

# The Post-Abortion Review

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## Targeting “Excess” Children Created *In Vitro* Infertility Treatments and the Problem of “Multifetal Pregnancy Reduction”

Elizabeth Ring-Cassidy and Ian Gentles

Just as reproductive technologies have changed obstetrical practice, so too have they led to a type of abortion which affects a different population of pregnant women from those who do not want to be pregnant. These women want very much to have a child, and it is ironic that they and their partners who are suffering the problems of infertility must often come face-to-face with abortion.

There is a large literature detailing the psychological distress experienced by couples who wish to have children but who cannot conceive naturally. The following quotation captures the feeling poignantly:

You can't have a baby—a numbness beyond desperation. Baby lust—do you know how it feels to want a baby so much that every other activity in life, everything you've worked for and planned for—jobs, friends, family, marriage, seem hollow as a tin can? To be in emotional pain so extreme that when you see a pregnant woman's stomach or a newborn baby the pain becomes physical?<sup>1</sup>

### An Emotional Roller Coaster

Laffont and Edelmann concluded that long-term infertility that is treated by in vitro fertilization (IVF) superimposes cycles of hope and disappointment on the already depressed and vulnerable psyche of couples who are having difficulty conceiving.<sup>2</sup> The process can take up to nine cycles of treatment because few couples conceive on the first attempt.

Indeed, the overall success rate of IVF is a matter of continuing controversy. Oddens and colleagues found that for women involved in this treatment psychological well-being may deteriorate after unsuccessful treatment cycles.<sup>3</sup>

Both partners experience psychological swings during treatment, and Boivin and colleagues observed that “Spouses appeared equally . . . to respond . . . with ambivalent feelings involving emotional distress and positive feelings of hope and intimacy.”<sup>4</sup> But the literature suggests that women report greater negative reactions to IVF failures than men. The coping mechanisms utilized by some women to face the cycles of failure,<sup>5</sup> are the same denial and desensitization often seen in post-abortion psychopathology.

Following this cyclical emotional roller coaster, the fortunate couple may find themselves pregnant. In increasing numbers, however, these pregnancies are “higher order” with three or more implanted fetuses. “The international rates of triplet or higher order pregnancies after assisted reproduction are 7.3 per cent at conception.”<sup>6</sup> In order to deal with such pregnancies, women must put themselves in the care of high-risk obstetrical experts who know the latest research on the new technologies used in the management of multiple pregnancies.

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**Ironically, couples who truly want children may end up facing abortion.**

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One of these new approaches is known as Multifetal Pregnancy Reduction (MFPR)—a form of abortion in which the most accessible fetuses are terminated by a needle stab through the heart and the overall pregnancy number is reduced to twins or a singleton. The dead fetuses

remain in utero until the delivery of the living ones. This approach was developed by genetic researchers, some of whom are active participants in the prenatal diagnostics aspects of the Human Genome Project.

While many researchers end their studies with a call for curbs on the number of embryos that are implanted (which would reduce the likelihood of higher order multiple births to near-natural levels),<sup>7</sup> many other continuing studies are committed to the improvement of the techniques for MFPR.

What is interesting about the studies in this area is the high degree of overlap between researchers. The twelve most prolific writers in this field all cite each other and often collaborate on research.<sup>8</sup> This self-referral or “incestuous citation”<sup>9</sup> is similar to that found in the general abortion literature. As in the other abortion areas, the majority of these researchers are themselves practitioners of the MFPR procedure and some have the distinction of being not only practitioners but also advocates for and cited as experts on the probity of the procedure.

The procedure for aborting some of the fetuses in multiple pregnancies has been improved and expanded to the point that all major teaching hospitals in North America and Western Europe now routinely offer couples MFPR as an option for management of multiple pregnancies. One problem, however, is that the couple who never imagined themselves actually having a single child, and who have succeeded thanks to advanced IVF techniques,

may feel themselves to be faced with what auto dealers call a “mandatory option” in dealing with their unexpected bounty.

