Suicides After Abortion Remain High Despite Better Screening Guidelines

Officials in Finland Concerned About Increased Risk of Suicide After Abortion

Voluntary guidelines for post-abortion mental health evaluations during the month following an abortion have failed to significantly decrease the rate of suicide after abortion in Finland, according to a new study.\(^1\)

Finland adopted the guidelines after a large-scale study of women’s health records, published in 1997, found that the suicide rate among women who had undergone abortions in the prior year was three times higher compared to women in the general population and six times higher compared to women who gave birth.

Mika Gissler of the National Institute for Health and Welfare, who was the lead author of the 1997 study, led a team of researchers who examined health records to see if the suicide rate went down after the new guidelines were published.

They found that the decrease in the suicide rate was not statistically significant.

“Women with a recent induced abortion still have a two-fold suicide risk,” they wrote. “A mandatory check-up may decrease this risk.”

Officials in Australia Also Concerned

The increased risk of suicide following abortion has been recognized in Australia as well. The 2013 Queensland Maternal and Perinatal Quality Council report noted:\(^3\)

Suicide is the leading cause of death in women within 42 days after their pregnancy and between 43 days and 365 days after their pregnancy. There appears to be a significant worldwide risk of maternal suicide following termination of pregnancy and, in fact, a higher risk than that following term delivery.

The potential for depression and other mental health issues at this time needs to be better appreciated. Active follow-up of these women needs to happen. Practitioners referring women for termination of pregnancy or undertaking termination of pregnancy should ensure adequate follow-up for such women, especially if the procedure is undertaken for mental health concerns.

Queensland’s Courier Mail newspaper reported that council chairman Professor Michael Humphrey said that the number of suicides was a key concern.\(^4\)

“There’s a lot of evidence that a significant proportion of women who have termination of pregnancies do have mental health issues subsequently,” the paper quoted Humphrey as saying. “Whether they are mental health issues related to the reason why the woman had the termination or whether they’re related to regret afterwards, we don’t know.”

Besides the Finland study, large record-based studies from the United States\(^5\) and Denmark\(^6\) have found that overall death rates were higher among women following abortion compared to those among women who had given birth.

The U.S. study examined Medi-Cal records for more than 173,000 low-income California women who had experienced abortion or childbirth. Linking these records to death certificates, the researchers found that women who had state-funded abortions were 2.6 times more likely to die from suicide compared to women who delivered their babies. Giving birth, on the other hand, was shown to reduce women’s suicide risk compared to the general population.

Abortion Not Beneficial to Women’s Mental Health

Abortion advocates have frequently argued that abortion is necessary to protect women’s mental health, or even beneficial.

But a 2011 study published in the British Journal of Psychiatry found that 10 percent of mental health problems among women, including 35 percent of suicidal behaviors, may be attributable to abortion.\(^7\) These findings were based on the combined results of all studies published between 1995 and 2009 that met strict inclusion criteria. The resulting analysis included 877,181 women from six countries.

Women who aborted were 81 percent more likely to experience mental health problems compared to all other control groups, and 55 percent more likely to have problems compared to women who delivered an unplanned or unwanted pregnancy.

Further, a meta-analysis combining the results of eight studies of
women who experienced unwanted pregnancies, published in 2013, concluded that “there is no available evidence to suggest that abortion has therapeutic effects in reducing the mental health risks of unwanted or unintended pregnancy.”

Lead author Professor David Fergusson, who has described himself in interviews as a pro-choice atheist, also led the research team in a 2008 study that concluded that women who continued an unwanted or mistimed pregnancy did not experience a significant increase in mental health problems. Further, having an abortion did not reduce their mental health risks.

“In general, there is no evidence in the literature on abortion and mental health that suggests that abortion reduces the mental health risks of unwanted or mistimed pregnancy,” the authors wrote. “Although some studies have concluded that abortion has neutral effects on mental health, no study has reported that exposure to abortion reduces mental health risks.”

