

Abortion Causes Mental Disorders: New Zealand Study May Require Doctors to Do Fewer Abortions

Pro-Choice Researcher Says Some Journals Rejected Politically Volatile Findings

Springfield, IL (Feb. 9, 2005) -- A study in New Zealand that tracked approximately 500 women from birth to 25 years of age has confirmed that young women who have abortions subsequently experience elevated rates of suicidal behaviors, depression, substance abuse, anxiety, and other mental problems.

Most significantly, the researchers – led by Professor David M. Fergusson, who is the director of the longitudinal Christchurch Health and Development Study – found that the higher rate of subsequent mental problems could not be explained by any pre-pregnancy differences in mental health, which had been regularly evaluated over the course of the 25-year study.

Findings Surprise Pro-Choice Researchers

According to Fergusson, the researchers had undertaken the study anticipating that they would be able to confirm the view that any problems found after abortion would be traceable to mental health problems that had existed before the abortion. At first glance, it appeared that their data would confirm this hypothesis. The data showed that women who became pregnant before age 25 were more likely to have experienced family dysfunction and adjustment problems, were more likely to have left home at a young age, and were more likely to have entered a cohabiting relationship.

However, when these and many other factors were taken into account, the findings showed that women who had abortions were still significantly more likely to experience mental health problems. Thus, the data contradicted the hypothesis that prior mental illness or other “pre-disposing” factors could explain the differences.

“We know what people were like before they became pregnant,” Fergusson told *The New Zealand Herald*. “We take into account their social background, education, ethnicity, previous mental health, exposure to sexual abuse, and a whole mass of factors.”

The data persistently pointed toward the politically unwelcome conclusion that abortion may itself be the cause of subsequent mental health problems. So Fergusson presented his results to New Zealand’s Abortion Supervisory Committee, which is charged with ensuring that abortions in that country are conducted in accordance with all the legal requirements. According to *The New Zealand Herald*, the committee told Fergusson that it would be “undesirable to publish the results in their ‘unclarified’ state.”

Despite his own pro-choice political beliefs, Fergusson responded to the committee with a letter stating that it would be “scientifically irresponsible” to suppress the findings simply because they touched on an explosive political issue.

In an interview about the findings with an Australian radio host, Fergusson stated: “I remain pro-choice. I am not religious. I am an atheist and a rationalist. The findings did surprise me, but the results appear to be very robust because they persist across a series of disorders and a series of

ages. . . . Abortion is a traumatic life event; that is, it involves loss, it involves grief, it involves difficulties. And the trauma may, in fact, predispose people to having mental illness.”

Journals Reject the Politically Incorrect Results

The research team of the Christchurch Health and Development Study is used to having its studies on health and human development accepted by the top medical journals on first submission. After all, the collection of data from birth to adulthood of 1,265 children born in Christchurch is one of the most long-running and valuable longitudinal studies in the world. But this study was the first from the experienced research team that touched on the contentious issue of abortion.

Ferguson said the team “went to four journals, which is very unusual for us – we normally get accepted the first time.” Finally, the fourth journal accepted the study for publication.

Although he still holds a pro-choice view, Fergusson believes women and doctors should not blindly accept the unsupported claim that abortion is generally harmless or beneficial to women. He appears particularly upset by the false assurances of abortion’s safety given by the American Psychological Association (APA).

In a 2005 statement, the APA claimed that “well-designed studies” have found that “the risk of psychological harm is low.” In the discussion of their results, Fergusson and his team note that the APA’s position paper ignored many key studies showing evidence of abortion’s harm and looked only at a selective sample of studies that have serious methodological flaws.

Fergusson told reporters that “it verges on scandalous that a surgical procedure that is performed on over one in 10 women has been so poorly researched and evaluated, given the debates about the psychological consequences of abortion.”

Following Fergusson’s complaints about the selective and misleading nature of the 2005 APA statement, the APA removed the page from their Internet site. The statement can still be found through a [web archive](#) service, however.

Study May Have Profound Influence on Medicine, Law, and Politics

The reaction to the publication of the Christchurch study is heating up the political debate in the United States. The study was introduced into the official record at the senate confirmation hearings for Supreme Court Justice Samuel Alito. Also, a U.S. congressional subcommittee chaired by Representative Mark Souder (R-IN) has asked the National Institutes of Health (NIH) to report on what efforts the NIH is undertaking to confirm or refute Fergusson’s findings.

The impact of the study in other countries may be even more profound. According to *The New Zealand Herald*, the Christchurch study may require doctors in New Zealand to certify far fewer abortions. Approximately 98 percent of abortions in New Zealand are done under a provision in the law that only allows abortion when “the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl.”

Doctors performing abortions in Great Britain face a similar legal problem. Indeed, the requirement to justify an abortion is even higher in British law. Doctors there are only supposed

to perform abortions when the risks of physical or psychological injury from allowing the pregnancy to continue are “*greater* than if the pregnancy was terminated.”

