



The Uniquely Destructive Psychological Experience of Elective Abortion: Comparisons with Other Forms of Perinatal Loss and Delivery of an Unintended Pregnancy

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Many studies have been published recently in psychology and medical journals throughout the world documenting the negative mental health effects of abortion¹⁻⁵.

However, very few studies have incorporated appropriate control groups comprised of women who have experienced other forms of perinatal loss or women who have carried an unintended pregnancy to term. The results of the few studies with such control groups have added significantly to the argument that abortion is

detrimental to women's emotional health as the findings have revealed that when abortion is compared to other very stressful pregnancy outcomes, abortion carries a greater potential to cause psychological harm. The primary objective of this article is to clarify why abortion is potentially more harmful to women's mental health than other experiences often construed to represent similarly stressful experiences. First, perinatal loss is described, emphasizing common emotional responses to abortion and involuntary forms of loss (miscarriage and stillbirth). Second, reasons why elective abortion might introduce more psychological risk than other forms of perinatal loss are provided. Third, an effort is made to explain how unintended pregnancy resolved through abortion and delivery may have some common psychological features. Finally, an attempt is made to explain why termination of unintended pregnancy through

abortion is likely to be more damaging to women's mental health than unintended pregnancy carried to term. Recently published studies are described to support the claims made and are summarized in the table on page 7.

Abortion compared to non-voluntary perinatal loss

Loss of a child is a profound source of suffering, leaving grieving parents to wrestle with *what would have been*. Before the 1970's, the death of a child prior to birth was not widely recognized as a traumatic experience⁶. The psychological significance of perinatal loss was minimized, with most professionals viewing miscarriage and stillbirth as unfortunate medical events. Fortunately today there is widespread recognition among healthcare providers as well as the general public that fetal death occurring as the result of miscarriage or stillbirth represents a tragedy often associated with

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The shift in perception was largely prompted by research demonstrating a strong maternal emotional connection to the fetus well in advance of birth⁶. With this new understanding of early maternal attachment came interest in understanding the psychological consequences of perinatal loss. Compared to other forms of perinatal loss, considerably less research has examined the potential for grief and feelings of loss associated with abortion. This oversight is seemingly due to the generally held belief that the optional nature of induced abortion precludes or reduces the likelihood of subsequent distress. However, the choice to abort is often filled with conflicting emotions and external pressures, rendering the decision to abort difficult and sometimes quite inconsistent with the woman's true desire⁷. A study by Lloyd and Laurence⁸ revealed that 77% of women (37 out of 48) who terminated a pregnancy in response to knowledge of fetal malformation, experienced acute grief after the abortion. Further, Coleman and Nelson found that 30% of college students who had experienced a past abortion agreed or strongly agreed with the following statement: "I sometimes experience a sense of longing for the aborted fetus"⁹ and Kero and colleagues¹⁰ recently found that approximately 20% of women who experienced an abortion described severe emotional distress in conjunction with the experience, with some of the women reporting having mourned the loss of the child. Finally, in a study by Rue and colleagues, 33.6% of Russian

women and 59.5% of American women who had an abortion responded affirmatively to the statement "I felt a part of me died"¹¹.

There are many logical reasons in addition to the involuntary nature of miscarriage and stillbirth why professionals might expect grief reactions to be more significant among women who have suffered from an involuntary form of loss compared to elective abortion. First, the tragic event is beyond the individual's control and occurs very suddenly without time for anticipatory grief. Second, the child was more likely planned for and wanted. Finally, there might be fears of not being able to have children.

With regard to prevalence data pertaining to the likelihood of psychological suffering following involuntary pregnancy loss, the available literature does in fact suggest that approximately 25% of women who experience an involuntary perinatal loss are likely to have persistent, severe negative psychological consequences⁶. Further, an early study by Peppers and Knapp revealed similar grief responses among women who experienced miscarriages, stillbirths, and neonatal deaths¹². The best evidence regarding negative effects of abortion indicates that at least 10-20% will experience profound psychological problems^{4,13}. With 1.3 million U.S. abortions performed annually, a large subgroup of women experience post-abortion difficulties. Specifically, a minimum of 130,000 new cases of abortion-

related mental health problems surface each year.

