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## A Common Sense Scientific Critique of the NCCMH and Royal College of Psychiatry Review

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**Corresponding Author:**

Dr. Philip Ney,  
Head, Dept. of Psychology, Mount Joy College - Canada

**Submitting Author:**

Dr. Philip Ney,  
Head, Dept. of Psychology, Mount Joy College - Canada

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# A Common Sense Scientific Critique of the NCCMH and Royal College of Psychiatry Review

**Author(s):** Ney P

## Abstract

The Royal College of Psychiatry, England, asked 10 principal investigators who had done research in the area of induced abortion and its consequences to comment on the draft paper written by the Academy of Medical Royal Colleges and the National Collaborating Centre for Mental Health. This paper is a summary of the 100 plus comments that I submitted.

Using critical comments made by the writers of this review, I have attempted to show that in most instances they were aware of how inadequate was the research on which they were basing their conclusions.

The *Abortion Act* of England, 1967, amended in 1990 states that a woman can have a safe, legal abortion only if two medical practitioners are of the opinion that a continuance of the pregnancy would involve a risk to the life of the pregnant woman greater than if the pregnancy were terminated. Since 98% of abortions are done ostensibly to prevent risk to the physical and mental health of the pregnant woman and her children, the necessary question is, does research show that there any measurable benefit to the hundreds of thousands of women who had an abortion for these reasons? From the extensive survey the authors performed, there is no evidence of prevention or benefit.

There are many fundamental flaws in the majority of the studies they reviewed. There are more significant scientific inadequacies in their draft and final paper.

## Introduction

I was one of ten principal investigators who had done research in the area of induced abortion and its consequences who were asked by the Royal College of Psychiatry, England, to comment on the draft paper written by the Academy of Medical Royal Colleges and the National Collaborating Center for Mental Health (NCCMH). I submitted over one hundred comments to which they replied courteously. They even modified their paper occasionally. But change their conclusions? Not a whit.

For the vast apathetic and unwary public, the NCCMH

pronouncements didn't seem right, but "who are we to question the experts, and besides we don't understand statistics." Well, here is someone who has all the necessary clinical experience and academic qualifications and taught graduate level research methodology, who can shift thru this maze of sophistry and deceit.

I write these observations in the best tradition of science. No, I don't belong to any prolife organization and yes I do not deny everyone has a choice, but it is not legitimate if it is at the expense of another human. For history clearly shows we cannot benefit at the expense of others, no matter what their size, shape, color etc. This is my bias of which I am not ashamed.

I hope I have written this critique in language that most people understand. I tried to explain terms and methods that were used and noted what should have been used. Throughout I have placed double quotation marks (") around the NCCMH author's statements and single ones (') when quoting everyone else.

Using the writers of this review own critical comments, I have attempted to show that in most instances, they were aware of how inadequate was the research on which they were basing their conclusions. It emphasized their determination to find what they wanted and only what they wanted. This is the most fundamental error in all scientific endeavors. If for no other reason, this review should not be taken very seriously and the conclusions not at all.

## The Law: governing the practice of inducing abortions in the United Kingdom.

The *Abortion Act* of 1967 was amended in 1990. It states that women can have a safe legal abortion only if two medical practitioners are of the opinion, formed in good faith, that;

- a) The continuance of the pregnancy would involve a risk to the life of the pregnant woman greater than if the pregnancy were terminated;
- b) An abortion is necessary to prevent the grave permanent injury of the physical or mental health of the pregnancy woman;

c) If the pregnancy does not exceed 24 weeks and the continuance of the pregnancy would risk the woman's physical or mental health;

d) (As above)....would risk the mental health of any existing child(ren) of the family of the pregnant woman.

e,f,g) Much less often used provisions.

It isn't hard to see a number of contradictions in these provisions, particularly that the "existing child" obviously discounts the preborn baby. Yet "it" must be something, which needs to be accounted for. The onus of proof lies upon those who want to terminate "its" life to show this "thing" is not a living person. Nobody bothers with such a proof.

It is clear from this review and many studies that abortions do not "prevent grave permanent injury" to the mental health of pregnant women. Abortion only worsens all types of mental ill health. This is a fact decided over 3 decades ago.

Nobody obtains the evaluation of "two medical practitioners". Even if they did it would not be in good faith. Those practitioners would not have the skill to predict if the continuance of a woman's pregnancy would risk a woman's or a child's mental health. No one has that skill partly because the research to elucidate the critical factors risking a pregnant woman's health has never been done and partly because they are Ob/Gyn specialists who are not taught this highly developed psychiatric skill.

The whole legislative and medical structure making abortions legal is a sham and a shame. Those who should test its viability with legal suits are pathetically lacking.

## NCCMH MANDATE: (Self Imposed).

The National Collaborating Center for Mental Health was established at the Royal College of Psychiatry to review evidence and produce clinical guidelines for psychiatrists. They wish to aid physicians in practicing evidence-based medicine all the time. If doctors do not practice according to the best scientific evidence, they must be made to cease and desist whatever medical activity that is not evidence based. Herein lies a cruel irony. The practice of abortion (killing babies) is unquestionably the exception to this rule.

