UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

	:	
WOMEN'S MEDICAL	:	CIVIL ACTION NO. C-3-00-368
PROFESSIONAL CORPORATION,	:	
et al.,	:	Judge Walter H. Rice
Plaintiffs,	:	
	:	
v.s.	:	REPORT TO COUNSEL OF DEFENDANTS FROM MENTAL HEALTH EXPERT PHILIP G. NEY, M.D., M.A., F.R.C.P.(C.), F.R.A.N.Z.C.P., R. PSYCH.
ROBERT TAFT, et al.		

I. Introduction

I have been asked by the counsel for the defendant to
1. review the research related to this action,;
2. comment from my clinical experience with people who have been affected by pregnancy losses, particularly abortion, and;
3. to review and comment on other reports.

I am to provide an opinion based on my knowledge and experience regarding the impact of HB 351 on the mental health of women who might or might not have a partial birth abortion. I understand this is the state of Ohio's second attempt to ban partial birth abortions. I further understand that Dr. Martin Haskell who performs the intact partial birth abortion procedure in Ohio has sued the state in an attempt to stop the bill from going into effect. I also understand the Attorney General of Ohio is attempting to uphold the constitutionality of this bill. I understand the statute prohibits a physician from knowingly performing a partial birth abortion when the procedure is not necessary, in reasonable medical judgement to preserve the life or health of the mother as a result of the mother's life or health being endangered by a serious risk of the substantial or irreversible impairment of a major bodily and mental health function. I understand Dr. Haskell claims this bill fails to include an exception that would allow the procedure to be performed so as to protect the mental health of the mother. In regards to the above I am being asked to specifically comment on either any real or possibly real instances where the mental health of the mother would be put at risk if the partial birth abortion was not available to her. I am also being asked to comment on the science related to mental health indications or contraindications for an abortion.

In preparation for this opinion, I have;
1. Perused the following documents:
    1. Mary K. Crawford, Assistant Attorney General. Letter of 08/25/00
    2. Declaration of Martin Haskell, M.D. dated 07/25/00
    3. Declaration of Rein Siiner, M.D. dated 07/26/00
    4. Report of Barbara Brewer, Ph.D. undated
    5. Court transcripts of the testimony of Jane Doe No. 1 and Jane Doe No. 2
    6. Court transcript of the testimony of Barbara Brewer Ph.D
2. Conducted a MedLine search of the most recent literature under the following headlines:
    1. abortion, depression (7 references)
    2. abortion, hazards (597 references)
    3. induced abortion, indications (274 references)
    4. induced abortion, consequences (179 references)
    5. termination for fetal anomalies (20 references)
    6. partial birth abortion, psychological effects (0 references)
    7. partial birth abortion, mental health indications (0 references)
    8. partial birth abortion, benefits (0 references)
    9. D&X abortion (35 references, nothing relevant)
    10. abortion techniques, comparisons, partial birth (no references)
    11. abortion techniques, comparisons, D&X (no references)
3. Reviewed my own publications and research pertinent to this case.

4. Further analysed data from our own studies.
5. Considered the histories of present and past patients in my practice.

II. Informed Consent

General Scientific Considerations

In responding to the questions raised by the court, it is necessary to understand:

A. The legal impositions on physicians regarding the quality and control of their practice.
B. What scientific studies have found regarding the mental health benefit, lack of benefit or adverse reactions to the patient regarding any surgical procedure in general and the partial birth abortion in particular.
C. In making a recommendation for treatment, how the potential benefits or hazards are explained by a physician to potential patients and how that explanation helps them make a decision which in turn affects their psychological response to the procedure.
D. Analyse the claims of those who perform or support partial birth abortions of the benefit that accrues to patients to determine their validity in the light of clinical experience and scientific scrutiny.

III. History

From the dawn of western medicine, those who perform or recommend any surgical, medical or psychiatric procedure are encumbered with the burden of proof to show beyond reasonable doubt that the procedure is both beneficial and safe for any given medical, surgical or psychiatric condition in general and their patient's condition in particular. Patients who are subjected to unproven remedies and have adverse medical, surgical and psychiatric sequellae are becoming increasingly vociferous in their complaint and determined in seeking redress for their unwarranted injuries. This does not mean that every medical procedure must be without hazard, but it does mean that the benefit must substantially outweigh the hazard. In desperately ill patients with few options left it is recognized that patients might choose an experimental procedure, but before they do so they must be informed of the experimental nature of that procedure.

IV. Medical Mandate

Whenever treating any condition, the physician is obligated to provide the most effective, least hazardous and the least expensive treatment available. This becomes the standard treatment. If physicians perform anything but standard treatment and there are any untoward effects they have opened themselves to litigation. "All physicians must use recognized generally accepted methods to establish diagnosis. Unconventional or unproven methods of diagnosis can only be used as an adjunct to generally accepted methods. The patient must be informed of the unproven nature of such a diagnostic method."[1]

[1] College of Physicians and Surgeons of British Columbia. Policy Manual 1995; U 2-1.

"The physician must offer the most effective generally accepted treatment to the patient. Treatment options, including potential risks and benefits, must be explained to the patient. The potential risks of refusing treatment must be explained. If a physician elects to use other than accepted standard treatment, that physician should be able to demonstrate that standard methods have been offered and explained to the patient and that the non-standard treatment option has been selected by the physician and the patient. The patient must be informed that the treatment is unconventional and unproven. The physician may consider unconventional treatment if there is no proven, accepted remedy for the patient's condition or if conventional treatment has been ineffective. Such unconventional treatment must be either harmless or the potential benefits must outweigh the risks. The deliberate avoidance by the physician of conventional or potentially curative treatment in the management of acute illness is unacceptable."[2]

If any physician has been providing a particular procedure, convinced that it is the best treatment for a particular condition, he/she must cease the procedure if (1) his/her own follow up with patients indicates there are hazards or there is little benefit, (2) there are reports of untoward side effects or (3) he/she is advised to do so by colleagues who have; i) found serious side effects, ii) discovered a more effective treatment.

The physician, in making his or her decisions and recommendations, must consider; 1) his or her qualifications to perform the procedure, 2) the results of his or her own follow up evaluation, 3) scientific evidence of benefit or side effects, 4) any contraindications 5) established risks, 6) recent reports of any hazards, 7) the patient's particular condition and personal situation.

Because the burden of proof lies with the physician or agency that performs or supports a surgical procedure to prove beyond reasonable doubt that it is effective treatment, safe treatment and better than no treatment or better than any other treatment, Dr. Haskell or any other person must show that abortion is safe, effective treatment for any given condition. It is not my or any other physician's responsibility to show that abortion is ineffective or hazardous treatment. If I, on the strength of *a priori* argument state, "Abortion is unlikely to be effective treatment for any mental condition." he must prove me wrong. If I can cite one case in which there have been deleterious effects resulting from abortion and I caution against abortion as treatment, Dr. Haskell or any other person performing or recommending abortions must prove me wrong.

V. Literature Review

Before 1940, almost all indications for therapeutic abortions were medical. After this date, there was increasing use of psychiatry to extend the range of indications for therapeutic abortions. By the 1950's, psychiatric reasons accounted for more than 50% of all abortions. Presently in countries where physicians are required to stipulate the reason for abortion, over 90% are for so-called "psychiatric reasons." These are usually "reactive depressions." It seems that psychiatry was exploited in an attempt to satisfy a

[2] College of Physicians and Surgeons of British Columbia. Policy Manual 1995; U 2-1.

social need within the context of the medical model. Most obstetricians will agree there are few, if any, medical indications for abortion. If a broad definition of medical necessity is used, it is variously estimated that between 2-5% of abortions are done for medical reasons. If another 5% are done for eugenic reasons, over 90% of abortions are justified on the basis of poor mental health.

The vast majority of abortions done in North America and Europe are on the basis of either social or psychological factors. Where the grounds are unequivocally stated, over 85% of abortions are for allegedly psychiatric reasons. In many statistical reports this figure is closer to 95%.[3]

A. Evidence supporting the need for abortion in psychiatric conditions

There has been no research even attempted to show any kind of abortion is indicated for any known psychiatric condition. The studies that have been done to show abortion is safe are retrospective and of short duration. There are unconvincing reports of beneficial effects; relief, increased personal control, maturity. The studies that show these benefits are not with psychiatric patients, have short periods of follow-up and have low levels of follow-up compliance.

The Canadian Psychiatric Association, after reviewing the research, issued this statement: “The justification of a decision to terminate a pregnancy under pseudo-psychiatric rubrics is to be deplored.”[4] Abortion increases the rate of suicide by 600%.[5] Pregnancy reduces the risk of suicide by a large factor.[6] A recent Medline search found no verifiable mental illness indications for abortion at any stage of a pregnancy.

