

## Behavioral Outcomes, Suicide, Healing



After an abortion, a number of behavioral and social outcomes which threaten women's health, their relationships, and their ability to cope have been observed. Teenage girls and women who have already experienced abuse or psychological problems are especially vulnerable. Post-abortion behaviors tend to be self-destructive and include suicide, both actual and attempted; deliberate self-harm such as mutilation and other punishments; unconscious self-harm in the form of substance abuse, smoking, and various eating disorders; and unstable, often abusive and battering, relationships.

Recent research reveals that the suicide rate following abortion is six times greater than that following childbirth, and three times the general suicide rate – sobering figures which should be of great concern to advocates of women's health and well-being. Self-destructive behaviors are ways in which women often deny or minimize the emptiness and pain they are experiencing. Abortion supporters tend to downplay these outcomes. There is a recognized pattern of abuse-abortion-abuse (including repeat abortions), which needs more study if women are to be helped from continuing the cycle of self-abuse and abuse of their children.

Frequently, women seek support to recover from post-abortion distress years after their abortion. Project Rachel, The Healing Choice, and The National Office for Reconciliation and Healing are among the many therapeutic options that have evolved in the wake of widely-practiced abortion.

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## **Behavioral Outcomes, Suicide, Healing**

It is commonly thought that most women emerge psychologically unscathed from the abortion experience and that rather than regretting their decision, they would make the same decision again; any distress they do experience is thought to be minor and short-lived. Thus, Brenda Major and colleagues found that only 1.4 per cent of the 442 women they studied for two years following abortion reported post-traumatic stress disorder.<sup>1</sup>

On the other hand, the British authors of a major review article concluded that “marked, severe or persistent” psychological or psychiatric disturbances occur in approximately ten per cent of women.<sup>2</sup>

Many studies are hampered by inadequate sample size, unsatisfactory study design, the reluctance of many women to be interviewed about their abortions, and political bias (See Chapter 17). As we shall see below, one objective and revealing approach to finding out the real consequences of abortion may lie in large-scale record linkage studies extending over periods of many years. Nevertheless, even if the true incidence of severe psychological distress is no greater than one to ten per cent, it means that many hundreds of thousands or millions of women have been affected over the past 30 years in North America alone.

Bearing in mind the reported magnitude of the problem, it is noteworthy that researchers have recently established that a high proportion of women conceal or deny that they have had abortions. Concealment is particularly common among non-white and unmarried women. The U.S. National Longitudinal Survey of Youth, begun in 1979, found that women who aborted had significantly higher depression scores ten years after their abortion than those who bore their children. After controlling for a wide range of variables, Cogle and colleagues ascertained that post-abortive women were 41 per cent more likely than non-aborting women to score in the “high-risk” range for clinical depression. In response to a self-assessment question, aborting women

were 73 per cent more likely to complain of “depression, excessive worry, or nervous trouble of any kind” an average of seventeen years later.<sup>3</sup> In a Canadian study of 50 postabortive women in psychotherapy, Kent and colleagues found that, “although none had entered therapy because of adverse emotional reactions to abortion, they expressed deep feelings of pain and bereavement about the procedure as treatment continued. Typically the bereavement response emerged during the period when the patient was recovering from the presenting problem.”<sup>4</sup>

Several behavioral and social outcomes from abortion have been identified that should be of concern to physicians or counselors. They include self-destructive behaviors such as suicide (actual and attempted); deliberate self-harm (mutilation, punishment); and unconscious self-harm, including substance abuse, increased smoking, and eating disorders.

There is also considerable evidence that childhood abuse may be a predisposing factor in abortion. Although this outcome may at first glance seem surprising, it is less so when the practitioner considers that the young woman with a history of sexual abuse may not connect sex acts with pregnancy, at least not in the same way that a woman might who has not experienced sex until she is physically mature. Sexual dysfunction or psychological numbing can follow abortion. In some cases, women may have repeat abortions hoping to quell the anxiety associated with previous ones, a phenomenon that will be explained later in this chapter.

#### **Self-Destructive Behaviors**

In the sociological literature, women who engage in activities which are unhealthy or which undermine their well-being are considered to be engaging, either consciously or unconsciously, in self-destructive behaviors. When their behaviors threaten their health, their ability to cope, or their relationships, they may come into contact with the healthcare system or seek out therapists or counselors. Under care, previous abortions may be identified as contributing to their problem in one of two ways: First, the women may readily admit to having had an abortion or, second, because of the comfort level and feeling of safety

in the ongoing therapeutic relationship with a counselor, they may find that they can discuss the sensitive topic of a previous abortion. However, the information that has been gathered about this is anecdotal.

