Chapter 11

Psychological Risk Factors

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Although more research on the psychological effects of abortion on women needs to be done, it is clear that women experience varying degrees of emotional distress. Both internal and external risk factors come into play, and women particularly at risk of future psychological problems include those who had psychiatric or psychological problems before the abortion, those who are in dysfunctional or abusive relationships (either present or past), those who hold religious or philosophical values in conflict with the procedure, those who are not sure how they feel about their pregnancy and lack support systems, and those who are in adolescence at the time of an abortion and lack the ability fully to understand future implications.

When women at any age are pressured by those around them to have an abortion they are likely to experience more distress around the decision, as well as guilt, anxiety and depression. In countries where counseling and psychological and practical help are offered to pregnant women, they are less likely to make the decision to abort. Unfortunately, most abortion facilities in North America offer no such counseling opportunities, nor do they make women aware of the possible negative psychological impact the procedure could have on them. It is not clear how likely women will be able to give informed consent under these circumstances.

Psychological Risk Factors

Shortcomings in the Psychological Outcome Literature
North-American researchers and practitioners of abortion tend not to identify psychological problems for women after abortion because they do not expect them. Rather, they assume that women, anxious about an unwanted pregnancy, will be relieved after the procedure. As a consequence, they minimize any damage abortion does to women's psychological health, and attribute negative psychological effects either to women's immaturity or to their pre-existing psychological problems.[1]

As in many other areas of abortion research, conclusive findings are difficult to arrive at owing to short-term follow up, subjective measurements, lack of volunteers for research studies (because many women do not want to recall their abortion(s)), researchers' politically motivated agendas, and stereotypes about the kind of women who exhibit negative psychological traits. As deVeber and colleagues observe:

> In the search for evidence of deep-seated, long-term adverse reactions to the abortion experience, the small-scale studies provide what the large projects lack: they examine reactions over years and probe for reactions in a variety of behavioural and symptom areas. Studying 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.[2]

Until information that is now only available in anecdotal women's stories can be subjected to critical analysis, it will be difficult to assess the risks abortion poses to women's psychological health.

Risk Factors: Introduction

There is a general consensus that women who exhibit certain pre-existing characteristics are at greater risk for post-abortion problems.[3]

In 1977, Belsey established the following high-risk criteria for British women undergoing induced abortion.[4] Women who exhibited any, some, or all of these factors would experience negative emotional reactions following abortion:

- Poor or unstable relationships
- Socially isolated (few friends)
- History of unemployment
- Psychosocial instability
- Contraceptive failure

While these factors have been generally accepted in the literature, over time other factors have been added. Dunlop added the following factors:[5]

- Pressure or coercion in decision-making
- Previous psychiatric condition
- Medical reasons for the abortion, such as genetic abnormalities

Shusterman isolated additional factors:[6]

- Anger at pregnancy
- Low intimacy with partner
- Dissatisfaction with abortion decision

More recent studies have included factors such as religiosity, feelings of loss immediately after abortion, and age.[7]

The risk factors that are reported depend in large measure on the focus of the research studies. Research that is directed toward psychological factors will isolate the pre-existing psychological and psychiatric issues that affect post-abortion adjustment, while studies that focus on interpersonal relationships will determine the relationship factors that affect women after abortion. Since no one study can address all

social and psychological factors, the list of factors included as pre-existing risks may be expected to grow and change over time and across disciplines.

Internal or Personal Risk Factors

Internal factors are the pre-existing risk conditions that have a significant impact on post-abortion well-being. McAll and Wilson speak to this in their discussion of negative emotional reactions following abortion "...it seems probable that because of their internal origin they may persist as repressed conflicts that can surface later in life if the person is stressed by later events."[8]

Internal or personal factors are part of a woman's personality development, and may contain components of genetics, past experience, and personal value systems. But they are still an integral part of the individual; they cannot be considered external even if they originated outside of the person and have been accommodated into the personality.

Included in this group are: Psychiatric or psychological history; history of abusive and/or dysfunctional relationships; religious values; ambivalence about the abortion decision; and age.

