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Study Finds High Rates of PTSD Among Women Who Had Abortions

Researchers: PTSD Rates Increased by 61 Percent After Abortion

According to a study published in the journal *BMC Psychiatry*, women who have experienced abortion have high levels of post-traumatic stress disorder (PTSD), which follow findings from earlier studies linking abortion and PTSD.

The study of 155 South African women who had abortions looked at symptoms before abortion and at one month and three months after abortion.

Almost one-fifth of the women had symptoms that met the criteria for PTSD, leading the authors to note that “high rates of PTSD characterize women” who have undergone abortions. Further, at three months after the abortions, the number of women with PTSD had increased by 61 percent compared to before the abortion.¹

The study found that using one form of pain management over the other did not effect rates of psychological trauma experienced by women after abortion.

The researchers compared levels of pain and psychological outcomes among women who had received a local anesthetic versus those who had received IV sedation. Women who had received a local anesthetic had higher levels of pain before and during abortion and were more likely to experience PTSD symptoms, but researchers found no difference in symptoms over a longer period of time.

These findings lend credence to the theory that abortion itself is the cause of trauma for women, not the amount of physical pain they experience.

This study is not the first to link abortion with increased levels of PTSD. In a 2004 study published in the *Medical Science Monitor*, 65 percent of American women who had undergone abortions reported symptoms of PTSD, which they attributed to their abortions, and slightly over 14 percent reported all the symptoms necessary for a clinical diagnosis of PTSD.²

Other studies have linked abortion to higher rates of sleep disorders, which are often associated with PTSD, as well as higher rates of anxiety disorders, clinical depression, substance abuse, suicide, and other problems.³ One study found increased rates of

death from cardiovascular rates among women who had abortions up to eight years earlier compared to women who gave birth, which the researchers speculated could be related to trauma symptoms.⁴

The authors of the *BMC* study called for more screening to be done on women prior to abortion in order to “help identify women at risk of PTSD and provide follow-up care.”

However, there is no evidence that abortion alleviates any psychological symptoms in women and abortion has been in fact linked to increased mental health problems

— including PTSD — after abortion.

The Elliot Institute has proposed legislation that would hold abortion businesses liable for failing to screen women for coercion and known risk factors that increase the likelihood for post-traumatic stress and other problems after abortion.

“Women should not be subjected to a procedure that is likely to increase or cause symptoms of post-traumatic stress or other mental health problems,” said Elliot Institute director Dr. David Reardon. “Furthermore, the evidence shows that many of these abortions are unwanted and the result of pressure or coercion from others. The abortion industry should be held liable for putting women at risk and performing unwanted, coerced and dangerous abortions.”

Citations

1. Sharain Suliman et. al., "Comparison of pain, cortisol levels, and psychological distress in women undergoing surgical termination of pregnancy under local anaesthesia versus intravenous sedation," *BMC Psychiatry* 2007, 7:24.
2. VM Rue et. al., "Induced abortion and traumatic stress: A preliminary comparison of American and Russian women," *Medical Science Monitor* 10:SR5-16, 2004.
3. See the Research Booklet at www.unchoice.info/resources.htm.
4. DC Reardon et. al., "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women," *Southern Medical Journal* 95(8):834-41, Aug. 2002.

The study shows that abortion itself, not the physical pain, caused the women's trauma.

What Women Want

(Hint: Not Reproductive Health Care)

Steven Mosher and Colin Mason, Population Research Institute

Pat McEwen was visiting the small village of Huaca, high in the Andes Mountains of Ecuador. The village, not far from the Colombian border, was teeming with refugees fleeing from the ongoing battles between government forces and the drug lords. Mostly women and children, the refugees had arrived with only the possessions that they could carry. Many had lost husbands, sons and daughters to the conflict.

“They had been poor even before the violence destroyed their villages,” Pat recalled. “Now they had lost everything and [were] the ‘poorest of the poor.’” These refugee women, in short, were perfect examples of the kind of “client” that the family planners would say needed “reproductive health services.”

Pat decided to ask the group of 42 refugee women that she was meeting with three simple questions: “What are the things you worry about most often? What are your greatest needs? What can I do to help you the most?”