A quantitative way of studying a connection between destructive lifestyle issues and abortion is through the analysis of studies that do not address reproductive issues as such but, as part of the overall study or survey questionnaire, ask background questions on fertility. The presence of abortion in a woman's history may not be seen as central to the original research, but the analysis of the abortion component of the data may provide insights into long-term relationships between abortion and lifestyle choices. This mathematical or statistical construct lacks the individual woman's perspective or story, but it does provide clinicians with information on the possible connection of present symptoms to past abortion experiences.

Self-destructive behaviors associated with abortion are symptoms of what Brende describes as "self-fragmentation" and part of a "traumatic matrix". This fragmentation may also predispose a person to "unstable and destructive (sadistic, masochistic, abusive and battering) relationships".<sup>5</sup>

A teenager engaged in these behaviors is more vulnerable and at the same time is likely to show insufficient self-awareness to recognize or admit the root cause of her difficulty. The egocentrism of youth, often identified in developmental literature, allows adolescents to take risks without awareness of consequences and also allows them to project onto others blame for any self-destructive behavior. Franz explains the adolescent response in the following way:

The girl who has had an abortion may find it very difficult to admit to having any psychological problems. She will be inclined to blame others for her unhappiness, because she couldn't possibly be a victim of such problems. She will deny that she has a problem or that she could develop one. If she is engaging in self-destructive behavior, she will deny that the root cause may be her abortion experience.<sup>6</sup>

**1. Suicide: Actual or Attempted**

In 1995, Gilchrist studied psychiatric morbidity following abortion and found that Deliberate Self-Harm (DSH) was a statistically significant 70 per cent more prevalent among “women with no previous psychiatric history who had an abortion...” In the definition of Deliberate Self-Harm used by these authors, the women's actions can be categorized as suicide attempts. Eighty-nine per cent were drug overdoses, and it is difficult to determine whether they were accidental (unconscious) or deliberate attempts to end their lives. Following a trend that is quite common in post-abortion literature, the researchers attempted to debunk their own results by stating that “The findings on DSH are probably explicable by confounding variables.” They also noted that the rate of DSH for women who abort dropped after the first year following abortion. A finding that they did not stress was that there was an opposite trend for adolescents, namely women who aborted under the age of nineteen.<sup>7</sup>

Using death records from hospitals and government death certificates Gissler and colleagues established that the suicide rate following childbirth and the suicide rate in the year following an abortion were dramatically different:

**Table 14-1**  
**Suicide rate per 100,000 women in Finland, 1987-1997<sup>8</sup>**

Associated with childbirth	5.9
Associated with miscarriage	18.1
Associated with abortion	34.9
Mean annual rate for all women	11.3

This prestigious study, based on the records of almost 600,000 women, discovered *a suicide rate among women who aborted nearly six times greater than among women who delivered their babies.*

Gissler and her colleagues also reviewed the hospital records to establish the reasons given for abortion by women who later committed suicide. They found that the reasons “did not differ from those for all abortions; over 80 per cent were performed because of social reasons.”<sup>9</sup> The researchers established that the suicide rate following abortion is six times greater than that for women following childbirth and three times the general suicide rate. They concluded both that “childbearing prevents suicide”, and that the increased risk for suicide after abortion may indicate “the harmful effects of abortion on mental health”<sup>10</sup> “Rather than being a relief, an abortion for them may be additional proof of their worthlessness and might contribute to suicidality and to the decision to commit suicide.”<sup>11</sup> The researchers also noted that only eleven per cent of the suicides following pregnancy had this connection reported in the death certificate. They conclude that there is a massive underreporting of suicide as an outcome of pregnancy, particularly following abortion.