1. Psychiatric or Psychological History

Women who suffer from diagnosed psychological or psychiatric disorders or conditions before abortion will have emotional difficulties following abortion, as a sampling of the literature shows:

> ...among women who had a termination, the rate of psychiatric illness in those with a previous history of psychosis was higher than the rate in those with no history of psychiatric illness.…[9]

> ...women who...have pre-existing psychiatric problems...are more likely to have emotional difficulty.[10]

Pre-existing psychiatric conditions, including depression, have been found to be associated with post-abortion problems: "...pre-abortion depression had both direct and indirect…effects on adjustment"[11] Severe grief reactions in women who aborted because of fetal abnormality were found to be linked to previous mental health treatment.[12]

David reported that an examination of admission rates to psychiatric hospitals showed 50 per cent significantly higher rates for women following abortion than for women who delivered.[13] The psychiatric admission rates for separated, divorced, and widowed women were nearly four times greater among those who aborted than among those who delivered. Most recently, a very large-scale study in California, using record linkage, found that over a four-year period women who aborted had a 72 per cent higher rate of psychiatric admission than women who delivered their babies.[14]

The Planned Parenthood Federation of America reports that ten per cent of women who abort will experience lingering depression. They go on to note that pre-existing psychiatric disturbances correlate with these negative emotional reactions.[15]

The prevailing interpretation of this finding is that the problems that these women experience is the result of their pathology and not the abortion itself. The "emotional harm some women experience post-abortion is not attributable to the abortion, but to their pre-abortion psychological fragility".[16] Abortion is seen as one of many stressful life events that will trigger their instability.

Zolese and Blacker analyzed follow-up studies of psychological sequelae and interpreted Greer as follows: "Two-thirds of those undergoing psychiatric treatment following abortion had in fact had psychiatric treatment before, so the cumulative incidence of new cases in the two-year period was only 6.5 per cent."[17]

But one limitation of this kind of research is the problem of long-term follow up. To measure psychiatric disorder as a complication of abortion requires identifying those women who have been retained in a follow-up sample who have used specific psychiatric services either as outpatients or inpatients. It is, therefore, only in jurisdictions where there is continuity of service that such information is available. In the United States and increasingly in Canada, where the majority of abortions occur in freestanding clinics, there is little continuity. Only those individuals who are especially willing to participate in research can even be traced.

It must also be remembered that pre-existing risk factors are not mutually exclusive; several characteristics may apply to the same woman. For example, women with psychiatric histories may experience unstable relationships, live more chaotic lives, and be exposed to other factors which may exacerbate post-abortion reactions. Such a loading of factors has not been fully analyzed to determine their interactive effects. It may be premature to conclude that the identified psychiatric problem is the only relevant factor, or even the main one, in a particular case.

In the newly-emerging literature on post-abortion healing, therapists have isolated other factors in women's histories that may predispose them to post-abortion guilt and depression. Of particular note are early relationship disorders such as parental abandonment or unresolved conflicts in the family of origin.

2. Abusive and/or Dysfunctional Relationships

A 1998 research paper by Glander and colleagues looked at the relationship between domestic violence and abortion. Their focus was comparative, to determine the level of abuse reported by women who had recently undergone an outpatient abortion. The results of the self-administered questionnaire indicated that 39.5 per cent of participants (the total participation rate was 81 per cent) identified themselves as having a history of abuse. Abused women were less likely to inform their partners or involve the fathers in the abortion decision. "Relationship issues were significantly more likely to be stated as the primary reason for abortion by women with a history of abuse than nonabused women."[18]

The presence of relationship dysfunction has been identified by researchers as a strong indicator of pre-abortion depression. These researchers also call for family assessment for any woman reporting abortion-related depression since "the association between depressive symptoms and denial might reflect a lack of perceived social support, engendered by unsatisfactory family relationships."[19]

Researchers have found this issue to be particularly significant in the relationships of adolescents who abort.[20] Barnet and Freudenberg considered the relationship outcomes for unmarried but co-habiting women who aborted and found that prior to abortion their relationships were characterized by "significantly more conflict and were less harmonious than in the control group." Following abortion, when separations occurred, more of the women who had aborted initiated the breakup than did the women in the control group and the majority of these women reported that the abortion was implicated in the decision.[21]

Women who have a history of abusive relationships are likely to experience what some researchers have called "poor obstetrical history." The researchers include in this category a previous premature or low birthweight child and two or more abortions. They found that abused women were less likely to have a recorded birth as an outcome of pregnancy (i.e., they were more likely to have either a miscarriage or abortion), and that abuse was a significant predictor of poor obstetric history. They conclude, "women with a history of abuse are more likely to tolerate abuse in future relationships."[22]

