Queensland Parliamentary Inquiry

by the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee into the

Health (Abortion Law Reform) Amendment Bill 2016

Thank you for the opportunity to give evidence regarding the mental health of women following abortion to your Hearing on Monday 7th November 2016. It was unfortunate that due to technical problems you did not have time to hear the seven points that I believe would be important to your deliberations.

These are:

1. **There are no mental health disorders for which termination of pregnancy is the treatment of choice.**

2. **Abortion is never a treatment for suicidality. On the contrary, abortion has been documented to be associated with increased suicide risk**

3. **Abortion does not reduce the mental health risks of unwanted or unintended pregnancy**

4. **There is a very strong psychiatric case against termination for foetal abnormality in favour of perinatal palliative care.**

5. **The extent to which a woman can continue to believe that there was no baby, and therefore no baby was killed, seems to predict whether she can continue in the long-term without emotional conflict or mental health problems.**

6. **The litigation risk of doctors referring for abortion is currently relatively untested in Australia but international precedent shows this is highly likely**

7. **The litigation risk of Governments which legalise socioeconomic abortion is also unquantified**

1. There are no mental health disorders for which termination of pregnancy is the treatment of choice.

- **The world's psychiatric literature,** all the psychiatric textbooks and even pro-abortion advocates are in agreement on this point.

- **Submission No. 052 to this Inquiry from The Australian Clinical Psychology Association,** is authored by Susie Allanson, a well-known Australian researcher in abortion. This ACPA submission states that "the research indicates that typically women experience heightened distress facing a problem pregnancy, and experience relief and improvement following an elective abortion". That is, relief of distress, not treatment of a mental health disorder, is all that is claimed.

2. Abortion is never a treatment for suicidality. On the contrary, abortion has been documented to be associated with increased suicide risk

1. **Irish Government Enquiry** Joint Oireachtas Committee on Health and Children (2012)
    - All the medical & psychiatric experts consulted agreed that abortion is never a treatment for suicidality
    - None knew of a case where an abortion was the only treatment for a woman who was suicidal
    - None knew of a case where a woman had died by suicide because abortion was not available
    - Senior psychiatrists testified that abortion would be "completely obsolete" in respect of a person who is extremely suicidal
    - Experts confirmed that suicide in pregnancy is very rare – and that treatment for suicidality included providing safety, nursing, psychological treatment and medication.
    - None of the core perinatal or general psychiatry textbooks mention the role of abortion as an intervention for women who are suicidal in pregnancy.
    - Evidence was given that abortion can increase the risk of suicide

        www.oireachtas.ie/parliament/media/committees/healthandchildren/PatriciaCaseySubmission.pdf
        www.oireachtas.ie/parliament/media/committees/healthandchildren/PatriciaCaseyOpening.pdf

2. **Finnish linkage studies**
    - Mika Gissler examined suicide and pregnancy outcome records of 650,000 Finnish women. The suicide rate after abortion was three times higher than the female population suicide rate. The suicide rate after giving birth was half the female suicide rate. Whatever the explanation for this, these findings show that abortion does not reduce the risk of suicide but rather increases it.

        Gissler et al (1996). „Suicides after Pregnancy in Finland, 1987-94: Register Linkage Study". British Medical Journal. 313, pp. 1431-4.
        http://dx.doi.org/10.1136/bmj.313.7070.1431

    - A further Finnish linkage study of pregnancy outcomes compared with deaths by accident, homicide and suicide from 1987-2000 replicated these findings. It showed that accidental death, homicide and suicide were all increased after abortion and were lower after giving birth, than the national average. In this study the authors commented on the protective effects of pregnancy. In contrast, the study concluded with a recommendation that a post- abortion check-up was necessary in order to detect signs of depression and to identify the rare cases of psychosis after an induced abortion. It also recommended "that such a check-up be made routine practice in all other countries where it has not yet been included in the current care practice scheme".

