

*A
Life
Worth
Keeping*



the abortion debate

‘A Life Worth Keeping – The Abortion Debate’

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We appreciate the testimonies provided by our anonymous authors. Thank you to ‘Salt Shakers’ and ‘Life News’ for permission to reprint two of the testimonies. We recommend these ministries to our wider readership.

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This footprint highlights your feet at 10 weeks after conception – it only needs time to grow.

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Foreword

Rev John Stasse

What price do we set on life? Throughout Australia parents are rejoicing as they hold a new born baby. They are filled with wonder and a sense of responsibility for that life. Tragically there are also those whose arms are empty and so seem their hearts. The child they had invested so much love and joy in since first hearing of the news ‘You are pregnant’ subsequently miscarried, was still born, or died shortly after birth. Each group of parents would set a high price on life – marked either by their joy or grief.

As Christians we are thankful to God for life and recognise that behind the human process involved lies the hand of God. God, being the author of life, has entrusted us with that life, both our own and that of those He places within our care. Surely that trust is felt most powerfully with reference to the weak and vulnerable. There is none more weak and vulnerable, and hence in need of greater care than the unborn child. This century has seen incredible advances in the ability to help the vulnerable as demonstrated by intricate operations on a child within the womb, yet it also has seen the tragic escalation of deliberate termination of unborn life.

The appalling loss of life in the present day through abortion, at least 100,000 lives a year in Australia alone, calls us to come out from behind our screens of ignorance and silence. As Christians we are to be concerned with the protection of the unborn child, to minister to mothers and fathers in distress, and to call the nation to knowledge and change. A failure to do so will result in further hardening of our corporate heart. It will expose us further to the wrath of a holy God who creates life for His glory, and who shows His ongoing commitment to life through the death and resurrection of His own Son Jesus Christ so that all who believe in Him will have life abundantly and eternally.



Our hope is that this booklet will prove useful to the wider community as it exercises its conscience over the tragedy we hide behind the word ‘abortion’. But our prime aim is to inform and assist Christian people. We recognise that this is not always an easy issue for those who find themselves confronted with the possibility, let alone with the reality, in their own lives. Our intent has not been to be confrontational but pastoral, to be caring for both the unborn child and for the parent. It is our belief that many are not in possession of full information and so we seek to bring biblical principles, a description of the wonder of development of life within the womb, a revealing of known medical problems associated with abortion procedures, as well as highlighting psychological consequences for those who procure an abortion.

We do not see this as women’s business or a booklet for women only. We call men to take an interest in the issue and begin to understand and see how they may share the burden being felt by women. It is a great tragedy that men have been sidelined from the responsibilities of bringing of life into this world by abortion with its emphasis on a woman’s body and women’s rights. Men, having responsibility under God for both the child and mother, need to be involved with sensitivity and passion.

We take this opportunity to thank those women who have written of their experiences under the pressure or reality of abortion. Their stories give a human face to the matters raised. We are sure people will appreciate the need for a measure of anonymity but be assured these are real people speaking of their very real situation.

We trust that the combined voice of these brave women will prove helpful especially to those who are contemplating an abortion or have had one, but also to those who are relating with such for it is so easy out of a passion for the unborn child to fail to be wise and gentle in ministering to the parent as well.

This booklet then is a call to stand against the increasing self-centred convenience trend in our society. We ask you to read and carefully consider the material presented to you. Life is precious. Life is worth keeping. May God in His grace and mercy use this booklet to help people know the joy of it.

An Incredible Journey

– from conception to birth

Dr Eloise Piercy

It was not long ago that the wonderful story of life before birth was a mystery. Today we are privileged to have the technology to observe in great detail the amazing process of growth and development of the unborn child throughout the 266 days from conception to birth.

The Beginning

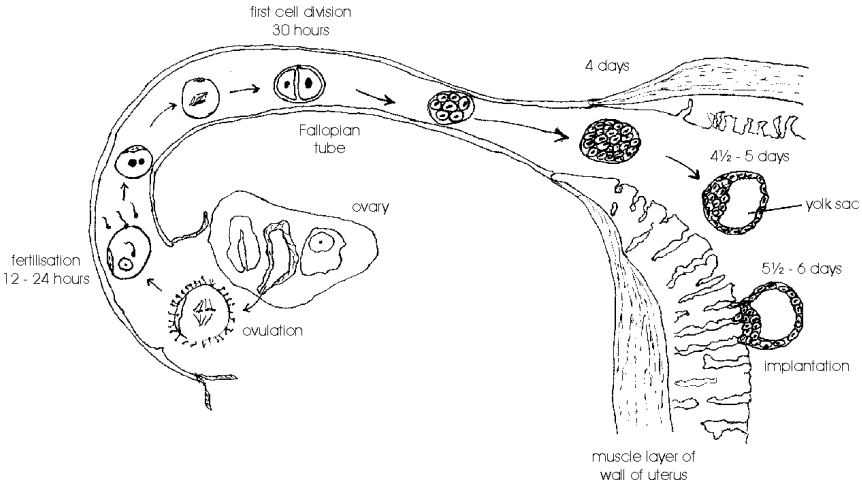
Conception occurs when one of the father's sperm joins one of the mother's ova (or egg cells). As the 23 chromosomes in each of the sperm and the ovum unite to form 46 chromosomes in one cell, the genetic blueprint of a new and unique human being is laid down. Hair colour, sex, eye colour, every genetically determined feature is set at conception. These chromosomes orchestrate the incredible development and growth of the child from that single-cell beginning, right through to adulthood.

Doctors use the date of the mother's last menstrual period as a marker for the beginning of pregnancy, even though fertilization occurs 2 weeks after this event. Therefore, the terms "10 weeks gestation" or "10 weeks pregnant" actually indicate that the mother's last period started 10 weeks earlier and the baby is eight weeks old (8 weeks of development since conception).



Implantation

Soon after conception, the cell divides into two cells, then four, eight, sixteen and so on as it is carried along his or her mother's Fallopian tube to her womb (uterus). This takes three to four days.



Within a week of conception, before the mother even knows she is pregnant, the new baby implants into the specially prepared lining of the womb and begins to draw nourishment.

Within the first week after conception, the cells have already been appointed to specific tasks, designated by the genes which coordinate the process of the baby's development. At this stage, the cells are in a ball; the central cells will form the embryo while the outer cells will form the "trophoblast" which becomes the placenta. The placenta is the organ which enables the mother to provide nutrition and oxygen from her bloodstream to the baby and also filters out waste products from the baby's bloodstream. At no time do the mother's and baby's blood streams come into direct contact; in fact, the mother and baby often have different blood types. The yolk sac, which helps provide nutrition to the early embryo, and then goes on to form the umbilical cord, begins to develop at this time. The umbilical cord is like a hose-pipe which carries the baby's blood to and from the placenta.

On the 1st day of the 4th week the amniotic cavity appears, and gradually enlarges to become “the bag of waters” which surrounds and protects the developing child and which breaks at the time of birth. At the end of this week the mother will be prevented from menstruating by a chemical message produced by the placenta. It is this chemical, called hCG, which is measured by tests to confirm pregnancy.

The Embryonic Period (5 - 10 weeks pregnancy)

Now the developing baby is called an ‘embryo’ and grows from the size of a grain of rice at 5 weeks to 28-30 mm in length at 8 weeks — measured from the top of the head to the buttocks (crown to rump).

During the fifth week, the cells of the embryo form three distinct layers. By the end of the tenth week, all the main organ systems have formed from these three layers. From the outer layer is derived all nervous tissue (such as the nerves and the brain), skin, nails, hair, lenses of the eye, sensory lining of the ear, nose and eye, lining of the mouth and teeth, the salivary glands and the milk glands of the breasts. The middle layer develops into kidneys, ovaries or testes, blood vessels, heart, muscle, cartilage and bone. Finally, the inner layer will form the internal organs: oesophagus, stomach, intestines, pancreas, liver, bladder and lung lining.

The speed of development is incredible during this time; early in week six the baby’s heart begins to beat and blood is circulating. By the end of the tenth week arms, legs, fingers, toes and facial features have formed and a cartilage skeleton is in place. The kidneys start functioning. Brain development is particularly rapid in week seven. Movements can be seen on ultrasound scans at eight to nine weeks. During the tenth week, the eyes are still open, but soon the eyelids shut and are sealed by a sticky layer to protect further development until the seventh month when the eyes reopen.

From then on, with all major organs and systems established, maturation and growth are all that are required. With such rapid development taking place, the embryonic period is the time when the baby is most vulnerable to damaging influences such as drugs and infections which can lead to birth defects.



The Foetal Period (11 weeks pregnancy till birth)

From the eleventh week of pregnancy the unborn child is called a “foetus”. By the beginning of the foetal period the cartilage model or mould of the skeleton begins to be replaced by real bone to form the permanent rigid skeleton, while rapid growth of the baby’s body and maturation of organs and tissues are taking place.

Weeks 11 to 14 of pregnancy: the crown-rump length has more than doubled to about the width of the palm of an adult’s hand. In the eleventh week, the baby’s head measures almost half of the total length of his or her body, but the head size decreases in relation to the rest of the body as the growth of the trunk and limbs accelerates and growth of the head slows.

The external genitalia also rapidly develop during this period so that the sex of the baby can be determined by external examination (eg, ultrasound). Now the spleen becomes the main site for the manufacture of blood cells (initially undertaken in the liver) and urination starts to occur into the amniotic fluid surrounding the baby. Also the amniotic fluid is swallowed, and inhaled and exhaled from the lungs to help them grow and develop. The baby can yawn, hiccough and suck, and recognizably move in response to touch on the mother’s abdomen.

Weeks 15 to 18 of pregnancy: fine hair, called lanugo, grows over the baby’s skin; eyebrows and scalp hair appear. The ovaries of unborn girls at this stage have developed with ova formed inside them. The length of the baby continues to increase rapidly.

Weeks 19 to 22 of pregnancy: the mother usually experiences “quickening” or recognizable movements of the child within her womb. With hearing and memory already functioning, the baby begins to recognize his/her mother’s voice. By the 18th week of development, the womb of a female baby is fully formed, and at the end of the 22nd week of pregnancy the baby weighs just under 500g.

A small number of babies have survived when born prematurely at 22 weeks, i.e. just 20 weeks from fertilization. But at this stage, the respiratory system is still immature and needs all modern intensive care techniques to give the baby a small chance of holding on to life.

Weeks 23 to 36 of pregnancy: the baby's chances of survival increase steadily as the lungs mature. The baby gains weight, is able to control body temperature and coordinate a rhythmic breathing pattern. The eyes open again and the baby fattens up. The bone marrow takes over the manufacturing of blood cells from the spleen, a function it will maintain for the rest of life. Legs and arms have reached proper final relative proportions and the minute thumb finds its way into the little mouth. A tiny person enjoys the comfort of thumb-sucking, still curled safely in his or her mother's womb. If the sun shines on the mother's abdomen, the baby's eyes, responding to light, perceive a glow and moves towards it. Increasingly chubby and strong, the baby weighs over 2kg.

Weeks 37 to 40 of pregnancy: with the end of pregnancy in sight, the special antibodies (chemicals which fight infection) which have been filtering from the mother's blood to the baby's blood since about the 16th week of pregnancy reach capacity. A baby born prematurely is much more susceptible to infection, having considerably less antibodies than the full term infant. Growth slows during this last month so that at the time of birth the baby weighs approximately 3½ kg and measures 50cm in length. Though birth is anticipated at 40 weeks after the beginning of the mother's last menstrual period (38 weeks after conception) it is quite normal for this new life to make his or her entry into the world within 2 weeks before or after the due date.

Conclusion

The development of the unborn child is an incredible story. Surely we are "fearfully and wonderfully made" (Psalm 139:14, NKJV). From the moment of conception, the process of development is masterfully orchestrated from miniscule cell and fragile tissue to complex organs and structures which constitute a living, breathing, thinking, active and very vocal and unique little person. We have seen that as early as the end of the eighth week of development, the baby's body has already established every organ and system and from that time on, maturation and growth within the warm, watery world of the mother's womb is all that is required. And the whole process (every moment of it) is known, planned and observed by God the Creator! (Psalm 139:15,16)

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Abortion and the Bible

Rev Dr Peter Barnes

The Scottish gynaecologist Rex Gardner has described the most common abortion operation – that which takes place during the first three months of an unborn child’s life: ‘It is a lonely operation... He [the abortionist] takes that first dilator and is tinglingly aware that he is about to seal the fate of a fetus, that he is about to alter history. In other operations the cervix will dilate up readily, but in this operation it will fight, grip the end of the dilator and force it back into his hand. And then at last he will win, and as he does so he will wonder who has lost’ (Gardner, p.14). The little infant will have been suctioned out and deposited in pieces in a jar, and the woman will undergo a curette to remove any parts of the baby’s body which may have remained. At a later stage of pregnancy, a concentrated salt solution might be injected into the amniotic fluid in the sac around the growing child. The child is poisoned, his skin is burned, and the mother delivers a premature and dead baby. Yet later, a hysterotomy may be performed, which is rather like a Caesarean operation, except that the intention is to kill the infant.

Occasionally, infants survive on their own – something of a complication to the abortion industry. Eight abortion survivors attended the 11th World Conference of Human Life International in May 1992 (O’Donovan and Stuparich, p.86 n.69). To prevent this, some abortionists have resorted to partial-birth abortions. These were outlawed by the American Congress but in 1997 President Clinton overturned this ban. One former abortion clinic nurse has described what happens: ‘The doctor delivered the baby’s body and the arms – he kept the baby’s head just inside the uterus [so that it was a legal abortion, not an illegal homicide]. The baby’s little fingers were clasping and unclasping, and his feet were

kicking. Then the doctor stuck the scissors through the back of his head, and the baby's arms jerked out in a flinch.... The doctor opened up the scissors, stuck a high-power suction tube into the opening and sucked the baby's brains out. Now the baby was completely limp...' (*News Weekly*, 29 November 1997, p.10).

