



## Therapeutic Influence in Abortion Counseling and Procedures: Creating the Illusion of Well-Being

### Introduction

*Sociologist Christopher Lasch has called the contemporary culture, "therapeutic, not religious" and says that, "People today hunger not for personal salvation...but for the feeling, the momentary illusion of personal well-being, health and psychic security".*

Similarly, sociologist Phillip Rieff has commented that, "the therapeutic has nothing at stake beyond a manipulable sense of well-being."<sup>2</sup> It is this contemporary attitude that has been and continues to be the driving force behind the legalization of abortion. Abortion is the response to a "health problem" that is expected to produce a sense of personal well-being. This article will examine some of the important ways in which contemporary abortion counseling and procedures attempt to produce a momentary illusion of personal well-being,

health, and psychic security in the woman. This procedure also attempts to create the illusion that there is no human life in the womb in order to attempt to achieve the desired therapeutic outcome in the woman.

### A Crisis Pregnancy Presents an Opportunity for Manipulation

Many authors have frequently identified women seeking abortion as being in a crisis<sup>3</sup>. Existing beliefs about oneself and morality tend to be inadequate guides for decision-making in the face of an abortion dilemma. In order to overcome this disequilibrium, it will often be necessary for the woman to develop a new cognitive construction of the situation<sup>4</sup>. Some of the reactions of pregnant women who seek abortion are ambivalence, guilt, anger, and deep confusion.<sup>5</sup> Other studies have found that the abortion decision was conflictual, options evenly balanced, with considerable indecision reported<sup>6</sup>.

Feminist Carol Gilligan found that women considering abortion tended to recast the moral judgment from a consideration for the good to a choice between two evils. Moral dilemmas were seen in terms of conflicting responsibilities. The women asked themselves, "Why care?" in a world where those who are strong end relationships. She concluded that the abortion decision centers on the self. The woman focuses on taking care of herself because she feels that she is all alone<sup>7</sup>.

Persons in crisis may regress to more primitive coping skills, be less stable, have heightened psychological accessibility, be more upset and very susceptible to any influence which will aid in resolving the crisis. Thus, they are very subject to influence or manipulation by others<sup>8</sup>.

Uta Landy, former executive director of the National Abortion Federation described four different coping methods women may use when they seek abortion. One is the "spontaneous approach" in which the woman makes the decision quickly without thinking too much about it. Another is the "rational-analytical approach" in which the woman weighs her options carefully but who is so preoccupied with being rational that she fails to take her emotions into account. A third type of coping method is the "denying-procrastinating approach" in which she initially denies she is pregnant and once she accepts the fact that she is pregnant, has many reasons why she cannot make a decision. The fourth type of coping method is the "no-decision making approach" where the woman refuses to make a decision herself and instead allows others such as her husband, boyfriend, parents, doctor or counselor to make the decision for her<sup>5</sup>.

These various types of approaches are consistent with crisis reactions. However, they are likely to result in the woman not living up to her own ideals. This was confirmed in a study of adolescents and

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young adults which found that the level of moral reasoning related to abortion was lower than their moral reasoning generally<sup>9</sup>.

### **Manipulative Abortion Counseling Techniques**

Fear has been identified as a “woman’s worst enemy<sup>10</sup>.” Women may fear being alone, fear that they are unloveable or unlovely, fear being ignored, or abandoned, or rejected or destroyed.<sup>11</sup>

Abortion facilities counseling staff may manipulate the pregnant woman into obtaining an abortion by appealing to her fears. This may be done in a telephone conversation, or in individual or group counseling session in order to identify the fear and then “sell” an abortion. These fears include the fear that parents or husband will find out she is pregnant, fear of interruption of school or career plans, or fear of death<sup>12</sup>.