Granted the fact that 98 % of abortions are done to prevent risk to the physical and mental health of the pregnant woman and her children, the authors write, "there has been some concern in recent years that abortion itself may increase psychological risk and

adversely affect women's mental health" This is blatantly untrue. There were studies by Prof. Myre Sim at the University of Birmingham and others before the Abortion Act came into being showing the hazards to mental health from abortion. There has been an increasing stream ever since, including our studies on the connection between abortion, poor bonding and child abuse and neglect which obviously indicates something has gone wrong with the mother's mental apparatus.

"We were not looking at abortion as a treatment of mental health, nor were we focusing on the indications for abortion." Yet abortion is a medical procedure, done in medical facilities, by medical personnel and paid for by taxes set aside for medical treatments. If it were any other procedure they would have wanted to know, does it work? Does it make people well or worse? Curiously they inadvertently answered those question and in the negative. It is no wonder for they found nothing new. In modern times, it has always been recognized that abortion is not medically necessary or beneficial. The best evidence is that abortion only harms.

"The starting point of this review is a woman who has met the legal requirements for an abortion." Very few, if any, meet the "legal requirements" mostly because they are not expected to and no abortionist really checks. Therefore the authors have no real starting point.

"The majority, 98 %" of UK abortions are done on the grounds that continuing the pregnancy would risk physical or psychological harm to the woman or child." One can only assume they mean some other child than the one they are intending to kill. This statement is a good example of their cynical sophistry. How can a person argue with their position? Continuing any pregnancy poses risks of harm but the harms are usually minor, heal quickly and naturally and are rare. The well known facts are that 99 % of abortions are chosen for matters of convenience. 34 % are repeat abortions and yet most women who have an abortion will also have a full term delivery. So how did the risks suddenly, magically dissolve?

"The NCCMH has a world class reputation for objectively synthesizing evidence."

"We used the best available evidence". No, they did not. They just lost their world-class reputation for objectivity or they should lose it. They did with me.

### **The Questions they ostensibly sought to address.**

1. How prevalent are mental health problems in women who have had an abortion?

2. What factors are associated with poor mental health outcomes following an induced abortion?

3. Are mental health problems more common in women who have an induced abortion when compared with women who deliver an unwanted child?

These questions were carefully chosen because the authors could easily guess that politically correct answers would result if they carefully chose their sources. In fact as you will soon see, they were in no position to give an honest answer to any of these questions. Yet they most emphatically not only give answers but also make many recommendations based on their answers.

### **Their Conclusions**

The NCCMH could not honestly answer their questions. Nobody can. So they made up these answers. To their credit the authors make modest conclusions but they are worded them in such a way that the press was able to make many mounds of rotten hay from it. They state there is no statistical association between pregnancy resolution and mental health problems. Even that most modest

conclusion cannot be made based on the studies they used and all the limitations that they acknowledge. They state that any unwanted pregnancy is associated with an increased risk of mental health problems. They claim that the rates of mental health problems for women with an unwanted pregnancy were the same whether or not they had an abortion.

To almost every reader of this report, it must be concluded that the problem is unwantedness (something they admit they could not define or measure) not the pregnancy or the abortion. The baby is causing the problem. So solve the problem by getting rid of "it". But hang on a minute, mate. This doesn't compute.

Their second conclusion states that having an abortion didn't resolve the unwantedness problem; otherwise the rate of mental health problems in women with unwanted pregnancies having an abortion would be lower, not the same as they state it is. Since it is not, the effort and money spent on abortions is entirely wasted.

Yet I suppose they had to make some statement to please their masters and their public. For most people these conclusions intuitively do not make sense but they felt unable to question them. For the committed pro-choicers, this is just what they were seeking.

They could only do this by ignoring large amounts of contrary evidence and being very foxy in how they worded their conclusions. For example, they carefully

ignore the substantial evidence of a large increase in suicides associated with abortions. I suppose they believe that being dead from a suicide is no longer that person's mental health problem.

Their recommendations are trite:

a) More support for women with unwanted pregnancies

b) More support for women if they have negative attitudes toward abortion. (Few women don't have some reservations and doubts)

c) More and better research. Of course I heartily endorse this, if there is research money made available equally between those who wish to defend health and life and those who promote death.

They acknowledge that a "small proportion of abortions are done on these (medical) grounds." These authors also accept the Royal College of Obstetrics and Gynecology statement that, "The risks (of abortion) are less than continuing the pregnancy." No evidence was given. This statement is not true because they were comparing maternal mortality rates when the length of the pregnancy are very different; 3 months or less for most abortions compared to 9 months for most women giving birth. Adverse effects for any event are more likely to occur by chance alone if it is measured for a period 3 times longer than the event to which is being compared.

### **Methodology problems with this review**

1. Outcome measures and factors controlled for.

a) Crude measures of mental problems.