An interesting feature of this Finnish study is the connection of abortion/suicide and social class. They note that, along with the negative effect of abortion on emotional well-being, there are also higher post-abortion suicide rates for women in the lower social classes. In Scandinavia in 1995, a study of abortion by Hamark and colleagues reported that the repeat abortion rate was highest for women in the poorest socio-economic group. They concluded that with unrestricted elective abortion, it was poorer women who had multiple abortions. This was the case before abortion on demand and continues to be so: “The class distribution was consistently uneven, with the majority within the indigent group.” Disadvantaged women are overrepresented in both the abortion and suicide statistics.<sup>12</sup>

**Suicide and Pregnancy, Childbirth, Stillbirth and Abortion**

Conversely, an Irish study found that the psychological effects of being refused an abortion did not put women at risk of suicide: “the risk of suicide is low in pregnancy and suicide is a rare outcome of refused abortion”.<sup>13</sup>

In the United States, suicide is the third leading cause of death among fifteen- to 24- year-olds. This age group also has the fastest growing suicide rate in the country. How many of the women in this group have committed suicide following abortion? No one knows for sure. Appleby does not address abortion as a variable but found that among women who gave birth, the standardized mortality ratio was one-sixth of that projected by the researcher. “The low ratio was less pronounced, but still present, in teenage mothers and in unmarried mothers.” These are the groups of women for whom pregnancies are often unplanned and whose children are considered unwanted by society, but of whom Appleby observed, “Motherhood seems to protect against suicide.” At the same time, “The low ratio was not found after stillbirth, which was associated with a rate six times that in all women after childbirth.”<sup>14</sup> Both stillbirth and abortion involve the death of a child. Both can have devastating effects on the woman. Clearly, more research is needed to specify the relationship between female suicide, stillbirth, and abortion.

In Chapters 11 and 12, it was noted that women with any history of psychiatric or psychological problems are at greater risk for negative reactions following abortion. It was also reported that adolescents have different developmental and cognitive issues which predispose them to post-abortion distress. When these two factors are combined, the outcome can be, as noted by Tishler, that young women with any history of psychiatric difficulties are vulnerable to “emotional stress and potential suicide...Should the patient’s perceived death of the fetus during abortion be punished by suicide?”<sup>15</sup> Campbell, Franco and Jurs suggest that adolescents do think their act is punishable by suicide. They report that teenagers are significantly less likely to attempt suicide before an abortion than adult women, but more than twice as likely as

adult women to attempt it after abortion (29 per cent compared to thirteen per cent).<sup>16</sup> Adolescents may, however, be less likely to recognize abortion as a factor. Franz notes that until adolescents develop more mature reasoning patterns they may continue to deny the effect of abortion on their lives.<sup>17</sup>

Reardon studied a self-selected sample of women who had elective abortions and who later experienced negative psychological *sequelae*. Among these women, "60 per cent had experienced suicidal ideation, 28 per cent had attempted suicide and eighteen per cent had attempted suicide more than once, often several years after the event." He concludes that "actual data suggests that abortion is far more likely than pregnancy and childbirth to drive an unstable woman to suicide." Reporting statistics from a chapter of *Suiciders Anonymous*, he goes on to say that 1400 of 1800 post-abortion women who sought help from the support group were between the ages of fifteen and 24.<sup>18</sup>

Suicide attempts often follow years of denial, repression, and depression. "Perhaps one reason for the strong abortion/suicide link exists in the fact that in many ways abortion is like suicide. Just as a suicidal person is crying out for help when she tells others she wishes she were dead, so a woman who is distressed over a pregnancy is crying out for help when she tells others she is considering abortion".<sup>19</sup>

A recent study addressing suicide and abortion was conducted in Wales among a population of 408,000 between 1991 and 1995. Morgan and colleagues studied hospital admissions for attempted suicide among women, post-abortion, post-miscarriage, and postnatal. They concluded that in women who abort, "attempted suicide may be a consequence of the pregnancy rather than some underlying mental illness." For women who miscarried or delivered, risk of suicide dropped after the event, while for women who aborted the risk increased from insignificant prior to the abortion to significant after the procedure: "Our data suggest that a deterioration in mental health may be a consequential side effect of induced abortion." They found that the relative

risk of suicide after induced abortion was 3.25; in other words, *women who had induced abortions were 225 per cent more likely to commit suicide than women admitted for normal delivery.*<sup>20</sup>

Similarly, Michels reports on women who mutilate themselves and later recognize the connection between such behavior and earlier induced abortion.<sup>21</sup>

A recent American record-linkage study came up with results similar to those uncovered by Morgan and colleagues in Britain. Medical records were linked to death certificates for 173,279 low-income women who underwent a state-funded delivery or induced abortion in 1989. Four years later the annual suicide rate was found to be *160 per cent higher (7.8 compared to 3.0) among the aborting women than among the delivering women.*

**Table 14-2**  
**U.S. annual suicide rate per 100,000 women**  
**aged 15 - 44<sup>22</sup>**

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All women	5.2
Women who aborted	7.8
Women who delivered their baby	3.0

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In all three countries, the U.S., Britain and Finland, abortion sharply increases the likelihood of suicide. Conversely, carrying a baby to term sharply reduces the risk of suicide.