In other situations, the counselor may use other methods of manipulation. If a pregnant woman states that she wants to bear a child in order that she may have someone to love, the abortion counselor may tell her that she is being selfish. If there is a fetal anomaly present which may result in a handicapped child after birth, parents are discouraged from carrying to term. This may be done by reinforcing their fear that they may not be equal to the task and not telling them of supportive resources for children with special needs. Or sometimes the counselor may encourage abortion by discouraging a woman from receiving needed financial assistance in order to carry the baby to term. Or counselors may emphasize “freedom of choice” despite the religious beliefs of the woman that abortion is a sin. As one natural law scholar put it, “You can make up a new rule that taking the life of infants is right

instead of wrong. Nobody can stop you. But if you want to get pregnant young women to believe it, the only way to do it is to confuse them about the moral laws they already know — to tell them, for instance, that it isn’t really killing but that it is somehow compassionate and prudent<sup>13</sup>.

Other counseling methods help foster the illusion of well-being by perpetuating a pre-existing denial in the pregnant woman. A woman may have required a high level of defensive denial of her tender feelings for the baby in order to help carry her through the procedure and shortly thereafter<sup>14</sup>. Various studies have confirmed this denial is frequent. Researchers found that women who participated in a clinical trial of Mifepristone abortion evidenced high avoidance, intrusion, and anxiety shortly before initiating the abortion process. The researchers concluded that “what appears to be happening is that the women are trying to control their response to the unwanted pregnancy/abortion situation by avoiding thinking about it<sup>15</sup>.” Another study of women seeking abortion found a generalized stress response syndrome with both “avoiders” as well as “non-avoiders<sup>16</sup>.”

### **Manipulation by Denial of Existence of Human Life in the Womb**

The pre-existing denial may be perpetuated and encouraged in a number of ways in the abortion counseling process. One way is to play down the existence of another human being in the womb.

Films used by proponents of legalized abortion attempt to depict the unborn child as lacking any possible humanity. For example, in a film produced by the Fund for the Feminist Majority entitled *Abortion for Survival* in 1989, a clinician is

seen removing the contents of a small pouch following an abortion. A small amount of blood and remains are spread on a glass dish. A second scene demonstrates the aspiration syringe.

The contents of the syringe are emptied onto a piece of cloth. An observer states that, “what appears in both scenes amounts to only several tablespoons of blood and tissue.” The researcher evaluating the films of early abortion concludes that, “while the fetus is presented as an image, it has no ‘voice’ as tissue, it is a mere object, not a victim<sup>17</sup>.” No scene depicts the fetal child before the destructive act, nor is any information provided about the stage of development at the time the abortion takes place.

In response to this practice, a medical doctor commented, “To refer to the fetus as fetal tissue or products of conception and convey an image of a blood clot or a fragment of placenta is an understatement... Women do not take lightly the decision to terminate a pregnancy (and) they deserve to know exactly what would be removed, before they make a decision. The doctor who protects them from the facts to preserve them from anxiety and guilt has made a moral decision on their behalf<sup>18</sup>”

### **Abortion as Advancing Destructive Impulses**

In some women, abortion appears to offer the illusion of well-being, but, in fact, may simply advance their own sadistic or masochistic impulses. The sadistic impulse is the assault on the fetus, while the masochistic impulse is the assault on the self. These impulses may be acted out in the interaction between the patient and the medical doctor as well as in the actual physical circumstances of the abortion itself.

Pregnancy as a normal developmental process has been observed to intensify a woman's ambivalence about and identification with and attachment to her own mother as a mother-to-be, with the unborn as a self-representation of her early relationship to her own mother<sup>19</sup>. Some studies of women who have abortions have found that frequently these women have substantial conflicts with their own mother. In women with a disturbance in the basic sense of self, a blurring of self and other may occur in which the nurturance of the fetus is unconsciously viewed as nurturance of the self.