How do we respond to this? Abortionists have differed amongst themselves. Dr Peter Bayliss of Brisbane claims that abortion is 'no more a moral issue than a haemorrhoidectomy or a toenail-ectomy; it's a surgical procedure...' (*Australian Magazine*, 20-21 May 1995) while Dr Robert Jones of Adelaide has asserted that 'If you face the fact you're doing murder, and you know you're doing it for good reason, then you can be relaxed about it. It is 'justifiable murder...' *(Sydney Morning Herald*, 6 April 1991). Increasingly, it has become obvious that Bayliss' complacent assertions are a flight from medical and moral reality.

Francis Schaeffer and C. Everett Koop have maintained that 'eventually every nation in every age must be judged by this test: How did it treat people?' (Schaeffer and Koop, p.15) The practice of abortion raises this question in a very stark way. The unborn infant is the most helpless of human beings – unable to defend himself or herself, having no access to wealth or power, without any capacity to do anything except utter what Bernard Nathanson has called a 'silent scream'.

The Bible and the Unborn Child

Despite the claims and implications of some evangelicals (e.g. Gardner, p.254; Spitzer and Saylor, p.xxii), God has spoken clearly in the Bible regarding abortion. The sixth commandment forbids murder – the deliberate taking of innocent human life. This includes the child in the womb, who is fearfully and wonderfully made by God (Job 31:15; Ps.139:13-16; Isa.44:2,24; Jer.1:5). As David praised his sovereign God, he declared: 'For you created my inmost being; you knit me together in my mother's womb' (Ps.139:13). David did not magically become David at birth; the man is identified with the child in the womb. Even sin is traced back to the conception, not the birth, of the child (Ps.51:5; 58:3).

A number of pro-abortion writers have reluctantly come to accept that life begins at conception, not at implantation, quickening, viability or birth. Linda Bird Francke has written of 'the ambivalence of abortion'.

She tells of the trauma and regret associated with many abortions, including her own. She admits: ‘there was no doubt that life was right there, in my womb’ (Francke, p.254). Leslie Cannold has written in a similar vein, and reports that the 45 women she interviewed, whether supportive of the right to abortion or opposed to it, ‘were clear that the fetus is alive, and abortion kills it’ (Cannold, p.xii).

This is precisely what Scripture teaches us. The unborn child can move, even leap (Gen.25:22; Luke 1:41), be consecrated in God’s service (Jer.1:5; Gal.1:15), be filled with the Holy Spirit (Luke 1:15), and blessed by God (Luke 1:42). The same Greek word is used to describe the unborn John the Baptist (Luke 1:41, 44), the newborn baby Jesus (Luke 2:12,16) and the young children who were brought to Jesus (Luke 18:15). When God became man in Jesus Christ, He did not come as a newborn infant but became a child in the womb of Mary. The major differences between the born and the unborn are thus to be found in growth and geography.

Since the child in the womb is alive, it is therefore possible for him or her to die in the womb (cf. Job 10:18). In the midst of an extraordinary cry of despondency, the prophet Jeremiah cursed the day of his birth and also the man who could have killed him in his mother’s womb but did not (Jer.20:14-18). The poor man’s ‘crime’ was that ‘he did not kill me in the womb, with my mother as my grave, her womb enlarged forever’ (Jer.20:17). The same Hebrew word is used in 1 Samuel 17:50-51 to describe David’s slaying of Goliath. What the Bible refers to bluntly as ‘killing’, many pro-abortionists have tried to dismiss as ‘a termination of pregnancy’ or even ‘a retrospective method of fertility control’.

When Elisha foresaw the crimes that Hazael, the king of Syria, would commit against Israel, he wept. Part of the reason for Elisha’s distress was the coming destruction of unborn life: ‘You will set fire to their fortified places, kill their young men with the sword, dash their little children to the ground, and rip open their pregnant women’ (2 Kings 8:11-12). Later, one of Israel’s last kings, Menahem, would perpetrate the same kind of barbarities (2 Kings 15:16). Such a practice is not only against the written law of God, but also the unwritten law upon our hearts. When the heathen Ammonites ripped open the pregnant women of Gilead, the prophet Amos announced God’s judgment upon them

(Amos 1:13).

The one text which has been used to justify attaching less value to the unborn child than to the child after birth is Exodus 21:22-25. The situation envisaged is, one would hope, a little unusual. Two men are fighting, and in their struggle one accidentally hits a pregnant woman. What exactly happens next is somewhat ambiguous. According to some translations, the woman miscarries (NASB, RSV, NEB, GNB, NRSV). The culprit is then fined, and only if there is any further injury - presumably the death of the woman - is there 'life for life'. Yet even on this interpretation, an accidental abortion leads to a fine; a deliberate abortion would obviously be regarded with greater seriousness. The main point of the passage would not be the weaker view of the unborn child but the greater protection given to the pregnant woman. Her death, albeit accidental, requires the death penalty.

According to others the woman does not miscarry but gives birth prematurely (KJV, NKJV, NIV). If there is no serious injury, to mother or child, the fighter is only fined, but if the infant dies, it is life for life. This interpretation has much to commend it. The Hebrew text in Exodus 21:22 does not actually use the word for 'miscarriage' (which is found, for example, in Genesis 31:38 and Hosea 9:14) but a word which simply means 'to go out' or 'to depart'. It is used to describe Abram's departure from Haran (Gen.12:4) and also to describe live births (Gen.25:26; 38:28-30). God cast His protective law around the unborn, even to preserve them from accidental death. As the Puritan Thomas Manton declared: '...it is murder to stifle an infant in the womb...' (Manton, *A Commentary on James*, Banner of Truth, p.101).

The child's right to life outweighs any supposed right to happiness on the part of the mother. This remains true even in the tragic case of pregnancy caused by rape. As terrible as the trauma of rape is, it cannot outweigh the child's right to life. The child should not pay for the crimes of the rapist. No matter how the child is conceived, his or her life is protected by God's law of justice and love. At the very least, the child could be adopted out into a loving home. It is hard to believe that any mother would resent this in the years to come.

We must reach a similar conclusion in the case of deformed unborn

children. As early as 1958 Glanville Williams vigorously asserted: ‘To allow the breeding of defectives is a horrible evil, far worse than any that may be found in abortion’ (Williams, p.212). God sets His face against such a view. He declares: ‘Do not curse the deaf or put a stumbling block in front of the blind, but fear your God. I am the Lord.’ (Lev.19:14) As He told Moses: ‘Who gave man his mouth? Who makes him deaf or mute? Who gives him sight or makes him blind? Is it not I, the Lord?’ (Ex.4:11) Assertions that to allow ‘defectives’ to live is unfair to the child, the parents or society in general, can be very powerful in an emotive way. They were so in Nazi Germany as the state tried to eliminate those whom it saw as physically, mentally, or racially deficient (cf. Michael Burleigh, *Death and Deliverance: ‘Euthanasia’ in Germany 1900-1945*, Cambridge, 1994). But it remains true that God is the creator of all human life, whether ‘normal’ or ‘defective’.

There are rare cases in which pregnancy causes (eg severe pre-eclampsia) or worsens a life threatening condition in the mother. Should an abortion be performed in such circumstances? In pregnancy, there are *two* patients – the mother and the child, and the aim should be to preserve both lives. Advances in medical technology means that the pregnancy can be continued as long as possible and the baby delivered prematurely. Usually pregnancy can be continued until the baby is beyond 22 weeks when survival outside the womb becomes possible with intensive care treatment. Even if the baby dies as a result of prematurity, the mother is spared the trauma of having chosen to deliberately end the baby’s life because every effort was made to save it.

Sometimes a serious illness in the mother requires treatment modalities which could affect her unborn child (eg. chemotherapy). The timing and type of treatment selected should be that which does least harm to the baby but which is the most effective in treating the mother’s illness. The decision is difficult and complex. It is not wrong to use treatment which may affect the unborn child in such cases because the aim is to save the life of the mother (without which the baby cannot survive) rather than to intend specifically to harm the baby. On the other hand, aborting the baby prior to treatment ensures his or her death when there was the possibility (even if small) of a live, even healthy, baby if the pregnancy had been continued.

In an ectopic pregnancy (where the unborn child is growing in one of the mother's fallopian tubes) the life of the mother is at grave risk. An emergency operation must be performed to remove the embryo from the tube because otherwise the tube will burst and haemorrhage. This differs in two ways from an abortion which simply intends to kill the child. Firstly, an ectopic pregnancy is usually diagnosed when bleeding around the baby stretches the tube and causes pain at about eight weeks of pregnancy. By this time, the baby is already dead or is dying. Secondly, there is no chance of the baby surviving even if the operation were not performed because of the limited space in the fallopian tube. Even then, there will be grief and sorrow, for life is the precious gift of God.

One American evangelical Professor of Christian Ethics, Paul Simmons, declared in 1983 that 'One is free to abort or not to abort, as God leads. This is the freedom of grace' (*Birth and Death: Bioethics and Decision-Making*, Westminster Press, p.106). Not so - that is the bondage of lawlessness. God is the God of life.

The Law upon our Hearts

God tells us that we all have His law written upon our hearts, and that our consciences bear witness to this (Rom.2:14-16). This is whether or not we have saving faith in Jesus Christ. Because of this, God calls to account people who do not worship Him (e.g. Amos 1:1-2:3). It also means that sin does something destructive to us. After his adultery with Bathsheba and his murder by proxy of Uriah, King David felt physically ill, he groaned all day, and was burdened by an oppressive lack of vitality. Only when he confessed his sin to God did he find relief and peace (Ps.32:3-5).

This has implications when the subject of abortion is raised. Dr Paul Tournier has affirmed: 'Every abortion is a murder. That cannot be doubted. It is not only the law of the Bible and of the Church; it is written in the human heart itself' (Tournier, p.158). Hence we should not be surprised at Post-abortion Syndrome (PAS), which Anne Speckhard and Vincent Rue consider to be 'an emerging public health concern'. They report the traumatic words of one PAS woman: 'It was so real when I woke up hearing my baby crying that I would get out of bed and start searching through the house. I looked everywhere for my baby. My housemates thought I had lost my mind' (Speckhard and Rue,

p.111). David Reardon has also found in his survey of 252 postabortion women that many suffer from flashbacks (61%), anniversary reactions (54%), temptations to suicide (33%), feelings of having less control over their lives (78%), difficulties in maintaining and developing relationships (52%), turning to drugs (49%) and stress (62%).

There has been a reluctance to make public any negative consequences of abortion for fear of discouraging the pro-abortion establishment, but PAS is real enough. The former abortionist Bernard Nathanson has reported the effects of abortion on medical personnel, including nightmares, marriage problems, drinking to excess, stress and fear (Nathanson, p.141). The effects on women who aborted their babies are even more pronounced. In 1982 Nancyjo Mann, who had undergone a saline abortion when she was five and a half months pregnant, founded the organisation Women Exploited by Abortion (WEBA), now known as Women Hurt by Abortion (WHBA). Her angry claim is: ‘We have been lied to, manipulated, and exploited’ (Reardon. p.xii).

The literature associated with the aftermath of abortion makes for sad reading – see Don Baker, *Beyond Choice: The Abortion Story No One is Telling* (Multnomah, 1985), Pam Koerbel, *Abortion's Second Victim* (Victor, 1986), Noreen Riols, *Abortion: A Woman's Birthright?* (Hodder and Stoughton, 1986), Linda Bird Francke, *The Ambivalence of Abortion* (Penguin, 1979), Nancy Michels, *Helping Women Recover from Abortion* (Bethany, 1988), Carol Everett, *The Scarlet Lady* (Wolgemuth and Hyatt, 1991); republished as *Blood Money*, (Multnomah, 1992), Terry Selby with Marc Bockmon, *The Mourning After: Help for Postabortion Syndrome* (Baker, 1990), Jennifer Doe (pseudonym), *One Day I'll See You* (Kingsway, 1991), Jeanette Vought, *Post-Abortion Trauma: 9 Steps to Recovery* (Zondervan, 1991), and Maureen Long, *Right to Choose?* (Christian Focus Publications, 1993). Each story has a similar theme: ‘The emptiness, the loneliness, the loss, the sadness’ (Christine Routley in O'Donovan and Stuparich, p.26). In 1995 the novelist Peter Carey made public his regrets over his involvement in abortions earlier in his life (*The Weekend Australian*, 14-15 October 1998). In the same year Naomi Wolf tried to defend abortion but conceded that it entailed the taking of human life, and so spoke of the need to recognise sin and the consequent need for atonement and redemption

(*The Weekend Australian*, 7-8 October 1995). Significantly, a Melbourne woman has just successfully sued the Royal Women's Hospital and a gynaecologist for her post-abortion depression (*News Weekly*, 17 October 1998, p.10).

In 1973 in the *Roe v. Wade* decision the US Supreme Court found the right to abortion in the US Constitution – or rather, it read this 'right' into the US Constitution. The Jane Roe of *Roe v. Wade* was actually Norma McCorvey, an ill-educated rough and ready type who felt out of place amongst the Hollywood pro-choicers. She had been pregnant, and even claimed, falsely, that she had been gang raped, but in truth she herself never had an abortion. She was greatly used by the abortion industry, but has recently come to faith in Christ, and told her story. She tells of the young women who came to the clinics for abortions: 'We would listen to them cry, listen to them pray, listen to them swear, listen to them beg their child for forgiveness' (*Won by Love*, p.59). Nor are the workers in the clinics unaffected: 'Believe me,' says Ms McCorvey, 'it takes a lot of beers to make yourself forget what you're doing' (p.60). As she comments: 'abortions are an inherently dehumanizing business' (p.54).

In the midst of the debates over abortion, which began in earnest in the 1960s, the pro-abortion lobby came up with the beguiling slogan 'Every child a wanted child.' Abortion was supposed to solve the problem of unwanted and abused children, and the result would be an increase of love and 'wantedness' in this fallen world. But Philip Ney has pointed out the connection between abortion and child abuse is not what the pro-abortion slogan would have us believe. Abortion so often leads to child abuse and child abuse to abortion – the result is, as Ney says, 'a vicious cycle' (Ney, 2.20). Indeed, abortion is the ultimate form of child-abuse. It is also revealing that Ney has found that lack of partner support is 'the most important factor that determines the number of abortions' (Ney, 2.23). Furthermore, a great many relationships – perhaps 80% – do not survive the abortion of a child (Ney, 2.24). The sin of abortion, like all sins, has a distorting and destructive impact on human relationships and well-being.