In a review of the MedLine literature, there were no articles able to demonstrate that abortion is beneficial for any psychiatric or social condition. Those who report benefit usually indicate there has been “relief” following the abortion. As an example, and the most recent study, Major et al[7] contend that 72% of 118 women were satisfied with their decisions to abort. In fact, this represents 72% of 50% of the people who were followed up at two years, which were 85% of those who could have been part of the study, i.e. 30%. Unless Dr. Major is absolutely sure this sub-sample is representative of the whole, she can make no claim of any benefit. Since there was no attempt to ascertain whether

[3] Doane BK, Quigley BG. Psychiatric aspects of therapeutic abortion. *Can Med Assoc J*, 125:427-32, 1981.

[4] Smith CM. *Canadian Psychiatric Association Bulletin* 1981; 13(4): 2-3.

[5] Gissler M et al. *Acta Obstet Gynecol Scand* 76:651-57, 1997. Shelton JD *Public Health Rep* 93;375-8, 1978.

[6] Appleby L. Suicide during pregnancy and in the first postnatal year. *BMJ* 1991;302:137-40.

[7] Major B, Cozzarelli C et al. (2000). Psychological response of women after first-trimester abortion. *Arch Gen Psychiatr*, 57:777-84.

this sub-sample was representative, I cannot understand why the results were published for they are entirely meaningless. The problems of the study were compounded by the fact that "women who consented, completed a pre-abortion questionnaire approximately one to two hours before undergoing a vacuum aspiration abortion."" It is not hard to imagine women in a clinic, having struggled with a difficult decision and still ambivalent about it, most of whom are in intense conflict and often feeling considerable duress, are now confronted by people who are attempting to assess their pregnant state before a significant operative procedure. Surely, this alone invalidates the findings. Dr. Major's bias is apparent in many ways, not the least of which is the way she summarizes the literature. In addition, that Major found only 1% of that follow-up had PTSD is hard to believe since it is generally recognized there is a much higher rate in the general population who have not undergone any type of treatment.

Major admits that negative emotions increased and decision satisfaction decreased over time. Presumably, as women become more aware of the impact of their decision, as they consider having children or having had children, they become more acutely aware of what the abortion really means. At two years, 19% of their cooperative sub-sample stated they would definitely not or probably not have a repeat abortion.

In Major's study, 17% indicated they had experienced physical complications. They found that depression consistently predicted poor abortion mental health and more negative abortion related emotions and evaluations. "Pair wise comparisons indicated that depression levels decreased from T1 - T2 and increased from T2 - T3 and from T3 - T4." This indicates, in fact, that the greater the time interval following abortion, the more likely the woman was to be depressed. "Across time, relief and positive emotions declined and negative emotions increased."

While it might be that there are individual physicians who do late term abortions and claim they are beneficial to people who have psychiatric or emotional illness, they have never published their data. Before they can claim benefit, they either have to cite references or show benefit from follow-up studies of their own practice. Until there is either considerable data to show benefit from abortions in general and late abortions in particular, or until a physician is able to demonstrate from his/her own practice there is long-term psychiatric and social benefit, no physician can do abortions of any kind for psychiatric reasons.

B. Evidence supporting psychiatric benefit to abortion.

There are no studies showing mental health benefit to psychiatric patients. It is generally concluded that the more severely ill a person is psychiatrically, the more likely they are to have psychiatric complications following the abortion. No one has ever proven any kind of psychiatric, psychological or emotional benefit from late term abortion. Any one who claims there is significant mental health improvement has either not followed up their own patients, or has not read the psychiatric literature. Standard psychiatric textbooks state there are no psychiatric indications for abortion. "Patients who were sicker before abortion had more serious post abortion problems." "Patients who were psychiatrically ill before abortions did poorly." "Psychiatric indications for

therapeutic abortions did not stand the test of scrutiny. Women suffering from psychiatric illness before abortion showed no significant improvement after abortion and had more difficulty in coping with the stress of abortion than the psychologically healthier women."[8] The so-called "social indication" of diminishing the rates of child abuse and neglect by making sure unwanted children were not born has never been proven. Evidence shows the opposite is true.[9] Rates of abortion correlate closely with rates of child abuse for a number of important reasons.[10]

C. Hazards.

a) Increased psychiatric admissions.

Using data extracted from the Denmark Centralised National Medical Services Registry, David, Rasmussen and Holst (1981) found the rates for psychiatric admission for aborting women was 18.4 per 10,000 compared to 12.04 for women who delivered their babies.[11] Women who were divorced, separated or widowed at the time of the pregnancy event were found to have admission rates of 63.8 per 10,000 for aborting women and 16.9 for women who delivered their babies. Another Danish study, using data from the Danish Central Psychiatric Register found that the rate for psychiatric admissions, no abortions, was 1.9 %; one abortion, 3.4%; two abortions, 4.0%; three abortions, 6.0%. No such increase was observed in relation to the number of live births.[12]

In our recent study of California Medicaid recipients, we identified a population of 168,551 low income women whose data could be record linked during the first two years after the pregnancy event.[13] Psychiatric inpatient claims rate was 287.4 per

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[8] Babikian HN. Abortion. In: Comprehensive Textbook of Psychiatry. 2nd Ed. Kaplan H, Freedman, AM (Eds.) 1975; Williams and Wilkins: 1496-1500.

[9] Ney PG. Relationship between abortion and child abuse. Canadian Journal of Psychiatry 1979; 24: 610-620.

[10] Ney PG, Fung T, Wickett AR. Relationship between induced abortion and child abuse and neglect: Four studies. Pre- and Perinatal Psychology Journal 1993; 8: 43-63.

[11] David H, Rasmussen N, Holst E. (1981). Post-abortion and postpartum psychotic reactions. *Family Planning Perspectives, 13,* 88-91.

[12] Somers R. (1979). Risk of admission to psychiatric institutions among Danish women who experienced induced abortion: An analysis based upon record linkage. Ph.D. Dissertation. Los Angeles: USC, Dissertation Abstracts International, Order No. 7926066.

[13] Cougle J, Reardon DC, Rue VM, Shuping MW, Coleman PK, Ney PG. "Psychiatric admissions following abortion and childbirth: a record-based study." Presented at "Perinatal Care in a Changing World" Obstetrics and Gynecology Conference, November 9-12, 2000 Banff. Dept. of Ob/Gyn, Faculty of Medicine, University of Alberta, Dept. of Ob/Gyn, Misericordia Hospital (CHHC), Edmonton, Alberta.

100,000 for delivering women and 435.7 per 100,000 for women who aborted their pregnancy. The present study revealed a psychiatric admission rate that was 94% higher among aborting women at 90 days and 81% higher at 180 days post-pregnancy event. Moreover, the gap in rate of admission between aborting and delivering women increased between the first (OR=1.83) and second (OR=2.46) years. Aborting women had a significantly higher rate of psychiatric admission than delivering women at 90 days, 180 days, and during every year of the four years after the first pregnancy event. The rates of psychiatric admission were significantly higher among aborting women at all ages. Differences between groups were greatest among women aged 13-19, a finding consistent with studies indicating that adolescents are more likely than mature women to experience postabortion difficulties (Adler, 1975; Franz & Reardon, 1992; Osofsky & Osofsky, 1972).

Table 1 shows psychiatric admission rates over the four year period stratified by age at the time of the pregnancy event. Aborting women had significantly higher psychiatric admission rates in every age group ($p<.005$). The difference in rates was greatest among women aged 13-19. Aborting women in this age group had an admission rate that was 118% higher than women who carried to term. Rates of psychiatric admission appear to be highest for women who deliver or abort between the ages of 35 and 49. Although this study measured only the rate of inpatient psychiatric care not the prevalence of psychiatric illness, it clearly indicates women are made psychiatrically worse rather than better by abortion.

b) Psychiatric complications following repeat abortions

Research demonstrates that repeat aborters are more likely than first time aborters to suffer from negative psychological reactions. Freeman et al.[14], comparing first and repeat induced abortions, state, “Elevated stress levels were similar in both groups prior to the abortion procedures, particularly depression, anxiety and somatization.” “After abortion, repeat aborters continued to have significantly higher emotional distress scores in dimensions relating to inter-personal relationships.” The fact that pre-abortion scores of repeat aborters were the same as those of first aborters suggests that familiarity with the experience of abortion did not decrease emotional distress. Repeat aborters remained significantly higher on scores of interpersonal sensitivity, paranoid ideation, chronic anxiety and sleep disturbance. Scores were higher on dimensions of somatization, hostility and psychoticism. A Japanese study[15] found that the more abortions a woman had, the more menstrual problems reported, especially “nervousness.”

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[14] Freeman EW, Rickles K, Huggins GR, Garcia C, Polin J. Emotional distress patterns among women having first and repeat abortions. *Obstet et Gynecol*, 55:630-6, 1980.

[15] Roht LH, Fonner MA, Aoyama H, Fonner E. Increased reporting of menstrual symptoms among women who used induced abortion. *Am J Obstet Gynecol*, 127:356-62, 1977.

c) Worsened general health.