Psycho-analyst Dinora Pines says that "For some women, the fetus is not represented as a baby in fantasy, dreams, or reality, but rather as an aspect of the bad self or a bad internal object that must be expelled. Analysis of such patients reveals an early relationship with the mother which is suffused with frustration, rage, disappointment, and guilt. Loss of the fetus is experienced as a relief, rather than a loss, as if the continuing internal bad mother had not given permission to become a mother herself<sup>20</sup>." Thus, among the women who experience abortion as a relief, it may bring about a temporary illusion of well-being. But, in fact, it may be a form of self-punishment because the "thing" that is sacrificed is felt to be a portion of the self.

Beverley Raphael points to pre-existing guilt as an important reason for self-punishment or self-destructive impulses. She says that "abortion [may] represent a way of [a woman] punishing herself for unrecognized feelings of guilt. This guilt may derive from earlier events in a woman's life, a previous abortion, a sadistic or rejecting act, or may be related to a deep-seated conflict concerning her sexuality, which she may perceive as being bad, sinful, dirty, or uncontrollable... Pregnancy may rep-

resent the punishment which may be timed so that school or career patterns are disrupted, shame is publically displayed, or a relationship which promised intimacy and security is broken. The abortion may represent the punishment of the loss of a longed-for child. Some women appear to harbour deep masochistic needs which lead them to repeated pregnancies or repeated illegal abortions, and their self-destructiveness may be so intense that they have personality characteristics in common with those who attempt suicide<sup>21</sup>.

### **Use of Drugs to Create an Illusion of Well-Being**

Pain and anxiety are among the worst evils in the therapeutic model. Thus, drugs are frequently used in connection with abortion for purposes of therapeutic control to assist in manipulating the sense of well-being of the woman. Sedatives may be used by an abortion facility in an attempt to reduce anxiety and nervousness prior to abortion. At least one abortion facility was found to be administering sedatives in violation of medical standards because the drugs altered the state of consciousness prior to women signing a consent for abortion<sup>22</sup>.

Sometimes drugs are used to ensure that an abortion takes place, even if the woman is uncooperative. A Swedish study reported that among women undergoing abortion under local anesthesia and pre-medication, 52% reported they felt calm while 48% said they were tense, worried, or horrified; 6% of the women were perceived by the doctors as not being cooperative and received additional anesthesia<sup>23</sup>. The routine use of additional anesthesia to secure cooperation with abortion appears to be relatively common. A leading review article on abortion techniques published in 1986 stated, "Unless lack of patient cooperation indicate otherwise, (abortion) is carried out under

cervical block<sup>24</sup>" [emphasis added].

One study reported that a Canadian abortion facility used drugs in an attempt to reduce or eliminate negative thoughts or dreams women may experience at the time of having an abortion<sup>25</sup>. Another study found that women seeking a first or repeat abortion may select general anesthesia, if offered, in an attempt to repress the abortion experience and to alleviate psychological distress<sup>26</sup>. Still another Canadian study found that pre-abortion depression, anxiety, fear, low pain tolerance, and moral and social concerns were among the predictors of intense pain and that local anesthesia alone did not alleviate the pain. It was concluded that up to 40% of women who were ambivalent or depressed, might benefit from general anesthesia or additional narcotic analgesia<sup>27</sup>.

However, women who fail to take emotional considerations into account, engage in denial, or let others decide for them, have not received proper counseling and may not only regret their abortion later<sup>5</sup>, but also suffer severe psychological reactions once the reality of the experience manifests itself<sup>28</sup>.

General anesthesia or heavy sedation is routinely used in late term abortions so that the woman does not see the procedure and the removal of fetal parts. In these situations, drug use helps reinforce preexisting denial. In one study, 250 women were interviewed who had undergone mid trimester abortion by dilatation and extraction (D&E) under general anesthesia three weeks earlier. D&E was seen by the women as helpful in getting through an ambivalent situation, and tended to reinforce preexisting denial. The use of general anesthesia resulted in an experience which was described as "like a dream" and "out of my hands<sup>29</sup>." In another report, a

woman who had a late term abortion said, "Fifteen minutes or so of Demerol-induced oblivion and that's it<sup>30</sup>."