Reversing the Trends

Recently, there has been a concentrated attempt in some circles to acknowledge that human life begins at conception, but to add that personhood begins at birth or later. The situation ethicist Joseph Fletcher has asserted that ‘a fetus is not a moral or personal being since it lacks freedom, self-determination, rationality, the ability to choose either means or ends, and knowledge of its circumstances’ (Fletcher, pp.150-1). This notion has been taken further by Michael Tooley and by Helga Kuhse and Peter Singer. Tooley wants to allow infanticide up to the end of the first week of the newborn infant’s life (Tooley, p.64) while Kuhse and Singer want to allow 28 days before the infant has a right to life. In the view of Kuhse and Singer, ‘infanticide is compatible with a stable, well-organized human society’ (p.108). Abortion is leading to infanticide.

In addition, children have been able to sue over car accidents suffered while *in utero* – which implies that the foetus has rights. Cocaine use during pregnancy is also causing concern. There has been disquiet over practices like abortion on the grounds of sex selection (where it is usually the female who is put to death) or women athletes deliberately falling pregnant, then aborting, in order to enhance their performances. From 1981 there has been a brutal one-child policy in China, with rampant female infanticide – yet another cause for feminist reflection. Trends such as these have led Leslie Cannold to withdraw support from what she now calls ‘the amoral rights-based approach to abortion’ (Cannold, p.117). However, she continues to uphold the right to abortion on the bizarre ground that the mother has the right to ‘kill from care’ (Cannold, p.128).

Schaeffer and Koop have warned us: ‘Times of monstrous inhumanity do not come about all at once; they are slipped into gradually’ (Schaeffer and Koop, p.110). Paul Ramsey adds a sober, if not altogether elegant, word: ‘the notion that an individual human life is absolutely unique, inviolable, irreplaceable, noninterchangeable, not substitutable, and not meldable with other lives is a notion that exists in our civilization because it is Christian; and that idea is so fundamental in the edifice of Western law and morals that it cannot be removed without bringing the whole house down’ (Ramsey, p.xiv).

We are all created in the image of God (Gen.1:26-27; 9:6; James 3:9), and protected by the sixth commandment against murder (Ex.20:13).

Hence human beings are, as Paul Ramsey graphically puts it, ‘fellow fetuses’ (Ramsey, in Noonan, p.67). The modern era is returning to the days of the Roman Empire when, as Juvenal said, there were ‘sure fire drugs for inducing sterility/Or killing an embryo child’ (Satire VI). The debasement of unborn life goes hand-in-hand with the debasement of life after birth. There is a well-known papyrus from Egypt where a man Hilario writes affectionately to his pregnant wife, and then adds: ‘If you chance to bear a child and it is a boy, let it be; if it is a girl, expose it’ (N. Lewis and M. Reinhold, *Roman Civilization: Sourcebook II*, Harper, p.404).

In 1793 William Carey left England to bring the gospel to India. Here he came across the exposure of infants, as well as their exposure to the river Ganges. Finally, he confronted the practice of sati (widow-burning). The British authorities tended to argue that the Indians ought to be allowed to practice their religion in peace, even if that meant that infants were sacrificed and widows were burned. Carey, however, was not so easily placated. He lived to see the banning of child sacrifices to the Ganges in 1804 and of widow burning in 1829. The campaign against the destruction of the unborn is going to require similar grace, strength, and persistence. But for all this world’s godless secularism, one senses that the ‘whispering in our hearts’ is becoming louder and clearer.

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A Christian's Anguish

Anonymous

The early nineties found us expecting our second child. Our first child was 2½ years old, we were looking forward to another baby, and the pregnancy started in happy anticipation.

I hadn't had an ultrasound in my first pregnancy, but I had changed carers and this time an ultrasound was offered. I naively went along expecting a happy event, and a video to take home to watch. I had gone alone, considering it all to be very routine and straight forward. Two minutes into the procedure the doctor stopped. He informed me that our baby had a serious and major abnormality. It was devastating and crushing news. The nightmare, the months of anguish, had begun.

From that moment on the pregnancy was joyless. In the early days I found myself focussing on the 'abnormality' rather than the 'baby with an abnormality'. My husband was able to see the baby as primarily a baby, not primarily a problem. I could consider abortion as this was not a baby. My husband saw it as a baby whom we could not abort.

We saw our obstetrician the next day who gave me some brief information on the condition, and details of his infrequent experience with it. The condition occurs 1 in 10,000 births, apparently as either an isolated defect or, more commonly, as part of a chromosomal problem. Our next step was to have an amniocentesis and see which type we were dealing with. Our doctor presented us with these options:

1. if an isolated defect, then with surgery the prognosis was fairly good.

2. if part of a chromosomal pattern, some of these were compatible with life, some were not, and abortion was an option in certain cases.

He did not say abortion was our only option. In fact he seemed to be saying it was a rare option. I was grateful for his emphasis, and his overall response was that it really was a fairly hopeful situation.

As I mentioned before, abortion had crossed my mind in the time after the ultrasound. I felt I couldn't cope with the problems we could encounter, and I did so want to be like others and have a healthy baby. Also, as there was some possibility of a threat to normal life, somehow I thought it was a waste of time (and emotional effort) to proceed with the pregnancy. My husband, on the other hand, felt that whatever the result we should continue with the pregnancy. I felt and knew that abortion was wrong, but the issue seemed not so clear cut when actually faced with the situation.

I had to wait 3 weeks for the results of the amniocentesis. This was an overwhelmingly stressful time. I was feeling very confused and angry, emotions aggravated by two friends being pregnant at the same time. They were expecting healthy babies and I found it very hard to be happy for them.

In those 3 weeks we were flooded with so-called helpful advice from people who had no idea of the hurt and pain. We wanted to know 'Why us?' Had we done something wrong? We were feeling absolutely crushed and alienated from everything. It was difficult to feel this was God's perfect plan for us. We really needed our fears and anxieties to be understood, a recognition of how alone we felt. We needed encouragement to continue to trust God even when we were finding that so hard to do.

Christian friends were saying we must never let the idea of abortion enter our heads, and 'you have to deal with what God gives you' – that God would give us strength (He did indeed). What they said was not wrong in itself, it was the way it was said. And so hurtful in our fragile state.

These comments were from the friends with healthy babies, who were not facing problems and difficult decisions. It is so easy, sitting on the other side of the fence, to tell me how wrong I was to consider something as sinful as abortion. One particular friend who was close to my husband and shared his views made me feel ungodly to have even let the notion enter my head. At such times I felt very alone and guilty.

There were other Christian friends who seemed to avoid us, while others, themselves pregnant, said they had asked the doctor to check carefully so that they would not have the same problem. Rarely did anyone try to step into our shoes to see how we might be feeling. I believe the experience has given me a deeper sensitivity in responding to the hurts of others.

We did have some dear Christian friends who truly listened and spoke a word in season and were a great source of comfort. Many were friends who had faced similar heartaches, some the loss of a child. These brought a different attitude and perspective to things.

Non-Christian friends advised it was madness to proceed to have a child with problems. But who can be sure of anything? Any child may have an accident and end up with brain damage, something worse than our best option. I was frustrated by both sides, only wanting people to understand how devastated we felt, not to judge us.

Thankfully our baby had normal chromosomes; it was an isolated defect. Before we experienced any of this I would say I was anti-abortionist and today I would still say I am anti-abortion. In fact when I speak to people who have terminated a baby it is heart-breaking, and I do get angry. But I have been through the torment and devastation and I know the decision is never as straightforward as we think it should be. It took weeks for me to accept that God had chosen us to have a very special baby and it was, in fact, His very best plan for us. Once I accepted this it became easier to see the baby as a baby. I could also see that we don't live in a perfect world and these things happen. It did not help to ask 'Why?', but to see the situation as an opportunity for God to work His work in us. We discovered the truth of the passage in Isaiah 40:27-31. We thought God had forgotten us, instead He wanted us to wait on Him and trust Him.

*But those
who wait on
the LORD
shall renew
their strength;
They shall
mount up
with wings
like eagles,
They shall
run and not
be weary,
They shall
walk and not
faint.*

Isaiah 40:31



We visited a pediatric surgeon a few times during the pregnancy to discuss treatment options. Ahead lay a long period of hospitalisation for our baby, many infections, dressings and surgery. It was a difficult, stressful, painful time but we were given the strength to deal with it. Looking back now, I can see how God may test you to your limit but supply all the necessary enabling to see you through.

Our baby did really well, although she still faces some surgery. She is a most delightful, bubbly, happy child we could never be without, and our hearts are full of thankfulness to the Lord for His never-failing grace to us all.

Difficult Cases: Abortion and Foetal Abnormality

Sara Oh interviewed
by Andrew Lansdown

Many people who oppose abortion on demand feel that abortion is justifiable in cases of foetal abnormality. Sara Oh does not agree. A general practitioner, a wife to Steve, and a mother to John (12), Lisa (10) and Victoria (6), Sara is nine months pregnant with a child who is so handicapped that he is not expected to live long after birth. Why has she refused an abortion? How has she coped? Andrew Lansdown interviewed her on Tuesday, 7 April 1998, to find out.

***Andrew:** Sara, the baby you are carrying has a serious abnormality. Can you explain the nature of the problem, and what it means for the baby?*

Sara: Our baby has Edwards' Syndrome, or Trisomy 18. This means that he has an extra chromosome in the eighteenth pair. Babies with that extra chromosome can be affected in a spectrum of ways. In our case the baby's brain is probably affected and he has a hole in the heart. His hands and feet are also abnormal in their postures.

***Andrew:** How did you discover that your child has this problem?*

Sara: Just before the eighteenth week into the pregnancy we did a routine ultrasound, which was prescribed by the doctor who was managing the pregnancy. The ultrasound showed defects in the hands and feet, the brain and the heart.



Andrew: *How did you react and feel, when you learnt the news?*

Sara: When the doctor was talking to me straight after the ultrasound I was just stunned. I was shaking, really. Literally shaking. Then I went to another room and I just cried. I just cried.

Then I went home and I told Steve. The first thing Steve said was, “We thank God and praise God.”

Andrew: *How did you feel when Steve reacted that way?*

Sara: I think in a sense I was relieved. And I expected him to react that way, knowing who Steve is, and what he is like.

Andrew: *Did you tell your children straight away?*

Sara: Yes, we did.

Andrew: *How did they react?*

Sara: They were quite sad. They didn’t say very much, but they looked sad and kept quiet. They were hoping for a boy, and it is a boy. Steve said we have got an answer to prayer, because we were praying for a boy.

Andrew: *Did you contemplate an abortion, either then or subsequently?*

Sara: No. My whole world view is always to preserve and to protect and to save lives in my work as a doctor. That’s what we do. So if you are at work, and you are always counselling people to opt for life, abortion is not in your thinking at all. So we never thought of that.

Andrew: *So your main reason for not even contemplating abortion is being a doctor and having a vocation to save life?*

Sara: No, I think the main thing really is a religious conviction.

Andrew: *What is that religious conviction?*

Sara: God says, “Do not kill.” That, actually, gives rise to the doctor’s part of saving life. Both go in parallel. But the first thing is the spiritual and personal conviction from one’s own faith. And it’s very clear in the Bible that you do not kill.

And this is our baby, given by God. You cannot think of killing a child – even more so when the child is weak and frail. The sense to want to protect him and heal him is so strong. You don’t feel, “Oh, this is an abnormal baby, let’s get rid of it.” He’s frail, and you want to help him, you want heal him, you want to relieve his discomfort.

***Andrew:** So that desire to heal and comfort the child really grows out of three things: one is your religious convictions, another is your medical profession, and the third is being a mother?*

Sara: That's right. I think being a mother is most important. I think it is a maternal instinct. Long before I knew the baby had problems, I started a journal. I went back to read it just the other day and found that that was the strongest theme that ran through all my writing and my thoughts. You know – I want to look after you; you are in my womb; I want to take care of you – that sort of thing. So it is just a mother's thing.

And after I knew he was affected this way, I had the feeling of wanting to hold him after he's born – just to embrace him, especially when he is dying.

It's all very confusing, but you're thinking about the baby dying, and the doctor kept saying that the baby will probably die in the womb. So there were times when you thought, "Oh, if the baby is dying in the womb right now, I want to hold him as he is passing away." Then you think, "Yes, that's exactly what I am doing. If he's in the womb, that's the way that I can hold him."

***Andrew:** How do you cope with knowing that the child could die as you carry him, or shortly after birth?*

Sara: It could be a very common reaction for mothers and other people to shrink away from a so-called abnormal child – to reject anything that is not normal, or anything that is not nice looking. A lot of people say, "How can you even think that you want to keep this kind of a child in your womb?" I think the fact that this is your own child changes everything – and that he is given by God. God doesn't give us anything that's bad. He gives us everything that's good. And we believe this child is good in that sense. Throughout this time, believe it or not, I have often felt thankful that God has allowed me to go through this experience. Without it I may not have had such thoughts about God.

The other thought I had is that God trusted us enough with our love for Him. He trusted us in a sense that He knows we are not going to question Him and turn our backs on Him. I see it as God allowing this for me to know Him and His love in a greater dimension. I find this very much a lesson in God's love, really.

***Andrew:** In the early stages did you have doubts about God's love, either*

for you or for the baby?

Sara: No.

Andrew: *Why is that?*

Sara: I have never questioned God's love. I know that He loves us very much. In fact, I think His love is even stronger. He must love me so much that He is putting me through the sort of experiences that I have always asked Him for. So I think that throughout this experience that's what He's leading me to.

Andrew: *Just to clarify something: When you speak of the sort of experiences you have always asked God for, you mean experiences that would draw you into a deeper understanding of His love, not specifically an experience of having a baby such as this?*

Sara: Yes, sure. I mean anything that is necessary for me to really know Him more intimately and more accurately, and to experience Him in greater and greater measure. I give Him free reign to do whatever He wants in my life for that purpose. So I think this is one of the things that He allows for that particular prayer that I always have.