We found (1994) in a study of 1428 women representative of all Canadian women attending a family physician for a wide variety of reasons that 34% of them at any point in time felt they needed professional help to deal with their pregnancy loss.[16] Since this was a point estimate, this is a very conservative estimate of all the women who needed professional help to deal with their pregnancy losses at some point in time. We found there was a deterioration in general health, probably due to the fact there was pathological grief. Pathological grief frequently results in depression. In depression, the immune system is not functioning as well and people are more likely to have infections and cancers.

It is generally understood that women are most ambivalent about their pregnancies in the early stages. We found[13] pregnant women become increasingly interested in and attached to their unborn child as the pregnancy progresses. Therefore, those who have late abortions are more likely to experience guilt, grief and the whole range of conflicts and symptoms of the Post-abortion Syndrome.

Berkeley and Humphreys[17] found that in a family physician's office there was an 80% increase in attendance for physical reasons and 180% increase in attendance for psycho-social reasons following abortion. A five year study in Canada showed that aborting women were over eight times as likely to visit a psychiatrist on an outpatient basis compared to women in the general population.[18]

Comparing the various kinds of pregnancy losses and normal outcome, we found there was a statistically significant increase in poor health following abortion as compared to a miscarriage, normal birth or a full term pregnancy. In this study an independent rater, looking at the family physicians charts, the family physician and the patients themselves rated their health.

There are no psychiatric conditions that would endanger the health of the mother that require abortion. If the couple want the baby, physicians can do any kind of medical, surgical or psychiatric treatment. Some of those treatments hazard the health of the baby, but hazarding the health of the baby is not an indication to kill him before hand to prevent the hazard. Though some psychiatric medications may pose a hazard to the unborn baby, that risk is usually small and some medication is much safer than others. In order to protect themselves, most manufacturers, eg. Lilly, state, "Safe use of fluoxetine (Prozac) during pregnancy and lactation has not been established. Therefore

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[16] Ney PG, Fung T, Wickett AR, Beaman-Dodd C. (1994). Effects of pregnancy loss on women's health. *Soc Sci Med*, 38(9): 1193-1200.

[17] Berkeley D, Humphreys PL, Davidson D. (1984). Demands made on general practice by women before and after an abortion. *J R Coll Gen Pract,* 34:310-315.

[18] Badgley RF, Caron DF, Powell MG. (1977). *Report of the Committee on the Operation of the Abortion Law,* Supply and Services, Ottawa. 313-321.

it should not be administrated to women of child bearing potential or nursing mothers unless, in the opinion of the treating physician, the expected benefits to the patient markedly outweigh the possible hazards to the child or fetus." Drug companies are carefully indicating that SSRI (Selective Serotonin Reuptake Inhibitor) medication is not absolutely contraindicated during pregnancy.

If the mothers deem that the potential hazard to the unborn baby is too great and the baby is "wanted" they will opt for more conservative treatments including rest, a secure environment, considerable nurturing, supportive psychotherapy etc. I have treated women who are pregnant and depressed with extensive backgrounds of mistreatment in intensive group psychotherapy with very good results.[19]

d) Increased suicides & death.

An analysis of death certificates and medical records by researchers in Finland revealed a suicide rate among aborting women approximately six times higher than women who delivered and three times higher than that of women in the general population.[20]

Abortion is contraindicated in women who are pregnant and suicidal. Pregnancy and childbirth reduced the risk of a suicide.[6] The number of children a woman has is strongly inversely related to the relative rate of suicide as demonstrated in a 15 years study of over nearly a million women.[21] A sense of family obligations and a fear of hurting one's children is associated with fewer suicide attempts and suicidal thoughts.[22] None of the women, with a prior history of psychiatric problems and who carried to term, subsequently committed suicide over an 8 - 13 year old follow-up, while 5% of those who aborted did commit suicide.[23]

For women with psychological problems, childbirth is likely to reduce the risk of subsequent suicide attempts whereas abortion aggravates the risk. Researchers[24] at

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[19] Ney PG, Sheils CK. Effectiveness of a new technique of group psychotherapy. Annual Meeting American Group Psychotherapy Association, May 2000.

[20] Gissler M, Hemminki E, Lonnqvist J (1996). Suicides after pregnancy in Finland, 1987-94: Register linkage study. *BMJ,* 313:1431-34.

[21] Hoyer G, Lund E. Suicide among women related to number of children in marriage. *Arch Gen Psych*, 1993 Feb;50(2):134-7.

[22] Linehan MM, Goodstein JL, Nielsen SL, Chiles JA. Reasons for staying alive when you are thinking about killing yourself: The reasons for living inventory. *J Counseling Clinical Psychology* 1983;51(2):276-286.

[23] Jansson B. Mental disorders after abortion. *Acta Psychiatr Scand.* 1965;41(1):87-110.

[24] Morgan CM, Evans M, Peter JR, Currie C. Mental health may deteriorate as a direct effect of induced abortion. *BMJ* 1997; 314:902.

the South Glamorgan Health Authority (Britain), population 408,000, reviewed records on admission for suicide attempts both before and after pregnancy events. Among those who aborted they identified a shift from a roughly normal suicide attempt rate before the abortion, to significantly higher suicide attempt rate after the abortion. In the post pregnancy period there were 8.1 suicide attempts per 1000 among those who had abortions compared to 1.9 suicide attempts among those who had given birth. The authors concluded that their data did not support the view that suicide after an abortion was predicted by poor prior mental health or prior suicide attempts. They state, "The increased risk of suicide after an induced abortion may therefore be a consequence of the procedure itself." In some cases the attempted or completed suicides have coincided with the anniversary date of the abortion or expected due date of the aborted child.[25] The record linkage studies from Finland indicate that a woman who has an abortion is 646% more likely to die by suicide than women who have a completed pregnancy.

Aborting women who had no known live birth were significantly more likely to die than women with no history of abortion, and women with a history of both abortion and childbirth. The relative risk was highest when comparing women with only one known pregnancy outcome. Compared to women who delivered, those who aborted had a significantly higher age adjusted risk of dying from all causes (1.62), from suicide (2.54), and accidents (1.82), as well as a higher risk of dying from natural causes (1.44), including AIDS (2.18), circulatory diseases (2.87) and cerebrovascular disease (5.46). The higher death rates were significant across an eight year period and over four of the six age groups examined. Stratification by two-year increments revealed significant differences in the death rates between the two groups over several time periods. The differences in death rates during the first two years were statistically significant for overall deaths, deaths due to natural causes, and deaths due to violent causes. Similarly, in the third and fourth years following the pregnancy event, the rates of overall and violent deaths were significantly higher for aborting women. In years five and six, the difference in death rates was not statistically significant, but in years seven and eight the death rate among aborting women was once again significantly higher than for delivering women overall and was very nearly significant for deaths from natural causes ($p=.052$). The greatest number of deaths were due to natural causes and so these were disaggregated. Examination of major categories of death from natural causes revealed that the most significant differences were in relation to deaths from AIDS and from circulatory diseases (ICD-9 codes 390 - 459). Additional analysis of those dying from circulatory diseases revealed that aborting women had significantly higher rates of death from cerebrovascular disease (ICD-9 codes=430-438), and other heart diseases (ICD9 codes=415-423,425-429).

An increased propensity for accidental injury among women with a history of abortion has also been reported in other studies. In a review of government-funded medical programs in Canada, researchers found that women who had undergone an abortion in the previous year were treated 25 percent more often for injuries or conditions resulting

[25] Tischler C. Adolescent suicide attempts following elective abortion*, Pediatrics* 1981; 68(5):670-671.

from violence.[15] Similarly, a study of Medicaid payments in Virginia found that women who had state-funded abortions had 12 percent more claims for treatments related to accidents (resulting in 52 percent higher costs) compared to a case matched sample of women who had not had a state-funded abortion.[26]

e) Increased child abuse and neglect.

We found that abortion impaired a woman's ability to bond to her subsequent children.[14] Thus, there was a significant positive correlation between previous induced abortion and rates of child abuse and neglect. We also found there was a diminished breast feeding rate with women who have had an abortion compared with those who delivered all their children.

f) Increased death, homicide and domestic violence.

There is strong evidence of increased smoking and drinking following abortion.[27] [28] There are increased rates of death by accidents, AIDS, cardio-vascular disease and cerebral-vascular disease in those who have abortions.[29] Domestic violence and marital break up are more common. Poor sleep, particularly as a result of nightmares, is frequently reported. Difficulties with diminished libido and disparunia are reported.

g) Grieving.

Stack states[30] "delayed, unresolved or pathological grief reactions are common and often unrecognised occurrences following spontaneous abortion. The loss is frequently not appreciated so women may not have the opportunity to work out their grief reaction." Klaus & Kennel[31] have outlined recommendations for the care of the parents of a stillborn infant or an infant who dies soon after birth. Their recommendations include;

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[26] Nelson J. Data request from Delegate Marshall. Interagency Memorandum, Virginia Dept. of Medical Assistance Services, Mar. 21, 1997.

