



editorial

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Abortion and mental health

SUMMARY

A recent Royal College of Psychiatrists' statement concluded that current evidence on abortion

and mental health is inconclusive. This contribution examines the background to the Royal College of Psychiatrists' statement and the

issues it raises. It is concluded that the best route to resolving such issues is through further and better research.

Recently, the Royal College of Psychiatrists (2008) issued a statement (Appendix) on the relationship between induced abortion and women's mental health that reached the following conclusions:

'The specific issue of whether or not induced abortion has harmful effects on women's mental health remains to be fully resolved. The current research evidence base is inconclusive – some studies indicate no evidence of harm while other studies identify a range of mental disorders following abortion.'

This careful and hedged position contrasts starkly with the confident statement made by the Royal College of Psychiatrists in 1994 (Royal College of Psychiatrists, 1994):

'The Royal College of Psychiatrists finds the risks to psychological health from termination of pregnancy in the first trimester much less than the risks associated with proceeding with a pregnancy that is clearly harming the mother's mental health. There is no evidence in such cases of major psychiatric risk or long-lasting psychological distress.'

The contrast between the recent statement and the 1994 statement arises from a growing body of evidence that has suggested that women may be at an increased risk of mental disorders (notably major depression, substance misuse and suicidality) following abortion (Gissler *et al*, 1996; Reardon & Ney, 2000; Reardon & Cogle, 2002a; Reardon & Cogle, 2002b; Cogle *et al*, 2003; Reardon *et al*, 2003; Rue *et al*, 2004; Broen *et al*, 2005; Cogle *et al*, 2005; Broen *et al*, 2006; Fergusson *et al*, 2006; Pedersen, 2007). At the same time, not all studies have found this (Zabin *et al*, 1989; Gilchrist *et al*, 1995; Major *et al*, 2000; Schmiede & Russo, 2005; Rees & Sabia, 2007; Taft & Watson, 2008) with the result that there have been ongoing debates about the extent to which links between abortion and mental health may be explained by methodological artefacts relating to the ascertainment of exposure, the ascertainment of outcome and control of confounding factors. These

divisions within the field have been heightened by an unfortunate tendency for research findings to coincide with the positions that authors have taken in the pro-life/pro-choice debates.

All of these difficulties were well illustrated by a recent and very public exchange that took place in the pages of the *British Medical Journal*. This dispute concerned the findings of two groups of researchers who had used data from the US National Longitudinal Study of Youth (NLSY) to examine links between abortion and major depression in young women. The first paper was prepared by Reardon & Cogle (2002a), who were aligned with the US pro-life Elliot Institute. Their research found that married women exposed to abortion had odds of major depression that were 2.38 (95% CI 1.09–5.21) times of married women who had unwanted pregnancy but did not seek abortion. These findings held after control for a number of prospectively-measured covariates. In a second paper, Schmiede & Russo (2005) re-analysed the NLSY data and produced an analysis that purported to show that, when a different sample selection method was employed, there was no significant association between abortion and depression (full sample OR=1.33, 95% CI 0.84–2.10). In contrast to the pro-life authorship of the first paper, the authorship of the second paper included at least one author with a strong and publicly stated pro-choice position.

These findings attracted a lively but unresolved debate in the pages of the *British Medical Journal* (Kahn *et al*, 2002). However, many of the disputants in this debate overlooked the fact that the data gathered in the NLSY were simply not of the quality required to produce a compelling conclusion about the linkage between abortion and mental health. The NLSY data contained three major flaws that prevented clear conclusions from being drawn. First, estimates suggested that only 40% of those exposed to abortion reported this fact (Jones & Forrest, 1992). Second, the measurement of outcome



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was based on a single measure of depression that was assessed up to 10 years following the abortion. Third, there was limited ascertainment of pre-abortion mental health and other confounding factors. Each of these problems poses a major threat to study validity (Rothman & Greenland, 1998) and together they made the NLSY data a very unpromising basis for resolving the complex issue of whether exposure to abortion increases (or decreases) the risk of mental health problems.

The difficulties that arose in the analysis of the NLSY reflect the complications that arise in resolving a highly emotive topic using often limited data and databases. These problems have tended to recur throughout the literature, with the result that no published study to date is immune from criticisms regarding the adequacy of sampling, measurement and control of confounding. Given this situation, it is perhaps not surprising to find that the only sound conclusion that may be drawn about the linkages between abortion and mental health is that the current evidence base is not strong enough to draw clear conclusions about the linkages between mental health and abortion. The Royal College of Psychiatrists' statement (2008) clearly and carefully reflects these concerns. However, the uncertain linkages between abortion and mental health raise a number of important issues that require resolution.

The first of these issues concerns the research and research designs that will be needed to clarify the unresolved debates about the links between abortion and mental health. Here, a range of design options should be considered. These include longitudinal studies of the mental health of women of child-bearing age; case-control studies to examine the role of abortion as a risk factor for mental health problems; twin and sibling studies to control for non-observed confounders; in-depth qualitative research into the reactions of women following abortion; and randomised controlled trials of interventions designed to reduce risks of mental health problems following abortion. By themselves, none of these research designs will resolve the complex debate about the relationship between elective abortion and mental health, but collectively they may lead to greater insight and understanding of these issues.