Grief is a natural process, without a precise time frame, and it is experienced in unique ways by individuals based on the characteristics and beliefs of the bereaved, the person lost, the relationship between the bereaved and the deceased, as well as numerous situational factors. Nevertheless, there are commonalities in the ways that individuals respond emotionally to perinatal loss, regardless of whether the loss was voluntary or involuntary. Grief from perinatal loss has been found to involve physical, emotional, cognitive, and behavioral reactions^{12,14-19}. Among the common physical reactions to perinatal loss are the following: a poor appetite, disturbed sleep patterns, an empty feeling in the stomach, restlessness, low energy/fatigue, weakness, chest tightness, and pain. Emotional reactions may include anger, sadness, depression, frustration, self-blame/guilt, numbness, anxiety/panic, persistent fears, nervousness, and nightmares. Cognitive reactions to perinatal loss may take the form of intrusive thoughts about the fetus, hallucinations of a baby's cry, visual images of the baby, phantom fetal movement, difficulty with concentration and decision-making, fantasies about the fetus, and diminished situational awareness. Finally, behavioral responses associated with perinatal loss may include substance abuse, avoidance of medical facilities/personnel, avoidance of pregnant women

and children, isolation, and impaired social and occupational functioning.

Although nonvoluntary forms of perinatal loss can be very emotionally taxing, there are a number of reasons why abortion may actually lead to more trauma than miscarriage or stillbirth. First, because abortion is a voluntary act, women may experience a considerable amount of guilt and self-loathing²⁰⁻²². In a recently published study led by Vincent Rue, the results revealed that even women in Russia, where the culture is very approving of abortion, levels of self-reported guilt were very high, 49.8% to be exact¹¹. Second, professionals who work with women who have lost a baby through miscarriage or stillbirth are inclined to encourage healing focusing on the loss of the fetus and open expression of the woman's feelings. A list of recommendations for healthcare professionals who work with women who have lost an infant through miscarriage or stillbirth is provided below and conveys professional recognition of the vital role of support for parents who lose a child through miscarriage or stillbirth. The recommendations are from an article by Stephen Bowles and colleagues that appeared in the *American Family Physician* in March, 2000²³

1. If the fetus has been named, use the name while talking to the parents to personalize the mourning process.
2. Offer an ultrasound picture if available.
3. Discuss the option of seeing the fetus (usually done at 15

weeks or more).

4. Discuss the option of a memorial service or funeral.
5. Discuss with the facts about the situation with both parents.
6. Inquire about the mother's thoughts and emotions regarding the loss, and educate the parents about any physical and emotional symptoms they may experience.
7. If the patient desires further support, refer her to a psychologist or a grief counselor.
8. The father often shows less emotion than the mother and may be torn between supporting the mother and struggling with his own grief. The best approach may be simply to ask the father if he has any questions or if there is anything you can do to help.
9. When there are other children in the family, advise the parents to discuss the loss with them honestly and openly.
10. Some patients will not experience the effects of the loss until after leaving the hospital so the next appointment or a follow-up phone call should be scheduled within a week to assess the patient's situation.
11. Refer for follow-up counseling if the patient's emotional state is not improving after a month.
12. Consider providing a follow-up call at the one-year anniversary for patients who experienced post-traumatic stress disorder after their loss.

Unlike with nonvoluntary forms of perinatal loss, opportunities designed to foster healing are rarely routinely available with abortion due to the well-entrenched view that

psychological problems in association with abortion are uncommon. Women seeking help for an abortion typically must identify sources of professional help on their own. In many cases, women may suppress thoughts and emotions related to an abortion, because they have not been able to process and/or openly express negative emotions, as Kluger-Bell²⁴ a psychotherapist states "When other people are reluctant to listen to us, when there are no ceremonies to publicly acknowledge the impact of our experiences, we receive the covert message that others would rather not hear what we have to say, and this makes it difficult to even identify our reactions to our losses" (p. 130).