[27] Drower SA, Nash ES. (1978). Therapeutic abortion on psychiatric grounds. *S Afr Med J,* 54;604-8; 55;643-7.

[28] Reardon DC, Ney PG. "Abortion and subsequent substance abuse" *Am J Drug Alcohol Abuse*, 26(1): 61-75, 2000.

[29] Reardon DC, Ney PG, Cougle J, Scheuren F, Coleman PK, Strahan TW. "Deaths associated with delivery and abortion- a record linked study". Presented at "Perinatal Care in a Changing World" Obstetrics and Gynecology Conference, November 9-12, 2000 Banff. Dept. of Ob/Gyn, Faculty of Medicine, University of Alberta, Dept. of Ob/Gyn, Misericordia Hospital (CHHC), Edmonton, Alberta.

[30] Stack JM. Spontaneous abortion and grieving. *Am Fam Pract*, 21:99-102, 1980.

[31] Klaus MH, Kennell JH. Maternal Infant Bonding. St. Louis: CV Mosby, 1976.

allowing the parents to see and handle the infant, holding a funeral, having repeated interviewings, avoiding tranquilizers, refraining from having a replacement baby until they have completed their mourning, engaging in group discussions with other parents who have lost a baby, and, involving their other children in the discussion in understanding the loss.

Researchers and clinicians[32] [33] have emphasised the importance of assisting parents to grieve the loss of an early pregnancy. Although it could be contended that the spontaneous loss of an early pregnancy or stillbirth has a greater impact on women because they want the infant, it is well recognised that grieving is more difficult when there is marked ambivalence felt toward the lost object. In addition, that ambivalence is intensified by desires to destroy or wish for the death of an object to which one has become attached.[34] Bernstein & Tinkham note abortion is the interruption of an important psycho-biological event and that grief will occur regardless of the infant's size or weight.[35]

Researchers in New Zealand[36] found that 24.2% of mothers in their study who had an abortion still grieved over the lost child compared to 15% who still grieved over a wanted but miscarried child. This result was in spite of the fact that the aborted fetuses were lost at an average fetal age somewhat younger than the miscarried ones, since over 90% of abortions are performed in the first trimester, but approximately 80% of miscarriages occur in the first trimester.

Women who are unable to grieve the loss of an aborted or miscarried pregnancy have difficulty bonding to the next child. It has been demonstrated that women should be given the body of the stillborn or miscarried child in order to help them grieve.[37] The better the attachment, the more likely the parents are to grieve. The better the opportunity to examine, hold and incorporate the body of the fetus, the better the woman is able to grieve. It has been contended that a woman who has had a D&X abortion can be given the whole body of the aborted fetus so she is then better able to

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[32].Affonso DD. Missing pieces: A study of postpartum feelings. *J Birth Family*, 4:159-65, 1977.

[33] Hildebrand WL, Schreiner RL. Helping parents cope with prenatal death. *Am Fam Pract*, 22:121-25, 1980.

[34] Warnes H. Delayed after effects of medically induced abortion. *Can Psych Assoc J*, 16:537-41, 1971.

[35] Bernstein NR, Tinkham CB. Group therapy following abortion. *J Nerv Ment Dis*, 152:303-14, 1971.

[36] Ney PG. Follow-up data on pregnancy outcomes. Unpublished results from the Christchurch Child Development Study. New Zealand, 1984.

[37] Lewis E.(1979). Mourning By The Family After A Stillbirth Or Neonatal Death. *Arch Dis Child* 54, 303-6.

grieve. It is hard to conceive how anyone can believe that a baby with a deflated or crushed skull is intact. The injury will be obviously what she intended. She will be reminded that she has dehumanised the infant in order to kill it. It is known that pathological grief is more likely to occur in any instance where the person, in fact or in fantasy, contributed to the death of the person he/she must now grieve. For that reason, it is far better for a woman to be allowed to come to term with fully developed, intact fetuses that have conditions that are incompatible with life. Clinical evidence frequently shows that women want to hold the encephalic child or the child with cardiac abnormalities incompatible with life. There is serenity that pervades the scene as the infant dies. The parents are then able to name and bury the child, which they cannot do if a child has been, by their order or consent, destroyed or deformed.

Whenever an individual dehumanises a person and then contributes in any way to their death, they are much more likely to have complicated or pathological grief.[38] Pathological grief is likely to result in depression. Depression interferes with the immune system, which increases the person's propensity to have cancers and infections. Grieving an abortion is probably the most difficult grief humans must face.[39]

There is substantial evidence to suggest that every woman becomes attached to every child regardless of whether she wants it or not. A human is a bio, psycho, social unit. What happens in their body affects their mind that affects their behaviour and relationships**.** Shortly after the woman becomes pregnant, (7 - 10 days) hormones alert her to the fact as the pregnancy progresses, the placenta results in the very high levels of hormones. "The productions of steroid and protein hormones by human trophoblasts is greater in amount and diversity than that of any endocrine tissue known in all mammalian physiology and patho physiology."[40] At term the placenta provides to women 10 times the level of steroid production in men. The human placenta synthesizes an enormous amount of protein and peptide hormones, massive quantities of chorionic gonadotrophin, chorionic thyrotrophin, growth hormone variant, parathyroid hormone- related protein, calcitonin, relaxin, and a variety of hypothalamic-like releasing and inhibiting hormones. All these hormones and more are designed to maintain the pregnancy, insure the child grows and the mother stays healthy. The mother cannot avoid the knowledge that she is pregnant because of the impact of these hormones. In addition, because the placental barrier is only 2 cells thick, she is constantly monitoring hormones (emotional changes) in her unborn infant. In this way she has an intense and intimate relationship with the unborn child, i.e. she knows that unborn child personally although she has never seen that child. When mothers later see an ultrasound picture of that child they are not surprised at the child's appearance.

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[38] Lindemann E. (1944). Symptomatology And Management Of Acute Grief, *Am J Psychiatry* 101, 141-48.

[39] Ney PG.(1997). *Deeply Damaged* Pioneer Publishing, Victoria, Canada.

[40] Williams (20th Edition). *The Placental Hormones in Obstetrics* (chapter 6) in *Obstetrics*, page 125; Appleton & Lang.

The wall of the uterus and the lining of the placenta intricately enfold each other to produce a very large absorbing surface. What happens in the body is recorded and reinforced in the mind. Because the uterus is attaching to the baby, so the mind is attaching to the baby. Willy-nilly every woman becomes attached to every unborn infant.

The process of attaching is called “bonding”. That bonding process is affected by many mechanisms including the duration of the attachment. The longer the pregnancy, the more the mother knows the child and the more she is attached to a particular child with an individual personality. Some of this individualization of the child is fantasy, i.e. the visualization of the person who produces these hormones, some of it is reality. When humans lose a person they are attached (bonded) to they must grieve. The grieving of an abortion is particularly difficult.

The grieving of a late term abortion is even more difficult. The grieving of a late term abortion the mother knows was a viable fetus will be the most difficult type of grief known to humans. The mother cannot help but be aware of the fact that she murdered her own child. If she is then encouraged, as Dr. Haskell suggests, to hold the infant, she now has a clear picture of the child she has killed. Though in some ways this might facilitate grieving because she is completely aware of the death, it is complicated by the fact that she now sees the form and features of the baby she killed, plus the fact the child’s head has been evacuated by Dr. Haskell’s suction. That suction has deprived him of his/her mind and life. It is like telling a woman who strangled her husband, “In order to help you grieve, we are giving you the body of your husband to hold. The husband you strangled.” It is not hard for parents to imagine their response if that was happening to them.

The question whether one type of abortion is more beneficial or damaging to pregnant women with mental illness is entirely the wrong question. If the mother has a psychiatric condition, there are many more standard treatments. It is like asking the question, “Which is the best way to relieve back pain, cutting off the right or the left leg or cutting off the leg with a saw or an axe?” The pain in the back is only remotely connected to the presence of limbs. It is not entirely impossible, but the probabilities are exceedingly remote that cutting of the limb will ease the back pain. Besides, there are many better treatments for back pain.

Carrying a child with genetically induced physical or psychological abnormalities, even an anencephalic child**,** provides the mother with the knowledge that she has done everything she could for this child. This is likely to help her mature, improve her self image, diminish her narcissism and give her something that she can proudly tell family and friends. Holding the intact baby that she tried hard to keep alive at birth provides her with the best opportunity to engage in uncomplicated grief.

Grieving is necessary and inevitable. From our study of a post abortion recovery help line in Canada, we discovered there were people, 40 years after the abortion, who were phoning up and asking for assistance in dealing with their abortion. The turmoil appears not to subside. This is the best explanation for the fact that psychiatric admission rates

following an abortion are not only higher than those following a delivery, but they actually increase in time. The conflict appears not to diminish. Using record linkages to study a large population of MediCal recipients in California, we found that the rate of psychiatric admissions increased over time.[13] Complicated grief is not an adjustment reaction. This is a deeply seated problem time does not heal (Table 1).

h) Post-Abortion Survivor Syndrome.

