

UNPROTECTED

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A CAMPUS PSYCHIATRIST REVEALS HOW
POLITICAL CORRECTNESS IN HER PROFESSION
ENDANGERS EVERY STUDENT

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SENTINEL

INTRODUCTION

about alcoholic binges but not hookups? What, her liver's more important than her cervix or fallopian tubes? I'm going to discourage certain behaviors, my colleagues will say? You bet I am! The real question is: *how can I not?*

So I* am speaking out, because I have to. But the story isn't finished. Even as I write these words, months before publication, I'm still "in the closet" at work: still not "out" with my values and beliefs. It's my choice; I'm just not ready. How odd, that among people who know so well the pain of hiding, I must hide. How sad, that in the midst of those flying the banner of tolerance and multiculturalism, I should hesitate. How scandalous, that the very profession we trust to guide and heal is sowing confusion and illness.

CHAPTER 1

UNPROTECTED

HEATHER WAS A NINETEEN-YEAR-OLD STUDYING PERFORMING arts. She came in during her freshman year to see a psychologist, due to moodiness and crying spells that came out of nowhere. Normally upbeat and social, Heather was always ready for a good time. But in the past months, she had often withdrawn to her room, feeling worthless—even self-hate. These episodes were painful, and had started to interfere with school and friendships. She tried eating better and practicing yoga, but Heather couldn't get back to herself, and she didn't know why. The psychologist sent her over to me.

As we spoke, she stressed that her moods really didn't make sense, because life was good, and there was nothing to complain about. Heather liked school and had many friends. Her family was supportive. She had enough money. Her health was fine.

"How long has this been going on?" I asked.

"Oh, I don't know. Maybe . . . I guess since the new year. I've always had low self-esteem, but now it's really bad!"

"Did anything happen to you around that time?"

*The identity of Dr. Miriam Grossman was revealed on November 20, 2006, on the *Dr. Lanza Show*.

She thought about it. "No, I don't think so... I can't think of anything."

There are times when symptoms may appear without any precipitant, but I decided to ask again. "Heather, please think about it carefully. In the fall or early winter, did you lose someone you love, or have a pet die? Did you go through something frightening or dangerous? Did any relationship begin or end?"

She thought it over. "Well, I can think of one thing: since Thanksgiving, I've had a 'friend with benefits.' And actually I'm kind of confused about that."

"Really? Tell me more."

"Well, I met him at a party, and I really like him, but there's this problem. I want to spend more time with him, and do stuff like go shopping or see a movie. That would make it a friendship for me. But he says no, because if we do those things, then in his opinion we'd have a *relationship*—and that's more than he wants. And I'm confused, because it seems like I don't get the 'friend' part, but he still gets the 'benefits.'"

She was genuinely puzzled. She had no clue whatsoever.

"I think many people would feel the way you do," I told her. "You're giving what he wants, but not getting what you want."

"Yes," she agreed. "I'm really unhappy about that. It's hard to be with him and then go home and be alone."

We talked about her frustration and her wish that things were different. "Do you think," I ventured, "that these moods you have, when you are so unhappy and critical of yourself—do you think they may be related to this?"

She considered my question. "I don't know ... maybe... What do you think?"

Olivia, eighteen, is also a freshman. She was valedictorian of her senior class, and hopes to go to med school. But Olivia just told me that she's been vomiting up to six times a day, so I'm sending her to the lab right away, to get her blood drawn. If her potassium is low, it could cause an abnormal heart rhythm.

Olivia originally developed bulimia in the ninth grade. With therapy, she did well, and she thought that the bouts of bingeing and vomiting were over, until she got to college. It's not the academic pressure—she is doing well in all her classes. No, it was the end of a romance that precipitated the relapse and brought Olivia to our center for help. Her therapist recognized Olivia's depression and eating disorder, and referred her to me for evaluation. During our initial meeting, Olivia described the short-lived relationship, her first experience with intimacy. "When it ended, it hurt so much," she said, weeping. "I think about him all the time, and I haven't been going to one of my classes, because he'll be there, and I can't handle seeing him. I was so unprepared for this... Why, Doctor," she asked, "why do they tell you how to protect your body—from herpes and pregnancy—but they don't tell you what it does to your *heart*?"

Olivia was a smart girl asking a good question. Why are students inundated with information about contraception, a healthy diet, sleep hygiene, coping with stress and

pressure—but not a word about the havoc that casual sex plays on young women's emotions? It's not as if there isn't any research on the subject.