## **2. Deliberate Self-Harm**

The cycle of self-loathing and self-punishment, although not thoroughly explored in the post-abortion research literature, is often painfully expressed in the personal stories of women who are attempting to recover and to find healing after an abortion.

Michels integrated the stories of women seeking post-abortion support into a psychological context and analyzed the emotional structures women developed to try to cope following their abortions. She points out that the mechanisms of coping were often methods of sublimating grief which were in themselves self-destructive. In the case of Jane, who was able to articulate her fear in terms of her possible self-harm, "I was very fearful of myself and didn't trust myself. I thought I might even kill myself."<sup>23</sup>

Even Sue Nathanson, self-described supporter of "abortion rights," says (after her own abortion) that "The inner torment is so unbearable that the only peaceful state I can imagine is death." She does not act on this feeling but attempts to use exercise as a way of both avoidance and self-abuse: "...Perhaps I can die if I keep going in this heat...I cannot drive my physical body to death. I am a Frankenstein who has transformed myself into a monster that will not die."<sup>24</sup>

### **3. Unconscious Self-Harm**

To cope with the dissonance and pain following abortion, women may also engage in activities that are intrinsically unsafe. The mechanisms involved are extremely complex and can reflect the disorder of a chaotic, abusive, or neglected background. They can also reflect psychological coping strategies that allow the individual to remain functional by forgetting or ignoring the abortion experience. The following factors are known ways of externalizing internal conflicts and disorders:

#### **a. Substance Abuse**

Reardon and Ney note that "Women who aborted a first pregnancy were five times more likely to report substance abuse than women who carried to term".<sup>25</sup> For the woman who wishes to ignore, forget, or minimize unresolved psychic issues resulting from an elective abortion, the use of drugs and alcohol can provide a ready vehicle for avoidance. Brende sees substance abuse as part of the constellation of self-destructive behaviors that are part of the woman's attempt to cope with her decision to abort, and describes this coping strategy as follows: "...victims develop repetitive

symptoms with splitting and dissociation as mental defenses; often using alcohol, tranquilizers or other substances”.<sup>26</sup>

Raphael observed that self-destructive behaviors have their origins in guilt surrounding the loss of the baby.<sup>27</sup> Speckhard, in a Ph.D. thesis, undertook in-depth interviews with 30 women post-abortion and found that 61 per cent reported increased alcohol consumption while 58 per cent reported increased drug use. Speckhard attributed this increase to the stress from the abortion. Only ten per cent reported any substance use/abuse before their abortion. The conclusions from this research are based on the assumption that substance abuse is a reactive response to distress, lack of personal control, or a lack of positive self-esteem.<sup>28</sup>

Drower and Nash found that eleven per cent of the women in their abortion sample reported increased alcohol and tobacco use while sixteen per cent had increased their use of tranquilizers.<sup>29</sup> Frank and colleagues found that cocaine users differed significantly from non-users on a number of obstetrical risk factors. Twenty-eight per cent of cocaine users had undergone two or more abortions compared to twelve per cent of non-users.<sup>30</sup>

While Frank and colleagues do not discuss the causative factors (for example, do more cocaine users abort or do women who have abortions turn to cocaine use to help them cope psychologically?), Mensch and Kandel found a correlation between illegal drug use, pregnancy, and a *five-fold* positive relationship between teenage users and abortion: “...illicit drug use increases the likelihood of an abortion by a factor of 5.”<sup>31</sup>

In a population-based study, Klassen and Wilsnack found that among 917 women in the U.S. Midwest, 26 per cent of those who described themselves as moderate to heavy drinkers had previously undergone an induced abortion.<sup>32</sup>

What seems to occur in the cycle of abortion and substance abuse is a cross-over between cause and effect. For some women, the problems that lead to substance abuse also lead to abortion while, for others, substance abuse becomes a way of coping with the emotional consequences of an abortion. Most studies do not attempt to establish cause-and-effect relationships in such circumstances, but Reardon and Ney did find that those women who had reported repeat abortions had higher rates of substance abuse than those who had had only one abortion.<sup>33</sup>