There is increasing evidence that wanted children, who are not aborted when their unwanted siblings are, have serious conflicts and difficult-to-treat symptoms. Most of these young people are not well bonded. Many strongly suspect or have been told that they are alive when other siblings have been aborted. Consequently, they view their parents with deep suspicion. They feel they do not deserve to be alive, have a sense of impending doom, do not use talents and opportunities well, have difficulty forming relationships and making commitments, tend to not want to have children and have outbursts of rage at parents and/or the state that was supposed to protect them when they were most vulnerable.[41] [42]

i) Abortion for Fetal Anomalies

An increasing number of abortions are done because the fetus may be abnormal. There is extensive literature to show the high rates of distress and depression, guilt and conflict in both parents when an abortion has been done because of genetic abnormalities in the child.[43] One study[44] states, "persistent adverse psychological and social reactions may be much more common in patients undergoing termination of pregnancy for genetic rather than social indications." Blumberg et al.[31] state, "The incidence of depression following elective abortion may be as high as 92% among those women and as high as 82% among men." In this study, the incidence of depression was greater than that usually associated with elective abortion for psycho-social indications or with delivery of a stillbirth, but the difference may be due to more in-depth interviewing than to more intense feelings of loss.

It appears that every type of abortion has a deleterious effect on a woman's mental health. There is no evidence to show that one procedure has a lesser consequence than another. In one study,[45] comparing prostaglandins, 2 prostaglandins plus urea, the

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[41] Ney PG, Peeters MA. (1996). *Abortion Survivors*, Pioneer Publishing: Victoria, 1996.

[42] Ney PG, Peeters-Ney MA. Abortion Survivors. Study in Progress.

[43] Blumberg BD, Golbus MS, Hanson KH. Psychological sequelae of abortion performed for genetic indications. *Am J Obst Gyn,* 122:799-808, 1975.

[44] Donnai P, Charles N, Harris R. Attitude of patients after 'genetic' termination of pregnancy. *Br Med J*, 282:621-22, 1980.

[45] Pahl IR, Lundy LE. Experience with mid trimester abortion. *Obstet Gynecol* 53:190-94, 1979.

researchers found that the prostaglandins plus the urea was more hazardous to the woman's health. However, prostaglandin **alone** often resulted in a live fetus, which was very disturbing to the staff**.** It was on that basis that they chose to do prostaglandin plus urea, ie. they chose a more hazardous procedure rather than upset their staff. There are studies comparing medical and surgical abortions[46] to determine women's level of satisfaction, but none that indicate comparatively the long term mental health effects of various procedures.

j) Pain.

Women report intense pain during and following abortion. This is difficult to explain given the degree of sedation or anaesthesia. Many later develop pain in their head or their body which is difficult to diagnose and to treat. It appears the woman is able to experience the terror of the unborn baby who is about to be aborted and the excruciating pain as it is being torn apart. Unborn children do feel pain, which is translated into biochemicals that cross the placental barrier. Stress results in circulating corticoids. Cholecystokinins (CCK) have effects opposite to those reported for opiods. "CCK may function as an endogenous antagonist of opiate action."[47] The CCK that cross the placental barrier may make the mother feel the baby's pain. This excruciating pain may be perceived as her pain and she may not be able to forget it.

All of these physical and psychological problems following abortion are combined together to provide family doctors and specialists difficult-to-treat problems. Women have to deal with the physical aftermath of the abortion, which compounds their psychological difficulties. Too infrequently, physicians are likely to diagnose the woman's problems as depression and prescribe anti-depressants. Anti-depressants interfere with the resolution of many conflicts and prohibit the grieving process.

k) Guilt

Women who do everything to keep a child alive are far less guilt ridden than those who have decided to terminate (kill) the child because it is abnormal in any degree. It is the difference between killing or attempting to keep alive a pet dog that has been injured by a car. A deliberate killing results in many conflicts that are not easy to resolve, damages a person's self respect and produces long lasting guilt that can result in a wide variety of attempts to reduce the guilt, eg.

1. Denial, "It never happened, why should I feel anything?"
2. Denial and projection, "It didn't happen, besides, he made me do it."
3. Distraction, "I don't think about it because I keep busy with fun, sex or work."

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[46] Borgatta L, French A, Vragovic O, Burnhill M. Early medical abortion with methotrexate. Outcome and satisfaction among women aged 15-20 years. *J Pediatr Adolesc Gynecol*. 2000 May;13(2):87-8.

[47] Faris PL. (1985). Opiate antagonistic function of cholecystokinin in analgesia and energy balance systems. *Annals of the New York Academy of Science*, 448 43724-47.

4. Self flagellation, “I can never forgive myself, I must keep punishing myself.”
5. Confession ad infinitum, “I have sinned, dear God, forgive me.”
6. Risk taking behaviour, “I can’t forgive myself, but I should be punished, therefore I will make sure that something happens to me.”
7. Avoiding joy, “I don’t deserve to ever be happy again.”
8. Reaction formation, “I will try to make up for my bad deeds by being good to other people all the time.”
9. Oblivion, “I can’t keep the guilt out of my mind so I will drown myself in drink or blot it out with drugs.
10. Depression, “I am so sad, guilt ridden and angry that I can only be depressed and maybe some anti-depressant will help me.

D. Contraindications.

Even those who propound the free choice of abortion recognise that psychiatric illness is a contraindication for abortion. Dr. Romans-Clarkson, well known for her pro-choice position, states, “The greater the psychiatric indication for legal abortion, the greater is also the risk of unfavourable psychiatric sequelae after the abortion”.[48]

In addition to the literature review in previous articles,[13 49] Gilchrist et al., in a study of 13,261 women, noted that women who are most at risk of psychiatric and psychological consequences following abortion are those with a history of psychiatric illness.[50] Major et al. indicated those with partners at the abortion coped less well.[51] Elder et al. showed that grief was most frequent if there was poor partner support.[52] Major et al. found women who were more resilient coped better with the abortion. This indicates that abortion is for well, not sick individuals.[53] Husfeldt et al. found that, of 339 women, “thirty percent were in doubt about the decision when the abortion was due” and “their

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[48] Romans-Clarkson SE. (1989). Psychological Sequelae of abortion. *Australian and New Zealand Journal of Psychiatry,* 23, 555-565.

[49] Ney PG; Wickett AR. (1989). Mental health and abortion: Review and analysis. *Psychiatr J Univ Ottawa*, 14(4): 506-516.

[50] Gilchrist AC; Hannaford Pc; Frank P; Kay CR. (1995). Termination of pregnancy and psychiatric morbidity. *British Journal of Psychiatry*, 167(2): 243-8.

[51] Major B; Mueller P; Hildebrandt K. (1985). Attributions, expectations, and coping with abortion. *J Pers Soc Psychol*, 48(3): 585-99.

[52] Elder SH; Laurence KM: The impact of supportive intervention after second trimester termination of pregnancy for fetal abnormality. *Prenatal Diagnosis* 1991; 11(1): 47-54.

[53] Major B; Richards C; Cooper ML; Cozzarelli C; Zubek J: Personal resilience, cognitive appraisals, and coping: An integrative model of adjustment to abortion. J Pers Soc Psychol 1998;74(3): 735-52.

decision-making was marked by doubt during the entire process.[54] Ashton found approximately 5% of participants had “enduring, severe psychiatric disturbance following abortion. Women especially at risk were those with a previous psychiatric or abnormal obstetric history or with physical grounds for abortion and those expressing ambivalence towards abortion.”[55]

Although it was contended that children who were unwanted pregnancies and whose mothers were refused an abortion would be worse off psycho-socially, the results were based on very dissimilar groups. The differences between the two groups narrowed with time.[56] “Women with a previous history of psychiatric illness were more at risk of disorder.” “In women with no history of psychiatric illness deliberate self-harm was more common in those who had a termination.”[38] “Women who find their pregnancy highly meaningful coped worse immediately after the abortion than did women who found their pregnancy less meaningful.”[39]

The deep conflicts associated with abortion are not easy to resolve. These are:

1. Guilt. “I shouldn’t have done it. I know I can’t undo it, what can I do to stop feeling so bad?”
2. Grief. “I know in my heart it was a real, little person. I can believe that he went back to heaven, nirvana, etc., but I know I have lost him. How can I properly grieve the death of somebody I dehumanized and to whose death I contributed?”
3. Anger. “My boyfriend/husband didn’t support me. If he had said, ‘Sure we can do this together and I will stick with you.’ I would have had that baby in a flash. He let me down just like all the other men in my life, including my father. They are all a bunch of S.O.Bs.”
4. Fear. “It didn’t seem right. I just closed my eyes and plowed ahead because I thought it was the only thing I could do, but I now realize I have damaged something in me. I can’t trust my control over my aggressive response to a helpless human anymore. I have got to be careful with my anger.” or “You can’t trust any of those people out there. They are going to make you feel guilty. It is not me that is aggressive, it is them. Especially those who tell a woman it is not her right.”
5. Identity. “I always thought of myself as a gentle, loving person, now look what I have done. Killing a helpless baby is the worst thing anybody could do and I did it. I no longer have any faith in myself. I am a bad person.”
6. Sexual identity. “As a woman I am supposed to be mothering and gentle, but I killed a baby. What kind of a woman can I be?”