According to researcher Dr. David Reardon, who has published more than a dozen studies investigating abortion’s impact on women, Fergusson’s study reinforces a growing body of literature showing that doctors in New Zealand, Britain and elsewhere face legal and ethical obligations to discourage or refuse contraindicated abortions.

“Fergusson’s study underscores that fact that evidence-based medicine does not support the conjecture that abortion will protect women from ‘serious danger’ to their mental health,” said Reardon. “Instead, the best evidence indicates that abortion is more likely to increase the risk of mental health problems. Physicians who ignore this study may no longer be able to argue that they are acting in good faith and may therefore be in violation of the law.”

“Record-based studies in [Finland](#) and the [United States](#) have conclusively proven that the risk of women dying in the year following an abortion is significantly higher than the risk of death if the pregnancy is allowed to continue to term,” said Reardon, who directs the Elliot Institute, a research organization based in Springfield, Illinois. “So the hypothesis that the physical risks of childbirth surpass the risks associated with abortion is no longer tenable. That means most abortion providers have had to look to mental health advantages to justify abortion over childbirth.”

But Reardon now believes that alternative for recommending abortion no longer passes scientific muster, either.

“This New Zealand study, with its unsurpassed controls for possible alternative explanations, confirms the findings of several recent studies linking abortion to higher rates of [psychiatric hospitalization](#), [depression](#), [generalized anxiety disorder](#), [substance abuse](#), [suicidal tendencies](#), [poor bonding with and parenting of later children](#), and [sleep disorders](#),” he said. “It should inevitably lead to a change in the standard of care offered to women facing problem pregnancies.”

Some Women May Be At Greater Risk

Reardon, a biomedical ethicist, is an advocate of “evidence-based medicine”—a movement in medical training that encourages the questioning of “routine, accepted practices” which have not been proven to be helpful in scientific trials. If one uses the standards applied in evidence-based medicine, Reardon says, one can only conclude that there is insufficient evidence to support the view that abortion is generally beneficial to women. Instead, the opposite appears to be more likely.

“It is true that the practice of medicine is both an art and a science,” Reardon said. “But given the current research, doctors who do an abortion in the hope that it will produce more good than harm for an individual woman can only justify their decisions by reference to the art of medicine, not the science.”

According to Reardon, the best available medical evidence shows that it is easier for a woman to adjust to the birth of an unintended child than it is to adjust to the emotional turmoil caused by an abortion.

“We are social beings, so it is easier for people to adjust to having a new relationship in one’s life than to adjust to the loss of a relationship,” he said. “In the context of abortion, adjusting to the loss is especially difficult if there any unresolved feelings of attachment, grief, or guilt.”

By using known risk factors, the women who are at greatest risk of severe reactions to abortion could be easily identified, according to Reardon. If this were done, some women who are at highest risk of negative reactions might opt for childbirth instead of abortion.

In a recent article published in *The Journal of Contemporary Health Law and Policy*, Reardon identified approximately 35 studies that had identified statistically validated risk factors that most reliably predict which women are most likely to report negative reactions.

“Risk factors for maladjustment were first identified in a 1973 study published by Planned Parenthood,” Reardon said. “Since that time, numerous other researchers have further advanced our knowledge of the risk factors which should be used to screen women at highest risk. These researchers have routinely recommended that the risk factors should be used by doctors to identify women who would benefit from more counseling, either so they can avoid contraindicated abortions or so they can receive better followup care to help treat negative reactions.”

Feeling pressured by others to consent to the abortion, having moral beliefs that abortion is wrong, or having already developed a strong maternal attachment to the baby are three of the most common risk factors, Reardon says.

While screening makes sense, Reardon says that in practice, screening for risk factors is rare for two reasons.

“First, there are aberrations in the law that shield abortion providers from any liability for emotional complications following an abortion,” he said. “This loophole means that abortion clinics can save time and money by substituting one-size-fits-all counseling for individualized screening.

“The second obstacle in the way of screening is ideological. Many abortion providers insist that it is not their job to try to figure out whether an abortion is more likely to hurt than help a particular woman. They see their role as to ensure that any woman who wants an abortion is provided one.”

“This ‘buyer beware’ mentality is actually inconsistent with medical ethics,” Reardon said. “Actually, the ethic governing most abortion providers’ services is no different than that of the abortionists: ‘If you have the money, we’ll do the abortion.’ Women deserve better. They deserve to have doctors who act like doctors. That means doctors who will give good medical advice based on the best available evidence as applied to each patient’s individual risk profile.”

Fergusson also believes that the same rules that apply to other medical treatments should apply to abortion. “If we were talking about an antibiotic or an asthma risk, and someone reported adverse reactions, people would be advocating further research to evaluate risk,” he said in the *New Zealand Herald*. “I can see no good reason why the same rules don’t apply to abortion.”

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Sources:

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