For those who trust academic journals more than Mom's wisdom, take a look at some recent research. In a study of 6,500 adolescents,¹ sexually active teenage girls were more than three times more likely to be depressed, and nearly three times as likely to have had a suicide attempt, than girls who were not sexually active. Another report, titled "You Don't Bring Me Anything but Down: Adolescent Romance and Depression,"² analyzed data on 8,000 teens. The two researchers concluded that "females experience a larger increase in depression than males in response to romantic involvement," and "females' greater vulnerability to depression in female teens."³

So the professors agree with Olivia: a broken heart hurts. And most likely Olivia's heart hurts more than the heart of the guy who dumped her. "Females' greater vulnerability" — that sounds right to me.

Sure, there are women on campus who are making wise choices in their relationships. But if you think Heather and Olivia are unusual, I have news for you: our schedules are overbooked with them. They're lining up for appointments and flooding our phone lines. I've seen so many students like these, they blur together in my mind, a pitiable crowd of confused, vulnerable young women, ill prepared for campus life, making poor choices, and paying high prices.

No amount of Prozac or Zolofl is going to solve this problem. These young women must, for their physical and emotional well-being, change their lifestyle. And the thera-

pirists, doctors, and nurses they consult have a responsibility to encourage them to eliminate their emotionally destructive behaviors, much as they would instruct an obese or nicotine-addicted patient to diet, exercise, and stop smoking.

Is it feasible? To acknowledge the negative consequences of the anything-goes, hooking-up culture would challenge the notion that women are just like men, and undermine the premise of "safer sex." And in our ultra-secular campuses, no belief comes so close as these to being sacred.

How are women like Heather and Olivia educated to make healthy choices in their private lives? What guidance do they get from university resources, like health and counseling centers, Web sites, and newspapers? Would parents—who fund these resources through taxes and student fees—approve of their content?

I set out to answer these questions after hearing the stories of Heather and Olivia—stories that were without a doubt being repeated innumerable times on campuses all over the country.

Soon I had a pile of brochures and Web sites to study. One thing was certain: there was no lack of information about the importance of diet, exercise, and sleep. A "healthy lifestyle" also includes learning how to relax and cope with stress. And obviously smoking is out. In fact, the American College Health Association went so far as to publish a position statement on tobacco on college and university campuses, which declares that "tobacco use in any form, active and passive, is a significant health hazard" and encourages colleges and universities to be "diligent in their efforts to achieve a campus-wide tobacco/smoke-free environment."⁴ To this end, the ACHA recommended a number of actions,

including: prohibiting smoking in all public areas on campus and in all campus housing (including lounges, hallways, stairwells, elevators, restrooms, and laundry rooms), offering prevention and education initiatives that address the risks and support nonuse of tobacco, offer programs that include practical steps to quit using tobacco, prohibit the advertising or sale of tobacco products on campus, and prohibit the sponsorship of campus events by tobacco-promoting organizations.

This is all good and fine—I agree that smoking is a nasty habit. But I was looking for something that would address the emotional distress of my patients. For example, to help Heather and Olivia understand their very normal reactions to relationships, and to guide young women to make healthy decisions, I was looking for material that declares casual sex hazardous to a woman's mental health. That aside from distress and anger, it can cause symptoms that will interfere with her ability to concentrate and perform academically. That hours better spent in the library will be used crying with girlfriends and at the campus counseling center. That her GPA—that mighty figure, critical to grad school acceptance—may fall. Such material could include data from the studies mentioned above, showing that girls are more vulnerable to depression when it comes to romance. It could also mention the fascinating research on the biochemistry of bonding.⁵

Neuroscientists have discovered that specific brain cells and chemicals are involved in attachment. The chemical Heather and Olivia need to know about is called oxytocin. It's a hormone, a messenger from one organ to another,

with specific tasks; in this case, it's sent from the brain to the uterus and breasts, to induce labor and let down milk. Not a surprise, then, that oxytocin is also involved with maternal attachment: a female rat injected with it will bond and protect another female's young as if they were her own.

More relevant to my patients at this stage in their lives is that oxytocin is released during sexual activity.⁶ Could it be that the same chemical that flows through a woman's veins as she nurses her infant, promoting a powerful and selfless devotion, is found in college women "hooking up" with men whose *last* intention is to bond?

Here's how one neuropsychologist put it: "You first meet him and he's passable. The second time you go out with him, he's OK. The third time you go out with him, you have sex. And from that point on you can't imagine what life would be like without him. . . . What's behind it? It could be oxytocin."⁷

The release of oxytocin can be "classically conditioned"—after a while, all it takes for it to be released is catching sight of the man. Is Olivia avoiding class because seeing him will bring a surge of this hormone, a rush of agonizing feelings of attachment?⁸

In addition to bonding, oxytocin increases trust.⁹ Researchers studying financial transactions made this remarkable discovery when they had pairs of subjects play a game in which they risked real monetary loss. Each was given a whiff of either oxytocin or placebo, then they played a game in which investors could win or lose based on their partner's honor or betrayal. Those who inhaled oxytocin

had more trust in their partners; they took risks avoided by the others.