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[54] Husfeldt C; Hansen SK; Lyngberg A; Noddebo M; Petersson B: Ambivalence among women applying for abortion. Acta Obstet Gynecol Scand 1995; 74(10): 813-7.

[55] Ashton JR: The psychosocial outcome of induced abortion. Br J Obstet Gynaecol 1980; 87(12): 1115-22.

[56] Kubica L; Matejcek Z; David HP; Dytrych Z; Miller WB; Roth Z: Children from unwanted pregnancies in Prague, Czech Republic revisited at age thirty. Acta Psychiatr Scand 1995; 91(6): 361-9.

7. Sex. "I used to enjoy sex, partly because I knew that someday I would have a baby. Now I find that my sex has resulted in the death of a little person. How can I ever enjoy sex? My womb was supposed to be the safest place for a baby and I made it the most dangerous. My vagina was supposed to be a passage to life, but I made it a death chamber. I don't like my sexual organs."
8. Relationships. "I can't trust myself and I certainly can't trust him (partner). I know he doesn't trust me. I aborted our baby without his awareness or consent, so how could he? I rejected him and he abandoned me. How can we possible have a relationship?" (We found in one study that 80% of all relationships break up following an abortion.)
9. Scapegoating. "People did bad things to me sexually (rape, incest etc.) and I took it out on the baby. I find no pleasure in revenge. There is no reason why that child should die just because I hate those men." (Any woman, born of incest or rape, that I have seen is very glad to be alive.)
10. Reality testing. "For the purpose of agreeing to the abortion, I made myself believe it wasn't a baby, but everything in my mind and heart told me it was a baby. This huge discrepancy in what I believe is reality is driving me crazy."
11. Bonding. "I was becoming attached to that baby. Now I have to detach. Part of me doesn't believe it was a baby. How can I grieve something I don't believe was a human? Now I realize I am having difficulty attaching to the children that were born subsequently. Sometimes I feel I can't even touch them." (We found the mother had significantly greater difficulty bonding to children who were born following an abortion. This is partly because she was more depressed and partly because there was a sense of abhorrence in touching the baby. We also found that the breast feeding rate diminished in women who had an abortion compared to those who had not, partly because of the mother has difficulty bonding and because bonding protects a child from the parents occasional rage or neglect. Following an abortion there is a greater chance of child mistreatment. There is no evidence anywhere to show that freely available abortion has decreased the rate of child abuse and neglect. The best evidence shows that as the rates of abortion have increased, so have the rates of child abuse and neglect.[9,10]
12. Risk taking. "I feel so awful, I would like to kill myself, but I know how my family and friends would react, besides which, I can't leave my children. However, I could make it look like it was an accident."
13. Oblivion. "I was never an alcoholic, but I can't stop thinking about what happened. The only time I feel any kind of relief is when I am drunk." (We found substantially increased rates of women who misused alcohol and drugs following an abortion compared to those who did not. This study is in agreement with a very good study by Drower and Nash[27] whose findings were based on two groups of similar women. One group was given an abortion. One group was denied an abortion. This is as close to a random assignment of the treatment of abortion that ethically can be done. They found that women who had an abortion were more likely to smoke, do drugs and drink alcohol.)

E. Other Untoward Effects.

Various studies have shown the hazards of abortion; none have shown significant

benefit.

a. Pregnancy: Those in the abortion group are more likely to try to get pregnant again following an abortion.[57]

b. Anniversary Reactions. “Women in the anniversary reaction group more often reported ambivalence about the decision to abort.”[58]

c. Emotional Distress. In a study of 854 women at 12-month post abortion follow-up, a “case” sub-group of 139 women satisfied all the following inclusion criteria; post abortion emotional distress, doubts about abortion decision, would not consider abortion again. “50-60% of women undergoing induced abortion experienced some measure of emotional distress, classified as severe in 30% of cases.”[59]

d. Depression. Women with more than one abortion are more likely to have poorly assimilated the abortion experience and “scored significantly higher on the Beck Depression Inventory.”[60]

F. Infertility

“Cervical Chlamydia trachomatis is a risk factor for postabortal PID, and prophylaxis with erythromycin significantly reduces the frequency of PID.”[61] “If women applying for termination of pregnancy with Chlamydia infection are not treated, 10-60% will develop pelvic infection abortion.”[62] “Salpingitis due to Chlamydia is regarded as one of the most important causes of tubal infertility and extrauterine pregnancy.”[63] “The majority of

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[57]Salvesen KA; Oyen L; Schmidt N; Malt UF, Eik-Nes SH; Comparison of long-term psychological responses of women after pregnancy termination due to fetal anomalies and after perinatal loss. Ultrasound Obstet Gynecol 1997; 9(2): 80-5.

[58]Franco K; Campbell N; Tamburrino M; Jurs S; Pentz J; Evans C: Anniversary reactions and due date responses following abortion. Psychother Psychosom 1989; 52(1-3): 151-4.

[59]Soderberg H; Janzon L; Sjoberg NO: Emotional distress following induced abortion: A study of its incidence and determinants among abortees in Malmo, Sweden. Eur J Obstet Gynecol Reprod Biol 1998; 79(2): 173-8.

[60]Ibid.

[61]Sorensen JL; Thranov I; Hoff G; Dirach J; Damsgaard MT: A double-blind randomized study of the effect of erythromycin in preventing pelvic inflammatory disease after first trimester abortion. Br J Obstet Gynaecol 1992; 99(5): 434-8.

[62]Sorensen JL; Thranov IR; Hoff GE: Genital Chlamydia trachomatis infection in abortion seekers. Strategy of examination and treatment in order to reduce the sequelae of the infection. Ugeskr Laeger 1992; 154(44): 3047-53.

[63] Ibid.

women applying for termination of pregnancy with Chlamydia infection have no symptoms."

G. Psychosis.

The best evidence shows that women are more likely to become psychotic following an abortion than following a pregnancy.[64] The research done by C. Brewer[65] contending the opposite is badly flawed. Relying on his own estimates of a British district's abortion rate, C. Brewer concluded that the rate of psychosis occurring after delivery was 1.7 cases per 1,000 compared to 0.3 per 1,000 after an abortion. Brewer's methodology, conclusions, and objectivity, however, have been sharply criticized by Sim , the psychiatrist who was chiefly responsible for pregnancy related psychosis in the district studied. Sim's records, like those of 75% of the psychiatrists in the district, were not included in C. Brewer's study.

VI. Summary

Having reviewed the literature, examined our own studies carefully and considered individual patients, I must conclude:

A. There is no evidence to show that any kind of abortion is effective treatment for any known psychiatric, psychological or social condition.
B. There is no evidence to demonstrate that abortion is safe treatment for any known psychiatric condition.
C. There is no scientific evidence to show that abortion is better than no treatment for any known psychiatric condition.
D. There is no evidence to show that abortion is better than widely used and available treatments for known psychiatric conditions.
E. In scientific literature and standard psychiatric texts, it is almost universally agreed that known psychiatric conditions are made worse by abortion.
F. It is stated in scientific studies and psychiatric texts, the worse the psychiatric condition, the worse the outcome following an abortion.
G. Authors and scientists agree that those who are least affected by the deleterious effects of abortion are those who are most healthy before the abortion, ie. abortion is not treatment for any mental illness.
H. There is no mental health issue that (1) is a medically diagnosed condition (2) is so complicated by a pregnancy (3) as to directly or indirectly cause the substantial or irreversible impairment of a woman's psychiatric state.
I. There is no such "mental health" issue that benefits from abortion known to science.
J. There is no such issue known to me from my practice.
K. There is no such issue known to me from my research. Every woman who wants to have a baby and becomes psychiatrically ill is able to be treated by standard

[64] Sim, M. (1981). Abortion and psychiatry. In Hilgers, T. W., Horan, D. J., and Mall, D. (eds.), New Perspectives on Human Abortion. Washington DC: University Publications of America.

[65] Brewer, C. (1977) Incidence of post-abortion psychosis: a prospective study, British Medical Journal, 1, 476-77.

medical therapies. If a woman is depressed before pregnancy, there is a possibility she will have a post-partum depression, but this condition is treatable by standard therapies. Abortion is contraindicated in depression.