Andrew: *The West Australian published an interview with you on the 17th of March (1998), and that same day you spoke at a large pro-life rally at Parliament House. Why did you decide to come out publicly about your condition and against abortion?*

Sara: I think this is an opportunity that God has given us to speak for the life of the unborn child. And being pregnant at this time [when the Western Australian parliament is debating whether or not to legalise abortion] seems just the right time. I want to show that life is precious, even the life of a baby who is not entirely normal.

Also, by going public I am telling women with handicapped babies that their worth is not diminished. It is humbling that we can have babies who have defects, but that doesn't make us defective or inferior. It is a message to women that if they do have children who have defects, they don't need to feel ashamed, because it's not their fault.

The other thing is, we found that the debate seems to be weighted in favour of the pro-abortion side. The doctors seem to give the impression they are on the side of pro-abortionists. We felt that we had to balance that debate.

Andrew: *I understand you are a founding member of the newly created*

Doctors Against Abortion. Why did you decide to found this organisation?

Sara: In the media the impression is that doctors are for abortion because of a few high-powered, heavy-weight doctors who came out publicly and said they are for “choice”. So there was this feeling among the public that most doctors are actually for abortion. I am a doctor and I know of other doctors who are just not for abortion. We felt that we needed a voice, a collective voice. And it seemed to be the right time to launch this group. Over fifty doctors have signed a declaration for the respect of human life.

Andrew: *How has your public profile over the past few weeks affected you and Steve and the children?*

Sara: It has had no particular effect.

Andrew: *The West Australian has carried a number of letters in response to the front page article it did on you on the 17th of March. Some of those letters have been in praise of your stance, but others have been quite hostile. How do you respond to some of those criticisms? Let me read several to you. One person asked: “Do Sara Oh and her husband think of the pain, heartache and frustration for the whole family when they bring a disabled baby into the world?” How do you respond to the notion that you are being cruel to your own family by not aborting your child?*

Sara: I think it is on the contrary. Our children know that abortion is actually taking the life of the baby in the womb. And if we were to do so with their little brother, there’s no stronger message to show that we really don’t love their baby brother. But to bring him into the world, to love him, to let him live as naturally as possible, and to let him die in the love of his family, is a good lesson for them.

They need to know about death in the family, even though this seems a premature lesson for them. It is for them to know that death is a part of life, and this is the way you deal with it. You don’t just take the baby’s life. If you do that, then they might think, “Okay, Mum can take away this baby because he is not entirely normal, or he is going to cause inconvenience. What if I become not as perfect as she likes me to be? She might also take my life away.” So really, bringing our baby to birth is not going to harm our children. It is entirely the opposite.

Andrew: *That leads me on to another question. Your child may not live*

very long. Do you intend that the whole family should be a part of welcoming the child?

Sara: Yes.

Andrew: *So you are not going to keep the baby hidden or apart from your other children?*

Sara: No. The plan is, when the baby is born, we will bring all the children there. It's all a family experience, because this is as much their little brother as our son. So they will be involved from the beginning, and they will be involved with the funeral.

We are all going to die. If death must come, you treat it as normally as possible. And with us as Christians, death is not the end of everything. It is not like we are never going to see this baby again, and he will just become dust. But we are going to see him again in heaven. So in a sense, we have victory over death. Death is just a part of life we have to go through.

Andrew: *Let me come back to the West Australian. The same person who asked the previous question also asked, "Have [you] thought of the suffering of the child?" So now this correspondent has shifted from the idea of cruelty to the family to cruelty to the child himself. How do you respond to that?*

Sara: I think we really do not know what sort of suffering the child has. There are different levels of appreciation of suffering. And suffering also is a part of life. If the child really has to suffer, that is better than suffering a very violent, cruel and painful death in the womb through abortion.

Andrew: *And isn't it better to be a witness to suffering, and to do what you can to alleviate it, than to be the brutal cause of it?*

Sara: That's right. And I think the first and foremost principle is, you just don't take a life. And when you have that principle, everything else is worked out.

Andrew: *In another letter a woman noted that you are fortunate to have a loving supportive husband in Steve. She asked, "Would she, perhaps, feel differently if she had no partner and was faced with the daunting prospect of caring for that child for the rest of her life, solely dependent on an inadequate welfare system?" How do you respond to that?*

Sara: I would still keep the baby even if I did not have the support of a partner, because I start from that very premise, that you do not kill. So if

it means suffering along the way, I will bear with it.

Andrew: There are, of course, some women who don't have supportive husbands. You mentioned earlier that Steve's reaction was to recognise God's goodness and sovereignty in your present situation, and to immediately give you his full support. Some husbands might do the reverse and put pressure on their wives to have an abortion. Wouldn't those women be justified in having an abortion?

Sara: No, still never.

Andrew: Why not?

Sara: Because the baby is alive. An abortion is killing the baby. I cannot over-emphasise just how important the support of a partner, of a husband, is. I think I am very, very fortunate to have Steve by my side giving me spiritual, emotional and practical support. And without his support I can see how difficult it would be. I think the thing is to actually lend these women practical support as they go through with their pregnancy and look after their children. But abortion is still out of the picture.

Andrew: Sara, how do you feel right now, now that the time of delivery is almost upon you?

Sara: I feel the need to be closer to God, to get strength from Him. I think the human feelings are there. There's no point denying them. There's a little bit of fear – afraid of what we are in for. But then, soon after I think like that, the next thought is that we can only take it one day at a time, and that God will be with us. God will be with me, and I will be able to cope.

And I suppose there's also a sort of sadness and grieving. It's all quite mixed. It's all human, maternal emotions. It's just trying to be strong and not to be overwhelmed by these emotions. I cried the last two nights. I have cried many times, but not for long, and not uncontrollably, not in a way that you are defeated, but just a release of sadness.

As the birth of the baby is coming closer – you know, he's been so much talked about, he's been with us for so long – sometimes I wish I could carry him forever because while he's in me he's alive.



Postscript

Six days after this interview, on Monday 13th April, Sara gave birth to her son, Jonathan Agape Oh. Jonathan died at birth, and his body was laid to rest on Friday, 17th April.

The day after the funeral, Steve and Sara published the following letter in the West Australian:

Jonathan, which means God has given us a son, did not die in vain. In the short time he lived he awakened his parents' conscience to the plight of the unborn child and inspired them to speak out for those who could not.

He fought against the odds to stay alive until full term. Most babies like him die in the womb by abortion or naturally.

His was not to be a normal life because he came for a purpose. He came at a time when people were beginning to lose their sense of what is right and wrong, when their hearts were being hardened by selfishness, when many law-makers who are given the mandate by God and man to protect and serve society have deserted its most defenceless members.

He came to remind us that life is precious, that life is worth respecting, that no matter how people think of others as ugly and useless in their own distorted minds, they are always beautiful to those who look at them through the eyes of love.

Jonathan was a beautiful baby. But for a slightly curled foot he was almost perfect. It was the unseen – his brain and damaged heart – that refused him life. His heart was beating perfectly until the last moment. I [Steve] saw his head emerge, his lips move for an instant and then he was gone. Perhaps this served as an ironic reminder to those who have normal brains and hearts yet are dead in their feelings and concern for others.

We would have preferred no publicity, but that was impossible. Jonathan led us into the war against abortion. As we gazed at his ultrasound image, it suddenly struck us that people were killing what we so earnestly wanted to save. We would have willingly traded some part of ourselves if only Jonathan had a chance to live. But from the beginning he did not. His was a death sentence. But 9,000 other WA unborn children who die needlessly each year are pink and healthy.

My Abortion Testimony

by Caroline (aged 30)

I was 15 years old, my boyfriend was 17. I was attending a Girl's High School, my boyfriend worked. I fell pregnant. We were absolutely terrified! We had a guest speaker come to my school from the abortion clinic. (I think it was in South Melbourne). She seemed so nice, I sat in the classroom listening to her speech about how they were there to help! I went to an aunt and uncle who I looked up to and shared the facts with them and they advised us to go to the clinic fast. My aunt was concerned for the heartbreak it would cause my parents. I was dazed. (I actually thought God had sent the clinic lady to help). I rang, made an appointment and went with my boyfriend. I was 12 weeks pregnant and nobody even explained the method of abortion, or even shared the meaning of being pregnant. This was just a problem to be solved quickly, pat us on the knee and say, "It will be alright, hand us the money and you can go home soon. No-one will ever know!"

When 22 years old I married after many relationships. I fell pregnant. I was not free, I felt guilt. I miscarried traumatically at 8 weeks and whilst in hospital a nun approached me and consoled me and said I should be

angry with God for letting this happen. I knew I had no right to be angry with God, I knew what I had done, I was a murderer. The statement of that nun played on my mind. I knew I was guilty and whilst listening to a tape by Carmen that I had just bought, the words of the song, 'This Blood is for you, the blood of the Lamb', brought me to repentance.

I knew when I killed my baby I was responsible for killing my Lord Jesus on the cross, I cried out to Him for forgiveness and that day He removed my guilt and I grew and continue growing as a born again Christian. I know, I know Jesus forgives my sin. I have 3 beautiful boys: Thomas aged 6, Adam aged 4, Luke aged 2, and a beautiful daughter Rachel aged one. My children are truly gifts from God. While pregnant I continually read the Word of God knowing He knows us before He even starts to form us in our mother's womb. There are so many barren women in the Bible who He blessed with children!

I know we cannot go back to our past, we must only look forward, but I want to say if only I had been informed about the baby I was carrying, if only someone had shown me a picture of a 12 week old baby inside me. If only they had spoken up and helped me as all too few are doing today, I would not have killed my baby like a problem to be swept under the mat. The abortionists and their staff do not help, they do not inform you about the baby you are carrying.

Please stand firm and tell the world abortion is a sin, it is murder. Your words may just reach the ears of a scared teenager and they may call for help.

I thank God that I am now free to live in His peace, to live to serve Him with the beautiful family He has given me.

May God bless all those who have the courage to speak out and give them continued strength to serve Him.

In the name of Jesus Christ my Redeemer.

The Psychological Effects of Abortion on Women

Dr Joanna Barlow

Introduction

I never should have been so...so arrogant. So confident that I could have a baby whenever I wanted one. I should have known that if I threw away one baby I would never have another one... I just never thought of it as a baby before. It was just a fetus. A clump of tissue. Nothing. But now I feel like I'm finally facing the fact that it was at least a potential life I cut off and I just feel so sorry about it (Klugger-Bell, 1998).

My immediate response was relief – but that soon passed away and all that I have ever felt since is guilt. I know that abortion is killing and I would give anything to have the child now (Korbell, 1990).

I just wanted to forget it, but after a year I started having anxiety attacks. I didn't think the abortion was causing them, though. I thought that was all past. On the anniversary of the abortion it got really bad. I started to shake and cry. I huddled on the floor and felt like I was screaming, and my



breathing became heavy and uncontrolled. I started having two or three attacks a week, and it was scary (Francke, 1978).

I wish I hadn't done it. I wish someone had told me how bad I'd feel afterwards if I did it. I see those protesters at the abortion clinics on TV trying to block women from going inside and I think – this is awful I know – but I think to myself I wish somebody had stopped me! I mean I know I had a right to do what I did, I know it was my choice, but still... (Kluger-Bell, 1998).

The literature, both secular and religious, contains many such accounts of women who appear to be suffering significant psychological distress related to abortion. However, a reading of the majority of scientific studies and reviews leaves one with the impression that adverse psychological effects after abortion are infrequent and generally not severe. This chapter considers the limitations of the scientific studies, particularly in determining the number of women* with psychological problems post abortion, as well as examining the nature of those problems, and considering ways in which we can best help and support those experiencing difficulties. If you have had an abortion and are experiencing psychological pain, I would encourage you to read on. There is hope and help available.

Why is it difficult to know how many women are affected?

At first glance it would not seem particularly difficult to determine the psychological effects of abortions. Surely one could take a group of women before their abortions, do some psychological tests, and then repeat them after the abortion and see what differences are found? Some difficulties are immediately apparent with this approach. The first is one of participation: women with unwanted pregnancies may not be in a

* There is evidence that men too may experience psychological difficulties after abortion (e.g. Shostak et al, 1984), as do some workers involved in the abortion procedure. This chapter will be restricted to women post-abortion.

frame of mind to consent to undergo interviews or psychological tests. Even if they do agree to participate, they are often not willing to return for follow-up, preferring to put the abortion episode behind them as quickly as possible. Thus almost all the studies suffer from a significant drop-out of subjects to follow-up, and those who remain may not be representative of the original sample (who may not be representative of women in general, if they come from a particular clinic or area). Indeed, those who do not return for follow-up may conceivably be suffering greater difficulties and want no reminder of the procedure.

A second difficulty is selecting what tests or interviews to use. Most psychological instruments are not designed for use in this situation, and if they are modified, may no longer be scientifically valid. Many studies rely on examining for specific psychiatric illnesses, and symptoms which may be subtle and not sufficiently severe to warrant the label of “illness” may thus be discounted.

A third issue is the timing of follow-up. Most studies have reviewed women in the weeks and months post abortion, and very few have sought to follow up women longer than two years afterwards. Thus the longer-term effects of abortion are untapped; anecdotal reports suggest that many women who experience psychological problems after abortion have a delayed onset, perhaps triggered by events such as a subsequent childbirth.

Another consideration is the position which the authors take on abortion. Ideally, research should be objective and not contaminated by the viewpoint of those who conduct it, but the reality is that it is almost impossible in a field such as abortion for this not to occur, even unwittingly. Bias may occur in the populations observed, the types of psychological instruments chosen, the ways in which questions are phrased, and many other ways.

An alternative method of study is to look at women who report psychological effects after abortion. This approach can help to focus on the particular difficulties which are experienced, but has the drawback that it is not possible to determine what proportion of women undergoing abortion will experience such effects. As well as this, it is not possible to ‘prove’ unequivocally that the psychological effects are due to the abortion and did not pre-exist. However, these small-scale studies often pro-

vide the elements which the short-term ones lack; they examine reactions over years and probe for after-effects in a variety of behaviour and symptom areas (de Veber et al, 1990).