Although very few studies have simultaneously examined the long-term effects of abortion, miscarriage, and stillbirth, there is some preliminary evidence that the pain of abortion is more difficult to resolve than the pain associated with nonvoluntary forms of loss. For example, a Norwegian team of researchers led by Broen recently found that women who had an abortion 2 years earlier were more likely than those who had miscarried to be suppressing thoughts and feelings about the event²⁵. Specifically, nearly 17% of 80 women who had an abortion scored highly on a scale measuring avoidance symptoms, compared with about 3% of those who miscarried. This was in contrast to responses 10 days after the pregnancy ended, when nearly half of those who miscarried and 30% of those who had an abortion scored highly on measures of

avoidance or intrusion, which includes symptoms such as flashbacks and bad dreams. Interestingly, Broen's team found that women with strong feelings of shame, grief or loss soon after the pregnancy ended were more likely than others to have symptoms of avoidance or intrusion two years later.

My colleagues and I recently conducted a study in which pregnancy substance use comparisons were made between women with histories of abortion, miscarriage, and stillbirth and women without the respective forms of loss²⁶. The study is due out soon in the *British Journal of Health Psychology*. The sample consisted of mostly unmarried, low income Black women. In all the analyses, we controlled for age, marital status, education, and number of people in the household. No differences were observed in the risk of using any of the substances measured during pregnancy relative to a prior history of miscarriage or stillbirth. However, a prior history of abortion was associated with a 201% higher risk of using marijuana, a 198% higher risk of using cocaine-crack, a 406% higher likelihood of using cocaine-other than crack, a 180% higher risk of using any illicit drugs, and a 100% higher likelihood of using cigarettes.

In contrast to the pain of non-voluntary loss, which tends to lessen over time, the pain of abortion is inclined to worsen as women learn more about prenatal development and have children²⁷⁻²⁸. This type

of reaction is sensitively conveyed in a poem entitled "Ghosts in the House" by Amanda Lewanski (copyright 2000, reproduced with permission).

Ghosts in the House

*Come, child. It's evening.
Come to me
And sit with me once more.
Let's rock here while the others sleep.
Let's see - your sister's four;
The baby is three months today;

Your little brother's two,
And I have not decided if I'll tell
them about you.*

*And you, you would be eight this year.
I do not know your name.
The color of your eyes, or hair,
Or where, or how, to blame
The fear was all, the fear of change,
For I saw change as loss
Against my dreams, my plans, my life
You seemed so small a cost.*

*Not knowing how your presence
Altered how I felt and thought,
Not knowing how you changed me
But sickness, pain, and fear -
But oh, I know, I know you now,
Now that these three are here!
Your scent, your weight within
my arms,
Your head upon my breast
I did not know these things when
I decided what was best.*

*And I am lost and so confused
And don't know how to feel,
For you, you were an illness,
Every year become more real;
Your sister and your brothers,
They proclaim you as they grow.
They make it harder still to face
The coldest truth I know:
That knowing - feeling - only*

*What I knew and felt back then,
I cannot say I would not make
The saddest choice again
Oh! My little lost unknown,
My first and neverborn,
Forgive the ignorance that sent you
To the dark, unmourned!*

*And no it isn't every day
I find your shadow here;
Most times I'm far too busy
For reflection or for tears,
But sometimes when the children sleep
And I have time alone;
I sit down in the dark, and rock,
And bring my baby home.*

