



consequences of abortion

By Andrew Fergusson and Peter Saunders

Abortion is now more common than ever in the UK and parliamentary review of abortion legislation is imminent. There has been much new evidence recently about serious physical and psychiatric consequences for women. This evidence base needs to be considered in the context of contemplating changes to the law, and should be incorporated into updated guidance for health professionals and into comprehensive counselling for women.

In 2003 we considered abortion in *CMF File 23*, but we concentrate here on the consequences of abortion. It is timely to review these.

First, the total number of abortions in the UK continues to rise, reaching the highest level ever in 2006 at 201,173 in England and Wales and a further 13,081 in Scotland, bringing the total to a record 214,254. Almost one in four pregnancies in England ends in abortion,¹ and it is widely acknowledged that one woman in three in England now has an abortion at some point.

Secondly, there has been much new evidence since 2003 of serious physical and psychiatric consequences for the woman, such that the guidance to women from two medical Royal Colleges must be updated.

The third reason why review is timely is that 27 October 2007 marks the 40th Anniversary of the passing of the 1967 Abortion Act. Coincidentally, in the 2007-

2008 session of Parliament the Human Tissue and Embryos bill is expected to be debated. Although this deals with other matters and does not currently mention abortion at all, its scope is so broad that either side of the abortion debate can put down amendments to abortion legislation. This happened in 1990 when abortion law was last amended on the back of the bill that became the Human Fertilisation and Embryology Act.

As amended in 1990, the current legal grounds for abortion in the UK can be seen in the box. Over 98% are performed under grounds C and D.

Consequences for the woman

Short term complications

The Royal College of Obstetricians and Gynaecologists lists² the major acute complications of abortion as:

- Haemorrhage – the RCOG calls this risk ‘low’ because it complicates around 1 in 1,000 abortions overall
- Uterine perforation at the time of surgical abortion – ‘moderate’: 1-4 cases per 1,000
- Uterine rupture in association with mid-trimester medical abortion – ‘very low’: well under 1 in 1,000
- Cervical trauma during surgical abortion – ‘moderate’: no greater than 1 in 100
- Failed abortion and continuing pregnancy – necessitating a further procedure. The risk for surgical abortion is around 2.3 in 1,000 and for medical abortion between 1 and 14 in 1,000 (depending on the regimen used and the experience of the centre)
- Post-abortion infection – up to 10% of cases

These problems are usually obvious early on, are generally short term, and are successfully managed by gynaecologists. In the last few years there has been

growing awareness of the following longer term complications, which are more likely to present to paediatricians, psychiatrists, and surgeons and oncologists.

Grounds for permitting abortions under the current UK legislation

A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated (applies up to term)

B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman (applies up to term)

C 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 (applies up to 24 weeks' gestation)

D the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman (applies up to 24 weeks' gestation)

E there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped (applies up to term)

OR
in emergency, certified by the operating practitioner as immediately necessary:

F to save the life of the pregnant woman

G to prevent grave permanent injury to the physical or mental health of the pregnant woman

Subsequent preterm delivery

The RCOG's 2004 guidance states that 'abortion may be associated with a small increase in the risk of subsequent miscarriage or preterm delivery'.³ However, there are many recent and methodologically robust studies which have investigated the association between abortion and subsequent preterm delivery and these give cause for greater concern than the RCOG's guidance suggests.

The link [with preterm delivery] is significant for health outcomes in subsequent pregnancies

Thorp et al published a detailed review in 2003. They had analysed results for 24 published studies⁴ and reported that 12 found a positive association between abortion and subsequent preterm delivery, with increased risk ratios which were consistently between 1.3 and 2.0. This means that if the woman had undergone a previous abortion, then compared to a similar woman who had not, she was at least 1.3 times and as much as 2.0 times more likely to give birth significantly early in a subsequent pregnancy. Seven published studies found a 'dose-response' effect: the more induced abortions there had been, the more the risk estimate increased.

Rooney and Calhoun's review⁵, also published in 2003, showed that at least 49 studies had demonstrated a statistically significant increased risk of premature birth or low birth weight following an induced abortion. Again most studies showed a dose response relationship. Only eight failed to show an increased risk of preterm delivery, and none demonstrated any protective effect of previous abortion.

This association is further supported by two more recent European studies (EPIPAGE⁶ and EUROPOP⁷). The link is significant for health outcomes in subsequent pregnancies, with all that means for the couple involved and for their baby, but it is also very significant

in terms of economic costs for the family, for the National Health Service, and for society. Extremely preterm delivery is associated with a high risk of neonatal death and of permanent brain damage causing long term disability. The lifetime costs of care when a baby is born with such disabilities are considerable.