You might say that we are designed to bond. Neuroendocrinology is suggesting that, in their unfortunate liaisons, Heather and Olivia unknowingly promoted powerful feelings of attachment and trust. Thus Heather's yearning, and Olivia's melancholy, may have roots in their biology.

Information members of our hooking-up culture, indoctrinated to believe they are "protected" by latex, need to know? I would think so. So why haven't they heard of it? Why isn't oxytocin—likened to a "love potion" by one neuroscientist¹⁰—part of the vocabulary of our youth; why aren't they as familiar with it as they are with carbs and fats, nicotine and steroids?

I submit that the notion of being designed to bond is to some an unwelcome finding. It implies that sexual activity, especially in women, might be more complex than, say, working out. It suggests women may be vulnerable, unprotected. To some on campus, these are fighting words. Psychology is strongly biased towards liberal views;¹¹ do the actions of oxytocin threaten the feminist agenda? I can think of no other explanation for the failure of this research to make headlines.

"When research is swept under the rug," read an article in the American Psychological Association's *APA Monitor*, "some of the best psychological research suffers for the sake of 'political correctness.'"¹² This is the largest professional organization of psychologists in the world, and to their credit, here was an admission of the hazards of unpopular research: lack of funding, overcritical reviews, and label-

ing of researchers. For example, when his study showed negative consequences from day care, an author was called "sexist." Others reporting controversial findings were stifled by threats of legal action.¹³ Maybe this explains why my patients, usually well-informed, are ignorant here: funding and publicity go toward research whose results support the politically correct agenda.¹⁴ Women more vulnerable than men? You can't get less politically incorrect than that.

Has research about the biochemistry of bonding been swept under the rug? It seemed that way where I work and on the Web sites of other colleges I explored.

When I advised Heather and Olivia to refrain, for the time being, from having relations, I would have liked to hand them a brochure, or recommend a support group. And it would've been great if there was a policy statement from a major medical or women's organization acknowledging the legitimacy of my efforts, and encouraging campus officials to give their prompt attention to these critical health issues.

I didn't find what I was looking for. Instead, throughout all the material directed at teens and young adults, the mantra of "sexual rights" and "safer sex" was repeated ad nauseam. There were descriptions of every type of possible behavior, too graphic for my taste, and much attention to topics of which I'd prefer to remain ignorant.

Take, for example, the popular site goaskalice.com—a "health question and answer internet service" produced by Columbia University's Health Education Program.¹⁵ Their mission: to provide readers with "reliable, accessible

information and a range of thoughtful perspectives, so that they can make *responsible decisions regarding their health and well-being*" (emphasis mine). Parents with college-bound children, I suggest you take a look at this site, which gets two thousand questions a week, and many more hits.

"Phone sex—getting started"; "Health risks of bestiality": these are some of the topics up for discussion here. Just click on your mouse—you will find useful information about sadomasochism, "tools and toys," and drinking urine. To a question about a ménage à trois, "Alice" (identified on the site as "a team of Columbia University health educators, health care providers, and other health professionals") advises, "Nothing wrong with giving it a try, as long as you're all practicing safer sex." To a reader calling himself "will try anything once," Alice provides advice on proper "swing club etiquette," as well as a link to the National Swing Club Directory. And for a reader who's wondering "how to clean a leather cat o' nine tails between uses, especially if it drew blood," Alice can help: hydrogen peroxide.

You'll be tempted to think the unexpected topics found on goaskalice.com reflect the funky scene in Manhattan. Far from it. In my research of college Web sites, I found normalization of behaviors that were once considered illicit—if not perverted—all over the country. At Virginia Commonwealth University, cross-dressing is a "recreational activity."¹⁶ At the University of Missouri, "external water sports" is described as a type of "safer sex."¹⁷ (For the puzzled, a definition is provided: "urinating on skin without open sores." Still don't get it? This type of perversion was once called masochism.) Compared to that, the University

of Wisconsin's tips for your *daughter* on how to pick up "that cute girl you noticed in your English class"¹⁸ is tame.