        Gissler et al (2005). "Injury Deaths, Suicides and Homicides Associated with Pregnancy, Finland 1987-2000". European Journal of Mental Health. 15,5, pp. 459-63

3. Abortion does not reduce the mental health risks of unwanted or unintended pregnancy and increases risk of mental health problems

1. **Reappraisal of the Reviews of abortion/mental health studies published by Coleman (2011) and National Collaborating Centre for Mental Health (2011).**
    - Examined anxiety; depression; alcohol misuse; illicit drug use/misuse; and suicidal behaviour.
    - There is no available evidence to suggest that abortion has therapeutic effects in reducing the mental health risks of unwanted or unintended pregnancy.
    - There is evidence that abortion may be associated with small to moderate increases in risks of some mental health problems.

    Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence David M Fergusson L John Horwood Joseph M Boden ANZ J Psychiatry September 2013 **vol. 47 no. 9** 819-827

2. **Academy of Medical Royal Colleges** 2011
    - This review found no evidence that abortion is a treatment that helps women's mental health or prevents suicide in pregnant women
    - In respect of mental health, the outcome was the same whether an unwanted pregnancy ended in delivery or abortion.
    - In respect of those with previous mental health problems, there was a risk of relapse following abortion.
    - As one psychiatrist (Ekblad) is quoted as saying in Motherhood and Mental Illness (Brockington) "The greater the psychiatric indication the greater the risk of adverse sequelae".

    National Collaborating Centre for Mental Health (NCCMH) 2011. "Induced abortion and Mental Health. A Systematic Review of Outcomes of Induced Abortion, Including Prevalence and Associated Factors" London: Academy of Medical Royal Colleges.

3. **Christchurch Longitudinal Study**
    - A study of 500 New Zealand women followed from birth to age 30
    - Abortion was associated with a small increase in the risk of mental disorders
    - Women who had had abortions had rates of mental disorder that were about 30% higher than those who had not had an abortion
    - There were no consistent associations between other pregnancy outcomes and mental health.
    - Exposure to abortion accounted for 1.5% to 5.5% of the overall rate of mental disorders

    Fergusson, D.M. et. al., (2008), "Abortion and mental health disorders: evidence from a 30-year-longitudinal study," *The British Journal of Psychiatry*, 193, 444 - 451

4. There is a very strong psychiatric case against termination for foetal abnormality in favour of perinatal palliative care.

1. **Mothers and also fathers of babies aborted for foetal abnormality** have a high rate of mental health problems
    - As parents of a dead child, the pain of grief is inevitable but attempts to avoid this by termination can derail or exacerbate the grief process.
    - Grief counselling involves "Saying 'Hello' before you can say 'Goodbye'". It is harder to say "Hello" to one's child if one has been instrumental in their death as opposed

to "loving them as long as they are alive, bonding them with their clan and celebrating their brief life after they have departed naturally"

2. **Scottish research** - A study of all couples in West of Scotland who had a second trimester abortion for foetal abnormality in 1989 found that 2 years later (of 84 women & 68 men)
    - 5% declined study "too painful"
    - 43% were unsure of the decision at time of abortion
    - 40% mothers & 9% fathers "deep shame"
    - 82% mothers "strong spiritual disturbance"
    - 55% mothers & 58% fathers abnormal grief
    - 20% mothers depressive symptoms
    - Marital problems, Inadequate therapeutic support

    White-van Mourik MC, Connor JM, Ferguson-Smith MA (1992)
    The psychosocial sequelae of a second-trimester termination of pregnancy for fetal abnormality. ***Prenatal Diagnosis*** **12:189-204.**

3. **Anencephaly Support Group website**
    - "You will not grieve more if your baby lives longer or less if your baby dies very soon"
    - "In our experience, we have never heard of any parents who carried their babies as long as they could who regretted that decision, but we have heard of parents who ended the pregnancy early and did regret that decision very much"

    www.anencephalie-info.org.

5. The extent to which a woman can continue to believe that there was no baby, and therefore no baby was killed, seems to predict whether she can continue in the long-term without emotional conflict or mental health problems.