Their worries centered around their children, their husbands, and family members from whom they had become separated. Their most pressing need was for blankets and warm clothes. Second was a way to provide for their families. A close third was medicine or health care for their children. Not one mentioned family planning.

Pat then went right to the heart of the “reproductive health care” controversy: “If I could provide a way for you to have fewer children, or no more children, or to not be pregnant if you are pregnant, would you be interested?” she asked them.

The atmosphere in the room, pleasant up to that point, instantly turned chilly. The women whispered among themselves, shooting Pat looks that were no longer friendly. Then one woman, her voice rising in indignation, spoke for all: “Sabe nada, estupida Americana!” Up to this point in the interview, Pat had been relying on translators to help with her halting Spanish, but this stinging barb came through loud and clear: “You understand nothing, stupid American!”

These refugee women had no use for contraceptives, sterilizations,

or abortions and rejected Pat’s offer of “reproductive health care” out of hand.

“The reproductive ‘right’ that these refugee women wanted was the right not to have me or anyone else interfere in their reproductive lives,” Pat recalled later. “They understood that more children meant more minds to plan the future, more hands to share the work, and more hearts to share joy and sorrow. These women had lost family members to violent deaths, but they understood that their children were the promise that there would still be a tomorrow.”

The woman said, “You understand nothing, stupid American!”

Pat McEwen’s encounter with the refugee women of Ecuador is corroborated by broader surveys of the real health needs of real women and men that the Population Research Institute (PRI) has carried out in the developing world. Who wants

reproductive health care? Not the people of Ghana, according to a 2001 survey carried out by PRI in the metropolitan port city of Takoradi.

“Reproductive Health Care” Comes in Last

A total of 397 individuals of both sexes were interviewed by one of four trained interviewers on one of Takoradi’s main thoroughfares, selected at random from the constant stream of passersby. Those interviewed were shown a list of 15 different health programs, and asked to rank order the list in terms of their own personal needs, putting their most pressing need first and their least important need last.

The health programs listed were: Malaria Eradication, Leprosy Treatment, Reproductive Health, Syphilis Treatment, Polio Prevention, Clean Water Programs, Natural Family Planning, Sleeping Sickness, Gonorrhea Treatment, Tuberculosis Treatment, Yellow Fever, HIV/AIDS Prevention, Cholera Treatment, Measles Prevention, and Other Programs (unspecified).

What do these modern Africans have to say about their health care needs? They list their most pressing concerns as malaria eradication, Natural Family Planning, clean water, measles prevention, and HIV/AIDS Prevention. Now malaria, measles and

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HIV/AIDS are all diseases which run at epidemic, or near-epidemic, levels in Ghana, confirming the good judgment of those we surveyed. Ghanaians are also aware that polluted drinking water is a vector for the transmission of cholera and other diseases, and so would like to see the water supply made safe.

The only mild surprise in this cluster of top-ranked health needs is the presence of NFP, which was welcomed by many respondents as a safe and natural means of regulating their fertility.

Second-order health needs listed included tuberculosis treatment, cholera treatment, leprosy treatment, polio prevention, yellow fever, sleeping sickness, and syphilis and gonorrhea treatment. These are all diseases that, although not affecting the large percentage of the population that, say, HIV/AIDS does, are nonetheless endemic to Ghana. Here again, the views of those we spoke with accord well with Ghana's epidemiological realities.

Reproductive health care came in dead last. Even the unspecified "Other Programs" came in higher, suggesting that the Ghanaians would prefer almost any kind of health care to the kind of programs that they have been force-fed in the past few decades.

This disdain is further underlined in the "Comments" section, where one reads such remarks as, "Stop reproductive health; it's not good," "We don't need reproductive health programs," "Stop reproductive health; eradicate malaria," and so on.

Bear in mind that those with whom we spoke were not "backward" tribal people, but highly westernized and educated residents of one of Ghana's most modernized cities. The residents are small shop owners and tradesmen, mechanics and other service providers, and agricultural proprietors and workers. Most of the inhabitants have received some education, and literacy rates are high.