The outcome measures they accepted are crude and have little resemblance to the real clinical state of individual women which are spread on a continuum from totally insane to fully grasping reality, "even if I don't like it and I get upset by it." Such was the controversial DSM IV R, on which they heavily relied and which has now been superseded. The authors admit, "Studies using a scale-based measure are more likely to report higher prevalence than those using clinical diagnoses".

b) Dichotomous measures

All measures of health are on a continuum. People are not marbles with health colored either green or red. Yet all measures used in the research they consulted in this review are arbitrarily segmented. In this way they imposed large distortions. When I pointed this out to the authors, they responded with, "This is a general problem with research conducted in this area" So why would they use data which so badly distorts how humans respond?

What should be used are visual analogue scales. We did and found most variables were distributed on W shaped curves.

c) Short follow-up

Together with other critics I pointed out that a follow up on mental health problems of 2yrs, (commonly used in these studies) will miss all those women whose defenses of frenetic work, play or study, collapse when they are older or infirm. Twenty to 40 years later they develop symptoms stemming from their abortion(s). The authors agreed and stated these studies using less than 4 years or more follow-up, "may underestimate the actual rates."

d) Low percentage of follow-up.

The attrition rate for people in research on abortion is notoriously high even when they are paid to return for another evaluation. The reasons include, laziness, (I don't have the time right now"), shame ("I want to forget the whole thing"), avoidance (It is higher for those who do not want to associate their ill health with a bad choice of abortion), etc. The authors accepted follow-up rates of 50 % or more if the researcher compared those who turned up after 2- 4 years with those who did not. This rate would not be accepted by most editors of reputable scientific journals because it is obvious that those who show up for follow-up are very different from those who do not.

e) Death, the least disputed measure.

The Death paper of Reardon, Ney et al (2002) makes the point as we did in comments for this review that death is the only outcome endpoint that can be used with confidence. They responded with, "Although you made a fair point....." but ignore the results of that study and those of Gissler and others.

f) Reliability and Validity.

No scientist should use any measure for which they have not checked to determine if it is valid (really measures what you are interested in) and reliable (can be used by different people in different circumstances and at different times to obtain the same result) When I commented on the fact that it appeared that there were few indications that these studies checked the validity and reliability of their measuring devices. The authors stated they relied upon the principal investigator to do this but acknowledged it was an important limitation. "You make a fair point."

g) Attitudes toward abortion.

The authors of this report noted that one investigator assessed the patients' attitude to abortion "at the time of procedures", when most women are in great turmoil. I pointed out that this is both bad science and

unethical. We found that attitude toward abortion was one of the most important factors in determining a woman's choice to have an abortion but it was usually not controlled.

h) Religious affiliation

The authors commended some investigators for including this as a factor that needed to be controlled for but wrote nothing about the obvious fact that affiliation bears little relationship to the importance of a person's faith.

i) Is the sample representative of the population in question?

Unless the subjects in a study are typical of the whole population of people under consideration, nothing can be concluded from the results about anybody except that sample. The authors agreed with me about not needing large samples stating, "We agree small samples may be representative." Yet these authors seemed to be impressed with large numbers. They also admitted that "In many of the included studies details about representativeness were not available." So how can they make any conclusions about any nation of women? They did consider this drawback, "We feel this is an important issue and have consequently added it as an item in the amended quality rating" but they used these studies anyhow.

Although the results of this review were for the United Kingdom, none of the studies they used were done there. Do they realize different countries have different attitudes to abortion, different funding and availability, etc? Of course they do, but having been commissioned they had to come up with something for the home team.

2. Definition of Terms:

a) Unwanted

To make comparisons, the authors used only those research studies, which separated two groups of women into those who wanted and those who did not want the child. Common sense should have informed them this was a totally unwarranted division because the term "unwanted" is indefinable. Humans are ambivalent about almost everything almost all the time, particularly about being pregnant. The same woman wants the baby on good days, and does not when she is feeling horrible because of nausea and vomiting, or when she is fighting with her partner, or when he loses his job, or when she is offered a promotion at work, etc. If they want to know about wantedness, are they interested on Sunday or Monday? Yet wantedness was used to categorize women regarding their attitudes toward their pregnancy. Since "wantedness"

is so indefinable and ephemeral, any study based on this characteristic cannot be accepted as scientifically valid. Yet these authors used “wantedness” as the basis for their conclusion that it was having an unwanted pregnancy that caused women to have “psychiatric problems”.

Our research on wantedness clearly shows that the degree of wanting a pregnancy drops sharply in the first trimester then rises as the pregnancy continues. For biochemical, physiological, psychological and social reasons, wantedness grows through 2nd and 3rd trimesters. Sadly women are persuaded and/or coerced to have an abortion in the first trimester when they are most vulnerable.

#### b) Unintended.

The authors acknowledged that an unintended pregnancy does not necessarily result in an unwanted child. In fact most couples are mostly intent on having as much pleasure as possible at the time of intercourse more than anything else. They were vaguely aware that a pregnancy might occur but felt secure in knowing an abortion was readily available. They are less aware of a deep instinct to propagate for the survival of the species that operates in most people at some level most of the time.