What do the scientific studies say?

It is difficult to generalise from the studies as their design and methods vary greatly, as well as the populations studied, the time of follow-up etc. Nevertheless, the majority of reviews maintain that psychological problems are rare. Romans-Clarkson's 1989 review acknowledges the considerable methodological difficulties, but concludes that induced abortion does not cause deleterious psychological effects. She goes on, in a somewhat contradictory fashion, to describe predictors of adverse reactions in a 'few women'. Other reviews concede that psychological disturbances occur but are only marked, severe or persistent in a minority (approximately 10%) of women (e.g. Zolse and Blacker, 1992). Rogers, Stoms and Phifer (1989) compiled a summary of investigations in English published between 1966 and 1988, and concluded that 'outcome incidence rates and methodological profiles vary substantially across studies... both advocates and opponents of abortion can prove their points by judiciously referencing only articles supporting their political agenda'.

Who is particularly vulnerable?

Despite the lack of consensus between the studies as to the proportion of women who experience psychological difficulties post-abortion, there is considerable agreement about the factors which place a woman at risk of such problems. All studies agree that women with a past history of psychiatric problems have a higher risk of psychological problems after abortion. Most studies identify younger and unmarried women without children as more likely to experience negative reactions than those who are older and have already given birth. Some post-abortion counsellors note that women who already have children may also describe significant difficulties, because of their personal experience and understanding of exactly what they are giving up. The ease with which the decision to abort is made is also a factor: the greater the difficulty of deciding to terminate a pregnancy, the more likely there will be negative responses. Women who have late abortions (second or third trimester)

are often identified as being at risk, in part because the delay may have been caused by ambivalence. In addition, the longer gestation increases the bonding with the baby, including the experiencing of foetal movement. Such later procedures tend to be more painful and prolonged, with a higher chance of medical complications, thus increasing psychological trauma. Women who perceive coercion from parents, boyfriend or others are also at risk, whereas perceived support appears to be a protective factor. Abortion which is performed for foetal abnormalities usually occurs in the context of a wanted pregnancy and increases the risk of psychological difficulties. Similarly, women who undergo selective foetal reduction in a multiple pregnancy (usually following IVF) may be at risk. Belonging to or identifying with a group which does not condone abortion, especially religious groups, is said to result in greater discomfort post-abortion. Some studies suggest that Catholic women develop more difficulties than other religious groups, while others identify members of 'conservative' Christian groups to be at most risk. The common factor seems to be regularity of church attendance. It has been suggested that conversion to Christianity at some time after abortion may also result in psychological problems. Coping style also affects the response to abortion: women who expect to cope appear to do better, while those who use denial experience more depression and anxiety. Some studies suggest that women who have undergone multiple terminations have a higher risk of problems.

What psychological problems are seen after abortion?

Overview of problems

Women describe a range of psychological effects following an abortion. Workers in the area have understood and classified these effects in different ways, some of which overlap. Most studies recognise a normal (non-pathological) response which is experienced by the large majority of women, and utilise a stress/coping model, seeing abortion as a life stressor with a variety of coping responses. The vast majority of researchers acknowledge that a proportion of women (the size of which is in dispute, as previously noted) will experience more prolonged and/or severe psychological difficulties following abortion. Other workers



conceptualise the response to abortion as grief related to a bereavement, while others prefer to distinguish abortion from natural losses such as miscarriage because of the added aspect of guilt experienced by some women. Still other workers believe that the best description is afforded by the post-abortion syndrome, a term coined by Rue (Speckhard and Rue, 1992) as a specific subtype of the post-traumatic stress disorder, described below.

Each of the models recognises the significance of the anniversary phenomenon, where psychological symptoms appear or are increased at the due date of the baby or the anniversary of the abortion. Psychological difficulties may also be magnified by the so-called 'catalytic event', such as a subsequent pregnancy or miscarriage, or even losses of a different nature.

My own view tends to the eclectic, in that syndromes overlap and they are, at best, descriptive 'labels'. Some women's main symptoms are those of depression and grief, some reaching a level where the appropriate diagnosis is a major depressive disorder. Others are troubled primarily by intrusive re-experiencing and avoidance, and the most helpful 'label' in that situation is a post-abortion syndrome.

Women with a past history of psychiatric problems may experience a recurrence of their illness following abortion. The appearance of psychosis for the first time after abortion is very rare.

A "normal" response to abortion

Most studies as well as pamphlets given to women post-abortion acknowledge that many women will experience a range of emotions, which are felt to be generally transient and self-limiting. Many such studies emphasise positive feelings, in particular relief, especially soon after the procedure. Other emotions include sadness, guilt, anger, and regret. Unless these responses are severe or prolonged, they are considered normal. There tends to be a reluctance to call attention to negative consequences of abortion for fear of providing support to anti-abortion groups (Speckhard and Rue, 1992). Kluger-Bell, a pro-choice psychotherapist, came to recognise this in her own practice:

After a particularly difficult session in which I kept probing and [Patricia] kept resisting me, it finally occurred to me

that I was not hearing what she was trying to say. What kept coming up in session after session was her guilt and regret over the abortion she had had six years before. Probably because of my own commitment to the legal right to abortion, I considered early-first-trimester abortion a fairly straightforward medical procedure with few, if any, long-lasting effects. Women, I believed, should be legally entitled to choose to terminate a pregnancy they are either unwilling or unable to bring to term. But my political convictions led me to view Patricia's abortion only in the context of her empowerment. I had failed to recognise that in her present circumstances the abortion felt to her like a huge, irrevocable mistake. It was threatening to my political convictions to allow her to fully explore the range of her feelings about abortion. After all, if there was a shadow side to abortion, wouldn't those opposed to it cite the painful emotional fallout from abortions as another reason why women should not be entitled to a choice in the matter of whether to bring their pregnancies to term? Once I realised that I had been minimising the psychological impact Patricia's abortion had had on her, I began to make a concerted effort to help her express the profound regret she felt over her abortion, particularly in light of her current struggle to become pregnant again (1998).

Grief/bereavement and depression

The loss of any significant person or relationship results in grief. When a death in the family occurs, a period of grief is expected and seen as legitimate, while the funeral enables the reality of the loss to be acknowledged and faced with the support of others. Pregnancy loss, in contrast, is often a private loss surrounded by a shroud of silence. In addition, the loss may

seem so intangible and unreal, especially in the case of pregnancies which end before a heartbeat is heard, or an abdomen begins to swell. But even in the case of later pregnancy losses... there are no memories to hold on to, no life to



recall outside of the womb, only fantasies of who these babies might have been (Kluger-Bell, 1998).

Over and above the difficulties attached to pregnancy loss in general, women who have had an abortion face the difficulty of speaking out about their experiences, fearing condemnation from pro-life advocates. Thus the necessary work (and work it is) of grieving must be done in secret and in solitude.

Working through it involves learning to withstand the certainty and the finality of the loss, uncovering the personal significance of what has been lost, and neither holding on to nor pushing away the sorrow, anger, guilt, shame, despair and envy that arise in response to it. Obviously it is not possible to do this if most or all of the relevant thoughts and feelings are immediately repressed, denied or minimized – if the loss is never identified as being real (Kluger-Bell, 1998).

Grieving a loss is painful and difficult enough when one feels free to express emotions and receive support and practical help from others. It is not surprising, then, that women who have had an abortion are at a great disadvantage in their ability to work through their grief, with the result that it may become protracted and slow. In some women, the symptoms may become severe enough to warrant the diagnosis of an adjustment disorder or major depressive episode, for which specific treatment may be required, whether pharmacological or psychotherapeutic. Such a depression is characterised by a number of features, which may include lowered mood, loss of interest and pleasure in daily activities, weight loss or gain, sleep disturbance, feelings of worthlessness and hopelessness and difficulty concentrating. Suicidal ideas may occur and indeed have been described specifically as an anniversary phenomenon post abortion.

The post-abortion syndrome

The post-abortion syndrome, a sub-type of post-traumatic stress disorder, has been invoked by a number of workers to conceptualise the psychological difficulties which some women experience post-abortion. Post-traumatic stress disorder is a syndrome described in the DSM

(Diagnostic and Statistical Manual) of the American Psychiatric Association (1994), where the response to a significant trauma includes re-experiencing of the trauma in dreams or flashbacks, avoidance of any reminders of the trauma, and increased physical arousal (such as rapid heart rate, sweating, jumpiness etc). Abortion is not specified by the DSM as an example of a trauma; the text notes that the trauma must be of an extreme (i.e. life-threatening) nature, which may be experienced directly or witnessed. Specific mention is made however of the trauma of unexpectedly witnessing a body or body parts, which does occur occasionally during abortion, especially second trimester procedures. The post-abortion syndrome is considered a 'myth' by some leading workers in the field (e.g. Stotland, 1992), while others argue that it cannot be a type of PTSD because the abortion is volitional. Interestingly, post-abortion trauma is acknowledged in a commonly-used post-abortion pamphlet which is provided by abortion clinics (Baker, 1992), and accounts of women who meet the diagnostic criteria are not restricted to Christian literature.

Re-experiencing the trauma of the abortion may occur in several different ways. Recurrent, intrusive recollections may occur in response to experiences that resemble the abortion, such as being placed on a table with feet in stirrups or the sound of a vacuum cleaner evoking the memory of the suction machine. Flashbacks may occur where sounds, sensations, sights and emotions occur as if the abortion were currently being experienced. There may be intrusive nightmares, which may include themes of judgment or of searching for something precious which cannot be found.

Avoidance may occur of any situation which is reminiscent of the trauma. This may include making efforts to avoid people, places and situations that remind a woman of aspects of an abortion, such as child-related activities or gynaecological investigations and treatment. There may be an inability to recall aspects of the abortion experience, in an attempt to 'forget' parts of the trauma. There may be a lack of reactivity or 'numbing' and a feeling of estrangement from significant others, such as difficulty bonding with one's children.

Increased physiological arousal may be manifested as difficulty sleeping, trouble concentrating and/or an exaggerated startle response

to situations which resemble or symbolise an aspect of the abortion, such as breaking into a profuse sweat upon a pelvic examination.

Specific to PAS, some women become anxious about infertility and are preoccupied with becoming pregnant again. They may feel that God is punishing them for their abortion with infertility, or with the later birth of a disabled child. There may be significant guilt and the feeling that the act was so bad it could not be forgiven. It has been suggested that women who have had an abortion may be more likely to abuse their living children (Ney, 1979) although this has been disputed.

As a result of these problems and in an attempt to self-medicate, some women turn to drugs and alcohol. Eating disorders may occur and some women have described turning to promiscuity.

What of denied abortion and adoption?

Alternatives to abortion – those of so-called ‘mandatory motherhood’ or adoption - are rarely seen as realistic possibilities. The psychological ramifications of ‘denied abortion’, with its implication that the child born as a result will be unwanted, as well as the results of adoption will be briefly considered.

The unwanted child

It is often assumed that if a pregnancy is unwanted, it will remain that way for its duration and following birth of the child. However, there is evidence to suggest that some initially unwanted pregnancies become wanted. Even where this is not the case, the assumption that the outcome for the child is inevitably poor should be critically examined. There have been two major studies on the outcome of unwanted children. In Sweden, Forssman and Thuwe (1996) traced 120 children whose mothers had sought unsuccessfully to abort them, comparing them with 120 control children. Examining the study group at age 21, the authors found more insecurity, a greater need for psychiatric care, more reported delinquency, more drunken misconduct, less higher education, and several other indices of social and emotional disabilities. The study however has been criticised for failing to control for illegitimacy. A second, more rigorous study was carried out in Czechoslovakia (Dytrych et al, 1975), examining the outcomes of 220 children whose mothers had twice been denied abortion,

the second occasion on appeal. On many of the comparisons with a matched control group, the differences between the groups were too small to be statistically significant. Burtchaell comments on these studies:

The most rigorous research into the ups and downs in the lives of children rejected during pregnancy does not show them to be blighted by adversity. They seem, on an honest reading of the studies, to be in arrears in some areas of their lives, but far less than one might have anticipated, and decidedly less than would reasonably support the thought that society and the children would both be better off had the children been denied birth. Presumably even those willing to entertain the view that the unborn are being done a favour by extirpation would need evidence of a more dreadful destiny for them than these studies describe (Burtchaell, 1975).

Adoption

Adoption, once a common outcome of unwanted pregnancies, has become relatively uncommon. Abortion service providers may not even mention it as an alternative to women considering abortion; indeed, some counsellors actively discourage the possibility, citing difficulties for both relinquishing mother and child.

There is no doubt that the decision to relinquish a baby in adoption is a difficult and painful one. Martha Zimmerman (1997) describes ‘Sharon’, a young woman who chose to do so:

Even though she knew that this was the “best choice”, the decision was not an easy one. In fact, it was the “most challenging and heart-wrenching” decision she ever faced, [and] carried through with, in her life... “The truth about adoption is that it hurts. No one can quite explain how difficult it is to carry a child in your womb, nurture him, feel his movements, give birth, hold him, love him deeply, and then carefully place him into the arms of another mother”.

Nevertheless, Sharon noted in her journal

[The adoptive couple] have been wanting, waiting and preparing for a child... It brings me so much joy to think

that I could give them a gift of life, which they never could have had otherwise. That is one of the beauties of adoption.

Children raised by adoptive parents are not at a disadvantage when compared with those brought up by birth parents. Burtchaell (1982) comments that

There seems to be a general unawareness that adopted children are cared for by parents whose desire for them is, by and large, more demonstrably keen than that of physical parents... [A]dopted children are emotionally and personally as well integrated as anybody – and sometimes a little more so.

What help is available to women with psychological difficulties post-abortion?

If you or someone you know is experiencing psychological problems after an abortion, there are a number of avenues of assistance. Talk to your GP or minister – if he or she is not experienced or comfortable in the area of post-abortion counselling, a referral may be made to someone who is. Christian counselling services often have someone on staff who is familiar with the issues and experienced in assisting women and couples. Most cities and towns of reasonable size have a crisis pregnancy centre, which is established not just for women with a pregnancy dilemma, but also for those who experience difficulties post-abortion. Many such centres facilitate the formation of groups, where women can meet with others in similar situations and offer support and advice based on experience. There are a number of organisations which exist in order to help post-abortion sufferers, some of which have web sites. Women who have used self-help books such as those listed below have reported help and healing.