1 Hypothesised mechanism

a. Pregnancy implies a baby will be born around a particular date and into the context of the mother's life, with her ongoing responsibility to care for her child.
b. Distress ensues from wanting not to have that baby born around that time or into those circumstances
c. No mother wants to kill her baby
d. If she's not a mother and there was no baby then the pregnancy can be terminated to avoid distress
e. But she knew she was "having a baby" because this was the reason for her distress
f. She must bury the truth of the fact of the baby in her subconscious and keep it buried
g. She does not have permission to celebrate the fact of her baby's existence nor to grieve her loss and she cannot share her joy or sorrow with her support network.
h. Burying traumatic memories and suppressing grief is psychologically costly and can lead to PTSD, anxiety, depression, self-destructive behaviour, substance use, dysfunctional relationships, relationship breakdown or suicide

2 Clinical experience

- Terry Selby, experienced PTSD counsellor, author of *"The Mourning After",* [Baker, 1990, ISBN-10: 0801083109]
    a. First encountered Post abortion PTSD when asked a patient 's PTSD symptoms had not remitted despite processing various past traumas "Have we missed something?" and the patient volunteered "Do you think it was because I killed my baby?"
    b. Selby discovered that by employing the general principles of PTSD treatment including accessing and processing the repressed incident and grieving her losses, the woman improved.
    c. Selby subsequently developed training in the treatment of post-termination PTSD and grief, published his book and was stunned to become the target of vitriol from people attempting to discredit the data and what he had clinically learned from his patients.
    d. Selby teaches that it is essential to say "Hello" to the baby before being able to say "Goodbye". [Personal communication, 2003]

- Anne Lastman, a psychologist with 19 years of experience of counselling patients with post-termination grief and loss, author of "*Redeeming Grief', 2013 Freedom Publishing, ISBN: 9780646476018*
    a. Describes themes of grief at the loss of what her patients consistently refer to as "my baby
    b. Lastman reports that "no matter what they thought at the time of termination, by the time they present with symptoms for counselling they are calling it 'my baby'".
    c. Lastman has also found that many women she counsels have suffered childhood sexual abuse and that these traumas must first be processed before they can resolve the termination grief [Personal communication, (2013), anne@victimsofabortion.org]

- Anne Neville, Director of Open Doors Counselling; 28 years' experience in pregnancy loss counselling (including miscarriage, stillbirth and termination)
    i. Women who suffer after termination do so because of the central theme of loss of their "baby".
    ii. Open Doors therapists also provide pregnancy options counselling and support women who may choose to continue the pregnancy or choose a termination. Women who have returned for counselling after termination with grief or trauma symptoms report that they would find it too traumatic and triggering of their emotional distress to return to their abortion provider, but feel safe returning to Open Doors therapists who were not part of the termination referral process. [Personal communication, (2013), anne@opendoors.com.au]

- Aisha Baker and others from University of Mississippi Medical Centre have published an account of successfully treating a man with abortion-related PTSD with a standard PTSD treatment. [Baker, A. et al. (December 2011), "Using Prolonged Exposure to Treat Abortion-Related Posttraumatic Stress Disorder in Alcohol-Dependent Men, A Case Study", *Clinical Case Studies,* **10** (6), **427 - 439**

3 Pro-abortion website providing information and support for Post-abortion Grief

a. www.Afterabortion.com This currently active website has been providing education and an internet forum of peer support for women working through post-termination grief and PTSD symptoms since 1998. This website has a philosophy of being politically neutral, neither pro-termination nor anti-termination, non-judgemental, and does not have professional counsellors although strongly urges women with serious symptoms to seek professional help. There have been over 2 million posts from over thirty thousand "members" who have supported each other through their post-termination journeys.

4 Published accounts of post-termination experiences

a. Melinda Tankard-Reist, a journalist advertised for "women hurt by abortion" to submit their stories. She compiled a book *"Giving Sorrow Words"* of these experiences of grief, lack of choice and untreated mental problems. Some of the women wrote that they had never shared their termination experiences with anyone before. A common theme of grieving women was their having personified the child that had been terminated. [Tankard Reist, M, 2000, "Giving Sorrow Words: Women's Stories of Grief After Abortion", Acorn Books, ISBN 0964895749]

5 Ex-Abortion Providers' Experiences. Even dedicated termination providers are not immune from their defence mechanisms failing to protect them from the "termination of baby" problem.