#### c) Mental illness:

The panel of authors could not use the prevalence of prenatal “mental problems” since it appears no author made an attempt to determine this. So they used a wide collection of estimates and measures. They relied heavily on psychiatric clinic or mental hospital attendance. However having treatment depends so much on which country, the patient’s income and waiting lists, etc. making before and after postpartum comparisons impossible. Using the DSM IV R only compounds the problem. There is very little standardization of its use between the various studies.

#### Who has mental problems?

This review repeatedly avoids the difficulty of defining mental illness and refers to women who have mental problems. Is there anyone who at some time in life doesn’t have mental problems? Thus they try to avoid a problem only to make another far worse.

Women who appear to have adverse psychological difficulties post abortion are not necessarily sick in any sense but may be having a normal reaction to a very abnormal event (abortion) rather than an abnormal reaction to something of minimal stress. If the assumption is that abortion is no worse than a tooth extraction then, as with these authors, they will assume a strong reaction is abnormal. Killing one’s

own innocent, helpless, totally dependant child used to be considered the most horrific act of any human. To many people who have yet to become dehumanized it still is. Their reaction of horror, extreme guilt, complicated grief, terror of reprisal (from God and human), persistent self blame, nightmares and sleep deprivation is a normal reaction. Those who feel little or none of the above may have become so insensitive, callous, proud, determined not to let it ruin their lives that they must keep frenetically busy and happy. Probably they should not be the principal caregivers of children and this they can sense. Thus they are more inclined to place their children in day care from an early age.

Suffice to say, the authors of this review have measured reactions in a reverse fashion, abnormal when a woman is filled with grief and remorse and normal if it appears post abortion women are unaffected by having killed their preborn baby. This twist in their logic is only possible by convincing themselves the clearly human object in the woman’s uterus is a “piece of tissue”. Yet they make no attempt to prove this baby is not a person. Surely in this area of science, this should be the most necessary pursuit of their research.

This huge gap demonstrates that when the NCCMH wish to make a finding to support their prochoice position, they will blithely disregard any difficult questions and make huge biased assumptions while loudly asserting their objectivity. If they made the assumption that since for very nearly all human history this object was treated as a child, a child he must be, then all of their findings would be thrown into a cocked hat of utter nonsense.

#### Types of Response

Though all human reactions are somewhere on a continuum, it appears from my long experience with post abortion people, there are 7 main types of response:

a) Usual. Immediately post abortion there is a sense of relief soon followed by growing guilt, shame, anger, fear, withdrawal etc. This is seen particularly when a woman has her first baby following an abortion and more fully realizes the extent of her foolish decision. Then too often she seeks help from a physician who superficially listens, diagnoses “depression from a chemical imbalance ” and prescribes medications which suppress her intense feelings and conflicts thus interfering with mourning and thereby producing a pathological grief which often results in a real depression.

b) Sensitive. People (women, men and children) who

are more emotionally sensitive soon sense the excruciating pain, terror and anger of the murdered child. They reinforce each other's turmoil and begin a vicious cycle of mounting psychological chaos but will not talk about the roots of it. They find temporary relief in drugs, alcohol, frenetic activity, confession ad infinitum, good works and bad counseling.

c) Post Abortion Survivors. We discovered that one of the best predictors for who choose to abort babies are, those who have siblings who were aborted. It seems that they are attempting to resolve their essential conflicts by reenacting what their mother did. They only find the root problem is not understood any better but the pain is doubly intense.

d) Vulnerable. We also discovered that of the 55 factors we considered, the variable most closely associated with the choice to abort is the woman being neglected as a child. These women are very afraid of being abandoned and so quickly acquiesce when their partner threatens to leave "if you don't get rid of it". She has an abortion and he leaves anyway, partly because he does not relish the thought of having intercourse in the canal where a baby was murdered. That she has now abandoned her baby to avoid being abandoned fills her with remorse and shame. That psychological pain piled on top of a shaky personality structure may precipitate deep depression or a psychosis.

e) Committed. Women who: are angry at men for neglect and abuse, may adhere to a philosophical point of view, embittered by vain attempts to find love and encouraged by their "sisters" to assert their woman's rights. They steel themselves to go through with an abortion in order that their lives can become "fulfilled" with money and praise. Some are persuaded that they should deliberately get pregnant, then abort the "idiot's brat" in order to hurt him and discover their power over life and death.

f) Hardened. Those who have already had one abortion and recovered are often more emotionally hardened. These people are more or less able to deny any distress and keep up appearances until: they become unwell, have a crippling accident or are struggling with aging. Then their defenses collapse and they have all manner of illnesses. Because they are afraid of death and dying, fear God's revenge, and don't want to live depending on family who clearly want their money more than them, these women grit their teeth, plan their doctor assisted death and invite significant others to their funeral on a predetermined date.

g) Psychosomatic. Many women feel emotional pain in

their bodies and express their psychological conflicts primarily in some gut or joint. Following an abortion they present to their physician with a variety of hard to diagnose problems. Then they often begin a round of tests and specialist investigations.