Although denial aided by drugs may occur at the time of the abortion and last for a period of time thereafter, it may very well break down and women may report high levels of long term stress from the experience. Among the long term stresses women have experienced from late term abortions are anxiety about pain the fetus may have experienced, and guilt over the knowledge that a second or third trimester fetus had been dismembered<sup>31</sup>.

Drugs or other therapeutic techniques may also play a role in attempting to reduce post-abortion trauma or other negative psychological effects. In one case, a woman saw the head and arms of her aborted child following an incomplete abortion. She became hysterical with uncontrolled sobbing and could not sleep because she thought of the "baby she killed" (her words). She became listless and depressed and lacked energy. She was treated for depression with Prozac and was told by doctors that she would have to be on Prozac for a year.

### **Creating an Illusion of Well-Being by Emphasizing that Abortion is "Safe"**

One of the major techniques to create the illusion of well-being is to claim that abortion is "safe" for the woman. Of course, abortion is never safe for unborn human life in the womb, because abortion destroys that life. Thus, this approach attempts to totally ignore the presence of another life in the womb. For example, an article posted on the website of the National Abortion Federation entitled Safety of Abortion says, "Abortion is one of the safest types of surgery. Complications from having

an abortion in the first three months of pregnancy are considerably less frequent and less serious than those associated with giving birth... One death occurs for every 160,000 women who have legal abortions... a woman's risk of death in carrying a pregnancy to term is ten times greater." The article cites The Centers for Disease Control, The Alan Guttmacher Institute and members of the National Abortion Federation as the sources of information for the article<sup>32</sup>.

Information provided to women seeking abortion make similar claims. One abortion facility said, "Early abortion is one of the safest operations in all of medicine... The risk of a woman dying from full-term pregnancy and childbirth is at least 7 times greater than that from early abortion<sup>33</sup>." However, this claim is illusory because it fails to take into account many other factors, some of which are briefly listed below which indicate that induced abortion is not safer for women than childbirth.

### **Influence of Induced Abortion on Subsequent Pregnancy-Related Deaths**

According to the Centers for Disease Control (CDC) statistics for 1987-90, 156 women died from **ectopic pregnancy** which represented 10.7% of all pregnancy-related deaths during that period<sup>34</sup>.

Induced abortion is implicated in the death of women as a result of neglect of abortion facilities by not undertaking prompt pathology tests after an attempted abortion to determine whether or not an ectopic pregnancy was present.<sup>35</sup> In addition, induced abortion, particularly where there are post-abortion infections, or repeat abortions, significantly increases the risk of ectopic pregnancy<sup>36</sup>.

Another important cause of

pregnancy-related deaths is **obstetric hemorrhage** which accounted for 21.1% of pregnancy related deaths from live birth and 27.2% of pregnancy-related deaths from stillbirth during 1987-90<sup>34</sup>. Retained placenta is a major risk factor for life-threatening obstetric hemorrhage. Several studies have found that a history of induced abortion increases by several fold the likelihood of retained placenta in subsequent pregnancies compared to other pregnancy outcomes, and particularly if the induced abortion is immediately preceding a current pregnancy<sup>37,38</sup>.

Meta-analysis of published studies on the incidence of **placenta previa** and reproductive history found that placenta previa is significantly more likely to occur in subsequent pregnancies intended to be carried to term where there has been a prior induced abortion<sup>39</sup>. One U.S. epidemiological study during 1979-86 found that placenta previa complicated 4.8 per 1000 deliveries annually and was fatal in 0.03% of the cases.<sup>40</sup>

According to the CDC, pregnancy-related deaths from **infection** (usually sepsis) among U.S. women in 1987-90 represented 12.1% of pregnancy-related deaths from live births and 19.1% of pregnancy-related deaths from stillbirths.<sup>34</sup> Prior induced abortion has been found to significantly increase the risk of septic infection in subsequent childbirth compared to other prior pregnancy outcomes.<sup>41</sup> Prior induced abortion has also been found to significantly increase the likelihood of premature rupture of the membranes, which is a major factor causing infections in childbirth. The risk of intraamniotic infection in a subsequent pregnancy is significantly increased in women who have had an elective abortion compared to women who have had a previous birth<sup>41</sup>.