Why, then, should their views on their own health care needs, including their rejection of so-called reproductive health care, not be taken seriously in planning foreign aid programs?

The Disdain of Family Planners

Population control organizations find it highly inconvenient that their programs are not greeted with joy by their "targets," and they go to great lengths to disguise or explain away this fact. Overseas, they work overtime to create the impression of robust popular and government support for their anti-natal programs.

However, this facade falls away in discussions with donors, in which they arrogantly suggest that the women's reluctance to contracept comes about because they either don't know their own minds, or because they simply don't know what's good for them (or their country, or the environment, etc.)

To suggest that a woman does not know her own mind in such a private and important matter as childbearing is, at the very least, patronizing.

To deal with this perceived problem, population controllers have

contrived the concept of "latent demand," and the related concept of "unmet need." "Latent demand" means that, while a woman has a supposedly obvious need for a modern contraceptive, she is kept from demanding it by ignorance, fear, or superstition. Consequently, an "unmet need" is the percentage of women in a given country who are said to have a "need" for modern contraceptives that is not being "met."

How do USAID and other population control agencies arrive at the number of women in a given country who have an "unmet need" to be contracepted or sterilized? Certainly not, as the term itself suggests, by respectfully asking a representative sample of women about their actual contraceptive needs.

Rather, the "unmet need" for modern contraceptives is circuitously inferred from survey questionnaire data as the percentage of women who (1) say they wish to delay the birth of their next child, or who want no more children, and who also (2) say they are not using modern means of contraception.

It is surely no accident that each and every one of the methodological shortcomings of determining "unmet need" and "latent demand" strengthens the case for population control by inflating the percentage of women in developing countries who are said to require the services of the controllers.

"Unmet need," like "latent demand," is nothing more than a self-serving verbal dodge, used by the controllers to justify their budgets and design their programs, furthering the pretence that, in so doing, they are but serving the "deepest" needs of womankind.

If this sounds too harsh, consider how the controllers would behave if they were truly interested in meeting the reproductive health needs of women, as women themselves understand them. Their way forward would be simple and straightforward.

They would merely have to ask women how many children they wished to have, and then provide the necessary maternal and infant health care programs necessary to safely achieve that number. Surveys show that parents throughout the developing world, just like parents from wealthy countries, have pronounced views on their own "desired family size." So these numbers would be easy to obtain.

What this means is that the controllers cannot, at one and the same time, pursue their anti-natal agenda and respect the fertility desires of women in the developing world. There is simply no way to reconcile these two mutually antagonistic goals.

Instead, they serve the first, and pay lip service to the second. They invent spurious measures of flawed design which supposedly reflect the reproductive health needs of women but which are actually calculated to serve an anti-natal agenda.

The alternative is, for them, quite unthinkable. For if the controllers

**"They're refugees,
don't you see! They
can't have children!"**

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“Living is Hell for Me”

Woman's Death Part of Dangerous Trend of Unwanted Abortions, Post-Abortion Trauma

The recent suicide of a British woman highlights an international epidemic of coerced and unwanted abortions and post-abortion trauma.

According to the *London Daily Mail*, Emma Beck, a 30-year-old artist, took her own life after in 2007 after undergoing an abortion. Her mother told a coroner's court that her daughter had not wanted to have an abortion, but that Beck's boyfriend had not wanted the pregnancy and that she had not been adequately counseled at the hospital beforehand.

Beck had been pregnant with twins and, according to her mother, was happy about the pregnancy. Her doctor said she had cancelled at least one hospital appointment before the abortion and described her as being “extremely vulnerable.”

The doctor at the hospital where the procedure was performed noted that Beck lacked support but denied claims from Beck's family that she did not receive adequate counseling before the abortion.

In a suicide note, Beck wrote: “Living is hell for me. I should never have had an abortion. I see now I would have been a good mum. I told everyone I didn't want to do it, even at the hospital. . . . I was frightened, now it is too late. I died when my babies died. I want to be with my babies—they need me; no one else does.”

Her story echoes that of other women who say they were in despair after their abortions, many of which were coerced and unwanted.