In proposing the need for further research there is a further complication that needs to be recognised. The issue of abortion is a highly emotive and polarised topic. As a consequence, to produce a resolution of debates in this area will require the development of a body of evidence that is sufficiently compelling to change strongly held and entrenched views about the costs and benefits of induced abortion. The central difficulty in this field is that relatively weak evidence has been used to challenge (or support) strong and polarised opinions. The inevitable consequence of this is that reviewers of this evidence have had considerable latitude to reconstruct the available evidence in ways that support their particular viewpoint. This state of affairs will continue for as long as we have to rely on the current and inconclusive evidence base.

An important but unexplored feature of the Royal College of Psychiatrists' statement relates to the extent to which mental health concerns are a justifiable ground for abortion. It is important to note that current debates about abortion concern the extent to which abortion may have *harmful* effects on mental health. However, within the UK, issues about the linkages between abortions and mental health extend beyond showing that abortion does not have harmful effects. The 1967 Abortion Act (Office of Public Sector Information, 1967), as amended under section 37 of the Human Fertilisation and Embryology Act 1990 (Office of Public Sector Information, 1990), requires that abortion may only be conducted on a number of grounds. Of these grounds, the most common reasons for abortion are under: 'a: The continuance of the pregnancy would involve risk, greater than if pregnancy were terminated, of injury to the physical or mental health of the pregnant woman . . .'. In practice, in the region of 94% of abortions in the UK are justified on the grounds that continuance of the pregnancy would pose risk to the mental health of the mother (Department of Health, 2004). However, to provide such a justification requires strong evidence showing that the mental health risks of unwanted childbirth outweigh the mental health risks of abortion. Although decisions on whether to proceed with induced abortion are made on the basis of clinical assessments of the extent to which abortion poses a risk to maternal mental health, these clinical assessments are not currently supported by population-level evidence showing the provision of abortion reduces mental health risks for women having unwanted pregnancy. The available evidence on the benefits of abortion focuses on the way in which abortion may improve the life opportunities of women in the areas of education, reduction of poverty and welfare dependence, and related outcomes (Zabin *et al*, 1989; Bailey *et al*, 2001; Fergusson *et al*, 2007). The hiatus that exists between the evidence on the beneficial consequences of abortion and the current demands of British law highlights the complex issues that arise in developing a strictly psychiatric justification for induced abortion. These complexities are considered in the last paragraph of the Royal College of Psychiatrists' report:

'These difficult and complex issues should be addressed through additional systematic reviews led by the Royal College of Psychiatrists into the relationship between abortion and mental health. These reviews should consider whether there is evidence for psychiatric indications for abortion.'

It is unlikely that these problems of evidence, uncertainty and the law will be resolved by further medico-legal debates between pro-life and pro-choice advocates. What is required is a well-designed, well-funded and, above all, impartial programme of research into the mental health risks, benefits and consequences of abortion. The recent Royal College of Psychiatrists' statement makes an important contribution to this process by highlighting the real uncertainties that exist in the current evidence on abortion and mental health.



Appendix

Position Statement on Women's Mental Health in Relation to Induced Abortion 14th March, 2008

In the Government Response to the Report from the House of Commons Science and Technology Committee on the Scientific Developments Relating to the Abortion Act 1967, the following request was made:

'In view of the controversy on the risk to mental health of induced abortion we recommend that the Royal College of Psychiatrists update their 1994 report on this issue'

The College has undertaken a literature review to inform the following position statement, which includes the recommendation that a full systematic review around abortion and mental health is required.

The Royal College of Psychiatrists is concerned to ensure that women's mental health is protected whether they seek abortion or continue with a pregnancy.

Mental disorders can occur for some women during pregnancy and after birth.

The specific issue of whether or not induced abortion has harmful effects on women's mental health remains to be fully resolved. The current research evidence base is inconclusive – some studies indicate no evidence of harm, while other studies identify a range of mental disorders following abortion.

Women with pre-existing psychiatric disorders who continue with their pregnancy, as well as those with psychiatric disorders who undergo abortion, will need appropriate support and care. Liaison between services, and, where relevant, with carers and advocates, is advisable.

Healthcare professionals who assess or refer women who are requesting an abortion should assess for mental disorder and for risk factors that may be associated with its subsequent development. If a mental disorder or risk factors are identified, there should be a clearly identified care pathway whereby the mental health needs of the woman and her significant others may be met.

The Royal College of Psychiatrists recognises that good practice in relation to abortion will include informed consent. Consent cannot be informed without the provision of adequate and appropriate information regarding the possible risks and benefits to physical and mental health. This may require the updating of patient information leaflets approved by the relevant Royal Colleges, and education and training to relevant health care professionals, in order to develop a good practice pathway.

These difficult and complex issues should be addressed through additional systematic reviews led by the Royal College of Psychiatrists into the relationship between abortion and mental health. These reviews should consider whether there is evidence for psychiatric indications for abortion.

Declaration of interest

None.

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