Physical or sexual abuse causes a severe rupture in a woman's perception of her own self-worth. Mannion and colleagues found that when abortion is sought as part of a pattern of accepting abusive relationships, it may cause women to internalize abusive or profoundly dysfunctional relationships from the past or present, and may make it more difficult to break the cycle. For example, "Mary" and "Liane" tell their stories of abuse as children:[23]

> *Mary*: I was quite sexually permissive, believing very wrongly that my worth to men lay in pleasing them physically. I was taught [through the abuse] that if I could make them happy sexually, they would stay forever.
>
> *Liane*: I had been sexually abused for two years by a family friend when I was nine and ten years old, lost my virginity by rape in high school and had an overall poor self-image. This feeling did not start with the abortion. It started with the abuse at age nine...The abortion merely intensified this feeling.

Torre-Bueno focuses on the nature of what she calls shame following abortion. She distinguishes between guilt and shame by saying that shame is internal and reflects the collapse of self-esteem, leading to feelings of worthlessness and stupidity. She describes a patient she calls Michelle who had been molested by her cousin and by a school teacher and had never felt strong enough to follow through with prosecuting them. "These events left her feeling flawed and pathetic and the abortion confirmed for her that she was a powerless, shameful person." Torre-Bueno records that her therapy was unsuccessful because the patient was unable to confront the role that shame played in her life.[24]

Rue notes that "Abuse in relationships complicates both the abortion decision and its aftermath...[the aborting woman] may feel there is simply no other 'choice' or even feel coerced, as many women feel today in abusive relationships... 'Learned helplessness' is a fundamental aspect of a battered woman's functioning that is repetitively reinforced in an abusive relationship. Consequently, without a thorough exploration of her relationship in pre-abortion counseling, this woman's abortion decision-making is likely to be passive, highly conflicted and burdened by feelings of hopelessness."[25]

Women who have histories of abuse may present two pre-existing high risk characteristics: possible coercion or ambivalence about the abortion and reinforced feelings of

shame or powerlessness. These characteristics can result in post-abortion psychosocial and social difficulties, not the least of which is the continuation of the cycle of abuse.

3. Religious Values

Although the literature on the psychological outcome of abortion does not deal much with the issue of abortion among women with strong traditional religious convictions, it appears that for them, abortion can lead to both psychological and spiritual damage.

Research on adolescent abortion patients has suggested that religious affiliation and church attendance did not stop young women from choosing abortion.[26] A Canadian study on unplanned motherhood found that:

> ...few mothers regard religion as a factor influencing a woman's decision in a crisis pregnancy...Nor do agencies regard religion as a factor of importance in any of the three dimensions in question: the likelihood of pregnancy, the abortion and the parenting decision.

In this study, only one out of five social service agencies reported that clergy played any determining role in women's decisions about their pregnancies.[27]

While the religious background of young women may not alter the original decision to abort, it is an important precursor of post-abortion distress. Dirks concluded that women from religious denominations which strongly opposed abortion were more likely to experience depression following abortion.[28]

Tamburrino and colleagues, noting that "Research has not adequately addressed how women cope with religious conflict after abortion, or whether religion is experienced as another stress factor or as a support system," studied religion as a psychosocial variable in women who describe themselves as *dysphoric* (depressed, lacking a sense of well-being) one to fifteen years following an induced abortion. The women in this sample experienced regret, guilt, and

sadness, and 46 per cent "have changed their religion to Evangelical or Fundamentalist Protestant denominations...to help themselves cope with their post-abortion feelings."[29]

One difficulty with research in this area is that a distinction is not always made between religion as an extrinsic factor (the woman feels that she has violated the beliefs of others to whom she may be attached) and religion as an intrinsic factor (the woman feels that she has violated her own beliefs). Some researchers and therapists report that a woman from a religious background may suffer intense guilt over abortion if it is incompatible with her intrinsic value system. The guilt is a personal response to the violation of a value that she herself has believed and accepted but has not been able to act upon.[30]

This dissonance between the choice for abortion and accepted beliefs – for example, beliefs about the sanctity of human life – may lead to the onset of later disorders. These difficulties often arise as women mature and are able to evaluate their earlier actions in light of a more adult understanding of their faith. Women may seek resolution in one of several possible ways:

a. Denial and Repression

These tools are often used to accommodate psychologically incompatible ideas. Denial can become pathological when women use drugs, alcohol, or sexual promiscuity as a way to avoid confronting an underlying problem. When repression is used to suppress unpleasant thoughts and feelings about a previous abortion, they remain unresolved and can lead to future psychological problems.