Management of PAS varies to some degree depending on the particular practitioner, but most share in common the following steps:

- acknowledgment of the reality of the abortion and its effects
- acknowledgement of guilt, shame and anger
- working through depressive feelings
- forgiveness of oneself and others involved in the abortion, and recon-

ciliation (for the Christian, this includes God's forgiveness and cleansing)

- memorialisation of the child and letting go.

I would urge women whose symptoms may be sufficiently severe that they represent a clinical depression to seek specialised help via their family doctor.

In conclusion

Abortion has a marked psychological aftermath for some women; even if only a minority of women who have had abortions is so affected, this translates into significant numbers. The pain and burden of many women is documented in the literature and seen by practitioners who work with women post-abortion. For some there is a real disruption of their relationships and ability to cope with day-to-day activities. Many find comfort in knowing they are not alone and that they are not going crazy. Help and healing are available through a variety of agencies, many of which provide a specifically Christian focus.

What helpful books are available?

Self-help

Her Choice to Heal: Finding spiritual and emotional peace after abortion, Sydna Masse and Joan Phillips (Colorado Springs, Chariot Victor Publishing, 1998). Written by two Christian women who themselves underwent abortion, this small book aims to 'offer a tangible hope to women struggling from post-abortion pain'.

A Season to Heal: Help and hope for those working through post-abortion stress, Luci Freed and Penny Yvonne Salazar (Nashville, Cumberland Publishing House Inc, 1993). The authors are post-abortion counsellors with extensive experience in crisis pregnancy centres.

Does Anyone Feel like I Do? and other questions women ask following an abortion, Pam Koerbel (New York, Doubleday, 1990). Koerbel experienced significant psychological difficulties following a saline abortion, and she chronicles her journey to healing along with insights gleaned from others who shared with her.



Unspeakable Losses: Understanding the experience of pregnancy loss, miscarriage and abortion, Kim Kluger-Bell (New York, W.W. Norton and Co, 1998). Written by a psychotherapist who herself experienced pregnancy losses; her perspective is pro-choice but nevertheless offers many helpful insights.

For women considering abortion, especially teens

Should I Keep My Baby? by Martha Zimmerman (Minneapolis, Bethany House Publishers, 1997). A small, practical book written from a Christian perspective and encouraging the choice of life, by either keeping the baby or adoption.

Re Psychological effects

A Time to Choose Life: Women, abortion and human rights, Ian Gentles, Editor (Toronto, Stoddart Publishing Co, 1990). Especially the chapter on Abortion and Bereavement. A scholarly Canadian collection of essays on different aspects of abortion, pro-life but not overtly Christian.

Aborted Women: silent no more, David Reardon (Chicago, Loyola University Press, 1987). A survey and 20 case profiles of members of WEBA (Women Exploited by Abortion), most of whom acknowledge Christian faith.

The Ambivalence of Abortion, Linda Bird Francke (New York, Random House, 1978). A compilation of women's (and some men's and parents') stories following abortion, Francke's book is written from a pro-choice point of view but makes compelling reading. Of significance is the fact that it has not been embraced by the pro-choice movement, having been considered too 'dark'.

Pregnant by Mistake: the stories of seventeen women, Katrina Maxtone-Graham (New York, Remi Books, 1990). Like Francke, Maxtone-Graham interviewed a series of women, however here two children were adopted out.

Rachel Weeping and other essays on abortion, James Tunstead Burtchaell (New York, Andrews and McMeel, Inc. 1982). Burtchaell, a Catholic theologian, has written an elegant and carefully-researched se-

ries of essays on aspects of abortion. Interestingly, he includes commentary on some of Francke's and Maxtone-Graham's cases.

Soul Crisis: one woman's journey through abortion to renewal, Sue Nathanson (New York, New American Library Books, 1989). Nathanson, herself a psychotherapist, decides on abortion and tubal ligation after three children. This account of her subsequent difficulties is well-written and poignant; her focus on feminist mysticism may alienate some readers.

Abortion in general

Won by Love: Norma McCorvey, Jane Roe of Roe v. Wade, speaks out for the unborn as she shares her new conviction for life, Norma McCorvey with Gary Thomas (Nashville, Thomas Nelson Inc, 1997). The fascinating story of the woman whose case was used to legalise abortion in the United States; McCorvey never in fact had an abortion but did go on to work in an abortion clinic. She subsequently became a Christian and developed a new conviction for life.

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Abortion Methods and Complications

Dr Eloise Piercy

Abortion is usually thought of as a safe procedure. Induced abortion is the deliberate interruption and cessation of pregnancy with the intention being to cause the death of the baby in the uterus (womb). Surgical or chemical methods are used to achieve this end. This is different from spontaneous abortion (miscarriage) in which the unborn child dies naturally. However, whether surgically or chemically induced, there can be physical complications with induced abortion just as there are with any medical procedure. An important difference between induced abortions and other medical procedures, though, is that virtually all abortions are carried out for *social* not medical reasons. It is vital that women considering abortion be informed of the risks they face.

Surgical Abortion

There are a number of surgical methods of induced abortion which are used according to the size of the embryo or foetus.

4-6 weeks of pregnancy

In very early pregnancy, within two weeks of a missed period, abortion is carried out by “*menstrual extraction*” in which a fine plastic catheter (tube) is pushed through the cervix (neck of the womb) and the embryo is removed by suction produced by a syringe or suction machine attached to the catheter.

6-14 weeks of pregnancy

As the baby grows larger, the cervix must be dilated to allow the extraction of the larger parts. The cervix is dilated (opened) by dilators and strong suction is used to remove the developing child. A curette



with a sharp-rimmed loop is then used to scrape the wall of the uterus to ensure that all tissue has been removed. This method is called *dilatation and vacuum aspiration*.

12-14 weeks pregnancy and beyond

Induction of labour

In this method drugs called prostaglandins are administered vaginally and orally to start a “premature labour”, which can be quite prolonged. Sometimes a solution of potassium chloride is injected through the mother’s uterus and the baby’s chest into his or her heart in order to ensure that the baby is dead on delivery.

An injection of potassium chloride into the heart is also used for the purposes of “selective reduction” where one of a set of twins has abnormalities (eg. Downs syndrome) or the number of babies in twins or higher multiples (eg. triplets, quadruplets etc.) is to be decreased. In these cases, the baby or babies which have been killed with potassium chloride remain in the womb until the time of birth of the live one(s).

Dilatation and Evacuation

In this abortion operation the cervix is dilated and then instruments are used to crush and dismember the unborn child, which is then removed through the cervix. The completeness of the abortion must be checked by examination of the foetal parts to make sure all of the baby’s body and placenta have been extracted. It is no surprise to read of this method: “This technique is more psychologically traumatic to the doctor, compared with the alternative methods” (Mackay et al, 1992).

Partial Birth Abortion (Dilatation and Extraction)

Late term abortions are performed beyond twenty weeks of gestation. The induction of labour and dilatation and evacuation methods of abortion are both used, but a third surgical method, used by a small number of doctors, for procuring a late term abortion is *partial birth abortion*, also called *dilatation and extraction*. This involves delivery of a live, moving baby, feet first, and, before the head is delivered, the baby is killed by suction of its brain. This allows collapse of the skull for completion of delivery. The American Medical Association called for a ban on this procedure on the grounds that it is of increased risk to the

mother's health and life, and that it is never medically necessary as other safer methods exist (American Medical Association, 1997).

Complications of Surgical Abortion

Method-Specific Complications

Menstrual Extraction, and Dilatation and Vacuum Aspiration

- Perforation of the uterus. The tip of the catheter (or sponge forceps) can puncture the wall of the uterus during vacuum aspiration. The uterine artery can be punctured if this occurs, causing severe bleeding.
- Haemorrhage (bleeding) from the uterus. This may be due to inability of the uterus to contract adequately, trauma to the uterus, the embryo implanting low down in the uterus, or the embryo being of a more advanced age, and therefore larger, than was thought.
- Failed abortion. Sometimes the procedure fails to kill and remove the embryo and so the pregnancy continues. Pregnancy can also continue following the procedure in cases where the embryo is not in the uterus but has implanted in a fallopian tube (ectopic pregnancy).
- Injury to the cervix. "Cervical injury is one of the most frequent complications of suction curettage abortion" (Schulz, 1983).
- Retained products. Sometimes parts of the placenta or foetus can be left inside the uterus. This can lead to bleeding and infection .

Induction of Labour

- Tears of the cervix.
- Rupture (bursting) of the uterus.
- Retained products of conception.
- Prostaglandins have a high incidence of side effects and need to be avoided in patients with asthma, cardiovascular disease and various other conditions. Nausea, vomiting and diarrhoea occur in most patients. High temperature, increased heart rate and low blood pressure also occur.
- Infection of the uterus is also a risk because of the often prolonged (average 16 hours) nature of the labour.
- The baby can be born alive which is distressing to staff.



Dilatation and Evacuation

Complications specific to abortion by this method include:

- Retained products. “After the procedure, the operator carefully examines the foetal parts to be sure all have been evacuated. On occasion, the foetal calvarium [skull] is retained in the uterus” (Stubblefield, 1986).
- Perforation of the uterus.
- Cervical incompetence. Cervical incompetence is a condition in which the cervix is weak and so, when the amniotic sac containing the baby and amniotic fluid fills the uterus and starts to stretch it, the cervix cannot remain closed. The cervix opens and miscarriage occurs. “The majority of cases [of incompetent cervix] follow termination of pregnancy, which accounts for a recent increase in incidence” (Beischer, 1986).

Partial Birth Abortion

This method requires the doctor to reach into the womb and turn the baby around to the feet first position. This has been avoided as an obstetric technique for the last 30 - 40 years because of the significant risk of haemorrhage or rupture of the uterus. Suction of the brain to cause skull collapse involves insertion of scissors or other instrument into the birth canal in order to puncture the skull. This poses a risk of laceration of the uterus or cervix and possible severe haemorrhage. Such complications may necessitate hysterectomy (American Medical Association, 1997).

Complications According to Time since the Abortion

During the Operation

- Anaesthesia-related accidents
- Perforation of the uterus +/- damage to other organs
- Laceration of the cervix
- Haemorrhage
- Bleeding disorders
- Amniotic fluid embolism: a dangerous condition in which the amniotic fluid enters the mother’s circulation.

Burnhill (1986), in his article “Risk Management in Pregnancy Termination”, deals with various crises which abortionists may face: “The following is [part of] a list of crises which can and do occur in free-standing facilities.

Medical crises

- Cardiac and/or pulmonary failure related to a procedure
- Life-threatening haemorrhage
- Major injury to the viscera [internal organs]
- Shock [inadequate blood pressure], syncope [fainting] and seizure
- Coma.”

Regarding life-threatening haemorrhage, Burnhill states: “Profuse vaginal bleeding may occur during the procedure. This may be due to profound uterine atonia [inability of the muscle of the uterus to contract], especially if general anaesthesia has been employed, to lacerations of a small vessel within the cervix or internal os [area just inside the neck of the womb] following dilatation, or to rupture of a tubal ectopic pregnancy or disruption of a cornual or interstitial pregnancy [an embryo implanted in the wrong place] during preoperative examination, during the procedure itself, or afterwards.”

In relation to major injury to the viscera, he says that “It is possible to lacerate the cervix, perforate the uterus, injure the bladder, avulse [tear away] a ureter [tube which transports urine from a kidney to the bladder], or damage the rectosigmoid [part of the large intestine], small intestine or omentum [fatty layer which hangs over the intestines].”

During the days/ early weeks following the abortion

- post-abortion bleeding and anaemia
- retention of part of the placenta, baby or other gestational tissue
- infection
- clots in the veins which can lead to clots in the lungs
- depression, psychosis and suicide.

According to Castadot (1986), “Pelvic infection with at least 3 days of fever at 38 degrees celsius, bleeding requiring transfusion, and unintended surgery (laparotomy [opening of the abdominal cavity], hysterotomy [opening of the uterus] and hysterectomy) represent 88% of all major complications.”



In a study by Heisterberg and Kringelbach (1987), “Complications subsequent to 5851 consecutively induced first trimester abortions during the period 1980 - 1985 were analysed. Three hundred and fifty-six abortions (6.1%) led to complications requiring hospital admission.”

Long-term problems

Long-term complications of induced abortion can jeopardise future term delivery of subsequent children and are due to:

- Post-abortion infertility (usually a result of pelvic infection damaging the fallopian tubes ensuing from the abortion)
- Cervical incompetence
- Low birth-weight and premature delivery of future children
- Rhesus isoimmunisation (where mixing of mother’s and baby’s blood during the abortion can cause an immune reaction against subsequent unborn babies, leading to miscarriage unless treatment is given)
- Psychological problems.
- Epidemiological and animal studies indicate that induced abortion is a risk factor for the later development of breast cancer.

Further Information about Particular Complications of Surgical Abortion

Mortality

Deaths can and do occur as a result of legal abortions. Castadot (1986) noted that “The major causes of deaths related to abortion in the United States are infection (23%), embolism [clots in the lungs] (23%), haemorrhage (20%), and complications of anaesthesia (16%).” He also noted that “On average, the mortality rate increases 30% with each passing week of gestation”. The National Health and Medical Research Council recorded 3 deaths associated with abortion in Australia in 1985-7 (NH&MRC report on Maternal Deaths in Australia 1991-1993), while in 1994, abortions in a particular abortion clinic in Queensland resulted in the death of one woman and another is severely brain damaged. (Courier Mail (Brisbane), Feb 14,15,16,17, 1996 and Feb 7, 19, 1998)

The American Medical Association has stated that “Maternal mortality is the most serious complication resulting from induced abortion,

and the risk of maternal death increases with gestational age.... At 21 weeks or more it increased to one in 6,000 procedures, and exceeded the risk of maternal death from childbirth, which was one in 13,000 deliveries” (American Medical Association).