### Suicide

While it is true that few women die immediately from having an induced abortion, the risk of death within one year of a pregnancy is much higher among postabortion women compared to postpartum women. A well-designed register linkage study during 1987-1994 found that Finnish women who committed suicide within one year of a pregnancy found that the suicide incidence associated with induced abortion was 34.7 per 100,000 postabortion women compared to 13.1 per 100,000 post-miscarriage women, and 5.9 per 100,000 postpartum women, and a mean annual suicide rate of 11.3 per 100,000 women generally<sup>42</sup>. A follow-up Finnish register linkage study during the same time period identified all deaths that occurred up to one year after an ended pregnancy. The mortality rate was 27 per 100,000 births, and 101 per 100,000 abortions<sup>43</sup>. These Finnish studies confirmed the results of an earlier Swedish study of 57 women with prior psychiatric problems who subsequently had induced abortions which found that three committed suicide in long-term follow-up studies 8-13 years later. In contrast, of 195 women with psychiatric problems who carried their children to term, none committed suicide<sup>44</sup>.

These studies indicate that there may be more serious mental health problems among postabortion women compared to postpartum women. This was the finding of a Danish register linkage study during a 15 month period which found that the age-adjusted incidence of psychiatric hospitalization was 3.42%, 4.06% and 6.0% for women with one, two, and three induced abortions respectively compared to 2.56%, 1.97%, and 2.15% among women with one, two, and three live births respectively<sup>45</sup>.

A recent U.S. study of

California women who received state funded medical care and who either had an abortion or gave birth in 1989, found that postabortion women were more than twice as likely to have from two to nine treatments for mental health as women who carried to term.<sup>46</sup> A Saskatchewan, Canada study published in 1977 found that postabortion women had "mental disorders" 40.8% more often than postpartum women<sup>47</sup>.

### Fatal Accidents

Fatal accidents within one year of a pregnancy have also been found to be more likely to occur following an abortion compared to childbirth.

The Finnish Register linkage study during 1987-1994 which identified all deaths within one year of an ended pregnancy found that compared to women of reproductive age with no pregnancy (1.0), the risk of death from an accident following abortion was 2.08 (1.03-4.20, 95% CI) compared to 0.49 (0.18-1.33, 95% CI) for childbearing women<sup>43</sup>. A study of California women linked state funded medical insurance records for paid claims for abortion or delivery in 1989 to the state death certificate registry in a population of low income women. Compared to women who delivered (1.0), those who had aborted had a significantly higher adjusted risk of dying from accidents (1.82)<sup>48</sup>.

One reason for the higher incidence of fatal accidents among postabortion women compared to postpartum women may be substance abuse. In a random national study of 917 U.S. women in 1981, 4% of the women who abstained from alcohol use, and 5% of lighter drinkers reported a non-spontaneous abortion compared to 13% for moderate drinkers, 13% for heavier drinkers, and 6% for women who had ever been pregnant. The same survey

found that 27% of moderate drinkers and 45% of heavier drinkers said they had driven vehicles while high at least once in the preceding year compared to only 17% of all women drinkers<sup>49</sup>. A relatively small increase in blood alcohol content while driving can greatly increase the likelihood of being involved in a fatal crash. A traffic safety study by the Insurance Institute for Highway Safety based on 1986-87 data found that each 0.02% increase in blood alcohol content nearly doubles the risk of being in a single vehicle fatal crash.

The study reported that the risk of dying of a female 21-24 years of age at a blood alcohol level of 0.05%-0.09% in a single vehicle accident was reported to be 35 times higher compared to a blood level of 0.00%-0.01%<sup>50</sup>.