b. Isolation

When post-abortal women feel unaccepted, unworthy, or hypocritical in continuing the affiliation with their denomination or faith community, feelings of isolation develop. The director of a counseling program that assists women with spiritual healing puts it this way:

> The abortion is for many an experience of the first serious perceived sin. She believes that she has committed the unforgivable sin, leaving her isolated from God…She realizes that she has victimized an innocent being and she must take responsibility for the choice and the outcome...This spiritual woundedness crosses denominational lines.[31]

These women may still attend services and appear to be part of the community, but they often carry the burden of guilt and grief, viewing their sin as unforgivable, which places them emotionally outside that community.

c. Rejection of the Previously Accepted Value System

Delegitimizing of the previously accepted morality is a third way of coping with psychic distress. This last response is suggested by some therapists as an appropriate way of coping. Authors such as Torre-Bueno view the post-abortion distress of religious women as a problem with the faith or denomination rather than as a factor internal to the women themselves. It is their contention that because these churches or religious systems are philosophically opposed to abortion they are burdening women with "religious guilt".[32] To avoid such "religious guilt," they suggest that women re-evaluate their commitment to that denomination and develop their own personal spirituality that accepts their choice. This prescription amounts to changing their religious affiliation, which the women did in Tamburrino's sample above, but the difference is that in this case the change will probably be to an affiliation that accepts abortion rather than one that repudiates it.

It is worth noting that women who express philosophical, though not necessarily religious, opposition to abortion are also at risk for developing post-abortion symptoms. Franz and colleagues observed, "For women who view abortion as morally wrong prior to the procedure, undergoing an abortion may initiate a life-time of suffering. This may be particularly true for younger women."[33]

4. Ambivalence

Ambivalence exists when a woman is unsure if the abortion decision is the correct one. Ambivalence is an important factor in the decision-making process because the majority of crisis pregnancy decisions are marked by ambivalence. A 1994 study of unmarried single parents in Canada found that "...in a crisis pregnancy women do change their mind about the direction they will take."[34] When this ambivalence was measured by Decision Shift, there was a "...significant shift toward investment in the life of the child," and toward the parenting option. Social service agencies dealing with single mothers reported that 51 per cent of those women who were ambivalent were likely to move from abortion to parenting, while another 40 per cent occasionally made that shift. On the other hand, only seven per cent of those who originally considered parenting were likely to move toward abortion and ten per cent would occasionally make such a move. Few women make the choice to abort or to parent without experiencing some degree of uncertainty. If this uncertainty is not resolved before the abortion, it will often surface later as regret and guilt. In the Canadian research, for those who opted to parent, there appeared to be a qualitative difference in how that choice was perceived. The social workers dealing with women experiencing crisis pregnancies interpreted the decision to abort in the face of ambivalence as a result of negative influences, and one agency response stressed that women who are abandoned or are dominated, most often choose abortion even though they might want to carry to term. Osler and colleagues and Husfeldt and colleagues found that "ambivalent women run a greater risk of suffering negative emotional sequelae such as depression and guilt."[35] In short, women who are feeling ambivalent about their pregnancy are much less likely to resort to abortion if they receive positive encouragement and support, particularly from their male partners.

Ambivalence in making the decision to abort has also been isolated in the published works of Trost, Holmgren, Lemkau, and Bracken.[36] At the time of the decision, at least 25 per cent of all women and perhaps as high as 55 per cent are uncertain that abortion is the right choice. These ambivalent

women are seen by Husfeldt as a separate cohort from those for whom the decision seems straightforward and unambiguous.[37] The researchers established that ambivalence could be affected by external socio-economic factors. Ambiguous women report significantly more often they would have continued their pregnancy "...if the partner had wanted the baby or if personal finances had been better." Following abortion, as women consider the possibility of acting without the support of their partner or as their financial circumstances improve, the past abortion decision may come to be viewed as a negative event.