Retained Products

“Failure to remove all the products of conception during a therapeutic abortion is an acknowledged complication whose incidence increases with increased gestational age” (Wiebe, 1986). Failure to completely empty the uterus can lead to haemorrhage and infection of the uterus, which in turn can cause other physical problems for the woman.

Infection, Pelvic Inflammatory Disease and Infertility

Many medical studies have found that if a woman who has an infection of the vagina or cervix undergoes an abortion, the infection can be carried up into the uterus by the instruments. Often the woman does not even know that she has such an infection. The infection can then spread to the fallopian tubes causing a condition called salpingitis (when the infection is short-lived) or pelvic inflammatory disease (when the infection lasts longer). Ridgway et al (1983) stated that “Prospective studies have shown that nearly one quarter of women with chlamydial infection at the time of termination of pregnancy will subsequently develop pelvic inflammatory disease.” Pelvic inflammatory disease can cause scarring and blockage of the fallopian tubes with the resultant risk of infertility and ectopic pregnancy.

Heisterberg et al showed in their study published in 1986 that women with postabortal pelvic inflammatory disease had significantly higher rates of miscarriage, infertility, pain on intercourse and chronic pelvic pain than women without postabortal pelvic inflammatory disease. They further stated that ”Induced first-trimester abortions are often performed in young healthy women who intend later to bear a child. Postabortal infectious complications with subsequent tubal damage may affect the fecundity [ability to bear children] of these women in the forms of ectopic pregnancy, infertility and spontaneous abortion.”

Ectopic Pregnancy

The rate of ectopic pregnancy has been shown in many studies to



have risen in line with the rise in the rate of abortion around the world; however, it is difficult to show induced abortion as a risk factor for ectopic pregnancy on its own, since it is found so often in association with pelvic inflammatory disease. Abortion leading to pelvic inflammatory disease and damage to the Fallopian tubes is the most obvious means by which abortion could contribute to the risk of ectopic pregnancy. Indeed, a French study published in 1998 found a 50% increase in the risk of ectopic pregnancy in women with previous abortions and an even higher increase in risk in women with two or more previous abortions (Tharaux-Deneux, 1998).

Cervical Incompetence

Cervical incompetence results in loss of the baby in the second (mid) trimester of pregnancy, at which time the uterus is being stretched and the weakened cervix is unable to stay closed. A number of studies point out that the risk of causing cervical incompetence during an abortion is greatest in women who are in their teens (Schulz, 1983). A study in California revealed that women who had undergone abortions in the past had nearly twice as many deliveries in the second trimester as those who had not (Madore, 1981).

Perforation of the Uterus

The first instrument introduced into the cervix is a rod (called a sound) which is used to show the direction of the cervical canal and measure the size of the uterus. The sound can be pushed too far or too hard, perforating the uterus. "Some oppose the use of the sound, labeling it a 'perforator'. In our experience, the sound gives useful information and may prevent perforation with a sharp dilator or vacuum cannula which, should it occur, would produce greater injury" (Stubblefield, 1986). Even with the use of the sound, however, the vacuum cannula can still perforate the uterus.

Breast Cancer

Studies showing a link between induced abortion and the development of breast cancer have been in medical literature since 1957. In the past, this link was seen to be inconclusive, but more recently, a comprehensive review and statistical analysis of all the world-wide medical literature on the subject up until 1996 was undertaken (Brind, 1996). Of

the 21 studies which looked at induced abortion and breast cancer specifically, 17 showed a positive association between the two. These studies spanned three continents (Asia, Europe and North America) and also included women of African descent. The overall finding was a 30% increased risk for the development of breast cancer in women who had undergone induced abortion.

A brief summary of the findings of the meta-analysis as well as of important individual studies is as follows:

- women who have had an abortion increase their breast cancer risk by an average of 30%
- there is evidence that undergoing repeat terminations increases this risk even further
- teenagers who abort their first pregnancy are particularly at risk, as are women who have an abortion after 30 years of age
- the risk of breast cancer in women who have a family history of breast cancer is increased even further following abortion
- data from the only study on Australian women regarding the abortion-breast cancer link was published in 1995 and reported a significant 160% increased risk in the women who had undergone one or more abortions (Andrieu, 1995)
- animal data has shown a strong correlation between surgical abortion and the development of breast cancer
- natural miscarriage has not been shown to be a risk factor for breast cancer. This is thought to be because of the lower oestrogen levels when a pregnancy is destined to miscarry

Currently, the lifetime risk for the development of breast cancer in Australian women is 1 in 14 and is increasing (Breast Cancer in Australian Women 1921-1994, NH&MRC). Induced abortion therefore increases a woman's risk by a further 30% to 1 in 11.

Not only is the statistical evidence for a link between induced abortion and breast cancer compelling, but there is also evidence for a biological mechanism by which the increased risk occurs. Well-known risk factors for breast cancer, such as early age of commencement of menstruation and late age of menopause, are attributable to oestrogen excess. Oestrogen is the primary growth promoter of breast tissue and breast



cancer tissue. During the first three months of pregnancy, oestrogen levels rise dramatically. Oestrogen causes the immature cells in the breast to divide rapidly to eventually become milk-producing cells. If this process is interrupted suddenly by an induced abortion, the cells are left in a vulnerable state and are more at risk of developing into cancer cells. However, when a pregnancy continues to full term, the dividing cells are able to mature and are less vulnerable to becoming cancerous.

The editor of the *Journal of Epidemiology and Community Health* stated in an editorial:

...in the light of recent unease about appropriate but open communication of risks associated with oral contraceptive pills, it will be surely agreed that open discussion of risks is vital and must include the people - in this case the women - concerned. I believe that if you take a view (as I do), which is often called 'pro-choice', you need at the same time to have a view which might be called 'pro-information' without excessive paternalistic censorship (or interpretation) of the data. (Donnan, 1996)

Complications of Chemical Abortion

Some abortions are induced chemically by drugs at an early stage of pregnancy. Some of these drugs are used before the woman is able to know whether or not she has conceived (morning-after pill, emergency "contraception"), and others are used when pregnancy is confirmed (eg. RU 486).

The Morning After-Pill

The morning-after pill is a very high dose of synthetic female hormones. In fact, some morning-after pill regimes consist of giving the woman instructions on how to take her own oral contraceptive pill as a morning-after pill. The three most commonly used forms are oestrogen only pills, progesterone only pills, and pills with both combined.

The morning-after pill is taken within 72 hours of intercourse. The actual mechanism by which the morning-after pill works depends on the stage of the menstrual cycle during which it is taken. If the woman takes the morning-after pill at a time prior to ovulation, it can act to prevent

ovulation. However, if ovulation is not prevented because it has already occurred or because ovulation was very imminent at the time of taking the morning-after pill, fertilisation can occur. There is general agreement in the medical and pharmaceutical literature that in these cases the morning-after pill exerts its effect by altering the lining of the womb to make it hostile to the fertilised ovum.

The most common side-effect of the morning-after pill is nausea and vomiting. There are also a number of medical risks associated with the morning-after pill. Due to the very high doses of female hormones involved, there is a risk of inducing clotting problems, eg. clots can travel to the lungs. Questions about how such large doses of oestrogen affect a woman's life-supply of eggs or her risk of breast cancer have yet to be answered. There is also the potential for inducing abnormalities in a surviving embryo.

RU 486

RU 486 (also called mifepristone) is a synthetic hormone which has an antiprogestosterone effect. Progesterone is often called the “pregnancy hormone” and is vital for the development and maintenance of the lining of the womb (endometrium). Because of the action of progesterone, the lining of the womb is able to accept the implantation of an embryo and supply it with oxygen and nutrition. Antiprogestosterones such as RU 486 block the action of progesterone so that the thickened womb lining of the pregnant woman cannot be sustained and it degenerates. If RU 486 is given after conception but before implantation, the breakdown of the endometrium means implantation cannot occur and the embryo dies. If implantation has already occurred when the drug is given, the degeneration of the endometrium deprives the embryo of its source of oxygen and nutrition. It therefore dies and is expelled.

Most studies involving the use of RU 486 for pregnancy termination recommend that it be limited to a period within 7 weeks of the woman's last menstrual period, although some authors promote it as a useful abortifacient in the second trimester of pregnancy and beyond (Ulmann, 1995; Ashok, 1998; Klein, 1991).

Effectiveness of RU 486



RU 486 has a poor success rate of causing abortion when used alone. Studies have shown rates varying from between 54% and 90% when used in the first 7 weeks of pregnancy. Complete abortion occurs at an even lower rate if RU 486 is used in subsequent weeks. RU 486 was intended to enable women wishing to terminate pregnancy to avoid surgery. However, if RU 486 fails to bring about complete abortion, surgical intervention is necessary. In these cases, the woman is exposed to the risks of both types of abortion. To increase its effectiveness, RU 486 is used in combination with the chemical prostaglandin.

RU 486 and Prostaglandins

Prostaglandins are made naturally by the body and have powerful and varied effects such as altering blood pressure, the tone of the muscles of the internal organs (such as the uterus and stomach), central nervous system activity and the actions of hormones. Chemicals have been synthesised which mimic many of the effects of natural prostaglandins, including the ability to cause strong contractions of the uterus. A number of these synthetic prostaglandins have been combined with RU 486 to enhance its action in emptying the womb of the embryo or foetus.

Administration of RU 486 and Prostaglandin

Because of the adverse side effects of the RU 486/prostaglandin combination, a 4-step procedure is required for its administration.

1. Confirmation of pregnancy, usually by blood test, and an internal pelvic examination. A vaginal ultrasound examination may also be performed to assess more accurately the age of the baby.
2. After at least 24 hours, the woman returns to the hospital or clinic and takes the tablets in the presence of a medical professional.
3. After 48 hours, the woman returns again to the clinic for a prostaglandin injection, tablet or suppository, and undergoes another pelvic examination. Her blood pressure is monitored frequently over the next 3 - 4 hours. While it is hoped that the baby will be expelled during this time, many women experience this event at home or elsewhere hours or days later.
4. A few days after the prostaglandin is given, the woman returns to the clinic to make sure that the abortion is complete and to monitor the

amount of bleeding. This involves yet another pelvic examination and possibly a further vaginal ultrasound.

In an interview for *Le Monde* in 1990, Edouard Sakiz, chairman of Roussel Uclaf (the pharmaceutical company which developed RU 486) conceded that:

As abortifacient procedures go, RU 486 is not at all easy to use. In fact it is much more complex to use than the technique of vacuum extraction. True, no anaesthetic is required. But a woman who wants to end her pregnancy has to ‘live’ with her abortion for at least a week using this technique. It’s an appalling psychological ordeal (*Le Monde*, Aug 1, 1990 and reprinted in *Guardian Weekly*, UK, August 19, 1990, as quoted by Klein, 1991).

Side Effects of RU 486 and Prostaglandin

Death

A French mother of eleven children died of heart and circulatory failure when RU 486 was combined with an injection of the prostaglandin sulprostone. (Australian, 13-14/4/1991) Because of this and other deaths attributable to sulprostone, Roussel-Uclaf recommend the use of alternative prostaglandins, particularly ones called gemeprost and misoprostol, instead. (Ulmann, 1995)

Haemorrhage (Heavy Bleeding)

Bleeding can be heavy and prolonged, and trials have consistently demonstrated increased bleeding compared to that of surgical abortion. A small number have required blood transfusions.

In their book “RU 486: Misconceptions, Myths and Morals”, feminists Klein and colleagues detail the following case:

A nurse who was part of the US trials undertaken by David Grimes in Southern California relates — in a letter to the *Los Angeles Times* — that she was one of the non-success stories of the US abortion pill experiment. After 12 hours of severe cramping and vomiting, she went to the County university hospital emergency room where she was given

an excruciating pelvic examination, a shot of Demerol (a narcotic analgesic), and a prostaglandin inhibitor to slow down her contractions. Then after mild bleeding for six more days, she hemorrhaged. She continued to bleed for three months....She chose chemical abortion because it was presented to her as a 'relatively benign experience' and because she thought it would advance the causes of both women and science' (Klein, 1991).

In a report on induction of abortion with RU 486 and the prostaglandin misoprostol in the *New England Journal of Medicine*, the authors stated: "Hemorrhage requiring transfusion is a recognized side effect of medical as well as surgical induction of abortion. Although this complication is uncommon, the possibility of hemorrhage with medical abortion highlights the need for vigilance and ready access to medical help" (El-Refaey, 1995).

Pain

Pain severe enough to require narcotics for relief is experienced by a significant proportion of women using RU 486/Prostaglandin.

Uterine Rupture

Gemeprost (a prostaglandin used with RU 486) has been associated with rupture of the uterus when used for 2nd trimester abortions.

Pelvic Infection

Infection of the uterus complicates a small percentage of RU 486/prostaglandin abortions.

Other Side Effects of RU-486/ Prostaglandin

Prostaglandins have wide-ranging effects on the systems of the body. Normally, however, naturally produced prostaglandins in the body are made in very small concentrations in the local area or organ on which they are to act. It is not surprising, therefore, that giving a comparatively large dose of a synthetic prostaglandin, which circulates throughout the whole body, results in diverse side effects. These include changes in gastric juice secretion, low blood pressure, chest pain, palpitations, bronchospasm (narrowing of the airways), fever, headache, and nausea,

vomiting and diarrhoea. Severe hypotension (low blood pressure) requiring intravenous infusion of fluids, and heart attacks have occurred with the use of RU 486 and prostaglandin in France.

Birth Defects

There is concern that RU 486 may have the capacity to cause birth defects in babies who survive attempted abortion with this drug. Similar concerns have been raised in relation to misoprostol, one of the prostaglandins used with RU 486. Further research will be needed to determine whether the abnormalities detected so far are a result of these drugs or occurred coincidentally.

RU 486 has been shown in a number of studies to alter the hormones produced by the placenta, which may affect an ongoing pregnancy. There is also evidence that the disruption of the action of progesterone by RU 486 may have a lasting effect on tissues. Cekan and colleagues conducted a study in which eggs were collected from women for IVF purposes following administration of RU 486. They found that RU 486 enters the follicles (the egg and its surrounding barrier of cells) of women's ovaries (Cekan, 1988). Therefore, use of RU 486 may be accompanied by serious adverse reactions which are not yet fully understood.