For many couples their new situation is very uncomfortable, not least because the gestational age at which these abortions are occurring has steadily increased to the point where Evans and colleagues are supporting the use of the technique into the third trimester (or after 26 weeks of pregnancy).<sup>10</sup>

The use of this technique is often a logical outcome of the psychology of desperation of infertile couples, and itself produces a logic described by Berkowitz and colleagues:

The medical justification for performing multifetal pregnancy reduction is philosophically similar to the “lifeboat analogy” . . . it is justifiable to sacrifice some “innocent” fetal lives to increase the chances of survival or decrease the risk of serious morbidity in the survivors of the procedure.<sup>11</sup>

### **MFPR Compared to Genetic Abortions**

In an attempt to make the use of MFPR a more readily-accepted part of obstetrical practice, the literature links the procedure to the already well-tolerated practice of abortion for genetic or fetal abnormality. The proponents of this technique believe the linkage addresses two important concerns.

First, they conclude that patients will not tolerate multiple births, so the use of MFPR will avoid the “trauma”<sup>12</sup> of the abortion of a wanted pregnancy on the grounds that if reduction is not offered, the patient will choose to abort all the embryos. Second, MFPR will lead to the ultimate goal of having their own child. This principle of Ethical Justification has also been articulated in terms of three goals:

1. Achieving a pregnancy that results in a live birth of one or more infants with minimal neonatal morbidity and mortality;
2. Achieving a pregnancy that results in the birth of one or more infants without antenatally detected anomalies;
3. Achieving a pregnancy that results in a singleton live birth.<sup>13</sup>

The research literature assumes that parents faced with the potential birth of three to seven children at once are “free” to choose to abort most of them to achieve a family size of their choice. Individuals acting out of desperation, however, are not “free,” and without freedom there is no true choice.

The psychological impact of coercive choice is well documented in the decision-making literature. Miller delineated several models that apply to the decision to abort<sup>14</sup> and Cassidy expanded upon these in relation to decision-making in abortions for fetal abnormality.<sup>15</sup> The consensus among psychologists is that major life decisions based on perceived or overt coercion result in significant psychological distress.

In North America, the prevailing model for making medical decisions is based on the concept of “personal autonomy” and informed consent which have become cornerstones for the ethical acceptability for all medical procedures.<sup>16</sup> Often, however, the decisions taken by couples to reduce the number of fetuses can be seen as lacking true personal autonomy because of parental desperation, medical coercion, and a lack of informed consent.

## **Medical professionals have assumed that parents want MFPR.**

### **Restricting Choice and the Lack of Informed Consent**

A couple’s capacity to give full assent is badly compromised due to the pre-existing psychological trauma brought on by long-term infertility and the IVF process itself. As the number of these multifetal abortions grows, the families involved are now coming forward to discuss pursuant issues which are only just beginning to be dealt with in the clinical therapy and post-abortion healing literature. Kluger-Bell describes a family of triplets whose IVF resulted in a quad pregnancy. As her client notes:

. . . I really didn’t feel like I had a whole lot of choice about reducing it. And I was pretty much told by the doctors, ‘Oh, well, you’re not going to carry that many babies.’ And most likely it would have to be reduced to two. And not knowing anything about it, we thought that was just the way it was.

It was only when this family firmly expressed their desire to have all four babies that the doctors agreed to leave three. The MFPR was successful, but the client paid an emotional price

. . . emotionally there’s still an ache that will probably always be there. We had been trying for so many years to create life, it was very contradictory and painful . . . no one ever said we could consider keeping all four . . . why wasn’t that an option?<sup>17</sup>

Ninety-nine per cent of the women who go through fetal reduction had achieved pregnancy through infertility treatment. Therefore, they represent a group which Tabsh describes as “highly motivated

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to have a successful pregnancy outcome. They tend to be compliant with the medical plan for their care,<sup>18</sup> and will therefore, as Macones and Wapner imply, assent to whatever approach will most likely assure them of a healthy child. In general, women seeking such an outcome will do anything the medical experts deem necessary.<sup>19</sup>

Ironically, until 1995, the attitude of infertility patients towards multiple births had never been investigated. Gleicher and colleagues found that the medical profession's implementation of MFPR was made without input from patient populations:

It can therefore be no surprise that the survey reported here about patient attitudes is in strong conflict with the rather universally accepted practice patterns of minimizing multiple pregnancy rates . . . [infertile patients] express a considerable desire for multiple births . . . The medical profession so far has assumed that the decision to minimize multiple births . . . was reflective of patient desires. This study suggests otherwise.<sup>20</sup>

The ethical justification for MFPR is the desperate desire of parents to have a healthy baby. But what is the psychological price?