L. The best evidence shows that women are more likely to become psychotic following an abortion than following a pregnancy.[66]
M. Abortion greatly increases the psychiatric admission rate.
N. Abortion removes the protective effect of pregnancy and, in addition, greatly increases the incidence of suicide.
O. There is no evidence that one kind of abortion is better treatment for psychiatric illness than another.
P. There is no evidence that a partial birth abortion is the preferred or necessary treatment for mental illness or psychological distress.
Q. The preferred and recommended treatment of mental illness or psychological distress does not include abortion of any kind.
R. Those who do abortions are not qualified to state what is the best psychiatric or psychological treatment for any pregnant woman experiencing psychiatric distress.
S. The two Jane Does indicate emotional distress but no medically diagnosable psychiatric illness. Their distress could have been dealt with by far more conservative, less invasive methods. There is no evidence of long term benefit to them. Their children are likely to experience Post-Abortion Survivor Syndrome.[42]
T. There is no scientific evidence of a situation where a woman risks severe irreversible psychological or emotional injury if she does not have an abortion by any method.
U. There is no scientific evidence of a situation where a woman risks severe irreversible psychological or emotional injury if she does not have an abortion by the D&X method.
V. There is no scientific evidence that a woman who is already experiencing a severe risk of irreversible emotional injury must be permitted to undergo the partial birth abortion, post-viability, because it is safer (medically) than the alternative.

VII. Review of Dr. Brewer's report

I note Dr. Barbara Brewer has a Ph.D in clinical psychology, which usually means less emphasis on research. Her practice specializes in marital relationship therapy, family and parenting issues, mediation and therapy for separating couples, gay and lesbian issues and sex therapy for individuals and couples. In her CV, she indicates that she is an adjunct assistant professor and has been since 1978, indicating she has not been promoted academically. I note that her CV states that she was an adjunct assistant professor until present whereas her report says from 1978 - 1997. Her teaching appointments all indicate a prominent interest in women, feminists, psychology and a concern regarding control. She does not cite what were the research topics for her

[66] Sim, M. (1981). Abortion and psychiatry. In Hilgers, T. W., Horan, D. J., and Mall, D. (eds.), New Perspectives on Human Abortion. Washington DC: University Publications of America.

doctoral or master's thesis. She has only one article in which she is the first author, published in what appears to be a professionally reviewed journal.

Dr. Brewer contends that "pregnancy has been associated with emotional well being in women, but for women with various psychiatric disorders, pregnancy may be a time of increased vulnerability." She doesn't state, and it is not known, whether that vulnerability has to do with the pregnancy *per se* or to the turmoil in relationships, financial support etc. Since it is not clear whether it is pregnancy or other factors during pregnancy that create the stress, she should not argue that the best treatment for that "increased vulnerability" is to abort the pregnancy. The only reference she cites is "id", whatever that might be. I suspect she has references 1 and 2 inverted.

When Dr. Brewer contends that "up to 70% of women report experiencing negative mood symptoms during pregnancy" citing a reference, she is not comparing this to any other group of women as a contrast group and she cites no reference (12, p.3). Moreover, she states depression following childbirth, "not only wreaks havoc on the family, but seriously affects her family etc."(13, p.5). This appears to be untreated depression, but there is no reason for a woman not to receive treatment. She does not compare this rate of post partum depression to post abortion. The best evidence is provided by Kumar and Robson and its quite the contrary.[67] Women who had an abortion are more likely to be depressed following childbirth.

Post partum psychosis (15, p.5-6) is indeed a difficult to treat disorder, but I have had considerable success hospitalising mother and infant. The end result was a happy mother and healthy baby and many difficult issues preceding the psychosis having been dealt with, partly because there was a pregnancy. Professor Myre Sim, who was the psychiatrist in charge of the district where Brewer did her study indicates that Brewer's study is faulty on many scores. Brewer was very selective to which psychiatrists she gave out her questionnaire, namely, those who would tend to support her hypothesis. Sim and Neisser[68] found that post abortion psychosis was more frequent and more difficult to treat than post partum psychosis. Since the only example that Dr. Brewer cites is something that she has almost no personal knowledge of, she "could only hypothesise". It appears that the Dr. Brewer did not interview the patient in her example during the pregnancy. She didn't know if the woman had a previous abortion.

Dr. Brewer contends (16, p.6) there is a high risk for, "a serious psychiatric emergency if the pregnancy is carried to term." She is unprofessionally unaware of the fact that risk is higher if the baby is aborted. Moreover, though post partum psychosis is a serious illness and requires prompt treatment, one would not consider it a psychiatric

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[67] Kumar R, Robson K. Previous induced abortion and ante-natal depression in primiparae: A preliminary report of a survey of mental health in pregnancy. *Psychol Med*, 8:711-15.

[68] Sim M, Neisser R. Post-abortive psychosis; a report from two centers. In: *The Psychological Aspects of Abortion.* Mall D, Watts F, (eds.) Washington: University Publications of America, pp. 1-13, 1979.

emergency.

Dr. Brewer states, “We must assume that these figures” but makes no reference to which figures nor did she provide any evidence of her contention. All of the factors which she cites apply in any pregnancy. Women who decide they want the baby are never advised to terminate the pregnancy to deal with these conditions.

Dr. Brewer believes that the mother with obsessive compulsive disorder, who stopped her anti-depressant during the pregnancy would have been better served by having an abortion. She has no evidence that this is so. Moreover, antidepressants are not absolutely contraindicated in a pregnancy, otherwise the Lilly pharmaceutical would be the first to declare it so. Not only that, other methods of treatment are available.

Dr. Brewer contends the, “hormonal fluctuations that occur during pregnancy represent a serious risk for women with pre-diagnosed psychiatric conditions.” The hormones do not fluctuate during the pregnancy, they gradually build. All of those hormones improve the health of the mother. She seems to be unaware of the fact that, failure of attachment with the infant more frequently results from abortion than it does from a completed pregnancy.[10]

Dr. Brewer states 90% of all adolescent suicides are girls. This is not true. The majority of suicidal attempts are by girls but the majority of completed suicides are adolescent boys. Dr. Brewer states, “Pregnant adolescents are 10 times more likely to suicide than non-pregnant girls” citing a 1984 reference. This statement is not true. The reference is out of date. In a study of 3636 rural high school girls, Garfinkel et al. found 0.4% of girls with no previous history of abortion attempted suicide in six months compared to 4.0% of girls with a prior abortion.[69] Appleby et al. found the standardized mortality ratio for suicide is 0.17 for the first 12 months after childbirth, 0.05 during pregnancy.[6] Professor R.E. Kendall, Royal Edinburgh Hospital states, “Motherhood and the imperative social role this entails militates strongly against self-destruction.”[70] Rayburn et al., monitoring 179,893 calls to a metropolitan poison control centre in Michigan found the calls from pregnant women were 0.07%.[71] Approximately 2.5% of the population is pregnant at any one time, thus suggesting pregnancy decreases the tendency to suicide by a factor of 3500%. Hook[72] studied 249 Swedish women whose abortion request was refused and found that no-one made a suicidal attempt during follow-up. Since it appears that pregnancy diminishes the tendency of abortion by a factor of 35 and abortion increases suicide by a factor of 6 to 10, the net impact of aborting a pregnant woman is to increase the chance of suicide by a factor of up to 4500 %.

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[69] Garfinkel RS. et al. Full citation forthcoming.

[70] Kendall, RE. *British Medical Journal* Full citation forthcoming.

[71] Rayburn W; Aronow R; DeLancey B; Hogan MJ. Drug overdose during pregnancy: an overview from a metropolitan poison control center. Obstet Gynecol 1984 Nov;64(5):611-4.

[72] Hook B. Full citation forthcoming.

Dr. Brewer (23, p. 8) indicates that a woman is in a "catch 22 scenario" because she may have to stop taking Lithium if she has manic depressive illness and is pregnant because of the reported birth defects. There are many other medications to deal with manic depressive psychosis and there are many ways to treat manic depressive psychosis, at least during the pregnancy, that do not require medication.

Dr. Brewer states the major researcher in this field (Pregnancy and Manic Depressive Illness) is K. Redfield Jameson, who believes manic depressive illness is associated with some risk for the fetus. It is interesting to note that the first author of the paper she cites is Goodwin, Frederick K. Ostensibly she is writing about untreated manic depressive illness but there is no reason not to treat manic depressive illness during a pregnancy. So why does she cite this as an example? Not everybody would agree the major researcher in this field is K. Redfield Jameson.

Dr. Brewer states (25, p.9) "With optimal conditions of family medical support, there is a possibility of positive outcome; many women with this condition do not have this support." Is she arguing that women should have an abortion if they don't have family and medical support? Why not provide the family and medical support? Is she aware of the fact that people without support who have abortion do more poorly? Dr. Brewer believes, "The pregnant woman ... must have access to the best possible medical psychiatric advice." There is no question that this is true but that certainly does not include abortion. Nowhere does anybody recommend abortion as the best psychiatric treatment for a person with manic depressive illness.