### Drug and Alcohol Abuse

Substance abuse has been identified as a psycho-social problem following abortion. A survey of young postabortion women receiving a variety of services at Akron Pregnancy Services in Akron in 1998-93 reported that 17% reported drug/alcohol abuse as a psychological problem following abortion<sup>51</sup>. Among a subset of African-American postabortion women, 6% reported drug/alcohol abuse as a psychological problem following abortion. Another study published in 2000 using a mailed questionnaire to U.S. women found that women who aborted a first pregnancy were five times more likely to report subsequent substance abuse (16.5%) compared to women who carried to term (3.3%)<sup>52</sup>. Women who report being stressed or exploited by abortion or those in support or recovery groups consistently report that they began to abuse alcohol or drugs, or increased their use of alcohol or drugs following their abortion<sup>53</sup>.

A study of young women in the state of New York found that the current use of illicit drugs, other than marijuana, was 6.1 times higher if there was a history of a prior abortion compared to no prior abortion history. In contrast, women with post-marital births were much less likely (0.14) to report current use of illicit drugs<sup>54</sup>. A Canadian study found that women who are binge drinkers during their pregnancy have a significantly higher rate of previous therapeutic abortions<sup>55</sup>. Several studies have found that the incidence of illicit drug use (cocaine, heroin, methamphetamine) increases among pregnant women intending to carry to term as the number of reported prior elective abortions increase. For example, in a study of drug abuse among Boston inner-city women during pregnancy, those using cocaine were twice as likely to have a history of two elective abortions (19% vs. 9%) and three times more likely to have had three or more elective abortions (9% vs. 3%) than non-cocaine using controls<sup>56</sup>.

### **Smoking**

According to the American Cancer Society and the Centers for Disease Control, smoking is estimated to cause about 30% of all cancer deaths. Smoking increases the chances of a woman dying from lung cancer by nearly 12 times and triples the risk of dying from heart disease among middle aged men and women. On average, U.S. women lose 14.5 years of life because they smoked. Each year from 1995-1999, smoking caused more than 178,000 deaths of women. The likelihood of women dying from lung cancer has greatly increased since the legalization of abortion. In 1971-73, the rate of death from lung cancer of U.S. females was 12.7 per 100,000 population. By 1994, it had risen to 42 per 100,000 population<sup>57</sup>.

At least three studies have

found that induced abortion increases the incidence of smoking in women. A Scottish study correlated the number of cigarettes smoked by women with post-abortion anxiety with the most anxious women having the heaviest smoking habits.

A Swedish study found that postabortion women were more likely to smoke and more likely to be heavier smokers than light smokers when compared with parity matched controls or Swedish women generally. A South African study of women who sought and obtained abortions on psychiatric grounds were more likely to report increased tobacco or substance abuse (14.7%) compared to women who sought abortion on psychiatric grounds, were refused abortion, and had a variety of other pregnancy outcomes (7.2%). Interviews with women in Los Angeles or Montreal who were in a clinic for a pregnancy test found that women continuing a pregnancy to term reported reducing their incidence of smoking, while those who had abortions did not report any change in their smoking behavior<sup>58</sup>.

Researchers have found that women are more likely than men to smoke in an attempt to alleviate emotional problems. Pregnant women also report that they smoke because they are under stress or feeling upset. Several studies have found that a prior induced abortion is a significant risk factor for depression or anxiety in a subsequent pregnancy. Thus, the higher incidence of smoking in postabortion women compared to women with other reproductive outcomes, may be due to the need to alleviate the effects of abortion-related emotional problems. This higher incidence was confirmed by a Danish study which found that women whose last pregnancy ended in abortion were more likely to be smoking during a subsequent pregnancy and the least likely to stop smoking during their pregnancy compared to

women whose last pregnancy ended in childbirth or to women with no previous pregnancies.

Studies on the incidence of smoking and reproductive history among British, Swedish, Danish, Eastern European, Arab and Jewish, Hong Kong as well as U.S. women have consistently found that a history of induced abortion significantly increases the incidence of smoking compared to other pregnancy outcomes.