**b. Smoking**

Lydon and colleagues report that Canadian women who reported being committed to their pregnancy displayed their commitment through a reduction of the use of cigarettes. Those who decided to continue their pregnancy smoked fewer cigarettes a month after a positive pregnancy test.<sup>34</sup> Obel established that a prior induced abortion is a risk factor for increased cigarette use in subsequent pregnancies,<sup>35</sup> and a study by Thomas and Tori found that women who aborted or relinquished children were more likely to have a history of substance abuse.<sup>36</sup>

**c. Eating Disorders**

The use of food as a tool for *sublimation* or repression/denial is well known in the literature on anorexia and bulimia. The connection between abortion and such eating disorders has not been adequately explored. Psychiatric case profiles have linked the cycle of multiple pregnancies and abortions to eating disorders such as bingeing and purging. Personal accounts of post-abortion behavior strongly support the clinical research on unconscious self-harm. Women often report the use of substances as a means of dealing with pathological grief – that is, grief that cannot be integrated into normal life. As is common in the study of post-abortion problems, the stories have often surfaced in healing programs or support groups, such as Project Rachel and The Healing Choice. These groups are discussed at the end of this chapter (see “Healing”). The impact of these stories is gripping:

*“Wendy”*: I developed anorexia shortly after my abortion, but I never connected the two. I disowned my body. I became an eighty-pound skeleton. A totally non-sexual, non-woman.<sup>37</sup>

*“Jane”*: I was becoming anorexic and didn't care about my appearance or health.<sup>38</sup>

### **Childhood Abuse and The Abortion Cycle**

Sometimes, a history of induced abortions can be related to childhood abuse. Wyatt and colleagues studied revictimization of women who were sexually abused as children and found that “women who were sexually abused in childhood and revictimized in adulthood... as well as those with more than one incident in both childhood and adulthood were most likely to report high rates of unintended and aborted pregnancies....” The sex act itself is often perceived in isolation from the consequences....”Just as they may perceive sex and its consequences as separate issues, survivors of sexual abuse may not consider that one of the risks of engaging in sex is becoming a parent and may choose, instead, to terminate unintended pregnancies....”<sup>39</sup>

In the epidemiological literature and clinical case histories the abuse/abortion/personality disorder correlations are so strong that psychiatrist Ney developed a therapeutic treatment program which addresses these issues. Called Hope Alive: Post Abortion and Abuse Treatment, this inpatient program is based on the conclusion that “people who have had an abortion are more likely to abuse their children and people who have been abused are more likely to have an abortion...Abortion results in more post-partum depression and therefore less bonding, less touching and less breast feeding...It should be noted that one of the earliest arguments was that aborting unwanted children would diminish the incidence of child abuse. Statistics show precisely the opposite; that is, with more frequent abortions, all kinds of child abuse have increased.” Ney and Peeters add that “Child mistreatment and abortion are both cause and effect, one of the other. Abortion also runs in families, with mothers and grandmothers for three to four generations having had abortions often for the same reasons.”<sup>40</sup>

Ava Torre-Bueno, a clinical social worker and Planned Parenthood volunteer, describes the effect of physical abuse on the guilt women feel following abortion. Women who have suffered abuse internalize responsibility for the feelings of others, usually due to their perception that their actions are the cause of other people's problems. The guilt of these women becomes pathological and encompasses those around them: "Sarah felt guilty about everything...Her guilt wasn't only about harming herself by having her abortion it was just how she felt about everything."<sup>41</sup>

What Torre-Bueno does not explore with this client is the underlying motivation for the abortion. She gives the usual reasons that young adults provide for their abortion – too young, not financially self-sufficient – but does not delve into the role the damage from abuse played in her decision. Torre-Bueno may be committed to the assumption that post-abortion guilt is rooted in systemic clinical pathology, not in the abortion itself, but why was the young woman's motivation to abort not explored? In ignoring this question, a pre-abortion counseling process might miss the presence of abuse or a chaotic personality, which if recognized would obligate the therapist to consider the possible outcome of pathological guilt and to question the choice to abort.

In particular, anecdotal counseling stories from this literature lack discussion of the recognition of *borderline personality disorder*, a condition characterized by impulsive and self-destructive behaviors of the kind potentially magnified by abortion.