Abortion compared to unintended pregnancy carried to term

Studies comparing the psychological effects of abortion using control groups of women who carried to term are often criticized, because the life circumstances of the two groups are likely to differ dramatically. When more pronounced negative mental health effects are detected in women who abort, it is difficult to know if the differences are due to the pregnancy outcome or to other factors such as a childhood history of abuse, relationship instability, or partner violence that might be systematically related to the choice to abort. Therefore, a more logical comparison group is women who have decided to carry an unintended pregnancy to term. This provides a means for assuring that the groups are more equivalent prior to making mental health comparisons. There is evidence that both unintended pregnancy carried to term and abortion can

have detrimental effects on women's mental health^{1-5; 29-34}. Specifically, both abortion and delivery of an unintended pregnancy may lead to many problems including depression, anxiety, substance use, feelings of insecurity, a sense of hopelessness about the future, and relationship problems. Considering the potential for emotional problems associated with delivery of an unintended pregnancy, any mental health differences observed between women who abort and deliver an unintended pregnancy, suggesting higher rates of disturbance among women who abort would underscore the potential for abortion to initiate negative outcomes. Although very few studies of this form have been conducted, there are at least two important reasons to believe resolution of an unintended pregnancy through abortion, compared to birth, may be more detrimental to women's psychological health. First, many women who decide to abort do so despite considerable ambivalence based on interpersonal, moral, and religious conflicts surrounding the decision³⁵⁻³⁶, which can lead to feelings of guilt, depression, anxiety, anger and/or fears of impending danger³⁷⁻³⁹. Second, feelings of shame and secrecy frequently surround abortion, which may preclude reaching out to others for needed emotional support. The presence of a sympathetic social support system is a vital component to effective recovery for the bereaved and many women do identify abortion as a death experience²¹.

I have recently been involved

in two studies in which we compared women who carried an unintended pregnancy to term to women who aborted. Both studies employed nationally representative data sets and controlled for potentially confounding variables. In the first study, we looked at substance use and in the second we examined anxiety. The first is entitled "Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study" and it was recently published in the *American Journal of Drug and Alcohol Abuse*²⁹. We compared substance use among 535 women with prior histories of delivering an unintended pregnancy, 213 women who aborted an unintended pregnancy, and 1144 women who had not ever been pregnant. In all the analyses we controlled for age, ethnicity, marital status, income, education, and prior psychological state. The results revealed that compared to women who carried an unintended first pregnancy to term, those who aborted were 100% more likely to report use of marijuana in the past 30 days and they were 149% more likely to use cocaine in the past 30 days (this difference only approached statistical significance). Women with a history of abortion also engaged in more frequent drinking than those who carried an unintended pregnancy to term. Except for less frequent drinking, the unintended pregnancy delivery group was not significantly different from the group that had never been pregnant.

The results of this study are consistent with other studies in which drug and alcohol use were

found to be related to abortion experience⁴⁰⁻⁴¹ and with clinical evidence indicating that some women attempt to cope with negative emotions associated with an abortion by using substances^{42,43}. What is particularly new about our study is that we included the comparison groups and controlled for several potentially confounding factors. Substance use represents a convenient way of escaping from unpleasant thoughts and emotions associated with the experience that does not require disclosing the source of pain to family members, friends, or professionals. There are many obvious problems with using substances to cope with a painful abortion experience. Substance use facilitates avoidance and hinders women from addressing the underlying cause of their discomfort. Further, as the emotional pain of an abortion is denied, the many physical, psychological, social, and practical problems associated with substance abuse are likely to introduce new sources of suffering that in turn may fuel the trauma of an abortion.