- Drs Haywood and Noreen Robinson were successful abortionists until Noreen became pregnant and they realised they "*couldn't continue to provide prenatal treatment for a young pregnant mother and then offer to kill her unborn child*" [Bereit, D and Carney, S, *"40 days For Life"* 2013, Cappella Books, pp 87-88.]

- Abby Johnson was a Manager of a Planned Parenthood facility in Texas. She had experienced her own termination prior to being married with children. She described herself as having firm "pro-choice" views and was comfortable in media debates against anti-abortion activists. However, in 2009 when she viewed an abortion performed with ultrasound guidance and saw the 13-week foetus kicking to avoid the instrument before being sucked into the tube, she realised that much of what she had believed and had told pregnant women was not true. In her autobiography, she relates her subsequent emotional turmoil and then healing. [Johnson, A with Cindy Lambert, C, 2010, *UnPlanned*" Chicago, Illinois: Tyndale House Publishers, Inc., 2010]

- The Society of Centurions is an organisation which provides support and healing for former abortion-providers. It was started by Dr Philip Ney, a Canadian Psychiatrist who pioneered post-abortion trauma counselling and Joan Appleton, a former head nurse at an abortion clinic who had sought his help for her depression after she had left her profession. Appleton reports that many former abortion providers experience extreme guilt, isolation and some who experience depression turn to alcohol, drugs or even suicide. Appleton is quoted as saying ""***One thing that needs to be understood is that those of us who were in the business of killing babies had to dehumanize them. So, the healing process consists of re-humanization*.**" [National Catholic Register, Sept. 6-12, 1998. http://www.priestsforlife.org/clippings/98,09-06ncregistercenturions.htm]

6 **My Cases: vignettes of patients I have treated between 2003 and 2016. (Identifying details have been changed to protect their privacy)**

- **Case vignette #1: PTSD, unresolved grief and alcohol abuse immediately post-termination in a female.**
  A 45-year-old separated female accountant was referred for treatment of alcohol dependence. When asked why and when she had started drinking to excess, she burst into tears and replied that it was after her abortion eight years previously. Her husband had been unfaithful and she had decided that she couldn't rely on him to support her having a third child, so despite knowing that she was carrying "a baby" she chose termination. She had been crying prior to the operation and both the nurse and the abortion provider had asked her whether she was sure she wanted to go through with the procedure. She did not, but felt she had no other option, so said "yes". She suffered grief and insomnia immediately and began using increasing amounts of alcohol to self-medicate. As she related her story she remarked "I don't know why I always cry when I think about the abortion; you'd think I'd have gotten over it by now"

- **Case vignette #2: Severe anxiety, emotional turmoil and delayed grief response to past terminations triggered in a previously healthy woman by separation from a grandchild.**
  A 45-year-old female social worker who had a history of two terminations during her teenage years. She was functioning well in all areas of the life until she lost access to her grandchild due to a family relocation. She was suddenly emotionally incapacitated to the extent of a "mental breakdown". While undergoing psychotherapy, she became aware of a subconscious belief that "I deserved to lose my grandchild because of having aborted my two babies". With therapy, she accepted and grieved her "babies" and made a full recovery.

- **Case vignette #3: PTSD and major depression triggered by termination of a grandchild in the context of unresolved past multiple traumas and termination.**
  A 48-year-old woman had an extensive history of childhood sexual abuse and emotional neglect which had led to severe psychiatric problems. She could function in a clerical job with antidepressant medication and infrequent psychotherapy, until her son's girlfriend came to stay with the patient to have a medical termination. This event triggered previously suppressed memories for the patient of the coerced late-term abortion she had endured as a teenager. She decompensated emotionally and remains in therapy although is making progress in resolving her multiple past traumas.