The Elliot Institute has called for congressional hearings to investigate the risks of suicide and other mental health problems after abortion (see sidebar).

**Citations**

A year ago, *Kai Tiaki Nursing New Zealand* published Rose Stewart’s challenging article, “Conscience ‘not always a force for good’,” giving her perspective on conscience and health care.¹

In the article, Stewart expressed her concern that health professionals who invoke their conscientious objection to abortion or contraception risk infringing the rights of women to reproductive health care. She argued that “conscience is not always a force for good.”

In this article, we suggest freedom of conscience is essential for a healthcare worker and protects the rights of the patient, the healthcare worker and society as a whole.

As healthcare workers, we bring ourselves as whole persons to our important role. We are present as real people, not robots. Our background, culture, beliefs, and especially conscience, will and should affect how we care for our patients.

**A Healthcare Worker’s Privileged Role**

Care, empathy, altruism and conscientiousness all stem from the values we have developed during life. They are influenced by our beliefs, culture and background. Many of us have chosen to enter health care as a calling. We see our role as a privileged one, where we have the opportunity to work in partnership to help ease the suffering of our fellow human beings.

For many of us who are Christians, this calling is an extension of our belief in Jesus, who calls us to serve all with dignity—especially the disadvantaged, the poor and the marginalized.

We believe God is the source of all life and that human life is particularly sacred. These beliefs are part of our purpose, allow hope, encourage our deepest being and inform our conscience. Our beliefs encourage us to seek to care for others through our work in the healthcare professions. They drive us to keep serving even when our work is difficult and unrewarding.

Christians do not hold these views uniquely, however. Healthcare workers from other religious traditions also share the same belief that human life is sacred.

Our conscience necessarily guides our actions inside and outside our workplace. It guides the choices we make daily between right and wrong—whether this relates to stealing from the corner store or lying to a fellow worker.

Our conscience also informs our choices in health care—whether to be fully honest with a patient about a mistake we have made, whether to allow a patient his or her full autonomy, whether to spend a little longer with a distressed patient, thereby encroaching on our paperwork time. Our conscience also guides our actions with regard to abortion and contraception.

There is no reason to suggest that human life begins at any other time than at the point of conception. At this time, a new individual is formed, with their unique genetic code, characteristics and future.

Given the necessities of life, this person will grow to become a mother, a musician, a healthcare worker. Many of us believe we do not have the right to end a person’s life, even at this early time.

Our conscience and our professional ethics do not allow us to take part in what we regard as the killing of this person.

How can we respond as health professionals, if we have these views about life?

**Conscience Requires Understanding Pressures Women Face**

When Joseph began practising as a general practitioner (GP), he initially felt he needed to ignore his beliefs and practise in a way which was “unbiased.” He met many women requesting abortion. In a large number of these cases, he saw these women as making a decision for abortion based on fear, lack of support, threatened relationships and other pressures. Often the decisions were hurried, and the woman would not seek support from those closest to her, out of shame.

In some cases where women requested abortion, there was a repeated pattern of unexpected pregnancy where little had changed to improve choices and decision-making. In some cases, Joseph saw women who experienced grief and trauma as a result of abortion.

He referred several patients to secondary care, despite having misgivings about how the choice was being made. He hoped they would receive pre-decision counseling to address their social issues and that abortion procedures would only occur once all other avenues had been explored with the women.

In every case referred, however, the women had their pregnancies terminated with what seemed like little further opportunity to discuss alternatives to abortion. The dominant opinion seemed to be that the best way to reduce trauma to a distressed pregnant...
woman was to offer a rapid termination service, rather than to provide a window of time to explore the complexities of her situation and to ensure an authentic informed choice.

Joseph recognized that he could not continue to practise medicine in this way. He was not being fully present to the patient, nor fully himself in his practice of medicine. Nor did he consider he was offering the standard of care necessary for these women in crisis and nor was he fully considering the life they carried within them.