This MCCMH review cannot account for these and other individual responses. It can only make limited generalizations, treating women as having mental health problems or being free of them. Thus its findings cannot apply to any individual. It doesn't help in determining those who will react to an abortion most strongly. Certainly to assume those with the most intense symptoms are most unwell is completely incorrect.

#### **Prevalence:**

Prevalence, by definition is the total number of individuals with a specific disease in existence in a given population at a certain time. This review has used the term prevalence incorrectly. When I pointed this out in my comment they replied, "Although we agree that a population based study would be the best way to determine prevalence, we have estimated prevalence..." "As these rates are estimates...."

They used various rates of incidence in place of prevalence. They are not the same. Incidence is the rate of a disease, which is known from the number of people reporting for help and being diagnosed. These 2 figures can be different by 50% or more. This is particularly true of abortion where women because of shame, guilt and the desire for privacy, are reluctant to present to a physician for help. They are more likely to present to their physician with somatic complaints. These women will not be counted in a study of the effects of abortion on mental health. That is why we measured both physical and emotional health. The author's response to my comment was, "We have noted the use of treatment records as a limitation of the evidence base."

A quick search of [PubMed](#) using the terms, "prevalence of depression" found 46,575 references, at least some of which could be useful in determining prevalence in ways better than the estimates based on incidence that these authors have accepted.

#### **Other critics:**

There were many good comments (1b) from those invited and many others representing pro-choice and prolife groups. From prochoicers it was mostly plaudits and from those defending preborn babies lives it was mostly expressions of astonishment and disappointment at the poor science.

The following is a very small sample:

British Psychological Association: "We have a number of broad concerns." "We find the makeup of the steering group to be fundamentally unbalanced and unfit for purpose."

Christian Concern UK: This review used "only research which demonstrated effects of abortion more than 90 days" after the abortion when there are many bad reactions after that period.

Family Planning Association: "We believe it will support our work."

Dr. David Ferguson is considered to have the best evidence. He states, 'The report makes absolutely no reference to the compelling evidence that abortion does not appear to have therapeutic benefits in mitigating the risks of mental health problems caused by a woman's pregnancy. The failure of this report to address this issue seriously undermines both the policy value and the validity of this report.'

Dr. David Reardon: "Why anyone should lack confidence in the record linkage process is unclear. (Masterful understatement). These authors apparently did not understand the record matching procedure. We now refer to these as the California Medical Record studies."

Dr. Priscilla Coleman: Commenting on the author's selection of which study to include and rate highly, 'There are studies that are ignored and a large number of studies that were entirely dismissed for vague and inappropriate reasons.' 'There were factual errors' (in the authors analysis of PC's studies.)

Dr. Philip Ney: 'Their (NCCMH) statements accurately illustrate that as treatment to improve or prevent mental illness, abortion is not effective.' 'The question whether or not abortion is good treatment for any mental health problem of pregnant women was completely ignored. Therefore this review is irrelevant and invalid', "Thank you for your comment."

'It is unlikely that any woman is single minded about a pregnancy before, during or after, all the time.'

'Since these two conditions (post abortion and post-partum) cannot be compared, all the research that make these comparisons are of no scientific value.'

'Because of the gross level of under-reporting (50 to 60 %) of abortion and mental health problems, any estimate of prevalence cannot be correct.'

'Although studies that are less financially profitable or politically correct are well known to be less often published, these authors made no allowances for unpublished but valid data.'

### **Biases of authors, observations and conclusions:**

#### a) Personal.

The writers of this NCCMH review state they have no financial conflict of interest in this matter but their biases are left unrecorded. Obviously they have a bias; everybody does. Their bias is shaped by their experience much more than their financial interests and their science. How much would you bet that they or their spouse or sibling or mother or friend had an abortion? It would have been very helpful in understanding their obvious predilections if they had truthfully answered a question regarding their personal experience of abortion &/or poor mental health.

#### b) Bias seen in emphasis:

Although B. Major's study (2000) was so poor it should not have been published, this panel cited it almost more often than any other reference. In an effort to make it look better than it was, they persistently described the study as taking place in three hospitals when they actually occurred in 2 private clinics ("abortion clinics") and one private office, (that of an abortionist.) When I pointed this out they hastily corrected it.

#### c) Bias seen in the selection of papers

Drs. Coleman and Reardon (1b) have done a very good job criticizing the selection and grading of papers referred to in this review. It seems selection had less to do with the papers' findings or credibility than it did with whether or not the conclusions agreed with the panel's bias. For example: Both Reardon and Gissler were rated low even though they used large samples and the gold standard (record matching) approach. Fergusson's study which was probably the best because it was a long, longitudinal survey was rated only fair until the authors were corrected. Ney et al (1994) were excluded even though these authors used much more sensitive (visual analogue) measures, included all pregnancy outcomes for the woman's whole reproductive life, had a verified representative sample, included many more factors than most authors, had a 3 way check for reliability and validity on major measures, assessed physical health as well as mental health, had useful measures of wantedness on a continuum and had the same measures for 2 groups of patients from physicians with different attitudes toward abortion for comparison.