It would appear that the socio-economic and interpersonal circumstances of ambivalent women are the main forces impelling them toward abortion. Hamark and colleagues found that, while only eight per cent of women were ambivalent when they arrived at the abortion clinic, 43.1 per cent reported initial positive or mixed feelings about the pregnancy.[38] This finding is consistent with the results of the Holmgren research which established that 42 per cent of women giving birth also had negative or mixed feelings about their pregnancy.[39] Indeed, ambivalence can occur in pregnancies that are defined as wanted and planned, and Tornbom notes that the initial unwanted or unplanned nature of pregnancies does not exclude welcome or acceptance at the time of birth, just as planning does not exclude ambivalence.[40]

When women are ambivalent, they are likely to be influenced by the views of others or by social attitudes generally. Pressures to abort for relational, financial, or social reasons may make the decision subtly coerced. The combination of ambivalence and coercion can lead to dissatisfaction and, ultimately, to psychological distress. The survey by Husfeldt and colleagues reported that 30 per cent of the women who aborted felt doubtful about the decision up to the time of the abortion. "Ambivalent women more often felt exposed to social pressure and some felt that the abortion was not their own choice...The ambivalent women more often stated that it was their partner who decided on abortion...Only a minority initially wanted abortion when the pregnancy was

established...."[41] Hamark and colleagues also found "unstable relationships to be an important motive for abortion".[42] Counseling often helps in such situations.

In North America, where such counseling is not mandated or available as part of the medical system, attempts to resist the external pressure may not lead to a re-evaluation of the decision but may lead to a delay in making it. Such delays make the abortion procedure more difficult and the post-abortion distress more apparent. As Peppers found, "...where external control is strong the decision may be laden with ambivalence, anxiety, and concern for subsequent consequences. Indeed these external factors appear to be the most frequently mentioned reasons for delaying the abortion beyond the first trimester of pregnancy...The longer the pregnancy continues the greater the grief response."[43] It is at the point when ambivalent women are exposed to external pressure that they perceive a lack of control. In the research of Franco and colleagues, women who experienced negative emotional reactions on or about the date that the aborted child would have been born – known as Anniversary Reactions – often reported ambivalence about the decision to abort.[44]

This expression of ambivalence was also detected in the work of Allan and Astbury. They established that: "Too ready acceptance of women's endorsement of knowing the procedure is safe and simple may obscure important areas of ambivalence...all but one woman endorsed that she knew that a 'termination is a very safe and simple procedure.' Despite this, half the sample endorsed being really scared and 40 per cent agreed they were scared that a termination might damage them emotionally or physically."[45]

Based on the information gathered by researchers, the clinical experience of therapists, and the information from women themselves, it is clear that the presence of ambivalence at the time of an abortion is a risk factor for significant post-abortion dysfunction. What remains to be determined are the exact internal psychological processes that produce ambivalence. Tornbom has determined that ambivalence

can occur in pregnancies that do not end in abortion and that wanted or planned pregnancies are not the same as welcome pregnancies.[46] Similarly, unwanted or unplanned pregnancies may well elicit feelings of ambivalence, but women who choose not to abort often describe the resulting birth as welcome.

5. Age

Abortion during the formative adolescent years carries with it problems that are significantly different from those experienced by mature adults. American figures show that one in three abortions are performed on teenagers, while recent British research establishes that abortion occurs in "69 per cent of conceptions to under sixteens...[and] 37 per cent of conceptions in those aged sixteen to nineteen."

The literature suggests that this group of aborters are at greater risk for subsequent physical, as well as psychological, problems. Age is the one predisposing factor that affects both medical outcome and emotional adjustment.

Coleman and colleagues studied the cognitive and developmental difference between adolescent females and their adult counterparts.[47] As well as exhibiting less intellectual, moral, and emotional maturity, adolescents are more likely to have unrealistic views of the future. Even if goals are articulated, the adolescent may be too immature to undertake the long-term planning required to reach them. Adolescents live in the present. Their decisions are egocentric; while their network of friends and peers may be wide, it is usually composed of other equally immature persons. Such relationships lack the depth required to provide appropriate support for young women experiencing crisis pregnancies.