Judith, who was married at the time of her abortion, describes being pressured to abort by her husband and doctor, who did not give her accurate information on fetal development. She writes:

My doctor said the baby—at six-and-a-half weeks—was “just a blob,” and I believed him. Afterwards, before I even got home, I began to cry. It didn't help. When finally I stopped crying on the outside, I kept crying on the inside. . . . I felt cheated, betrayed, and manipulated. I went to counseling and the psychologist said, “Forgive yourself,” and “Let yourself go on.” She didn't say how.

Another woman, Janet, described the despair that many women feel after abortion and how their feelings of trauma and grief often remain hidden. A police officer, Janet attempted to shoot herself after her abortion, but the gun misfired:

With quiet deliberation, I took my handgun from under my pillow. I chambered a round, walked into my living room, sat in a chair, put the gun to my head and pulled the trigger. . . . To this day, I cannot think why the gun did not fire. . . . I find it amazing in retrospect, how we can function so well in front of others, while suffering like that.

A Widespread Epidemic

Such stories are common. In one survey of U.S. women who had undergone abortions, 64 percent said they felt pressured by others to abort and 84 percent said they did not receive adequate counseling before abortion, even though more than 50 percent said they felt rushed and uncertain. In addition, 60 percent of the women in the survey said they felt that “part of me died.”¹

While the suicide rate is usually lower among women who have recently given birth than among those in the general population, a study of medical records in Finland found that women who had undergone abortions were six times more likely to commit suicide in the year following than were women who gave birth.²

The study was confirmed by research lead by Elliot Institute director Dr. David Reardon, which

examined medical records for women in California and found that, an average of eight years later, women who had abortions had a 154 percent higher suicide rate than women who gave birth.³

Studies have also linked abortion to an increase in depression, substance abuse, trauma symptoms, self-destructive behavior and other problems.⁴ The increased risk for suicide after abortion may also be attributed to the increased risk for problems such as depression, which is a known risk factor for suicide.

A Hidden Grief

The role of abortion in leading to suicide may go unnoticed in many cases, however, because people may not recognize that a suicide is linked to a previous abortion. Further, some counselors may not be aware of a woman's abortion history, or may not address the underlying issue of abortion, either through ignorance or an unwillingness to address the abortion for political reasons.

The lack of authentic support and viable options that often leads to abortion is also often a factor afterwards. Many women have described being dismissed or ignored when they attempted to talk about grief or trauma related to an abortion while in counseling.

One woman was told by it couldn't be the abortion bothering her; it must be something else: “They said the reason (your are hurting) is that you've got stuff in your background that you need to resolve. But I don't think I've got unfinished business.”

Family members and friends may also be unwilling or unable to help a woman or man process their pain following an abortion. Expressing grief after abortion is often a “taboo,” notes Melinda Tankard Reist in her book *Giving Sorrow Words: Women's stories of Grief After Abortion*. This often leaves suffers with no way to

“I told everyone I didn't want to do it ... now it is too late. I died when my babies died.”

process their pain:

[T]here is no period of mourning for a woman suffering grief after abortion. There are no grief teams, no body for her to cuddle and dress, no footprints or photographs to keep in an album, no grave on which to lay flowers; in short, nothing to acknowledge that this baby ever existed.

The grief over the loss of an often wanted child may be exacerbated by the trauma of abortion itself, especially in cases where the abortion was unwanted or coerced or the woman had a previous history of abuse. In the previously mentioned survey of American women who had abortions, 65 percent reported symptoms of post-traumatic stress disorder following abortion, which they specifically attributed to their abortions. Just over 14 percent reported all the symptoms necessary for a diagnosis of PTSD.

Theresa Burke, a therapist and founder of Rachel's Vineyard post-abortion ministries, has noted that people suffering from unresolved trauma often subconsciously reenact the traumatic experience in an attempt to master it. For women and men struggling with a past abortion, this may often involve recreating feelings of fear, anger, abandonment, and loss through self-destructive behavior, such as substance abuse, risk-taking, abusive relationships, criminal behavior or suicide attempts.

Suicidal impulses can "serve as a means of reenacting a traumatic abortion experience," Burke writes in her book *Forbidden Grief: The Unspoken Pain of Abortion*. "Thoughts of death mirror the death experience of abortion."