#### d) Cutoff date.

This review arbitrarily decided on a cutoff date that excluded many valuable studies for consideration. They nearly excluded the very useful study by Dr. Priscilla K. Coleman because it was in not print at the

time their draft was written.

e) Further comment

A small carefully selected few were contacted to see if they were wishing to give further comment. None of these were authors who reported harmful effects of abortion.

## Some of the other factors not addressed in this review: (Short list)

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Post pregnancy circumstances  
 Earlier mental health problems  
 Childhood mistreatment  
 Partner not present, during pregnancy, at delivery and after birth  
 Partner, family or employer coercion  
 Physical illness before or after the abortion  
 Previous hospitalizations for all kinds of illness  
 Drug abusing or alcoholism  
 Change of partner or being abandoned  
 Employment conditions and threat of losing job or promotion  
 Difficulties during delivery for pregnancies before and after abortion  
 Outcome of pregnancies of subject's mother  
 Frequency of abortion in country of study  
 Having aborted siblings  
 Subsequent difficulties with pregnancies  
 Bonding problems (commented on by MJC), responded to by the authors "Bonding with the baby...is an important area"  
 Better health of surviving children and sibling interaction  
 Treatment availability and cost. "We agree this is a limitation of the data set as a whole."  
 Sex life and multiple partners  
 Infertility  
 Weight problems.  
 Sleep disorders and night-mares  
 Previous abortion(s). "We agree this is an important confounding variable within studies throughout."

And there are many others. Their lame response to this criticism was, "The list of potential risk factors here is not exhaustive." "They are beyond the scope of this review."

### Caveats used by NCCMH authors :

"Further interpretation of the relationship between abortion and mental health outcomes has been made possible through the finding that unwanted pregnancies are associated with higher rates of mental

health problems before an abortion compared with women who gave birth." Since they assert this evidence is "poor" and they have not empirically defined wantedness, and since this categorizing variable changes so often, the authors have not made this finding. They therefore cannot make further interpretation even though they very much wanted to do so.

"We have used the best evidence available." They repeatedly rated the evidence they relied upon as poor or very poor, so why not conclude they cannot make any conclusion? Would they make a recommendation for major surgery on the basis of very poor evidence from their investigations?

"...Yes, but it is beyond the scope of this review". This statement was made often, in particular to suggestions I (Mount Joy College) made about important factors not being investigated or for which they did not control. Yet that was their self-assigned mandate #2, "What factors are associated....."

### Studies selected:

Using various devices, like PubMed, they detected 8909 research studies from which they selected 2%.

They rejected any study that included less than 80% of the people who were approached to volunteer to be a study subject. Very few studies indicated about the % of those enrolled to those approached to volunteer, but these studies were used anyhow.

They rejected any study with a follow-up of less than 50% but still used and frequently quoted B. Major with less than 50% and Russo with less than 40% follow-up. These 2 studies were so poor they should not have been published yet have become the darling of the prochoice stance.

1. They used 25 studies to answer the prevalence question 0% of which were rated as very good or good and only 50% were rated as fair. The rest were poor or very poor. "The high degree of heterogeneity in prevalence rates and the difference in outcome measurement make it difficult to form confident conclusions or generalizations for these results" Yet they did just that with such emphasis so as to create the impression to all and sundry that they knew precisely about what they wrote in their conclusions.

2. The authors of this review used 27 studies to answer question # 2, only 6 of which they rated good or very good. They then stated, "It is likely that a range of factors ....reviewed here did not constitute an exhaustive list." (Such a masterful understatement). It is not because other studies did not include a host of relevant factors. Ours (Ney et al 1994) measured both

physical health and mental health. Surely, I argued, physical health must have an impact on mental health and the ability to bond to the next child. The authors responded with, ".....yes but beyond the scope of our review." They included studies that attempted to measure only 5 of the 50 factors we considered in our research on factors which determine pregnancy outcome.

3. To answer the third question they posed for this review (Are mental problems more common in post abortion women) they included 15 studies, which did not control for whether or not the pregnancy was wanted. Of these 9 were considered good even though they did not control for the categorizing variable.

Of the 4 studies that tried to control for wantedness, 2 were considered good. Yet one of those could not be generalized to the whole population of women because their sample of subjects was bound to be biased. (Some women were recruited from some GPs who were prepared to do this study) The authors write, "The evidence for this section of the review was generally rated as poor or very poor...." Again they use bad information to make sweeping, totally unwarranted conclusions without a blush of embarrassment.

#### **Statistics:**

The authors of this review did meta-analysis on only 4 studies because of heterogeneity in the rest "In the absence of meta-analysis.... rightly due to high levels of heterogeneity...." The main study they used (Gilchrist) though rated very highly used a sample of patients (% agreeing to be subjects not indicated) drawn from the practices of some family physicians who appeared to support the study. It is unlikely this sample represented any larger population. The authors were so skeptical of the statistics used in all the other included studies that they discounted them and used a 'narrative review'.