To desperate people, the avenue that promises the greatest hope may appear to be the morally best option, especially if pregnancy reduction is presented as the medically appropriate decision—the decision that will guarantee them one live baby. To refuse such an option requires freedom from coercion and access to other management approaches that provide alternatives. It is clear that these couples do not meet the criterion for free choice and, indeed, the actual level of coercion in this procedure is striking in the recent literature on surrogacy.

### Medical Outcomes of MFPR

The main rationale for MFPR is clearly the birth of at least one healthy child. Does MFPR guarantee this? This seems to be a matter of debate. Groutz and colleagues found that “Contrary to previous studies we found a higher incidence of pregnancy complications after MFPR compared with spontaneous twins. . . .”<sup>21</sup>

Souter and Goodwin did a meta-analysis of all 83 of the articles published on the procedure since 1989 and found that “there is a general consensus that reducing triplets to twins results in significant secondary benefits: lower cost and fewer days in hospital and a decrease in a variety of moderate morbidities associated with prolonged hospitalizations and preterm delivery for mother and baby. However, it is not clear that couples are more likely to take home a healthy baby, if they undergo multifetal pregnancy reduction.”<sup>22</sup>

A recent Swedish study also identified the presence of post-procedure full miscarriage in 21 percent of the cases undertaken in that country; a further 18 percent died in the womb or shortly after birth, or were born with defects.<sup>23</sup> Likewise, Elliott has suggested that studies of properly managed triplet pregnancies “show an equal or better outcome with nonreduced triplets compared with selective reduction.”<sup>24</sup>

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## IVF, Mass Production, and Coercion

David C. Reardon

Multifetal pregnancy reduction (MFPR) is recommended by the practitioners of artificial reproduction methods on the grounds that it is necessary to safeguard the health of the mother and surviving children. As with other abortion procedures, however, there is little, if any, evidence that this procedure actually attains the desired outcome.

In regard to the other children, MFPR introduces the additional risk of miscarrying all the children. The emotional trauma and self-blame that couples must experience after consenting to MFPR and then miscarrying all of their children, after years of longing, prayer, and payment of huge medical bills to become pregnant, is unimaginable. It has yet to be studied. And how can the pain of this devastated couple be weighed against the joy (tinged with grief) of couples for whom MFPR *may* have helped to avoid a natural miscarriage?

These points are hinted at by Ring-Cassidy and Gentles in the accompanying article. What they do not discuss, however, is the financial motivation of IVF clinics to risk high rates of multiple pregnancies and subsequent MFPR procedures.

My reflection on this problem was prompted by a call I received last year from a woman who was experiencing severe post-abortion reactions following an MFPR procedure. Prior to undergoing an in vitro fertilization procedure, she had told the doctor she would not agree to abortion under any circumstance and he had expressed respect for her beliefs. Despite this, he implanted several embryos with the expectation that most would not “take.” When several of the implanted embryos did implant, he quickly began to pressure her to abort the “extras” to avoid losing them all.

Eventually, the mother, who desperately wanted children and abhorred abortion, gave in. Like the Polish woman in *Sophie's Choice* who was forced by Nazis to pick which of her children would live and which would die, this woman submitted to the pressure to respond to a question that is immoral to ask.

Even though this doctor knew this woman was morally opposed to MFPR, why did he put himself in the position of “needing” to recommend MFPR by creating and implanting more than the one or two embryos which he believed it was safe for her to carry to term?

The answer, I believe, lies in the fact that IVF clinics are run like competitive businesses. IVF is an expensive procedure with high failure rates. Clinics want to be able to report success rates as high as 20 percent to prospective new clients. The best way to boost “success” rates is to implant many embryos

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## Psychological Outcomes of MFPR

Given the difficulties inherent in the MFPR procedure, it is not surprising that even following the achievement of the goal of parenting a child, couples who have participated in MFPR decisions experience the grief and emotional distress associated with the loss of a child. Some researchers have claimed that these families do not experience significant psychiatric disturbance because “the birth of healthy children helps reduce the traumatic impact of fetal reduction.”<sup>25</sup> What is not stressed in the literature, however, are the following observations:

1. There are significant attrition and refusal rates in study samples.
2. Couples who miscarried the whole pregnancy following the procedure are unwilling to participate in follow up.
3. There is no study of the full psychological impact on the children who are described by practitioners as “the surviving fetuses.”