Yet, as Burke points out, "despite the overwhelming evidence linking abortion to suicide, abortion providers do not provide the type of psychosocial screening necessary to identify patients who are at higher risk of suicide. Nor do they provide women with information about suicide intervention in the event that they begin to feel suicidal after abortion."

The tragic stories of Emma Beck and other women point to a real need to both acknowledge the trauma of abortion and the common occurrence of unwanted, pressured or coerced abortions, which can further traumatize women. Meaningful support and alternatives to abortion, counseling for those struggling with post-abortion trauma or the loss of a child, and further research to understand the links between abortion trauma and suicide are also needed.

* * *

Both *Giving Sorrow Words* and *Forbidden Grief* are available from Acorn Books at 1-888-412-2676. For more information, visit www.afterabortion.info/resource1.html.

Visit www.unchoice.info/healing.htm for more information on post-abortion counseling and healing, or call 1-888-467-3463.

Citations

1. VM Rue et. al., "Induced abortion and traumatic stress: A preliminary comparison of American and Russian women," *Medical Science Monitor* 10:SR5-16, 2004.
2. See the Research Booklet at www.unchoice.info/resources.htm.
3. M. Gissler, "Injury deaths, suicides and homicides associated

Men, Abortion & Suicide

At this point, there are few studies examining the impact of abortion on men. Counselors who work with men after abortion say that men have reported a large number of problems that they claim were a direct result of their abortion experience.

These include broken relationships; sexual dysfunction; substance abuse; feelings of self-hatred; risk-taking and suicidal behavior; increasing feelings of grief over time; feelings of helplessness, guilt, and depression; greater tendencies toward becoming angry and violent; and feelings connected to a sense of lost manhood.

As with women, the link between abortion and suicide may go unnoticed except in a few cases. A 1992 article in *Linacre Quarterly* reported on the case of an 18-year-old man who committed suicide three months after his father's death. According to the article, the young man was despondent over his girlfriend's abortion. He had told a friend that the baby had been conceived the day his father died and he planned to name the child after his father.

In another case, 44-year-old Brad Draper killed himself in front of a Planned Parenthood abortion business in Overland Park, KS, in 2002. The *Telegraph Observer* newspaper reported that Draper had published an obituary for his aborted child in a community newspaper, reading,

"Zachary Duncan Draper was beautiful as his mother, loved by God and others. My little baby boy didn't make it to his Daddy's arms. I never got to hold and kiss him, tell him stories or read him rhymes. I love you Zachary and look forward to seeing you in heaven."

There is certainly a great need for more research, counseling and support for men affected by abortion as well as for women. As Vicky Thorn of the National Office for Post-Abortion Reconciliation and Healing has pointed out, the movement to help men find healing after abortion is in its infancy, as it was for women a few decades ago. But as more anecdotal evidence comes to light, this will help drive research and make others aware of the need for healing and help.

Healing information and resources for men can be found at www.menandabortion.info. Many support groups that help women after abortion are now offering help to men as well, including Project Rachel at 1-800-593-2273 and Rachel's Vineyard at 1-877-467-3463.

with pregnancy, Finland 1987-2000," *European J. Public Health* 15(5):459-63, 2005.

4. DC Reardon et. al., "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women," *Southern Medical Journal* 95(8):834-41, Aug. 2002.

Editor's Note: The following testimony is from the book Giving Sorrow Words: Women's Stories of Grief After Abortion, by Melinda Tankard Reist. For ordering information and a special sale offer, see the next page.

My boyfriend and I had been going steady for over 12 months, sure we were going to wait until we got married. I was 16 and a virgin, but we saw each other every day and one time the petting went to the point of no return. I had just had an appendix operation and I thought that was why my period was late. Think again: sure enough, I was pregnant.

By three months my pregnancy was starting to show. My boyfriend and I were really happy about it and I bought my first maternity dress. One Sunday night, instead of going to church, we decided to tell my parents. Their reaction took me totally by surprise. They told my boyfriend, whom they never liked anyway, to get out. Their only words to me were, "You are having an abortion!"