Therapists such as Torre-Bueno help post-abortion women deal with the consequences of their choice, but will not suggest that the choice itself might have been inappropriate. The most they can say is that the resulting feelings are part of an underlying problem, usually related to the family of origin. In this model, abortion is only a trigger or stress. However, while abortion may not be the main causative factor in post-abuse effects, it is certainly an avoidable one.

If the literature on abortion and abuse is accurate, of the 1,300,000 women in the U.S. who abort yearly, 25 per cent have a background of abuse. Indeed, if the proportion of abuse victims in the aborting population is higher than non-victims then this number could be significantly larger. Thus, 325,000 North American women may be experiencing the psychological impact of abuse and abortion. Without appropriate therapy, the abuse cycle can continue into further generations, assuming that the women have live births at some point. These women, in turn, may be physically abusive with their children and/or not act to protect their female children from sexual abuse.

Crawford and Mannion put it this way: "Several studies now show that many aborted women were victims of sexual abuse as children. They who were the victims of violence, now become perpetrators. How? Why? Does not this knowledge of the women's history or similar insights demand even greater compassion and commitment to help heal?"<sup>42</sup>

The mechanisms at work in this transmission of self-destructive behaviors from one generation to the next seem to be mediated in part by the parent-child attachment.<sup>43</sup> Cole and Woolger found that this was particularly true of the child-rearing practices of women who had been victims of incest as compared to women whose abuser was extra-familial.<sup>44</sup>

What is applicable about this research is the emphasis on the parent-child bond which is, by definition, severed in the abortion decision. As Benedict, White and Cornely put it, "it is apparent that reproductive history and the circumstances surrounding past pregnancies may provide important clues in eliciting more precisely what family dynamics may be related to subsequent maltreatment." Their study also found that women who are abusive have more stillbirths and abortions.<sup>45</sup>

### **Sexual Dysfunction**

Following abortion, women may suffer from sexual dysfunction. For some women, the abortion experience leads to a fear for the possibility (or the impossibility) of future

pregnancy. As Torre-Bueno puts it, they “become convinced that they will never be able to get pregnant, or they may fear another pregnancy so much that they become afraid of having sex. This fear may look more like a sudden or slow loss of interest in sex.”<sup>46</sup>

In addressing psycho-spiritual healing following abortion, Crawford and Mannion found that in structured clinical interviews, both verbal and written, a patient whose profile included sexual dysfunction also included chaotic relationships.<sup>47</sup>

### **Psychic Numbing: The Absence of Affect**

In a Greek study Naziri and Tzavaras found that women experienced a feeling of guilt following abortion and that this is an “unavoidable consequence of the violation of some prohibitions concerning particularly female sexual fulfillment and/or the possibility of pregnancy without becoming a mother...To whom and to what is this feeling [of guilt] directed?...the answer to this question led us to distinguish two tendencies among the women interviewed: Either they felt guilty toward their family or immediate environment or they felt guilty toward themselves.”<sup>48</sup>

This study also found that guilt was linked to aggressiveness and to anxieties about bodily integrity. “Before the operation women often felt ‘a big anxiety’ and immediately after the operation ‘an emptiness’, ‘a cold feeling’”. These same feelings are also found among women following *multifetal pregnancy reduction (MFPR)* (see Chapter 13) and are identified by Kent as a clinically pathological outcome.<sup>49</sup> Many women who tell their own abortion stories use the terms “numb” and “disconnected” both of which describe an acute phase of post-abortion psychological dysfunction.

A recent Canadian study also found that guilt (ambivalence about the decision), as well as thoughts of suicide, helped to explain why “being involved in a first-trimester abortion can be highly distressing” for women.<sup>50</sup>

### **Repeat Abortion**

Although repeat abortion is sometimes considered to be caused by an inability to find a comfortable contraceptive routine, it can, in fact, have deeper psychological motives. Some research suggests that it is an attempt to find an abortion situation that relieves anxiety. As reported by Naziri and Tzavaras, "Repetition of the act (even on an impressive number of occasions) does not alleviate the pain and the anxiety brought on by the experience; repeated abortion leads neither to adjustment nor to a solution to the anxiety."<sup>51</sup>

Regarded from a clinical and psychoanalytical viewpoint, these researchers consider repeat abortion as related to unresolved Oedipal conflicts of the faltering image of the father figure because of absence or indifference. "Unwanted pregnancies then unveil the steady unconscious incestuous desire and at the same time the attempt to fill the narcissistic rift which the absent or indifferent father had caused."<sup>52</sup>