Because approximately 50% of all abortions in England and Wales are undertaken in women under 25, whereas 75% of all live births occur to mothers aged over 25⁸, most women considering abortion will subsequently deliver one or more live children, who will face these risks.

Only recently has the full extent of this association been appreciated. The RCOG guidance should be updated and all women should be adequately counselled about abortion and this particular risk for subsequent pregnancies.

Serious psychiatric consequences

Two medical Royal Colleges have been dismissive of the significance of any links between abortion and mental health consequences. The Royal College of Psychiatrists (RCPsych), in a 1994 statement which does not appear to have been revised subsequently, has stated that it 'finds that the risks to psychological health from the termination of pregnancy in the first trimester are much less than the risks associated with proceeding with a pregnancy which is clearly harming the mother's mental health. There is no evidence in such cases of an increased risk of major psychiatric disorder or of long-lasting psychological distress.'⁹

Any association [with psychiatric complications] has effectively been dismissed as incidental

Hitherto, whenever possible psychiatric complications of abortion have been considered, any association has effectively been dismissed as incidental, rather than that the abortion had caused the psychiatric situation. For example, the RCOG guidance stated in 2004¹⁰ that 'some studies suggest that rates of psychiatric illness or self-harm are higher

among women who have had an abortion compared with women who give birth and to nonpregnant women of similar age. It must be borne in mind that these findings do not imply a causal association and may reflect continuation of pre-existing conditions.'

It is possible though to design studies to eliminate the effect of such possible 'confounders'. Since 2000, there has been much evidence from around the world in robust and methodologically sound controlled studies that abortion does cause the following:

- **Increased psychiatric hospitalisation** – admission rates to psychiatric institutions were higher for women who had undergone abortion than for women who had given birth, when those with a prior psychiatric history were excluded¹¹
- **Increased psychiatric outpatient attendance** – outpatient funding claims were higher in the post-abortion group when prior psychological problems were controlled¹²
- **Increased substance abuse during subsequent pregnancies carried to term** – women who had undergone abortions were significantly more likely than women who had not to abuse cannabis, other illicit drugs and alcohol during a subsequent pregnancy¹³
- **Increased death rates from injury, suicide, and homicide** – shown in a long term controlled study in Finland conducted between 1987-2000¹⁴
- **Higher rates of major depression, suicidal ideation, illicit drug dependence, and overall mental health problems** – the careful study design confirmed that these increased rates were not due to prior vulnerability, and because this landmark 2006 controlled population study¹⁵ was carried out in New Zealand, it represents a population closely comparable to the UK one.

There is some anecdotal evidence from women's accounts that abortion seems to resolve the pressing social problems that precipitated their request for abortion and therefore reduces their stress, just as there is anecdotal evidence to the contrary. However, the quantitative evidence base

that abortion causes significant rates of serious mental health problems is now so overwhelming that the American Psychological Association has removed its guidance from its website and is reviewing it. The RCOG guidance should be updated and the RCPsych should urgently produce new guidance.

This is particularly so as the Commission of Inquiry into the Operation and Consequences of the Abortion Act¹⁶ heard as long ago as 1994 from witnesses who were members of the Royal College of Psychiatrists that ‘although the majority of abortions are carried out on the grounds of danger to the mother’s mental health, there is no psychiatric justification for abortion’. The Commission concluded that to perform abortions on this ground was not only questionable in terms of compliance with the law, but also put women at risk of suffering a psychiatric disturbance after abortion without alleviating any psychiatric problems that already existed.

Psycho-social consequences

The preceding section considered serious psychiatric consequences, major mental health problems, but there is also much qualitative evidence in women’s accounts of psycho-social consequences. One of the country’s two leading Christian groups involved in post-abortion counselling lists¹⁷ the following common complaints:

- Feeling the need to ‘replace’ the baby
- A feeling of distance from or, conversely, over-protectiveness of existing children
- Inability to maintain normal routine
- Depressed feelings stronger than ‘a little sadness’
- Sleeping problems
- Flashbacks
- Tearfulness
- Relationship tensions or breakdown resulting from the abortion

Another source¹⁸ lists symptoms specific to post-abortion reactions as:

- Anniversary syndrome – an increase of symptoms around anniversary dates of the conception, abortion or due date
- Anxiety over infertility

- Avoidance behaviours – avoiding pregnant friends, babies, vaginal examinations
- Eating disorders
- Inability to bond with children
- Preoccupation with becoming pregnant again – atonement babies
- Psychosexual disorders – inability to engage in sexual activity or sexually acting out
- Sudden, uncontrollable crying