- **Case vignette #4: Major depression and delayed grief response to a past pregnancy loss triggered by the termination of a grandchild**
  A 64-year-old married woman was referred after being arrested for shoplifting baby clothes. She was found to be suffering a major depressive disorder which had been triggered by the news of her only son's girlfriend having had a termination. Further history revealed that the woman had delivered a stillborn daughter many years previously. The prevailing wisdom of the time had been that she and her husband should avoid distress by never mentioning the baby. She had not done so, but had raised her son, seemed to have normal function although developed a hobby of dressing dolls. To her mind, her son's girlfriend's abortion was not just a termination of a pregnancy, but signified the loss of her own grandchild, which she was unable to mourn, having not mourned her own stillborn daughter. This inability

to mourn had triggered a depressive disorder which gradually improved with medication, grief counselling and psychotherapy to assist her to recognise and accept her emotions.

- **Case vignette #5 PTSD: Substance abuse and suicidal attempts, delayed onset following termination, in the father of the baby**
  A 25-year-old male labourer was referred with diagnosed post-abortion grief syndrome, recurrent suicidal attempts and poly-substance abuse disorder. He had been a social user of cannabis until his girlfriend's abortion four years previously. She had had previous abortions and had reassured him that she would deal with her pregnancy, so he had paid little attention to the process. However, on the day of her abortion he witnessed a colleague's two-year-old son take his first steps and the colleague's delight at being a father. The labourer suddenly realised that the termination involved his own child so asked his girlfriend to reconsider but the termination had been done. The relationship broke down, his substance use escalated and he attempted suicide on the anniversary of when his child would have turned two years old. Only after four more suicide attempts did he reveal that the reasons for his self-harm was related to the loss of his child. Post-termination grief counselling was provided while he attended a residential substance abuse treatment program.

6. The litigation risk of doctors involved in abortion is currently relatively untested but international precedent shows this is highly likely

1 **Failure to inform of material risks inherent in a procedure may constitute negligence**

- Rogers v Whittaker (1992) was a watershed case in Australian litigation law when the High Court ruled that "*a medical practitioner has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.*" (**Rogers v Whitaker (1992) 175 CLR 479. page 490)**

- Australia has a high level of litigation www.rasmusen.org/papers/litigation-ramseyer-rasmusen.doc

- Doctors who fail to warn women of psychiatric risks may be medico-legally vulnerable
  a. In 1998 two Australian cases ("Ellen's" case in Victoria and "Cynthia's" case in NSW) of women suing abortionists for not disclosing potential psychiatric risk were settled out of court. **Andrew Bolt, Sept 29 1998, The Herald Sun Newspaper, Melbourne**

- Doctors who fail to consider a woman's past mental health history may be medico-legally vulnerable in the event of a termination being demonstrated to have exacerbated a pre-existing condition without the woman having been advised of this possibility.

- Doctors who counsel women with crisis pregnancies face a medico-legal dilemma.
  i. Should Doctors humanise the "baby" by providing information about foetal development, by allowing the pregnant woman to view an ultrasound and

by validating the women's potential to succeed as a mother? This information has been shown to increase the chances of a woman continuing the pregnancy and expressing gratitude for the information. However, should a woman choose termination, but later suffer related mental health problems then she may have grounds to sue the doctor for contributing to her distress when she would have preferred to have remained ignorant.

ii. Or should Doctors use the traditional euphemisms of 'foetus", such as "products of conception" and "pregnancy tissue" and not mention possible mental health sequelae with the aim of assisting the woman cope with the procedure? Should she later develop mental health problems related to a "baby" she may have a Rogers vs Whittaker-type case against her referring doctor, as well as her abortion provider.

2 Doctors providing terminations also face a similar dilemma.

- Medical terminations are performed up to 9 weeks when a foetus is the size of a kidney bean and has a recognisable head, pigmented eye, upper and lower limbs, hands and feet. Woman who have been informed only about "tissue" or "clots" have reported feeling traumatised when they recognised a foetal form. Should this lead to or exacerbate mental health problems then there may be grounds for Rogers-vs-Whittaker-type litigation.

7. The litigation risk for Governments which legalise socioeconomic abortion is also unquantified

1 The current Queensland Maternity and Neonatal Clinical Guideline on Therapeutic Termination of Pregnancy April 2013 is based on information that is long out of date and inaccurate and gives no guidelines regarding informing women of risk of mental health problems post-termination.