ABORTION! That was something that had not even entered my head. Abortion was murder. I loved this baby growing in me; I didn't want to kill it. But I wasn't asked what I wanted.

The next step was an appointment with the family doctor. Yes, no worries—hadn't he arranged the same thing for his daughter when she got into trouble? Anything to help a friend.

Dad told me how one of his girlfriends had become pregnant and had an abortion and years later had thanked him that she had. I didn't want to know; all I knew was they were trying to kill my baby.

My boyfriend and I were going to run away. I saw him waiting outside in the car that night but Mum and Dad just wouldn't go to sleep so I could sneak out and in the end I fell asleep.

A couple of days later Dad and I flew to Sydney (Australia). We went to see another doctor and I was taken to a hospital with chandeliers. I can still picture them as if it was yesterday. The nurse came in to give me my pre-med needle. I begged her to let me see the doctor. "You will see him in the [operating room]," she told me.

A group of about 15 women were sitting in the waiting room. There were two open doorways and one closed door that led to the operating room. A nurse continually walked past one doorway with a stainless steel bucket with a lid on it. I had nightmares about that bucket for years. Even though it has been almost 23 years, everything is so clear in my memory.

When my turn came, I walked in and promptly told the doctor that I wanted my baby and didn't want it killed. "Fine," he said. A nurse was called in and I was taken to a room on my own. When Dad rang later to see if I was all right he was told that I hadn't gone

through with the abortion and he suffered a heart turn in the phone booth.

When I returned home I got hell from Mum, Dad, and Grandma. I was told how stupid I had been and what were they going to do with me now. They argued the baby was sure to be deformed after the appendix operation. By now my nerves were fragile and I was a constant wreck. Under continual pressure, I agreed to return to Sydney.

This time we drove down. Mum bought me a new outfit because you could see my bulging tummy in the one I was wearing. Dad had to do a lot of talking to the doctor to get him to agree after I had said no the first time. That week, however, there was no room in the hospital and we would have to come back yet again.

The next week Dad and I flew down to Sydney once again. We stayed at the ritzy Double Bay. Dad took me to the movies and restaurants and bought me new clothes trying to make up for what he was

about to do. All I wanted was my baby.

The next day back to that hospital with chandeliers, back in that waiting room with a different group of women, into that theater with my legs up in stirrups. I woke up with intravenous drips in both arms, an empty womb and a terrible pain in my heart. I was 16 weeks pregnant; the baby they threw in that horrible bucket that day was a fully formed baby with even its own fingerprints, a small beating heart and a body that had been moving around feeling protected inside his mother. I felt it was a little boy.

We flew back home that night. For the next few days I didn't eat, or bathe or even brush my hair. All I did was cry. The nightmare had only just begun.

My baby was killed on Sept. 20, 1973, my sister's 21st birthday. There was a party for her and I was expected to act normally, but my mind and body would not let me forget. I had milk in my breasts. I told my sisters what had happened and they were all so surprised at Mum and Dad, but now it was over and nobody was to mention it again. In those days there was no counseling, no discussing it. I had bought shame on the family; the sooner it was hushed up the better.

I was forbidden to see my boyfriend but with the help of a friend, I secretly met him. One day I got caught. What did it matter? Life wasn't worth living anyway. The doctor had put me on nerve tablets—I came home and took the lot. I can't remember the next three days. For the next few years I would hear babies crying, think something was chasing me, and have nervous blackouts.

I was terribly depressed. In 1975, I married the same man; we moved into a rented double-story house. He came home one day to find me trying to hang myself under the house.

I loved this baby growing in me, but I wasn't asked what I wanted.

In 1976, I had another child, a boy, but I couldn't love him. If I loved him like I did the other one, someone would take him away too. Even though I was married this time I remember how angry my grandfather was at me being pregnant. Years later my grandmother said she had never seen anyone turn their back on a baby the way I did.

My marriage broke up. When I wasn't working I was partying. After all, didn't Mum call me a harlot when I got pregnant the first time even though I'd only ever been with one man? I'd leave my baby with Grandma all the time and I was drinking heavily. I became very bitter, never said anything nice to anybody. The daughter of the doctor who helped Dad organize the abortion was murdered. I couldn't have been more pleased. How I laughed when I heard the news: he had taken my child and now someone had taken his. I even fantasized that it was me who killed her.