This lead to intense personal reflection and inter-professional discussion. It resulted, finally, in a collaboration between GP, practice nurse and midwife to address this important area of practice and plan a new service.

**A Higher Standard of Care Requires Looking Deeper & Helping More**

We felt there was a need for a primary healthcare response to unplanned pregnancy, rather than simply referring all women to secondary-care abortion providers.

In 2001, we set up Crisis Pregnancy Support/Hapai Taumaha Haputanga. This is a service based within a general practice in Nelson. We engage volunteer health professionals as “acute response care coordinators” who meet with pregnant women.

Most of these volunteers are nurses, who receive specific training and attend regular peer review. They become expert in accessing community support for these women. We also have a larger group of community-based volunteers who provide some practical support.

If a woman presents with a crisis pregnancy, we recognize that our responsibility is to two patients, not only the mother (whose dignity and autonomy we give the utmost respect) but also her unborn child.

Our role is simply to offer hope and support in the midst of her crisis. She will be given space and time to reach an autonomous decision and she is assured that our support remains constant.

Unfortunately, there is no easy solution to an unplanned pregnancy. An abortion does not make the problem disappear. A woman goes from being unexpectedly pregnant, to living a new journey that may include unexpected feelings of loss and trauma as the result of an abortion.

We assess a woman’s level of support and then together build a more robust network where required. We link in with existing support services and provide community-based support. The goal is always to empower.

At times, we seek funds to help with one-off expenses such as driver’s license fees or rental accommodation bonds. At other times, we help with emergency accommodation, accessing ongoing education, advice regarding restraining orders or information about work and income assistance. We try to remain “present” with the woman and encourage her as she undergoes multiple transitions in this emotionally challenging time.

**Empowering Women to Avoid Unwanted Abortions**

In our work with pregnant women, we see that without this kind of service, many actually accept an unwanted abortion. In many cases, the woman is not opting for abortion as a “free decision based on her conscience,” but due to coercion, threats of an ended

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### Summary of Fergusson’s Longitudinal Study

Research which found links between abortion and mental illness arose out of an influential ongoing longitudinal study of 1265 people born in the Christchurch (New Zealand) region in 1977.

Data from the Christchurch Health and Development Study, founded and led by Otago University psychology professor David Fergusson, has spawned more than 400 academic articles and books over a range of disciplines. It has influenced public policy on a variety of social and health issues, from the need to fence swimming pools, to the dangers of passive smoking, to the link between low socio-economic background and poor access to preventive health care.

In a study from the Christchurch data, published in 2009, Fergusson found major mental illness was 30 percent higher in women who had had an abortion compared to those who hadn’t.

Substance abuse was the most common problem linked with having undergone an abortion. The higher level of mental illness was not present in women who had carried an unwanted pregnancy to term. Fergusson concluded that abortion was “an adverse life event” associated with a “modest increase” in risk of mental disorder, which supported a “middle of the road” attitude to abortion.

Investigating the impact of abortion on mental health had been the most controversial aspect of his research, he said. “There have been lots of attempts to discredit our research, but it has stood up to intense scrutiny.”

Last year in New Zealand, 14,073 abortions were performed—the lowest annual figure since 1995, when 13,653 women had abortions, Statistics New Zealand said.

Women aged 20-24 had the highest abortion rate—27 abortions per 1000 women, compared to the overall rate of 15.4 abortions per 1000 women aged 15-44 years. The median age of women having an abortion was 26, and 64 percent of abortions were the woman’s first.
relationship, financial pressures, worries about education or other similar outside pressures. If these factors are addressed and practical help provided, then many women choose to continue their pregnancy.

The outcomes of our work have been very encouraging and reinforce our conviction that this type of primary care service is essential if we are to offer our patients real choice.

We also care for many women for whom abortion has had severe and long-term adverse effects. These can include depression, drug/alcohol abuse and anxiety-related conditions, among others. The fact that these adverse outcomes are more common in those who have had abortions has been clearly demonstrated in work carried out by New Zealand researcher David Fergusson, at Otago University (see summary on p. 4).  