#### **Sophistry:**

The authors insisted, "Women (in the UK) have legal right to request an abortion." "She can choose or elect to have an abortion subject to the law and approval of physicians". These are very carefully chosen words. No one can deny that a woman has a right to request anything her heart desires. Everyone one may choose to have any physician recommended procedure. It may be granted by a good doctor, if the patient's condition warrants it. What this statement in the review doesn't say but everyone knows to be the fact, is that there are virtually no medical, surgical, psychiatric or social conditions that make it necessary to have an

abortion. There is no evidence abortion heals any psychiatric condition or prevents any mental illness from occurring.

## Conclusions

The NCCMH authors conclude, "The majority of studies included in the review were subject to multiple limitations". Most scientists making this statement would logically conclude that they could not make any conclusions until such time as good research was done to properly address their questions. By the rules of evidence based medicine, that would be the case in every other sphere of medicine. In psychopharmacology, if physicians reported 2 deaths associated with some new chemical, it would be immediately withdrawn from the market. There have been thousands of deaths associated with "legal induced abortions" but the practice continues unabated and seldom questioned. The problem is not with the scientific data showing harm, the real problem is humans putting self-interest ahead of science all the while maintaining a façade of scientific legitimacy. They do so to the great harm of the practice of medicine and the patient's confidence in physicians. 'They obviously are lying about abortions, so why should they be trusted in any other part of their practice?'

Though highly touted by believing professionals and widely praised in most of the media, this review is not worthy of the paper nor the computer screen upon which it is written.

#### **A short summary of the deficiencies of the NCCMH review:**

- i) It is based on the wrong terms of reference. Investigating the medical procedure abortion should first determine necessity, indications and benefit, not harms.
- ii) It does not use empirically derived definitions for important terms
- iii) It uses categorizing values (wanted, not wanted) that can only be measured on a continuum. They ignore the whole range of wildly swinging human reactions to becoming pregnant and they disregard the fact that preborn babies become more "wanted" as the pregnancy progresses.
- iv) It makes sweeping generalizations to large populations without knowing whether or not the sample was representative of a state or country.
- v) It accepts the use of measures whether or not their validity or reliability was established.

vii) It is shot thru with obvious biases, which determine inclusion and rating of various studies. They make feeble attempts to offset these biases.

viii) It ignores a wide range of damaging effects that have been authentically reported to occur as a result of abortion.

ix) It makes no attempt to account for essential human variables that should be measured on a continuum.

x) It misuses the concept of prevalence.

xi) It uses some of the worst studies available and ignores some of the best.

xii) It may acknowledge some valid criticism but discounts them with "beyond our mandate" (it should not be) or "we are using the best evidence available" which is blatantly untrue.

xiii) It does not account for the wide differences in culture and medical services in the different countries where the studies were done.

xiv) It uses sophistry and obfuscation to mislead all the while claiming transparency.

xv) It makes no comment on the obvious incongruity that if abortions are performed on the basis of a woman's choice, then it doesn't matter if it is good medicine or not. If it is, then providing abortions is not a medical matter (physicians do not provide services unless they are medically necessary) and thus this review was unnecessary.

xvi) There is no comment on the fact that if abortions are performed by the thousands to avoid the risk of damage to the mental and physical health of pregnant women and their children, there should be a measurable improvement in the health of women and their children in England. It appears the opposite is true.

If this were an assignment to design a research project by one of my students in a class of research methodology, he/she would miserably fail. So do the authors of this review.

Abortion is destructive to millions of babies and deeply damaging to women, men and children. It undermines the basic structures of society, law, medicine, science and theology. It is dehumanizing almost the entire race of humans. So why would people want to do it, legalize it, raise taxes to pay for it, have one and/or recommend it for others? The only plausible answer is that humans have always been self and species destructive and they have now found the method to make that possible.

Those methods have become socially, medically, legally and religiously acceptable only because they

conveniently get rid of a "problem" that interferes with the pursuit of non-stop pleasure. The more research that is done, the more convincing it becomes that abortion, though ostensibly medical, is not treatment for any medical, psychological or social condition.

The only conclusion that can be reliably based on the scientific studies of abortion is that abortion only harms women, men and children. There is no necessity for or benefit from abortion. It is not done in good faith.

#### **What they should have done**

Remember that in medicine as in every other scientific endeavour, those that postulate a discovery or new procedure must assume the awkward necessity of proving what they assert. It is not primarily for those who are skeptical to point out flaws in the research or lack of benefit or hazards to a new treatment. It is their responsibility secondarily to warn that a new procedure has no benefit over no treatment or that using it is damaging to the patient. Yet this secondary responsibility is duty to warn that every worthy physician takes very seriously.

One of the odd features regarding induced abortion is that unlike every other surgical procedure, it was not properly vetted on animals before it was allowed to be practiced on women worldwide. Abortion, unlike every other new medical, surgical, psychiatric treatment has never been approved. It should have been handled by the medical establishment as a very carefully controlled "unproven remedy". It should never have become a vast unscientific experiment on unsuspecting women and men. Why, you may well ask, was this aberration allowed? It is a very good question that judges, professors, legislators, scientists and practitioners must be required to answer.