It all came to a head about 18 years later. I had remarried by then and had another son, but instead of enjoying the children I had, I continually lived in the past. My eldest son even asked me one day, "Mum, why are you always cranky?"

I went into a catatonic state twice. I really liked it in there where nothing could reach me or hurt me. I ended up in a psychiatric ward.

I had turned away from God over the years. I had blamed Him as well as a lot of other people for everything that had happened to me. I came back to Him after the breakdowns. Now most of the bitterness is gone. The barriers between myself and my sons have been broken down. For the first time, I could tell them I loved them. I have learned to forgive my parents. I learned that Mum had had an abortion too. Recently my nephew's girlfriend also had one. That means my parents' first child, grandchild and great-grandchild have all been victims of abortion.

Recently my son's girlfriend discovered she was pregnant just

after they broke up. My son wanted her to have an abortion. Despite a lot of pressure and opposition, she is having the baby. I feel a curse has been broken. My grandchild will be born and his grandmother will love him dearly.

Giving Sorrow Words *Women's Stories of Grief After Abortion*

Abortion has been presented as a simple procedure that allows women to put the crisis of an unintended pregnancy behind them. These women were told they'd be able to get on with their lives after abortion. But their lives would never be the same.



Includes the personal accounts of 18 women who had abortions and draws on the experiences of more than 200 others.

These women share their stories of personal suffering and loss—stories that have often gone unheard in a society eager to dismiss abortion-related trauma.

Giving Sorrow Words examines the experiences of women, including the lack of resources and support, the misinformation and lack of informed consent, and the intense pressure and coercion applied by partners, families, and society in general to force women into unwanted abortions.

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What Women Want, from page 3

were to relax their relentless efforts at fertility control, and begin to truly serve the reproductive health needs of women, the denizens of the developing world would fall into what they would regard as an uncontrolled frenzy of breeding.

Modern controllers are careful to hide their anti-natal agenda behind concepts such as “latent demand,” “unmet need”, and “reproductive health care.” Occasionally the mask slips, however.

PRI investigator Joseph Meaney, visiting a UN refugee camp in Albania in 1999, was struck by the fact that many of the Kosovo refugee women he was speaking to were eager to have more children, in part to make up for those they had lost to Serbian atrocities. When he mentioned this to a UNFPA doctor, the man exploded with disdain for his charges: “They’re refugees, don’t you see! They can’t have children!

Who are we to tell the poor women of the world that they cannot have more children? This is not reproductive health. This is reproductive oppression, and the women from these developing nations recognize it for what it is: an assault on their fertility and ultimately, their race. We should give the poor nations of the world primary health care, not ideological imperialism.

* * *

The pro-life Population Research Institute is dedicated to ending human rights abuses committed in the name of “family planning,” and to ending counter-productive social and economic paradigms based on the myth of “overpopulation.” Learn more at www.pop.org.

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News Briefs

Abortionist Gives Up License After Woman’s Death

An Massachusetts abortionist has surrendered his medical license after one of his patients died following an abortion.

Dr. Rapin Osathanondh will no longer be able to practice medicine anywhere in the U.S. but still faces possible further disciplinary action over the 2007 death of Laura Hope Smith, 22, who went into cardiac arrest while under anaesthesia. Smith’s family only learned of the abortion when they received a call saying she was dead.

Texas Court Upholds Unborn Victims Law

The Texas Court of Appeals unanimously upheld the homicide conviction of a man who stomped on his pregnant girlfriend’s abdomen and caused the deaths of her twin unborn boys.

Gerardo Flores was sentenced to life in prison for two counts of capital under the Texas Prenatal Protection Act. Flores had argued that the law allowing charges to be brought in the death of an unborn child was unconstitutional, but the court disagreed.

Memorial Contributions

In memory of
Mary (Reardon) McCabe

Gifts to the Elliot Institute in memory of loved ones or to celebrate birthdays, anniversaries, or other special occasions will be acknowledged in this publication unless otherwise requested.

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