Adolescents often view themselves as affected by events but not in control of them. Things like pregnancy are seen as having "happened to" them rather than as the outcome of choices. When cognitive immaturity is coupled with limited ability to plan ahead, a teenager is predisposed to have an abortion. The adolescent is not able to conceptualize the

long-range implications of the abortion decision nor to take responsibility for them; thus, abortion seems to be an easy solution and thoughts of negative after-effects are not as frequent as in adults making the decision.[48]

While young women may lack a conscious understanding of the long-term outcomes of the abortion decision, the impact of that decision is real nonetheless. It can profoundly affect their cognitive development. Deutsch found lower levels of self-esteem in adolescents who aborted, while a Canadian study of women, post-abortion, found that "absence of affect [expression of emotion] ...especially of teenagers, was so marked as to be judged an adverse reaction in itself."[49] Kent and Linares compared adolescents who aborted a second pregnancy with two matched cohorts – teenagers who were pregnant for a second time but went on to give birth, and teenagers with no repeat pregnancy. They found that depressive symptoms among those who had abortions were nearly twice as frequent as among those who give birth, and nearly 60 per cent higher than among those who were not pregnant.[50]

Research makes it clear that important life-decisions, such as having an abortion, taken at a young age, can affect basic personality development. This becomes apparent from comparative data between adolescent and adult aborters. An American retrospective study conducted in 1988 determined that there were "significant personality trait differences between those who abort in adolescence and those who abort as adults."[51] Clinical scores indicated pathology in many of the adolescent samples. Dysfunctional levels were observed for antisocial traits, paranoia, drug abuse, and psychotic delusions. As well, the adolescent group also reported more suicide attempts.

A 1985 American study of high school students in a midwestern state found six to tenfold increases in suicide attempts when the adolescent had had an abortion.[52] The main factors underlying teen suicide attempts are anger, anxiety, and impulsiveness. The precipitating events are often relationship breakup, family disorder, and poor

decisions in academic, social, or moral areas. In the year following an abortion, 90 per cent of adolescent relationships end, and if the decision to abort is taken to maintain a relationship, the ensuing split will often elicit emotions of anger, hurt, or abandonment.

Within the adolescent group are young women who experience external pressure to abort from peers, family, boy-friends, medical professionals, or counselors. If young women experience such pressure, their abortion choice may be characterized by lack of informed consent and a perceived lack of control.

Even if adolescents are given full and accurate information, their immature cognitive processes may impede their understanding. Discussion of possible long-term consequences requires the ability to plan ahead, not a skill many adolescents possess. It also requires that information regarding medical and psychological sequelae be understood.

A Canadian study of Sexual Abuse Prevention Programs found that young people may verbally register information, but that being aware of facts does not necessarily lead to anticipated behavior changes.[53] Similar studies of adolescent smoking behavior and contraceptive usage confirm that, for immature persons, behavior change is less likely to follow from the acquisition of factual information.

Conclusion

Women who have a psychiatric history, live in abusive relationships, believe abortion is morally wrong, are ambivalent, or are adolescents are more likely to have serious problems coping with abortion. But for reasons that are not altogether clear, the presence of such a history is seldom considered by abortion clinic personnel or abortion researchers to be a reason to recommend against abortion.

Some clinicians may argue that the social impact of giving birth is worse for women than having an abortion. But that proposition is not based on documented findings. In any event, it is doubtful that information from abortion research about negative psychological sequelae is routinely shared with women who are having an abortion. This raises the issue of informed consent. By withholding information, is the clinician acting in the patient's best interest or in the perceived interests of society? It is also worth noting that all five of the higher risk categories noted above have to do with situations in which considerable pressure may be exerted on the woman to undertake a course of action she does not believe to be in her best interests. This factor of coercion may account for many women coping poorly after an abortion.

Key Points Chapter 11

• Women who have abortions are at risk of emotional difficulties after the procedure, especially those with pre-existing factors such as relationship problems, ambivalence about their abortion, adolescence, previous psychiatric or emotional problems, pressure by others into making a decision to abort, or religious or philosophical values that are at odds with aborting a pregnancy.

• The prevailing interpretation of post-abortion grief, depression, guilt, anger, and anxiety in abortion clinics and research studies in North America is that they are due, not to the procedure, but to a woman's pre-existing disposition to psychological problems.

• Where support through counseling is offered (for example, in Sweden) to pregnant women who are not sure if they should or can carry their pregnancy to term, they are more likely not to abort.

• Given the evidence that women in certain risk groups are more emotionally vulnerable after an abortion, should abortion clinics and medical facilities consider recommending against abortion in their cases? This question has becomes crucial given recent findings that women who abort are much likelier to commit suicide.

• Informed consent for the psychological well-being of women, post-abortion, is an issue which health care professionals should address.

Notes

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