Given these limitations, the studies that do address the psychological outcomes find that a significant proportion of their sample experience psychological distress following the procedure. The affective reactions are immediate, and intense grief reactions are characterized by repetitive and intrusive thoughts and images of the terminated fetus(es).

Schreiner-Engel and colleagues report that twenty per cent of those willing to participate in follow up experienced long-term dysphoria. “Their continued feelings of guilt appeared due to a wishful belief that some better solution should have been found.” The characteristics of the most disturbed group were those who were young, religious, came from larger families, wanted more than two children, and viewed the ultrasound of the pregnancy more frequently. The authors conclude that “seeing multiple viable fetuses on repetitive sonograms may interfere with the ability of women to maintain an intellectualized or emotionally detached stance toward the multifetal pregnancy.”<sup>26</sup>

Interestingly, the researchers assume that women who have undergone the stress and emotional impact of infertility and subsequent treatment can—and somehow should be able to—be detached from the one thing that has been a driving force in their lives, having children. This expectation goes against all that is known about maternal-infant attachment and psychosocial understanding of the nature of pregnancy.<sup>27</sup>

Garel and colleagues had a 44 percent interview refusal rate among reduction patients. Of those who agreed to be seen at one and two years post-procedure, one-third reported “persistent depressive symptoms related to the reduction, mainly sadness and guilt. The others made medical and rational comments expressing no emotion.”<sup>28</sup> In these latter cases, apparent lack of emotion following MFPR is similar to the repressed range of emotion found among those women who intellectualize their elective abortions.

Another issue of concern is the psychological impact this will have on parenting interactions with surviving children. About such parents, McKinney and colleagues noted: “Conscious and

## IVF . . . and Coercion, *continued from previous page*

and abort the “extras.” If clinics limited themselves to implanting only the maximum number of embryos that would be welcome, their success rates would be cut by half or more.

Respecting the anti-abortion attitudes of women like my caller threatens a clinic’s success rate. If the physician were to tell couples up-front that they *must* agree to a selective abortion if he tells them it is necessary, he runs the risk that they will walk out the door. In that case, he may lose the income to be had from up to nine cycles of treatment.

But if he simply nods his head reassuringly when they express their anti-abortion views, then proceeds to implant the normal quota of extra embryos, the odds are good that they won’t become pregnant with triplets or more. If they do, he knows from experience that he can still get his way. It is far more likely than not that they will eventually consent to MFPR if he just keeps insisting that is “medically necessary” in order to save at least one or two of their desperately wanted children.

The fundamental problem is that doctors working in IVF are accustomed to treating human embryos as commodities rather than as human beings. To cut costs, they use mass production techniques to create a large number of embryos for immediate and future implantation. They examine the embryos, discard those that are the least symmetrically formed, and keep the rest. Rather than freeze eggs and sperm so they can go through this process with each attempt, they can save time and trouble by doing the whole batch at once and freeze the “extra” embryos. Then when these “extras” are no longer needed by their parents, they can be used for such things as embryonic stem cell research.

The only justification offered for the mass production of “spare” embryos is efficiency—it saves money. But what if morality was more important than efficiency? Setting aside other moral problems inherent with IVF, what if IVF clinics were required to create only those embryos which they are prepared to immediately implant and nurture to term?

If this was the case, there would be no “spare” embryos, no court battles over who owns these frozen human beings, no worries about what to do with those no one wants anymore, no temptation to exploit them in experiments or to dismember them for stem cells. Moreover, if IVF clinics were limited to creating and inserting only the number of embryos that would be welcome to implant, normally two or three, the “need” for MFPR would not exist.

In essence, the true success rate of IVF should be measured by the percentage of human embryos which are created that survive to birth. The “need” for spare embryos represents the failings, not the success, of IVF techniques. The “need” for MFPR represents a failure, not a success.