The second study is entitled "Generalized anxiety associated with unintended pregnancy: A cohort study of the 1995 National Survey of Family Growth" and it was recently published in the *Journal of Anxiety Disorders*³⁰. We compared 1,033 women whose first pregnancy was unintended and resolved through abortion to 1,813 women whose first pregnancy was unintended and carried to term relative to symptoms of Generalized Anxiety

Disorder. The average age was 32 years and the sample was ethnically diverse. An average of 13 years had elapsed since the first pregnancy event. The primary features of Generalized Anxiety Disorder include unrealistic, but persistent anxiety, tension, and apprehension. People with the disorder worry constantly about vague, difficult to articulate fears. When compared to women who carried an unintended pregnancy to term, women with a history of abortion were 34% more likely to report an episode corresponding to Generalized Anxiety Disorder in the first several years following an abortion. Differences between the abortion and birth groups were greatest among particular demographic groups. For example, among Hispanic women, the risk of Generalized Anxiety Disorder was 86% higher for women who aborted compared to women who delivered. Among those who were unmarried at the time of pregnancy, there was a 42% higher risk among the post-abortion group. Finally, among women who were under age 20, there was a 46% higher risk of developing Generalized Anxiety Disorder. This study is particularly noteworthy because women who reported a period of anxiety prior to their first pregnancy event and women who reported having their first period of anxiety at the same age as their first pregnancy event were excluded from the analyses. Statistical controls were also instituted for race and age. Therefore, this study provides clearer evidence than previously published work that abortion carries the potential to trigger anxiety.

Generalized anxiety may be a logical way for post-abortion stress to manifest given what is known about the disorder and the nature of post-abortion discomfort. Specifically, the cognitions of patients with Generalized Anxiety Disorder often involve themes of danger and fears regarding potential future disasters, with innocuous events frequently misperceived as threatening. Further, the attention of individuals afflicted with this disorder is easily drawn to stimuli suggestive of physical harm and social misfortune. Evidence documenting cognitive themes of impending danger and punishment were identified in a study by Burke and Reardon of women reporting negative feelings about their past abortions⁴³. Other researchers have found that socially-based emotions such as shame, guilt, and fear of disapproval are common among women who experience difficulty with an abortion^{20-22, 39}. In addition to using nationally representative samples, the two studies reviewed above examined women's mental health over an extended time frame. Clearly, the problems associated with abortion persist longer than problems initiated by unintended pregnancies that result in delivery.

In conclusion, new efforts to compare the psychological well-being of women who have aborted to women who have experienced other forms of perinatal loss (miscarriage and stillbirth) and an unintended pregnancy carried to term should help to emphasize the uniquely destructive nature of elective abortion. Society acknowledges

that involuntary forms of perinatal loss and carrying an unintended pregnancy to term represent very difficult life experiences. Therefore, when the studies using these comparison groups are conveyed to the public, it will be difficult to deny the challenges introduced by abortion to women's mental health and quality of life. As the published research validates the suffering of countless women like Amanda, who profoundly grieve the loss of a child, more effort should be directed toward pre-abortion counseling. Had someone shared the experiences of other women with Amanda as she contemplated her abortion several years ago, her choice may have been different. The prevention of post-abortion emotional pain and mental health problems is ultimately far better for individual women and for society than reliance on subsequent intervention.