The incidence of smoking increases as the number of prior abortions increases. A study published in 1980 found that women patients entering Boston Hospital had smoking rates of 31.7% with no prior induced abortion, 40.3% with one prior abortion, and 51.7% with two or more prior induced abortions<sup>59</sup>. In a Washington state study of 6,541 white women who delivered a child between 1984-87, 41.6% of the women smoked during this pregnancy if they had a history of 4 or more induced abortions compared with 31.0% (2 prior abortions), 28.1% (1 prior abortion) or 18% (no prior abortion)<sup>60</sup>. It appears that the effects of induced abortion increase the percentage of women who smoke as much as 3% to 10%, depending upon the study. There is also evidence that induced abortion increases the likelihood of heavy smoking among women who smoke.

### **Breast Cancer**

The American Cancer Society estimated that there would be 178,700 new cases of invasive breast cancer in 1998 and an estimated 43,500 women would die from breast cancer in 1998. One out of eight U.S. women will have breast cancer in her lifetime<sup>61</sup>. According to the Centers for Disease Control, 45-50% of U.S. women undergo induced abortion of their first pregnancy, most often by age 20-24. It is well established that

an early full-term childbirth has a protective effect against breast cancer<sup>62</sup>. A significant number will abort their only pregnancy (19% in one study) and thus be at risk for breast cancer due to lack of childbirth. Women who delay childbirth until age 30 or more do not benefit from the protective effect due to early childbirth. An increasing number of live born children, as well as breast-feeding have also been found to have an independent protective effect against breast cancer<sup>63</sup>. Whether or not induced abortion is an independent risk factor for breast cancer is controversial. However, a majority of studies have found that induced abortion is a small increased risk factor (approximately 30% overall) for breast cancer. Based on these findings, it has been estimated that the independent risk of induced abortion adds at least 40,000 cases of breast cancer among U.S. women each year<sup>64</sup>.

### **Ovarian Cancer**

The American Cancer Society estimated that 25,400 new cases of ovarian cancer would occur in U.S. women in 1998 and that 14,500 women would die from ovarian cancer in 1998.<sup>61</sup> It is well established that women who never have children are more likely to die from ovarian cancer compared to women who have live-born children<sup>65</sup>. It has also been found that the risk of ovarian cancer decreases as the number of term pregnancies increases<sup>66</sup>. In contrast, incomplete pregnancies, including induced abortion, appear to offer either no protection against ovarian cancer, or provide a reduced level of protection compared with childbirth<sup>67</sup>.

### **Conclusions**

Various counseling techniques are used to manipulate the woman to obtain an abortion while she frequently is in a state of crisis

where she is vulnerable to the suggestions of others. Pre-existing beliefs about abortion may be altered and a variety of coping methods substituted. In many instances, the woman appears to be carrying out self-punishing or self-destructive impulses or attempting to punish another. The fetus or unborn child may be seen as an aspect of the "bad self" which must be eliminated. Counseling techniques deny the existence of another human being as part of the attempt to manipulate the sense of well-being of the woman.

Drugs are used prior to and during the abortion process to alleviate stress and anxiety, pain and moral concerns, obtain cooperation of the woman, perpetuate existing denial and as an aid in creating the illusion of well-being.

Abortion counseling attempts to create the illusion that abortion is "safe" and that childbirth is more dangerous than abortion. While it is true that few women immediately die from induced abortion, there is substantial and reliable evidence that deaths from suicide and accidents shortly thereafter are much higher among postabortion women compared to postpartum women. Prior induced abortion also contributes to pregnancy-related deaths in women during childbirth from infection or obstetric hemorrhage. A substantial number of postabortion women exhibit increased drug and alcohol abuse and smoking with both short-term and long-term adverse health effects including premature death. Childbirth protects against breast cancer while induced abortion does not. Childbirth protects against ovarian cancer while induced abortion provides no protection or a lesser degree of protection compared to childbirth.

- by Thomas W. Strahan, J.D.

### **Footnotes:**

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