*Continued next page*

unconscious responses to the procedure included ambivalence, guilt, and a sense of narcissistic injury, increasing the complexity of their attachment to the remaining babies.”<sup>29</sup>

No research has been done on the long-term implications of parental distress on the psychological development of these children, nor have any studies addressed the dynamics of post-abortion survivor syndrome.

### Conclusion

The psychological effects of multifetal pregnancy reduction on parents and surviving children appear to be similar to those associated with other induced abortions, namely, feelings of grief and loss, minimized somewhat by the carrying to term of at least some of the fetuses. Serious concerns exist about the quality of disclosure and counseling couples receive when MFPR is being recommended. The highly stressed psychological state of couples who have been struggling to become pregnant may predispose them to submitting to medical recommendations that violate their conscience. The possibility of emotional coercion by medical personnel exists.

MFPR does not guarantee that the remaining fetuses will remain healthy. It may instead precipitate complications and even the loss of all pregnancies. More research needs to be done into the effects of MFPR on couples and on their future family life with the surviving babies.

### IVF . . . and Coercion, *continued from previous page*

These proposals would be unacceptable to IVF clinics, however, because they would cut profits and expose their inflated “success rates.” Moreover, these proposals would have the inconvenient effect of better educating couples about the true failure rate of IVF—dozens of their children created, discarded, and lost so that one might be born.

In short, by imposing at least a minimal respect for the human lives created by IVF, these proposals would help couples to better confront the moral issues involved in IVF. Such steps may not be welcomed by the IVF industry, but they are certainly necessary on the path to restoring respect for human life.

*This article is excerpted from Women’s Health After Abortion: The Medical and Psychological Evidence, by Elizabeth Ring-Cassidy and Ian Gentles. Copyright 2002, Elizabeth Ring-Cassidy and Ian Gentles. Reprinted with permission.*

*For complete citations to the sources used in this article, see chapter 13, “Multifetal Pregnancy Reduction,” of Women’s Health After Abortion.*

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## Pull the Abortion Pill!

### Pro-Life Groups Petition FDA to Shelve RU-486 Pending “Full and Objective” Review

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Calling on the government to protect the health of American women, groups representing women and medical professionals have petitioned the Food and Drug Administration to suspend distribution of the abortion pill RU-486—also known as Mifeprex—pending a full review of the drug’s safety.

Representatives from Concerned Women for America, the Christian Medical Association, and the American Association of Pro-Life Obstetricians and Gynecologists filed a 90-page “citizen’s petition” asking for “a full and objective” review of the abortion drug. The petition, based on 22 months of research, outlined the groups’ concerns about health and safety risks associated with RU-486, including severe hemorrhaging, heart attacks, and serious bacterial infections. RU-486 has been blamed in the deaths of at least two women since the drug was licensed by the FDA in Sept. 2000.

Using information obtained through the Freedom of Information Act, the petition also documented corruption in the review process for RU-486 at the FDA due to political pressure to approve the drug. The FDA approved RU-486 through a fast-track process that is normally used only for experimental treatments for fatal illnesses such as cancer or AIDS, even when those treatments have not been thoroughly tested.

“This document outlines the significant health and safety concerns that have emerged after several years’ experience with RU-486,” said Dr. David Hager, a Kentucky obstetrician who assisted with the petition. “Women deserve a full and objective accounting of a drug’s dangers based on sound and complete medical evidence.”

The FDA said it would review the petition. Pro-life groups have called on Health and Human Services Secretary Tommy Thompson to make good on a statement he made early last year that he intended to review the abortion drug’s safety. The White House had also said at the same time that it would conduct a review of the FDA approval process for RU-486.

### *In Loving Memory*

Jim McDermontt, Sr.

✦ ✦ ✦

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# Abortion May Affect Mothering And Development Of Later Children

Study Shows Less Home Support, More Behavioral Problems Among Children of Post-Abortive Moms

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An Elliot Institute study published in the newest issue of the *Journal of Child Psychology and Psychiatry* found that children whose mothers have a history of abortion tend to have less emotional support at home and more behavioral problems than children whose mothers have not had abortions.