From the nonanalytic approach to psychology, repeat abortion can be seen as the outcome of a woman's grief surrounding the original abortion. If a woman has buried or repressed feelings of grief after multiple abortions, Rue noted that, "...reenactment of the first abortion trauma can become an organizing feature." For some, grief can lead to attempts to replace the aborted child with a baby, and for others, "...the resurfacing of the trauma in a subsequent pregnancy is too threatening and compels another abortion. When multiple abortions occur, the traumatizations and resulting psychological impairment can be overwhelming."<sup>53</sup>

Congleton and Calhoun discovered that the mechanisms that cause or trigger distress following a first abortion may be part of the pattern of behavior that results in repeat abortion.

Within the group of all women who abort, those who have repeat abortions have higher scores on measures of disturbance such as paranoid thoughts, phobic anxiety, and problems with sleep. Other correlations with repeat abortion rates appear to be: unstable relationships marked by lack of a partner or satisfaction with partner, a lack of perceived

control in their lives, and less reported religious affiliation and social connectedness.<sup>55</sup>

Here are the conclusions of four separate studies on repeat abortions:

i When asked about psychological problems and contacts with the social welfare service, women having another abortion differ significantly from women having a first abortion. [They] also evaluate their relationship with their partner more negatively.<sup>56</sup>

ii Most women having repeat abortions seem to have a psychological vulnerability and demonstrate current and previous problems. Poor self-esteem and lack of assertiveness seem predominant, especially in relationships with men.<sup>57</sup>

iii Patients having a repeat abortion are more often dissatisfied with themselves, more often perceive themselves as victims of bad luck, and more often express negative feelings toward the current abortion than women who are obtaining abortions for the first time.<sup>58</sup>

iv On the other hand two studies, one from Montréal and the other from Copenhagen, reported no major differences between women having their first abortion, and those having repeat abortions.<sup>59</sup>

During the 1990s, one half of the abortions in the United States and approximately 40 per cent in Canada were repeat abortions. In studies of social and personal factors pre-disposing women to repeat the abortion experience, researchers have found that in any given group of abortion seekers, the numbers of women who report at least one previous abortion ranges as high as 60 per cent in older women. Soderberg and colleagues found that in women 24 or younger "...a history of previous abortion was the factor most strongly correlated with the decision to undergo abortion." American research suggests that 50 per cent of women currently obtaining an abortion have already

undergone the procedure at least once.

#### **Abortion and Poverty**

In Sweden where socioeconomic data are collected on abortion patients, Hamark found that women from “indigent areas” were younger, more likely to have had previous abortions, and least likely to respond positively immediately following the abortion. What is startling about the Swedish experience is that abortion has the greatest negative impact on the poor. “So far, we have demonstrated that socioeconomic conditions have an impact on abortion prevalence, thereby confirming the persistence of the situation when abortion laws were restrictive.” Swedish women most likely to suffer the medical sequelae and psychological problems following repeat abortion are poor. The extent to which repeat abortion is part of the cycle of poverty needs to be more fully explored.

#### **Abortion and Crime**

Much attention has been given to the claim by Donohue and Levitt that “legalized abortion has contributed significantly to recent crime reduction.”<sup>62</sup> This claim has been vigorously contested by a number of social scientists. David Murray, the director of the Statistical Assessment Service, a non-partisan think-tank in Washington, stated that “the study poses an intriguing argument, but does not stand up to scrutiny.” He went on to observe that “using the authors' hypothesis, crime rates in other countries with abortion access should have seen a similar dip in crime. But in Great Britain, which liberalized abortion in 1968, violent crime has risen dramatically in the past decade.”<sup>63</sup> In a recent major paper Lott and Whitley severely criticize Donohue and Levitt's methodology and assumptions, concluding that “There are many factors that reduce murder rates, but the legalization of abortion is not one of them”. They add, “We find evidence that legalizing abortion increased murder rates by around 0.5 to seven per cent.”<sup>64</sup>

#### **Healing**

One sociological development that has followed in the wake of widely available abortion is a plethora of therapeutic groups for women seeking post-abortion support. Although support groups are particularly common in the United States

they appear to exist across cultures and religious denominations. "In Japan since the 1950s special mourning rooms have been established in temples for those who are seeking to grieve and atone for...abortions. The same is true in Taiwan where 'baby spirit' programs have been established in temples to help parents...There are support groups for aborted women in Ireland, England, Switzerland, South Africa, Australia, New Zealand, Uruguay and Hong Kong to name only some."<sup>65</sup>