Healthcare workers must be allowed to practise within their professional ethics and according to conscience, independent of outside pressure (including pressure from oppressive ideologies, unjust government or legislation). History has given us examples of the terrible consequences for healthcare workers and patients where this does not occur. For good reasons, the Hippocratic tradition was reinforced in the 1948 Declaration of Geneva, as the appropriate ethical framework for medical practice, following the atrocities committed against patients during the Holocaust.

For those involved in health care, working according to one’s conscience is not only a “force for good” but also an essential safeguard against corrupt or oppressive influences on the privileged role we have with our patients.

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Citations

contributing factor in women’s mental health problems, including depression, anxiety, substance abuse, and death from suicide.

In 2011, I published a meta-analysis titled “Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published from 1995-2009.” A meta-analysis has much more credibility than the results of individual empirical studies or narrative reviews.

In a meta-analysis, the contribution or weighting of any particular study to the final result is based on objective scientific criteria (sample size and strength of effect). The sample consisted of 22 studies and 877,297 participants (163,880 experienced an abortion). Results revealed that women who aborted experienced an 81 percent increased risk for mental health problems. When compared specifically to unintended pregnancy delivered, women were found to have a 55 percent increased risk of experiencing mental health problems. This review offers the largest quantitative estimate of mental health risks associated with abortion available in the world.

The Turnaway study researchers reported that two years later, women in both the abortion and childbirth groups were equally likely to still be with their romantic partners, implying that abortion does not introduce problems in relationships. This result is not consistent with the wealth of published results indicating the opposite. Partner communication problems and an increased risk for separation or divorce following an abortion has been reported in several studies.

In one study by Lauzon and colleagues (2000), 12 percent of the women and 18 percent of the men indicated that an abortion performed up to 3 weeks earlier had negatively impacted their relationship. Rue and colleagues reported that 6.8 percent of Russian women and 26.7 percent of American women indicated relationship problems caused by an abortion experience; whereas relationship benefit was reported by very few Russian women (2.2 percent) and American women (0.9 percent).

Finally, the Turnaway study authors reported that women in abusive relationships experience a decrease in violence following an abortion, whereas they are likely to report an increase in violence corresponding to childbirth. Based on the methodological shortcomings addressed above, these findings are suspect as well and represent an oversimplification of complex phenomena.

We do know that women in abusive relationships are more likely to be abused when pregnant. In fact, there are a number of peer-reviewed articles documenting murder of pregnant women by their intimate partners, particularly during early pregnancy, as a major cause of death among pregnant women. Many of the women killed are likely to have refused an abortion that an abusive partner was demanding. In fact, many homicide cases over the last several decades have been traced to women’s refusal to undergo an abortion.

A study by Pallitto and colleagues (2013) was recently published in the International Journal of Gynecology and Obstetrics based on results of the WHO Multi-Country study examining intimate partner violence, abortion, and unintended pregnancy. The results indicated that 30 percent of abortions are due to intimate partner violence. The authors concluded their report by stating:

The time has come for greater recognition of the fact that [under] the visible physical bruises of violence lie the less visible yet potentially more debilitating consequences to women living in an environment where their physical, emotional, and reproductive health are at risk in the short and long term.

Knowing this, shouldn’t all women who present at abortion clinics be actively screened for violence with a protocol in place to help them to safety, as opposed to quickly performing the procedure and sending them back into the hands of an abuser?