Researchers examined behavior and the quality of the home environment for 4,844 children. The study used data collected in 1992 by the National Longitudinal Survey of Youth, a survey conducted by the Center for Human Resource Research at Ohio State University and funded by the U.S. Department of Labor.

“The results of our study showed that among first-born children, maternal history of abortion was associated with lower emotional support in the home among children ages one to four, and more behavioral problems among five- to nine-year-olds,” said Dr. Priscilla Coleman, a professor at Bowling Green State University and the lead author of the study. “This held true even after controlling for maternal age, education, family income, the number of children in the home and maternal depression.”

Coleman noted that although the results of the study were probably unprecedented, “they were not all that surprising when considered in light of previous research linking unresolved grief associated with other forms of perinatal loss, such as miscarriage and stillbirth, to compromised parenting.”

Many women opt for abortion as the result of adverse circumstances or pressure from others, she said, making the decision difficult to cope with if the woman was emotionally attached to the fetus or desired to carry the pregnancy to term.

“An abortion could become psychologically similar to other forms of pregnancy loss in some women,” Coleman said. In some polls, as many as 80 percent of aborting women said that they would have chosen to carry the pregnancy to term under better circumstances or with more support from others.

Elliot Institute director Dr. David Reardon, a co-author of the study and of the book *Forbidden Grief: The Unspoken Pain of Abortion*, said that the new study confirms the insights revealed in the book by women in post-abortion counseling.

“Unresolved feelings about a past abortion can often impede bonding with subsequent planned children,” Reardon said. “Some women report becoming overprotective because they fear God will punish them for their abortions by allowing their children to come to harm. Others report a need to emotionally distance themselves from their newborns because the feelings of love that are aroused also give rise to intense feelings of grief and despair

over the children who were not born.”

Other differences in mothering among women who have had abortions and those who have not, Reardon said, may be related to other emotional reactions to abortion. Recent studies have shown that women who have abortions are at significantly higher risk of clinical depression in the long term, are more likely to require subsequent mental health care, are more likely to report abuse of drugs and alcohol, and are more likely to die of suicide and other causes. Any of these tendencies, Reardon believes, could have an impact on the children in their care.

Reardon said these studies underscore the importance of educating the public about post-abortion reactions and the availability of post-abortion counseling programs.

“Ignorance of the problem—or the fear of addressing it—deprives women of that interior sense of peace we all need. But by working through the forbidden grief over past abortions, women are more free to become the best parents they can be,” he said.

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## Citation

PK Coleman, DC Reardon, JR Cogle, “The quality of caregiving environment and child development outcomes associated with maternal history of abortion using the NLSY data,” *Journal of Child Psychology and Psychiatry*, 43(6):743-757, 2002.

More information on this study can be found on our web site at [www.afterabortion.org/news](http://www.afterabortion.org/news).

## Needed: Letters to the Editor

If you received our previous issue of *The Post-Abortion Review*, you know that the study mentioned above is just one of *three* studies we’ve had published in major medical journals this summer alone. Sadly, despite our efforts to promote this groundbreaking research, the mainstream media continues to ignore the evidence of abortion risks.

**We need your help!** You can find out more about our studies by visiting [www.afterabortion.org/news](http://www.afterabortion.org/news). Please write or call your local newspaper and TV and radio stations and urge them to cover these stories. Encourage your friends to do the same! Even if we don’t convince the media this time, you can help plant seeds for the next time we have breaking news.

# News Briefs

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## Study: Couples Who Pay for IVF Get More Embryos

A *New England Journal of Medicine* study shows that couples whose health insurance covers in vitro fertilization are less likely to become pregnant than those who pay for it themselves.

Couples in the study who paid for IVF themselves had more embryos implanted at each attempt, suggesting that doctors are under more pressure to bring about a successful pregnancy if the couple is paying for the treatments. Critics say implanting multiple embryos is more likely to result in multifetal pregnancies and selective abortion.

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## Texas Clinic Sued for Illegal Teen Abortion

A woman who used a fake ID to get an abortion is now suing an abortion clinic for violating Texas's parental notification law.