In North America as well, many organizations have established self-help groups run for and by women struggling after an abortion. "Crisis pregnancy counselling agencies and family service organizations provide post-abortion counselling, often by women who have had abortions."<sup>66</sup> Some groups are faith-based as part of a community outreach service. Still others are psycho-therapeutic, offering to help women integrate their abortion experience into their lives. Project Rachel, founded in 1984 by the Roman Catholic Archdiocese of Milwaukee, is probably one of the largest of them. Its London, Ontario chapter describes Project Rachel as a "post-abortion program offered by certified counsellors and trained clergy representing a variety of Christian denominations."<sup>67</sup>

A woman who seeks out Project Rachel goes through a process which involves telling her story and grieving her loss. Forgiveness is at the heart of this therapy: forgiveness of everyone involved in her abortion, forgiveness of herself, and finally, discernment of how to move on and make a positive impact on her world.

The National Office of Post-Abortion Reconciliation and Healing, Inc. is a group dealing with post-abortion issues and their impact on women. It networks with researchers and professional counselors, provides training and operates an "800" referral line. It also sponsors an annual conference on abortion's aftermath and its resolution called "The Healing Vision".<sup>68</sup>

Among abortion advocates there now exist some emotional recovery programs such as “The Healing Choice”. In the introduction to their book of the same title, Candace De Puy and Dana Dovitch explain the rationale for this program:

Psychological studies show that only 10 per cent of the 1.4 million American women who undergo abortions every year experience emotional trauma following the procedure and these women were most often psychologically unstable prior to their pregnancy. Unfortunately, most studies dismiss the other 90 per cent of women as if they had no reaction whatsoever. Because the majority of women move forward with their lives, any normal grief, confusion or ambivalence they might feel is dismissed.

In reality, women who find themselves confronted with the decision to abort do not always walk away from the experience unscathed, even though they move forward with their lives. As psychotherapists, we see such women in our practices every day.<sup>69</sup>

All of these and other therapeutic programs try to address the significant distress experienced by some women after an abortion. Insofar as post-abortion distress represents an unexpected outcome of pregnancy termination, the fact that some women do undergo psychological anguish after an abortion suggests that women should be informed about its possibility beforehand. After the fact, it is also important that these therapeutic options be made more public and available. “Indeed, what we are dealing with is the need we have to make sense of our parenting history, that is, to acknowledge, take ownership for, and grieve the loss of each pregnancy experience, whether it ends in abortion, miscarriage or stillbirth. This is a human need.”<sup>70</sup>

**Conclusion**

A number of self-destructive behaviors are identified after a woman has had an induced abortion, but for reasons that are seldom apparent, these are not usually regarded as a reason to avoid the procedure. Given the seriousness of post-abortion behavioral dysfunction among some women, which includes suicide, mutilation, substance abuse, and abusive behavior in family and partner relationships, it would make sense for the medical and helping professions to take a greater interest in finding ways to help women avoid these harmful tendencies. Repeat abortion as a means of relieving anxiety about a previous abortion is also a problem but, again, there is little knowledge as yet on how to prevent this outcome. Various therapeutic options for unresolved bereavement have evolved. Their purpose is to facilitate a means of healing for those women who continue to be affected emotionally after an abortion.

#### **Key Points Chapter 14**

- It is becoming clear, as women who have had abortions present themselves for therapy, that previous abuse sometimes leads to the decision to abort.
- After an abortion, women are more likely to display self-destructive behaviors including suicide and attempts at suicide; mutilation and various forms of punishment (including repeat abortions and sterilization); drug, alcohol and tobacco abuse; and eating disorders as a way of denying or minimizing the guilt, pain and numbness they feel.
- Women who abort often have trouble bonding with the children of future pregnancies and have a higher chance of eventually abusing them, which leads to a cyclical pattern of abuse-abortion-abuse.
- It seems clear, given the frequency of negative behavioral outcomes for women after abortion, that more thought needs to be given to appropriate therapy for women (and their children) who are at risk.
- Many women seek support in recovering from post-abortion distress, often years after the abortion. Project Rachel, The Healing Choice, and The National Office for Reconciliation and Healing are among the many therapeutic options that have evolved in the wake of widely-practised abortion.

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