A possible link with breast cancer

Breast cancer rates have been rising in Europe and North America for several decades and are projected to rise further.¹⁹ There is evidence suggesting that having an abortion may increase a woman’s risk of breast cancer in later life.²⁰ A 1997 review that pooled 23 studies found that the risk increased by 30%²¹ but authors of a 2001 review have denied a link.²² There are clearly powerful vested interests on both sides of this debate and space precludes the necessary in-depth review. However, it is undisputed that a full term pregnancy protects against subsequent breast cancer, and that significantly

The link [with breast cancer] is therefore biologically plausible

preterm deliveries make it more likely. The link is therefore biologically plausible.

While it may be prudent to acknowledge that ‘the jury is out’ with regard to a possible link between abortion and risk of subsequent breast cancer, further research is needed to conclude the debate. In the meantime, and in the interests of informed consent, every woman considering abortion should be offered as much information about the possible risks as she wishes.

Implications for informed consent

While the extent of some of these risks to the woman may still be uncertain, acknowledging that they definitely or possibly exist has significant implications for the question of informed consent. It is universally accepted within medical ethics that patients agreeing to any interventionist procedure must know

enough about the possible side effects to be able to make their own balanced judgments as to whether they wish to proceed. The guidance issued by the relevant medical Royal Colleges, of Obstetricians and Gynaecologists, and of Psychiatrists, must be updated.

Consequences for the father

There has been very little research, so that little is known about the effect of abortion on the fathers. Many men of course never learn from the woman in question that

Abortion diminishes the significance of fatherhood

she has become pregnant, but where they have been informed, abortion diminishes the significance of fatherhood. Men have no legal rights to stop the abortion of their children. Experience suggests that only a quarter accompany their partners when they go to apply for a termination, and the other 75% are never sought by general practitioners or by the clinics. This significant interpersonal event thus becomes treated by all as if only one person, the woman, were involved.

Consequences for siblings

There is anecdotal evidence that, following an abortion, other children in the family may experience depression, obsessions about babies, or eating or sleep disorders. It has been suggested that a living child may identify with an aborted sibling. More research should be conducted in this area.

Consequences for society

There are two ways in which the practice of abortion affects whole societies – quantitatively through the numbers of children actually born, and qualitatively through the effect abortion has on attitudes and other behaviour.

Demographic considerations

In England almost one pregnancy in four ends in abortion, and this contributes significantly to the fact that total fertility rates are now well below the rate needed for population replacement. In other

words, not enough children are being born to replace the adults who die, and were it not for immigration, the total population number would be falling. At the same time, people are living longer so together with this increase in longevity, the decline in the birth rate (with consequent reduction in the numbers of those of working age) strains the funding of pensions and National Insurance, with consequent pressures on health and social services. At current rates the problem will worsen.

Should liberalising amendments on abortion law come before Parliament, such that if they were passed the total number of abortions would be likely to increase, the medium and long term demographic implications must be taken into account.

Effects on attitudes and ethics

When considering the broad field of abortion, CMF commented previously that 'a permissive attitude to abortion devalues(s) our appreciation of fellow human beings'.²³ For example, it is frequently argued in the debates over euthanasia and physician assisted suicide that it is illogical for a society which permits liberal abortion to deny doctor assisted

dying. If doctors can perform abortions (a procedure which always has 50% mortality – one of the doctor’s two patients always dies) but where the fetus has no say in the matter, why should the law not be changed to allow doctors to end life when a competent patient repeatedly requests it?

Time for change

40 years... 6.7 million abortions... Time for change! is the rallying cry for a newly established network seeking to reduce the number of abortions performed in the UK.²⁴ The supporting organisations within that network are, through their separate ministries, seeking to build on the conclusion to the last *CMF File* on the subject: 'As a hospitable community we should seek ways of providing support for lonely and frightened mothers, and for lonely and abandoned babies. In following Christ's example of compassionate love we need to offer women with unplanned pregnancies as much love and support as they require and to assist them in finding compassionate alternatives to abortion.'

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Resources

British Victims of Abortion and BVA Foundation offer:

- Support to those struggling in the aftermath of a personal abortion experience
- Free, confidential, one-to-one counselling, telephone counselling and where possible support group counselling
- Literature (mailed discreetly on request)

Web www.bvafoundation.org

Tel 0845 603 8501 (office hours Monday to Friday, and 7-10pm every evening of the week. All calls charged at local rate.)

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