may request an abortion because of their lack of social support or difficulties in the relationship with their partner, reasons which themselves can make women vulnerable to psychological problems. These issues need to be borne in mind when the findings are interpreted.

Was the risk of psychological disorder after abortion increased compared with the risk if the unplanned pregnancy continued? Overall, women who had an abortion did not have an increased risk of psychological disorder compared with women who continued their pregnancy. Were women with a previous history of psychological or psychiatric disorder more at risk? This proved to be the case irrespective of the outcome of the pregnancy. Thus, in women who had an abortion, those who had previously had psychological problems were more at risk of subsequent psychological problems than women without such a previous history. Similarly, in women who continued their unplanned pregnancy those who had previously had psychological problems were more at risk after the end of the pregnancy.

Two further aspects of the results illustrate the caution required when interpreting the research findings. First, the rates of major mental illness reported after childbirth in this study were much higher than previously reported rates (usually about one per 1000 women). Review of the study follow up forms indicated that general practitioners were using the term 'puerperal psychosis' for a wide range of psychological disturbances after childbirth, resulting in an artificially high rate. We therefore repeated the analysis, including only women who were admitted to hospital as a result of their 'puerperal psychosis', a group likely to be severely ill. In this analysis, too, there was no difference in risk of major mental illness in the group who had an abortion and those who continued their pregnancy. We can therefore be confident that the rate of major mental illness after abortion is not increased.

Second, in women who had no previous history of psychological disorder, deliberate self harm was more common after abortion, or after an abortion was refused, than after childbirth. The number of events was very small, so any interpretation should be particularly circumspect, but a likely explanation is that these women are experiencing some common social stress or lack of support. This finding emphasises the need to be aware that women who request an abortion are likely to be different from those who do not and may already be at risk of later distress.

The findings from this study indicate that, as a group, women who have an abortion are not at increased risk of psychological disorder. Women who have had previous psychological problems are a vulnerable subgroup, whether they seek an abortion or continue an unplanned pregnancy. These research findings may offer one helpful perspective in clinical situations, both in identifying women at risk, and in indicating that there is no inevitability about any psychological disorder after an abortion. There is a clear need for further information on how psychological difficulties which do occur after an abortion are related to risk and protective factors for individual women. In clinical situations this individual perspective is essential, and it is helpful to recognise that polarised expectations about the psychological effects of abortion are neither warranted nor helpful. Women may have a variety of feelings or difficulties after abortion, and are most likely to feel supported when others acknowledge and accept their individual experiences.

(1) See 'Postabortion Syndrome: An Emerging Public Health Concern', Journal of Social Issues, Vol. 48, No. 3, 1992, 95-119.
(2) Peter Garrett, Post Abortion Trauma Syndrome, Life pamphlet, 1993, introduction.
(3) Abortion Act 1967, as amended.
(4) Henry P. David, 'Postabortion Psychological Responses', briefing published by the Transnational Family Research Institute, 1996.
(5) See 'Postabortion Syndrome: An Emerging Public Health Concern', Journal of Social Issues, Vol. 48, No. 3, 1992, 95-119 and Peter Garrett, Post Abortion Trauma Syndrome, Life pamphlet, 1993.
(6) Ibid.
(7) See Allan Young, The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder, Princeton University Press, New Jersey, 1995 and Elaine Showalter, Hysteries: Hysterical Epidemics and Modern Culture, Picador, London, 1997 for interesting accounts of the social construction of trauma.
(8) American Psychiatric Association, Diagnostic and Statistical Manual for mental disorders (DSM III-R), Washington DC, 1987.
(9) See Nick Hopkins, Steve Richer and Jannat Saleem, 'Constructing women's psychological health in anti-abortion rhetoric', The Sociological Review, Vol. 44, No. 3, August 1996, 539-64.
(10) G. Zolese, C. V. R. Blacker (1992), 'The Psychological Complications of Therapeutic Abortion', British Journal of Psychiatry 160, 742-749; P. K. B. Dagg (1991), 'The Psychological Sequelae of Therapeutic Abortion-Denied and Completed', American Journal of Psychiatry 148, 578-585; B. K. Doane, B. G. Quigley (1981), 'Psychiatric aspects of therapeutic abortion', Canadian Medical Association Journal 125, 427-432.
(11) A. C. Gilchrist, P.C. Hannaford, P. Frank, C. R. Kay (1995), 'Termination of Pregnancy and Psychiatric Morbidity', British Journal of Psychiatry 167, 243-248.