Without citing the evidence (26, p.9) Dr. Brewer believes that the illness of women with post traumatic stress disorder or substance abuse can be exacerbated by pregnancy. The best evidence indicates that both those conditions are more exacerbated by abortion.[73]

Dr. Brewer states, "Studies find that 58 to 67% of women exposed to abuse as children have unintended first pregnancies during adulthood" without citing the reference. She has previously stated that women are ambivalent about their pregnancies. In fact, almost every woman is ambivalent to some degree about every pregnancy. We have found the degree of wantedness fluctuates during the pregnancy. There is the J-shaped curve. Woman want children more before they are pregnant, lowest in the first trimester and then the desire for the child gradually increases during the length of the pregnancy. To categorically state that there are women with unintended pregnancies doesn't recognize 1) the intense and necessary ambivalence; 2) that "unintended" diminishes during the pregnancy; and 3) most women who appear to decide for an abortion are still ambivalent. 4) the crisis of a pregnancy is a necessary transition that allows the woman to incorporate a new being. Lenoski[74] who used a number of objective measures to determine wantedness found that wantedness or intention fluctuated almost on a daily basis.

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[73] Reardon DC, Ney PG. Abortion and Subsequent Substance Abuse. *Am J Drug Alcohol Abuse,* 26(1);61-75, 2000.

[74]Lenoski EF. Translating injury data into preventative health care services: Physical child abuse. Dept. of Paediatrics. USC. Unpublished, 1979.

Dr. Brewer admits that the CDC's pregnancy risk monitoring system PRAMS (30, p.11) excluded women who had miscarriages or abortions but states that the rates of violence toward women who are pregnant are probably underestimated. Our data indicated that homicide is more likely to occur following an abortion.[29] There is reason to expect that violence in general and homicide in particular following an abortion is greater because there are so many angry men whose partners have, without their awareness or consent, terminated the life of their "baby". Even if violence was more common to women during pregnancy compared to when they are not pregnant, it is hardly justification for killing the baby. The treatment should be directed toward the cause of the problem which is the person who does the violent assault. In all of the examples Dr. Brewer cites, there is no evidence that providing an abortion produces a better outcome.

In considering rape and incest (40, p.14), Dr. Brewer acknowledged that "If she destroys the embryo she destroys part of herself." She also states "If she protects the embryo she nurtures part of her attacker." but doesn't acknowledge that she is nurturing herself. She provides no evidence that abortion is good or safe treatment for women who have been made pregnant by rape or incest. In both instances pregnancies are relatively rare. She may not have encountered people who were born of rape or incest, but I have. They were glad to be alive. No one I met stated that they would rather have been aborted. Dr. Brewer fails to recognize there are more than three options: abortion, adoption and keeping the child. There are various kinds of adoption. More frequently open adoptions are preferred where the pregnant woman is given the opportunity to choose from a list of potential adopting parents. She is able to name the child and have occasional continuing contact. In addition to open adoptions, there are a variety of fostering arrangements or partial institutional care for mother and child. The mother and child may be placed in a supportive environment where they could live for as long as the mother needed to get her life together, complete her education, find a suitable mate, and be taught parenting skills.

Every human detaching from another must grieve. Babies given up for adoption must be grieved. However, grieving a live, happy, well looked after child is much easier that grieving a baby that died because a woman did not want it and paid someone to have it killed. Although women appear to be relieved following an abortion, our evidence shows that psychiatric admission rates increase in time, indicating that psychiatric problems following abortion don't fade away.[13] The psychiatric problems following an abortion are not adjustment reactions.

With the increasing emphasis on open adoptions and the opportunities of birth parents and adopted children of making contact, it is not hard for both parents and children to think of a day in the future when they will greet each other. There are many happy stories of birth parents and adopted child reunion. This could never happen with a woman who has aborted her baby.

Dr. Brewer contends (45, p.16), "It is imperative for psychiatric health of women that they be able to access the medical and psychiatric care best suited for their situation." The best medical and psychiatric care is determined by science. Physicians must practise by

evidence-based medicine, not by their political orientation or their philosophical precepts, or their desire that women “be in control of their bodies.” This being the case, the best medical and psychiatric care for women is not abortion of any kind.
It is difficult to understand how an obstetrician, gynecologist or family physician is in the best position to state what is best for a woman’s psychiatric well-being. Certainly they would not be consulted for psychiatric care by a woman who wanted their baby. The only reason they are even considered is the fact that the woman feels or is persuaded that she has no alternative but to abort her baby. Those physicians who contend abortion is the best treatment for psychiatric conditions are becoming increasingly aware that they are putting themselves in a situation where they increase the chance of malpractice suits. At this point in time none of them can be ignorant of the fact that abortion is not good treatment. In fact it is very bad treatment for people with psychiatric illness. As evidence of harm has accumulated, women have become increasingly angry and vociferous for being misled and misinformed by the abortionist.

Dr. Brewer states (49, p.16), “When the physician’s attitude toward abortion is one of assisting women to control her body and destiny.... affords a powerful opportunity to undo some of the damage sustained by the patient who has suffered previous abuse.” It is not the physician’s business to have a predetermined attitude about abortion but to determine whether abortion is good treatment. He/she is not there to assist a woman to control her body and destiny, but to make her well. To do so he has to be guided by evidence-based medicine. The evidence clearly indicates that he does the patient no good with abortion and the chances of harm are greatly increased by an abortion. The corrective experience of childbirth is more likely to undo damage sustained by a patient. A woman can look upon her infant and be pleased with herself at having overcome many difficulties in producing a chubby, smiling infant. To kill the infant only exacerbates her awareness of how destructive humans can be to each other.

Although from her philosophical position, Dr. Brewer believes that a woman must be in control of her body, she fails to recognize that most humans are constantly controlled by biorhythms, hormones, and illnesses over which they have very little control. Sleep is inevitable. People get hungry and thirsty. Menstruation occurs without your bidding. When you have cancer you cannot wish it away. Eventually people have to recognize that they can’t control all the forces that act upon them, neither biological, psychological, social, nor political. If human equanimity depended upon controlling their body at the expense of others, there would be no peace at all, personal or interpersonal.[75] If terminating a pregnancy puts the woman in control, she soon learns that she has gained nothing by killing another person. She does learn that power corrupts and the ultimate power over the life and death of a baby corrupts ultimately.

Dr. Brewer nowhere in her report makes mention of informed consent. Women who are treated without a full awareness or the possible outcomes are very likely to have psychiatric difficulties, particularly depression. They feel betrayed. They cannot express their anger toward their doctor because they depend upon his/her good auspices to remain healthy.

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[75] Ney PG. Some real issues surrounding abortion, or, the current practice of abortion is unscientific. *J Clin Ethics*, 4(2):179-80, 1993.

They internalize their anger and become depressed. Not knowing what were the real consequences of abortion they feel betrayed once again, just like they were betrayed by family or partners. There is an increasing reservoir of very angry women who, having been misled, are keen to seek redress with the assistance of the court.

In her court testimony, Dr. Brewer said yes to the question, "Have you treated women who have been manic depressive?" (p.166) It is generally agreed that these people need medication. If she treated them otherwise, it is substandard treatment. As she is not a physician she cannot prescribe and is not in a good position to state what is the best treatment for pregnant women who are manic depressive.

The case she cites (p.169) of a woman with sexual dysfunction does not indicate whether she had a previous abortion. Sexual dysfunction is a common post-abortion symptom. Dr. Brewer (p.171) contends she treated a patient who has a very serious depression and is suicidal. Was this patient referred to a psychiatrist, and if not, why not? Since there is no evidence of her complete pregnancy history, it is possible to conclude that at least one of her pregnancies was aborted. Dr. Brewer(p.173) indicates that this woman, who she uses as an example, decided to abort the baby and then moved out of the city. She does not know what the outcome was. How can she use this as a case to justify her contention for abortion as treatment when she does not know what is the outcome.

Dr. Brewer (p.175) states "In my clinical experience, I have found that the experience of giving up a child for adoption is actually more emotionally distressing to a woman than an early safe abortion." She does not indicate how many cases she has seen in either category. She shows no evidence of having done follow-up or any kind of statistical analysis of the outcome. In recommending treatment, doctors cannot be guided by what they feel is beneficial, but what careful science has shown to be beneficial to the patient in the long term. Emotional distress is not an illness, is transitory and often an indication that a person is struggling with rather than avoiding major conflicts.

Dr. Brewer contends (p.177), "what, if any, psychological or emotional toll would that take on a woman to know that she is being forced into a procedure that is not the safest." No woman can be forced to accept any kind of treatment by any kind of physician. All physicians recommend what they consider to be the most therapeutic and safest method according to evidence-based medicine. When women are encouraged to believe an abortion is good treatment for any condition and later learn what the evidence shows, it's not good treatment and it's not safe for their psychiatric illness, any psychiatric condition they have will be worsened.

Throughout her testimony Dr. Brewer believes that it is of primary importance that a woman feel that she is in control of her body. She cites no evidence to show that abortion helps a woman to feel that way or that giving her the impression that she's in control of her body improves her psychiatric condition.

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Philip G. Ney, MD, MA, FRCP(C), FRANZCP, RPsych