Cherise Mosley filed a lawsuit against the Aaron Family Planning Clinic, in Houston, saying she used a false ID card she purchased at a grocery store to obtain an abortion when she was only 17. The suit says that the clinic should not have accepted the ID because it was stamped, "This is not a government document," and Texas law requires that valid government documents be used to prove an abortion patient is not a minor.

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## EMS Supervisor Retires Over Coerced Abortion Case

An assistant EMS chief in the District of Columbia has retired after an investigation found she pressured employees to abort.

An investigation found that Samantha Robinson told a class of

trainees they would be fired if they became pregnant their first year on the job. Three women said they subsequently had abortions. D.C.'s inspector general recommended that Robinson be disciplined, but the U.S. Attorney's Office declined to prosecute, citing a lack of evidence of criminal intent.

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## Doctors Face Charges for Failing to Report Sex Abuse

Two doctors in Bridgeport, Conn., are charged with failing to report the pregnancy of an 11-year-old they referred for an abortion.

Prosecutors say Ann Lule and Mukeshkumar Shah had reasonable cause to report that the girl, who gave birth in May, was being sexually abused. The girl and her child are now in foster care, and DNA testing will be used to determine if the child was fathered by a 75-year-old child predator who admitted having sex with the girl. The two doctors will face fines of up to \$500 if convicted.

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## British Star Blames Music Industry for Her Abortion

A former member of the successful British girl band All Saints has written a book saying the music industry "violated" her by forcing her to choose between her unborn child and her career.

Nicole Appleton, now part of a singing duo with her sister, writes that she had the abortion under pressure from band members and her record label, and that it led to suicidal thoughts and her breakup with the baby's father, British recording star Robbie Williams. Friends of Williams say he was devastated by the abortion and upset that Appleton was airing the story in public.

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In 1982 I had an abortion. I wish I could say I was pressured into it by my family or by the father. But I wasn't. My pressure was my fear and shame. For me abortion was the only option. To get through it, I clung to the belief that this was not yet a life.

I tucked away the memory for many years afterward. Eventually I married and had two beautiful children. I savored every moment of each pregnancy. And with them I realized suddenly that life had begun the moment I conceived. Later that thought would begin to haunt me.

Every year for Christmas and Easter, we went to church so my children could, in some small way, have God in their lives. It was all I could handle. The reality of the abortion and the separation from God I felt increasingly hurt too much. I cried at every service I attended. I tried to silence the pain for eight more years. But all I did was distance myself further from God and begin to disconnect from my children.

Driving to work one day, I heard a message of hope on the radio—healing for Catholic women who had abortions. I wanted to call but was scared. Another year went by and I heard the ad again. This time, I called immediately. The woman I spoke with compassionately referred me to a priest who would help. The last thing she said before hanging up struck a chord in my heart: “God has been calling you and thank the Lord you have heard Him.”

The priest I met has lovingly and patiently walked the long journey of healing with me. After a while, I was ready to make my first Confession in decades. The words of absolution I heard as he

prayed over me were blessed words of freedom. To honor the moment, he held a Mass with just the two of us and God in a private chapel and shared the most holy of Communion I have made in my life. I was reunited with God. The ride home was the most peaceful moment of silence and beauty and goodness.

Later, he told me about the Project Rachel retreat that could help me finish my healing and reunite me with my aborted child. Led by

women and priests, through Scripture and sharing, and with the safety of complete anonymity, there is a place where women can make their journey to God and to their children. There, the healing begins as we are honored as women in a context that would define such generosity.

**“God has been calling you and thank the Lord you have heard Him.”**

Since the Project Rachel retreat, my heart has opened again. I love my two young children on earth in the most profound way. I can be a mother again. I have made peace with my child in heaven. And the gift that has left me forever changed is that I will always know that I have met Jesus and spent time in the fields of heaven with Him. It took me 17 years, but I am blessed to have made the healing journey to know I am loved and forgiven by Him and by my child.

No one ever told me that the moment I terminated my pregnancy, my spirit would begin to hemorrhage. I have always believed mothers are both the guardians of the future and the roots to the past. Abortion can shatter a woman's very core. But healing is possible through the loving touch of Jesus and the knowledge that our children are safe in the arms of God. I hope you will let God's call touch your heart too.

*Elliot*  
INSTITUTE

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