Klein and her co-authors raise concerns about this:

What will be the 'quality' of an egg that has undergone previous chemical arrest? If a woman *after* RU 486 decides to become pregnant, does she need to worry about RU 486 residues and/or irreversible damage to that follicle and perhaps others too? And what about cycle disturbances? To our knowledge no long-term follow-up studies of women after RU 486/PG [prostaglandin] have been undertaken to evaluate later pregnancies and menstrual cycles (Klein, 1991).

The RU 486 and prostaglandin form of abortion not only destroys the life of an unborn child, but poses significant risks to the health, and even life, of the woman who undergoes the abortion.

Summary

Abortion by any technique is ‘unnatural’ as it must interrupt a normal physiological process. As a medical intervention, abortion carries risks to the woman involved, risks which should be made known to, and be understood by, all women considering one.

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(A copy of the above article with detailed references can be obtained from The Church and Nation Committee, 156 Collins St, Melbourne 3000)

Afterword

Abortion is shrouded and camouflaged in myths which we need to see through. We have seen the lie that that which is in the womb is not a person but merely a mass of cells and tissue, that abortion is safe, and that abortion will free women from trauma in their lives. We have particularly seen the high value that God sets on life within the womb.

But the word that all need to hear, whether they are involved with abortion or ministering to those who are, is *grace*.

How we need to remember that our God is a God of grace; that He graciously meets us in our need and helps us as we look to Him! There is the grace to help us through the pain and confusion of unexpected circumstances, the grace of forgiveness to help us deal with sinful activity, there is the grace of restoration as we seek to live with the consequences of our actions, there is the grace of tenderness and wisdom as we seek to support and assist those who are struggling and grieving. But the one central fact is that this grace comes only from God through the Lord Jesus Christ. Our prayer is that it will be more evident amongst us – particularly as we wrestle with all the realities summed up in that word abortion.

Some who have read this booklet may be saying “If only I had known!” Can I draw you back to Caroline’s testimony and her discovery of forgiveness with God. O what joy to know that our God is “*God-Who-Forgives*” (Psalm 99:8). Though abortion is sin before God it is not unforgivable. That is the great message of the Gospel. Forgiveness is available because Jesus paid for and removed the penalty of sin including your sin of abortion in His death

The offer and promise of forgiveness is available to the person who till now has never acknowledged God let alone sought His mercy in forgiveness. It is available to believers who will find that God’s forgiveness is as real for sin committed since coming to Christ as it was for the sin they confessed when they came to Jesus Christ in faith. And yes, it is

even available to those who have been part of the abortion industry.

Others who read this book may also be confronted by sin, even though they were never directly involved in an abortion, such as that of silence or of insensitivity to those wrestling with the question as it is placed before them. It maybe even be that there has been sin in the way in which you have tried to resist the evil of the abortion industry. Increasingly around the world discredit to Christ and holiness has been brought by the use of unholy means under the guise of a holy end.

The Bible declares:

“If we confess our sins He is faithful and just to forgive us our sins and to cleanse us from all unrighteousness” (1 John 1:9). “Let us therefore come boldly to the throne of grace, that we may obtain mercy and find grace to help in time of need” (Hebrews 4:16).

Tragically there are Christian people who have confessed sin and received forgiveness, but can't forgive themselves. Though forgiven according to God's Word they do not know the joy of it in their lives. They continually live with the past, digging up their sin and renewing their sense of guilt. If this is true of you then you need to believe God and accept His forgiveness. It is true that when God forgives He does not expunge our memory. But we are to look upon it as a gravestone marking something buried by grace. If you find yourself reading the inscription on the gravestone don't engage in self-abuse and disbelief by digging up the past. Rather turn from the record of your sin, and rejoice in Christ and what He has done for you. Here is the source of joy – in clear and fresh views of Jesus Christ and His saving love for you.

How we all need to draw near to the Lord Jesus Christ! It is only from this vantage point that we can be helped and be a help to others. It is only from this vantage point that the scourge of abortion can be dealt with in our times.

Counselling and Advice Services available

VICTORIA

Caroline Chisholm Society 41 Park St. Moonee Ponds 1800 134863
(03) 9370 5122

Open Doors 5 Greenwood Ave. Ringwood (03) 9879 2332 (Pregnancy
loss no.) (03) 9870 7044 (Pregnancy counseling no.)

Pregnancy Counseling Australia Bendigo Centre, cnr. King St. and
Edward St. (Opposite Target) Bendigo (03) 5441 5795

Pregnancy Counseling Australia Suite 5, First Floor 228 Clarendon St.
East Melbourne 1800 650840 (03) 9419 7622

Pregnancy Counseling Australia La Trobe Valley Centre. 13 George St.
Morwell (03) 5133 7254

Pregnancy Counseling Australia 43a High St. Shepparton 03 5821 0991

Pregnancy Counseling Australia Warrnambool Centre, Walter House cnr.
Liebig & Lava St. Warrnambool (03) 5562 6679

Pregnancy Help Geelong Inc 17 Adams Place Geelong 1800 440540
(03) 5223 2425

Wodonga Pregnancy Help 14 Havelock St. Wodonga (03) 6024 6775

Victims of Abortion Anne Lastman P.O. Box 6094 Vermont South, 3133
Mob. 0408 175 033

NEW SOUTH WALES

Abortion Alternatives Telephone Counseling 24hrs. (02) 9299 1057

Bellingen Pregnancy Help Bellingen (02) 6655 0042

Campbelltown Pregnancy Support 18 King St. Campbelltown
(02) 4625 8028

Doonside Pregnancy Help 17/19 Hillend Rd. Doonside (02) 9622 8219

Parramatta Pregnancy Support Centre 119 Macquarie St. Parramatta
(02) 9635 4449

Liverpool Pregnancy Help 251 Bigge St. Liverpool (02) 9602 6543

Manly-Warringah Pregnancy Help Baby Health Centre Brookvale
(02) 9905 1974

Manning (Taree) Pregnancy Support 75 Albert St. Taree (02) 6551 3900

Newcastle Pregnancy Help 182 Union St. The Junction (02) 4969 6675

Pregnancy Caring Bathurst (02) 6332 4866

Pregnancy Counseling Blacktown Room 3/53 Main St. Blacktown
(02) 9671 5844 (02) 9622 2126

Pregnancy Support Line (02) 9413 1341 (02) 9299 1057 24hrs

Pregnancy Support Armidale/New England 80 Taylor St. Armidale
(02) 6772 7100

Riverina Pregnancy Support Lockhart Janice: (02) 6920 5647,
Marie: (02) 6929 3429

St. Vincent De Paul St. Vincent De Paul Building, 28 Wallace St.
Macksville (02) 6568 1046

Young Pregnancy Help (02) 6382 6660

QUEENSLAND

Centacare Pregnancy Support 193 Abbot St. Cairns (07) 4051 9511

Pregnancy Counseling Link (Qld) Inc 2nd Floor, Bowman House 276
Edward St. Brisbane 1800 777 690

Pregnancy and Family Support Inc 27 Connor St. Burleigh Heads
(07) 5535 0444

Pregnancy Help Mackay Mackay (07) 4951 1498

Pregnancy Problem Centre Inc Caboolture. By Appointment. Servicing
Brisbane's northern suburbs. (07) 5499 4366

Pregnancy Problem Centre Inc Mt. Gravatt. By Appointment. Servicing
Brisbane, Logan and Ipswich. (07) 3219 4288

NORTHERN TERRITORY

Darwin Pregnancy Help (Centacare) 18 Geranium St. The Gardens, Stuart
Park (08) 8981 8526

Centacare 8 Hartley St. Alice Springs (General counseling including
pregnancy counseling) (08) 8953 3177

Family Link cnr. Giles and First Sts., Katherine (General counseling
including pregnancy counseling) (08) 8971 0777

WESTERN AUSTRALIA

- Pregnancy Assistance** 195 Lord St., East Perth (08) 9328 2929
- Pregnancy Crossroads** 3/20 Rockingham Rd. Spearwood (08)
9434 4142
- Pregnancy Crisis Care** Pinjarra (08) 9531 2551
- Pregnancy Help Bunbury** Lotteries House, 101 Victoria St. Bunbury
(08) 9797 1922
- Pregnancy Help Geraldton** Geraldton (08) 9921 6544
- Pregnancy & Life Education** (08) 9497 9199
- Pregnancy Life Line** 138 Bennett St., East Perth (08) 9221 7117 or
a/h (08) 9271 6361
- Pregnancy Problem Group** Albany (08) 9842 1917
- Pregnancy Problem House** 342 Wanneroo Rd. Nollamara (08) 9344 8110

SOUTH AUSTRALIA

- Abortion Alternatives** Adelaide (08) 8365 3099
- Birthline** 49 North Tce. Hackney (08) 8363 1444
- Genesis Pregnancy Support** Basement, Stafford House, 25 Leigh St.,
Adelaide (08) 8231 8500
- Louise Place** 5 Randolph Avenue, Fullarton (08) 8272 6811

TASMANIA

- Pregnancy Support Service** McDougall Building, Ellerslie Rd. Hobart
(03) 6224 2290
- Pregnancy Support Service** 75 Cameron St. Launceston (03) 6334 4291

“Pro-Life” Organizations



Victorian

Prolife Victoria

672B Glenferrie Rd
Hawthorn 3122
P.O. Box 2115
Hawthorn, 3122
Tel (03) 9818 6186
Fax (03) 9819 0573
prolife@prolife.org.au

Right to Life Australia

233 Brunswick Rd
Brunswick, 3056
Tel (03) 9387 7098
Fax (03) 9387 2182

Action Pregnancy Problem Centres

5/228 Clarendon St
(Cnr Victoria Pde)
East Melbourne, 3002
Tel (03) 9419 7622

or

7 Baxter St.(Cnr Davey St.)
Frankston, 3199
Tel (03) 9783 6250
24 Hr call (03) 9419 7622

Open Doors

5 Greenwood Ave
Ringwood, 3134
Tel (03) 9870 7044
Free call outside Melbourne
1800 647995

Caroline Chisholm Society (Pregnancy & Family Support Services)

41 Park St
Moonee Ponds, 3039
Admin (03) 9370 5122
Fax (03) 9326 1045

24Hr Counseling Line
Tel (03) 9370 3933
or 1800 134 863

Helpers of God's Precious Infants

P.O. Box 4075
Patterson, 3189
Tel (03) 9585 5232
Fax (03) 9887 1978

Catholic Doctors Association of Victoria

P.O. Box 291
Kew, 3101
Tel (03) 9859 6563

Australian Family Association

582 Queensberry St
Nth Melbourne, 3051
Tel (03) 9326 5757
Fax (03) 9328 2877

Billings Family Life Centre

27 Alexandra Pde
Nth Fitzroy, 3068
Tel (03) 9481 1722
Fax (03) 9482 4208

Salt Shakers

P.O. Box 489
Blackburn, 3130
Tel (03) 9894 8780
Mobile 019 320 327
pstokes@ozemail.com.au

Focus on the Family

60 Carroll Rd
Oakleigh Sth, 3167
Tel (03) 9558 2977
Fax (03) 9558 2720

Endeavour Forum

79 Church St
Beumaris, 3193
Tel (03) 9822 5218
Fax (03) 9822 3069

qrtl@qrtl.org.au

South Australia Right to Life Inc

P.O. Box 264
Kent Town, 5071
Tel (08) 336 3758

National

Right to Life Australia

233 Brunswick Rd,
Brunswick, 3056
Tel (03) 9387 7098
Fax (03) 9387 2182

Federation of Right to Life Associations

P.O. Box 3612
Sydney, 2001
Tel (02) 9299 8172
Fax (02) 9290 1135

Human Life International (Australia) Inc

P.O. Box 205
Broadway, 2007
Tel (02) 9211 2793
Fax (02) 9211 6324
hliaust@ozemail.com.au

NSW Right to Life Association Inc

G.P.O. Box 3612
Sydney, 2001
Tel (02) 9299 8350
Fax (02) 9290 1135

Queensland Right to Life Association

G.P.O. Box 1507
Brisbane, 4001
Tel (07) 3229 5437
Fax (07) 3229 5424

Western Australia Right to Life

P.O. Box 6087 Hay Street
East Perth, 6892
Tel (08) 221 7117

Northern Territory Right to Life

P.O. Box 3016
Darwin, 5794
Tel (089) 27 3845
(24 Hr line)

ACT Right to Life

P.O. Box 333, Civic Square
Canberra, 2608
Tel (02) 6253 3100
actrtla@actrtla.org.au

Tasmania Human Life Protection Society

G.P.O. Box 1158M
Hobart, 7001
Tel (03) 6224 2632

World Federation of Doctors Who Respect Human Life (Australian Branch)

38 Judge St
Randwick, 2031
Tel (02) 9398 6444

Nurses for Life

P.O. Box 235
Welland, 5007
Ph/Fax (08) 8297 7172

Pharmacists Who Respect Human Life

Seven Hills Day & Night Pharmacy,
Shop 1, 36 Johnson Ave
Seven Hills, 2147
Tel (02) 9674 4248
Fax (02) 9624 1072

Dietrich Bonhoeffer International

Institute for Bioethical Studies Inc.
G.P.O. Box 588
Adelaide, 5001

Women Hurt by Abortion Inc.

P.O. Box 904
Canning Bridge, 6153
Ph/Fax (08) 9313 1784

Australia Family Association

582 Queensberry St
Nth Melbourne, 3051
Tel (03) 9326 5757
Fax (03) 9328 2877

Foundation Genesis

P.O. Box 414
Lane Cove, 2066
Tel (02) 9418 8678
Fax (02) 9418 6109

Coalition for the Defence of Human Life

G.P.O. Box S1505
Perth, 6845
Tel (08) 9321 2822
Fax (08) 9321 1798

Festival of Light

46 Holt St
Surry Hills, 2010
Tel (02) 9318 2892
Fax (02) 9698 7976

Dr Toni Turnbull

23 Osborne St
Hackney, SA, 5069
Work: (08) 8336 3378
Fax: (08) 8336 3988