* * *

Priscilla K. Coleman, PhD is a professor at Bowling Green State University in Ohio, and a founder of WECARE, the World Expert Consortium for Abortion Research and Education. This article was originally published at www.Aleteia.com, and is reprinted with permission of the author.
Most States Have No Safety Standards for Abortion Clinics—Complications Go Unreported

As a healthcare professional, I found it unbelievable that, since the Roe and Doe decisions, most states have had no standards for competence, sanitation or safety for first-trimester abortion clinics, because the courts deemed health regulations “impose an undue burden on a woman’s right to choose.” That is why I became involved in the process for drafting first-trimester abortion clinic regulations in my state, South Carolina. After several years, and two challenges which took our regulations to the U.S. Supreme Court, South Carolina has regulations for competency, sanitation and safety for first-trimester abortion clinics—thus, only recently, setting a precedent for other states to devise their own regulations.

Before we had our regulations, as an operating room nurse in the local indigent hospital, I interviewed many of the ob./gyn. residents as they rotated though my OR. All but one admitted seeing women with post-abortion complications, and one doctor told me, “I see them all the time.” Perforated uterus, retained products of conception, and undiagnosed ectopic pregnancy were the main complications they treated.

This is just one little hospital, in one city. I wondered, what is going on everywhere else? The CDC showed no incidence of abortion morbidity or mortality for South Carolina but we were seeing cases in my hospital. I checked on how this information would be relayed to the CDC and learned that there was no mechanism in place to record complications. The way any mortality stats would be found was by reading death certificates. Who is going to put on a woman’s death certificate that she died from an abortion? No. It would be from hemorrhage, or sepsis, but not from abortion.

Abortion is not physically safe, or emotionally safe.

The CDC has no source of data to draw the conclusions that it claims, that “abortion is safer than childbirth.”

Lynn Smith, R.N.
South Carolina
via www.afterabortion.org

Letters may be sent via email to elliotinstitute@gmail.com or by mail to Elliot Institute, PO Box 7348, Springfield, IL 62791. Comments on the articles posted at www.afterabortion.org may also be reprinted in this section. Letters will be published at the discretion of the editors, and may be edited for length and clarity.

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Recently an article titled “Is So-Called Post-Abortion Trauma Syndrome a Myth?,” written by Zawn Villines, appeared on GoodTherapy.org. In order to address the question she poses, Villines does not focus on the large international body of peer-reviewed scientific evidence indicating that abortion increases women’s risk of experiencing mental health problems. Instead she exclusively describes results of the flawed “Turnaway Study,” led by Diana Greene Foster.

Villines highlights the Turnaway findings that there were no significant differences in mental health trajectories between (1) women who had abortions and (2) those denied abortions because their pregnancies had advanced beyond the legal gestational limit.

Villines neglected to mention that 60 percent of the women in the Turnaway group who continued their pregnancies expressed happiness about their pregnancies. And no mention is made of the glaring methodological shortcomings of the Turnaway study.

The following major problems, among others, preclude trust in all the results obtained.

(1) Fewer than one-third of the women who were asked to participate agreed to do so. This is unacceptably low because those consenting may have differed systematically from those who declined. Consent to participate rates should be at least 70 percent for a study to be considered valid.

(2) Women who obtained or were denied abortions due to gestational limits in local laws included women for whom the legal limit ranged from 10 weeks through 27 weeks. This is not a variable that can be loosely defined, as there is a wealth of data indicating the psychological impact of abortion differs between first- and second-trimester abortions. Women aborting at such widely varying points in pregnancy cannot be lumped together.

(3) The increased risk of late-term abortion to women’s physical well-being is not addressed by Foster (the study’s author) or by her cheerleader, Villines.

Physical risks are uncontested in the professional literature. For example, using national data, Bartlett and colleagues (2004) reported that per 100,000 abortions, the relative risk of abortion-related mortality was 14.7 at 13–15 weeks of gestation, 29.5 at 16–20 weeks, and 76.6 at 21 weeks or later. This compares to a 12.1 rate for childbirth.

(4) The vast majority of research studies addressing the psychological implications of abortion do not measure “post-abortion syndrome;” instead, they examine mental illnesses identified by mainstream professional organizations. The results of hundreds of studies published in leading peer-reviewed journals over the past four decades indicate abortion is a substantial risk.

No mention is made of the glaring shortcomings of the study.