See "Psychological Support" on page 13:
Table 3 "Information and Counselling" & Table 4 "Mental Health Considerations"

- **In Table 3 under "Counselling" there is advice to "**Consider the requirement for formal mental health referral especially if there is a history of mental illness" with Reference #25: *Beyondblue. Clinical practice guidelines for depression and related disorders - anxiety, bipolar disorder and puerperal psychosis - in the perinatal period: a guideline for primary care health professionals. 2011 [cited 2012 November 12]. Available from:* http://www.beyondblue.org.au/index.aspx?link_id=6.1246.

- **However, there is no mention of abortion or termination in the BeyondBlue Guidelines**

Table 3. Information and counselling

Aspect	Good practice points
Information	• Support the decision making process by providing accurate, impartial and easy to understand information[2] including[22,23]: o Options to continue the pregnancy and parent the child o Options to continue the pregnancy and place the child for foster care/adoption o Information about methods of termination of pregnancy[23] o Post-termination of pregnancy considerations including contraceptive options and counselling support o Discuss birth registration requirements
Counselling	• Offer confidential, nonjudgemental support and counselling[2,15,24] • Counselling should be provided by someone (e.g. social worker, psychologist, counsellor) who: o Is appropriately qualified and/or trained[2] o Is familiar with the issues surrounding termination of pregnancy o Has no vested interest in the pregnancy outcome[22] • Where feasible, offer counselling 'close to home' to aid the establishment of longer term counselling support • Consider the requirement for formal mental health referral especially if there is a history of mental illness[25]

- **In Table 4, the References for these Evidences and Recommendations are** *Reference #26. National Collaborating Centre for Mental Health. Induced abortion and mental health. A systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors. London: Academy of Medical Royal Colleges. 2011.*

  Reference #13. Royal College of Obstetricians and Gynaecologists. The care of women requesting induced abortion. Evidence-based Clinical Guideline Number 7. November 2011, which states:

  Psychological sequelae

  5.13 Women with an unintended pregnancy should be informed that the evidence suggests that they are no more or less likely to suffer adverse psychological sequelae whether they have an abortion or continue with the pregnancy and have the baby.

  5.14 Women with an unintended pregnancy and a past history of mental health problems should be advised that they may experience further problems whether they choose to have an abortion or to continue with the pregnancy

  https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

- **The advice from RCOG is from 2011, and is not consistent with the current available evidence**

Table 4. Mental health considerations

Considerations	
Evidence	• There are significant limitations in the evidence examining the relationships between unwanted pregnancy, termination of pregnancy, birth and mental health[26] • For the majority of mental health outcomes, there is no statistically significant association between pregnancy resolution and mental health problems[26] • An unwanted pregnancy may lead to an increased risk of mental health problems, or other factors may lead to both an increased risk of unwanted pregnancy and an increased risk of mental health problems[26] • When a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has a termination or goes on to give birth[26] • Women with a past history of mental health problems are at increased risk of further problems after an unintended pregnancy[13]
Recommendation	• Offer referral to a mental health service where there is a pre-existing mental health problem[26] • Consider the need for support and care for all women who request a termination of pregnancy, because the risk of mental health problems increases whatever the pregnancy outcome[26] • Involve social worker support where feasible

2 **The morbidity and mortality of abortion appears to be suppressed by vested interests in a similar fashion as occurred with cigarette smoking, asbestos and thalidomide**

a. When the evidence of harmful health effects of cigarette smoking, asbestos and thalidomide were first raised by clinicians, this information was not welcomed by vested interests
b. Litigation tested the evidence and resulted in compensation payments.
c. Eventually it was revealed that the vested interests had been aware of the health risks even while decrying those who had attempted to reveal this evidence
d. Should a State legalise abortion and not mandate informing women of the mental health risks, that Government too may be medico-legally vulnerable.

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This submission represents my own professional opinion.
It may not represent the opinion of the Royal Australian and New Zealand College of Psychiatrists