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Editorial

You say "regret" and I say "relief": a need to break the polemic about abortion

Justice Kennedy writing for the majority in Gonzales *v.* Carhart (2007) posited that despite "no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained [and that] severe depression and loss of esteem can follow" [1]. This sentiment reflects a key message of the antichoice movement, namely, that "abortion hurts women." Given their claims and validation of their beliefs from the highest court, abortion rights opponents are pushing for new mandatory counseling legislation geared at telling women about the risks associated with abortion. Although some of these laws target preventing coerced abortion, others focus on the risk of regret and/or the potential for long-term psychological harm. These laws ostensibly seek to benefit women by providing them with information about abortion. Therefore, opposition to these laws by reproductive health and rights advocates appears unsupportive of women.

One problem with the laws is that the information conveyed may be inaccurate. What does the literature tell us about whether women are harmed psychologically by abortion? The answer to this question begins with a caveat: abortion happens only in the context of an unwanted pregnancy, and it is impossible to attribute psychological responses assessed after an abortion to the abortion per se. Because it is impossible to randomize women to abortion or delivery, no research addresses the issue conclusively. Despite these limitations, the best literature to date concludes that there is no evidence of psychological harm from abortion [2–6] and that the most reliable predictor of a woman's mental health after an abortion is prepregnancy mental health [4,7]. In addition, the literature reports that "relief" is the most common experience for women after an abortion [3].

The scientific consensus that abortion is not harmful to women is being challenged in recent papers that report higher rates of depression, anxiety, suicide, substance abuse and psychiatric admissions among women who have had abortions [8–18]. These studies are being used to justify the new laws informing women of the harms of abortion. However, they suffer from serious methodological flaws including inadequate control groups, small sample size, limited follow-up, poorly defined measures, reporting bias, and failure to control for prior mental health and other confounding factors [19]. The results of several of these studies have been significantly debated in the literature [19,20].

This editorial aims to stimulate a conversation within the reproductive health community about how to meet women's needs for information regarding abortion without ceding ground to those who use these needs to develop regulations that will make abortion illegal and/or less available. While critically important to us as scholars and clinicians, the public does not understand the mechanics of research and the problems of establishing causality. Instead, there are high levels of support for new mandatory counseling laws [21]. Given this reality, a new approach to the discussion of abortion and informed consent is needed, one that breaks the relief/regret polemic and better answers the claim that abortion hurts women. We suggest an approach that is grounded in the shared values of supporting women's emotional well-being, guaranteeing access to accurate health information and ensuring women's autonomous decision making.

We recognize that not all supporters of the new laws are hard-core opponents of abortion. Some proponents genuinely care about the wellbeing of women. The message "women are hurt by abortion" may resonate with them because they see abortion as a complicated social and personal issue. Some see it as ending a potential life and do not want the abortion decision to be taken lightly. Still others have personal experience with abortion — a decision they made, know to be the correct one but one they wish they did not have to make. We acknowledge these feelings among those motivated by genuine concern for women's wellbeing. We need to provide those who have such feelings with an understanding of why new laws that transmit misinformation and force a one-size-fits-all approach to the clinical care experience are not the way to promote women's wellbeing. Rather, individualization of care and counseling promotes health and well-being.

It is also important to look more closely at the laws themselves and ask why they are being promulgated. Forcing health professionals to tell women that they may be psychologically harmed by abortion does not represent informed consent. As noted earlier, there is no basis to assert

that an abortion by itself will cause harm. Telling a woman that it may do so perverts the informed consent process; it imparts information that is scientifically inaccurate and forces health care providers to give women information which they know is wrong and with which they do not agree. These laws do not help a woman make a better decision and, more seriously, create hardship and harm. The laws often stipulate a "waiting period" or other restrictions that are justified as giving women time to make a better decision. The true intent, however, may be to place more obstacles in the path of women seeking abortions. The need to wait may preclude some women from using abortion services. This requirement does not help women make a better decision; to the contrary, it takes that decision away from many. Ironically, it may force some to seek illegal abortions, which puts them at far greater risk.

Abortion is not an easy issue for most women. It is a complicated life decision in a situation where there is no easy option. Thus, women can experience a range of emotions, from sadness to elation and everything in between, and even many emotions simultaneously. Women can regret their abortions just as they can celebrate them. Complex feelings are a normal part of major life decisions, and having strong feelings, even negative ones, does not represent pathology [22]. Women do not need to be protected from their emotional responses to abortion. However, as with any stressful event, some women will have more severe responses; these women need support and access to mental health services.

In all of the discussions about abortion and mental health, we must never lose track of context. Women are likely to have complicated feelings about the aspects of their lives that led up to the abortion decision: sex, contraception, partnership status, economic conditions, motherhood potential, etc. In some cases, the unwanted pregnancy may be linked to abuse or violence. The alternative to abortion for women who will receive "informed consent" information is not never having become pregnant in the first place. If women experience depression and loss of esteem as Justice Kennedy expects some will, these may well be due to some of these contextual factors which led to the need for an abortion rather than to the abortion itself. Telling a woman that she will suffer a litany of negative outcomes from her abortion will not resolve the circumstances that contributed to the pregnancy. Moreover, it is not neutral to provide such information to the extent that it fuels a "self-fulfilling prophecy": women who expect to feel distress may be more likely to do so. Thus, the provision of this kind of "informed consent" information may serve to increase negative psychological responses.

There are many unknowns in the world of women's mental health and abortion. Although consistent with the data, simply claiming that "most women feel relief" ignores the complex emotional experiences of women seeking abortion and does not advance our overall goal of promoting women's health and well-being. We need to develop a new body of knowledge regarding what emotional support women want and need along with their abortion care. It should capture the lived and embodied experiences of women who have abortions alongside the clinical trials, psychometric scales and statistical analysis of population level databases. To do this, we need to partner with the women themselves and not be afraid to acknowledge the full range of feelings women have about abortion.

An enriched understanding of the complexity of the abortion experience and of the substantial individual variation will allow a more constructive conversation about informed consent. We can validate the concerns of the general public and the feelings women have about their abortion, while simultaneously rejecting the policy solutions that would ban or limit abortion. This returns the focus to where it needs to be: on a health care experience that validates women, promotes their access to pertinent information and allows them to make their own decisions. Under any circumstance, some women will have mental health needs, and policy propositions should include funding for mental health services for women who want and need them. A woman should be able to trust that the information she receives from her health care provider is accurate, free of bias and provided in language that promotes health and wellbeing, not shame. The proposed laws violate these core principles. Intrusions into health care relationships that are neither evidence-based nor therapeutic are counterproductive. Every woman should have the opportunity to make the best decision for herself, whether that decision is to raise a child, release a child for adoption, or have an abortion. We need less research on the "harm" or benefit of abortion and more research on how to provide the best care to all women, tailored to their individual needs.

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