It isn't so hard to do the necessary research. It would proceed something as follows:

a) Animal studies. Rats would be randomly impregnated then randomly assigned to one of three groups i) Never pregnant ii) Pregnant and aborted after various durations of pregnancy, iii) Pregnant, allowed to deliver. These 3 groups would be measured for physiological changes, longevity, cancers, bonding to young, parenting ability, social interactions, later mating capacity, etc.

b) Depending on the findings above and because it is so vital to the health of millions and the survival of the species, there would be primate studies, examining changes in behaviour, rivalry, mating, pregnancy outcomes and health of the animals.

c) If and when abortion was allowed to be done on a small selection of volunteer women, (the data to

present would indicate that is highly unlikely) who requested abortion for any reason, they would be carefully screened and given an abortion on a random basis. If they objected to not being given an abortion they could be financially remunerated and given the option of adoption or some other recourse. (There are at least 9 options). They would be carefully evaluated before, after an abortion and every 6 months for 30 to 40 years.

d) If and when abortion was found to be necessary for specific reasons and if and when abortions would be therapeutic and if and when abortions were done in good faith, etc., they might be allowed to be performed for a variety of valid reasons. All those participating in doing abortions would be evaluated regularly. The surviving children would be carefully followed for the duration of their lives.

e) Then if all the research shows that abortions are medically necessary, the government should approve of them.

The possibility of all this occurring is almost nil. Any agency that claims to have women's best interests at heart but does abortions doesn't need scientific scrutiny to tell them abortion is not a legitimate medical procedure. From their daily encounters with confused women and men, they know that the whole sordid process is a money making operation that is not only a blight on humanity but is the death of civilization as we have come to appreciate it and the destruction of our species.

Without the rudiments of justification, thrusting a curette into a woman and performing an abortion is tantamount to criminal assault. No civilized country can legalize and fund a medical act that is criminal. Nazi Germany did just that and was condemned as barbaric.

Nations must decide if abortion is to be granted according to the woman's unfettered "choice" or if it is only available when medically indicated. If it is a woman's choice, a right to be granted, forcibly if necessary, then it should be performed by technicians. For otherwise the noble profession of medicine will continue to fail. If abortion continues to be performed by medical staff, in medical facilities for medical reasons and paid for by medical funds, it must come under all the constraints of evidence based medicine. If that were the case there would be very few abortions.

Finally, everyone must realize we have a duty to warn of impending harm and hazard. We must warn women, men, children of prospective hurts to health and welfare, the medical profession of self-destruction, the legal profession of creeping dishonesty, the pastors

and priests of their cringing. For the current practice of induced abortion will result in a great catastrophe. The signs are here.

Remember this if nothing else:

a) There is no good evidence that abortion is medically necessary, beneficial, and relatively free from harms, or practiced in good faith.

b) Those who support and provide abortions are not being held accountable for their terrible medical practice.

c) Those that could hold abortion practitioners, their agents and their allies accountable for their wholesale use and abuse of women as guinea pigs in a vast uncontrolled experiment are not necessarily afraid and defensive.

d) Thus those that have a genuine concern for people must now take the offensive and demand of the government and medical councils that the current situation be rectified.

e) In public debate and personal discussion with those who claim to be pro-choice, those who are for life can and should keep insisting on "show me". Where is your evidence that the preborn child is not a person? Show me the evidence that induced abortions are necessary for any type of health problem. Show me the data that abortions are beneficial for any one, any city or nation. Put up or shut up. If you have no long-term reliable scientific evidence, shut down your "clinics", so called.

## Selected Sources of Information

1. National Collaborating Centre for Mental Health (NCCMH):

a) For their final report 'Induced Abortion and Mental Health: A systematic review of the evidence - full report and consultation table with responses' Dec 2011

Retrieved from [http://www.nccmh.org.uk/publications\\_SR\\_abortion\\_in\\_MH.html](http://www.nccmh.org.uk/publications_SR_abortion_in_MH.html)

b) For comments from researchers and public and the NCCMH response to them. Retrieved from <http://www.nccmh.org.uk/report/Abortion%20Review%20Consultation%20Table1.pdf>

2. David Ferguson, PhD, Dept Psychological Medicine,

University of Otago, New Zealand.

For scientific articles see [www.pubmed.com](http://www.pubmed.com)

3. David Reardon PhD, Elliot Institute, Springfield Illinois, [www.AbortionRisks.org](http://www.AbortionRisks.org) and [www.pubmed.com](http://www.pubmed.com) for published scientific studies

4. Priscilla K. Coleman PhD, Dept of Psychology, Bowling Green State University, Ohio, Royal College Hides Abortion's Harm to Women. [www.Lifenews.com](http://www.Lifenews.com) 15/12/11. See [www.pubmed.com](http://www.pubmed.com) for published scientific studies

5. Philip Ney MD FRCP(C) Mount Joy College Victoria, Canada for comments and relevant non-scientific articles: [www.messengers2.com](http://www.messengers2.com); for scientific articles [www.pubmed.com](http://www.pubmed.com)