Recent Studies

Publication information	Comparison groups	Data source and sample demographics	Outcomes examined	Controls	Positive methodological Features	Results
<p>1) Coleman, P. K., Reardon, D. C., & Coughle, J. (in press) Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy. <i>British Journal of Health Psychology</i></p>	<p>Women with a history of abortion (n=280), miscarriage (n=182), and stillbirth (n=30) were compared to women without the respective forms of loss: no miscarriage, n= 221; no abortion, n=144; no stillbirth, n= 371. Comparisons were also made between women who reported wanting a recent pregnancy (n= 306) and those who reported not wanting it (n=344)</p>	<p>Washington DC Metropolitan Area Drug Use and Pregnancy Study Full-sample demographics (1992): Married: 32% Age: 18 or under: 9.3%, 19-25: 37.4%, 26-34: 40.3%, 35 or older: 7.8% Income: Under \$10,600: 35% \$10,600 - \$19,000: 16% \$19,100 - \$30,000: 12% \$30,100 - \$50,000: 12% Over \$50,000: 14% Ethnicity: Black: 79.3%, White: 12.4%, Other: 4%</p>	<p>Use of alcohol, illicit drugs, and cigarettes during pregnancy</p>	<ul style="list-style-type: none"> - Other forms of loss - Age - Marital status - Trimester in which prenatal care was sought - Education - Number in household 	<ul style="list-style-type: none"> - Mostly Black sample (few if any post-abortion studies have focused on this group) - Enabled comparison of various forms of perinatal loss 	<ul style="list-style-type: none"> - No differences were observed in the risk of using any of the substances measured during pregnancy relative to a prior history of miscarriage or stillbirth. - A prior history of abortion was associated with a significantly higher risk of using marijuana (201%), cocaine-crack (198%), cocaine-other than crack (406%), any illicit drugs (180%), and cigarettes (100%). - No differences were observed in the risk of using various substances relative to pregnancy wantedness, with the exception of the risk of cigarette use being higher when pregnancy was not wanted (90%).
<p>2) Reardon, D. C., Coleman, P. K., & Coughle, J. (2004) Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study. <i>American Journal of Drug and Alcohol Abuse</i> 26, 369-383.</p>	<p>Women with prior histories of delivering an unintended pregnancy (n=535), abortion (n=213), or no pregnancies (n=1144)</p>	<p>National Longitudinal Survey of Youth Demographics measured in 1988 Delivery: Married: 66.5%, Avg. age: 26, Avg. income: \$22,949 Abortion: Married: 43.7%, Avg. age: 26, Avg. income: \$27,076 No pregnancies: Married: 35.4%, Avg. age: 26.3, Avg. income: \$29,667. An avg. of 4 yrs since the target pregnancy</p>	<p>Use of marijuana, cocaine, and alcohol</p>	<ul style="list-style-type: none"> - Age - Ethnicity - Marital status - Income - Education - Pre-pregnancy self-esteem and locus of control 	<ul style="list-style-type: none"> - Nationally representative, racially - diverse sample - Controlled for prior psychological state and other variables - Extended time frame - All women were experiencing an unintended pregnancy 	<ul style="list-style-type: none"> - Compared to women who carried an unintended first pregnancy to term, those who aborted were 100% more likely to report use of marijuana in the past 30 days and 149% more likely to use cocaine in the past 30 days (only approached significance). Women with a history of abortion also engaged in more frequent drinking than those who carried an unintended pregnancy to term. - Except for less frequent drinking, the unintended delivery group was not significantly different from the no pregnancy group.
<p>3) Coughle, J., Reardon, D. C., Coleman, P. K., & Rue, V. M. (2005) Generalized anxiety associated with unintended pregnancy: A cohort study of the 1995 National Survey of Family Growth. <i>Journal of Anxiety Disorders</i> 19, 137-142</p>	<p>First pregnancy event of either an abortion (n=1,033) or delivery (n=1,813). All were unintended pregnancies.</p>	<p>1995 National Survey of Family Growth Abortion: Ethnicity: Hispanic: 10%, Black: 26%, White: 61% Avg. income: 376% of poverty level Delivery: Ethnicity: Hispanic: 14%, Black: 36%, White: 47% Avg. income: 234% of poverty level Avg. age, both groups: 32 Avg. of 13 yrs since the 1st pregnancy event.</p>	<p>Symptoms of Generalized Anxiety Disorder – lasting for a period of at least 6 months.</p>	<ul style="list-style-type: none"> - pre-existing anxiety, age, and race (stratification by ethnicity, current marital status, and age) 	<ul style="list-style-type: none"> - Nationally representative, racially - diverse sample - Controlled for prior anxiety - Extended time frame - All women were experiencing an unintended pregnancy 	<ul style="list-style-type: none"> - Women whose 1st pregnancies ended in abortion were 34% more likely to report an episode corresponding to Generalized Anxiety Disorder. - Differences between the abortion and birth groups were greatest among the following demographic groups: Hispanic 86% higher risk; unmarried at time of pregnancy: 42% higher risk; under age 20: 46% higher risk.

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