No, there was nothing here that would help Heather or Olivia. No questions and answers about oxytocin, bonding, trust, and neurobiology. No consideration of the emotional consequences for young women of "hooking up." No data on their "increased vulnerability to romantic involvement." No mention of the truckloads of antidepressants prescribed to keep some of them functioning. No concern about campus counseling centers bursting at the seams trying to treat them all.

Why do the legions of Heathers and Olivias on our campuses not exist for "Alice"? Why her neglect of these victims of our culture? Why instead is she busy normalizing sadomasochism and other disorders?

Clearly, Alice's priorities—and those of many others with the responsibility of providing college students with "health education"—have nothing to do with addressing the problems of my clientele. My guess is that, like everywhere else on campus, Alice advises students from a place where ideology reigns supreme. Central is the dogma that desires are "needs," to be acted upon and satisfied; that behaviors considered aberrant by society and medicine are natural, while self-restraint is not; that regular sexual behavior—with or without a committed relationship—is necessary and healthy; and that any and all these activities can be free of consequences, as long as they're "protected." But believing doesn't make it so. In the world I inhabit, there are plenty of consequences. On my campus, sexually active students are much more likely to seek counseling,

and to rate their relationships as stressful. Almost daily, I prescribe medication to help students, mostly women, cope with loss and heartbreak. Like it or not, hard science suggests that intimacy initiates a trusting bond. Ask Heather and Olivia, two girls woefully unprotected: there is no con-
dom for the heart.¹⁹

CHAPTER II

DAMAGE CONTROL

STACEY, TWENTY-ONE, WAS REFERRED BECAUSE SHE CUT herself—not all the time, but following some stressful event, like a fight with her coach or roommate. More specifically, she would use scissors, a knife, or a razor to cut her forearm, not deep enough to hit an artery—she didn't want to die—but enough to see blood. We call it SIB—self-injurious behavior—and there's loads of it on campus. Most girls say they do it for relief from overwhelming emotions. Stacey, a French major, described it as “cathartic.”

I listened with interest as Stacey shared her life with me. She was an athlete, a swimmer who had been recruited. She got up at five to do laps, and worked out at the gym for at least two hours in the afternoon. Her physical condition was a priority, and she was careful about what she ate. A vegetarian, she avoided processed foods and additives, and took lots of nutritional supplements. No alcohol, nicotine, or marijuana. No soda for Stacey—only bottled water. This wasn't easy with her demanding schedule, living on campus where most students grab a taco or pizza slice for lunch. But she had strong convictions about the benefits of this lifestyle, and felt the extra effort was worth-

CHAPTER VI

KELLY'S SUMMER VACATION

KELLY, NINETEEN YEARS OLD, JUST HAD AN ABORTION. SHE got pregnant during the summer, while traveling. Something must've happened to the condom.

The boy goes to school in Canada. They had known each other for a week when, at a party, the two of them drank too much. When Kelly got home, her period was late, but with everything she had to do—move, unpack, and decide on classes—there wasn't even a moment to think about it. Anyway, why should she worry? They had used protection. A few weeks passed; still no period. A nurse at the campus health center had this news: her uterus was enlarged; Kelly was seven weeks pregnant. Sure enough, the blood test was positive.

From that moment, Kelly told me, she was clear about how to proceed. Since she had no particular religious beliefs and believed wholeheartedly in a woman's right to choose, there was never any question for her. She phoned the boy, but he didn't say much; he sounded more shocked than she was. Calling back the following day, he said he'd support her decision; he wanted to send a check, he even

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offered to come be with her. But Kelly said no. Nor that she couldn't use the money—she had to put the four hundred and fifty dollars on a credit card. And it wasn't that she didn't care for him—not at all. In fact, she explained, that's the worst part of this whole thing for her: she *did* like him, quite a lot. Before this awful mess, she had hoped to see him over Thanksgiving. But now everything between them was different; their relationship was so awkward and strained that it seemed unlikely that would happen. So, Kelly explained with sadness, it just felt better to handle it alone.

Kelly turned to Planned Parenthood, where she learned there were two kinds of abortions, surgical and medical, and that each had pros and cons. Overall, the counselor said, they were both very safe—many times safer than giving birth. Psychological problems afterward were rare, she explained, and most women felt relieved. Kelly decided to have the medical abortion, in which pills are taken to cause miscarriage. Even though it could take a few days, it would happen in the privacy of her apartment, and she'd have some degree of control over events. Now it's over. She feels relieved, but she also feels sad, guilty, and alone. Kelly would rather not speak to the boy, and she's at odds with her best friend. She'd been depressed before all this, and now she is more depressed. Could I prescribe some medication?

Before her psychiatric evaluation, Kelly had met with one of our psychologists. I pulled up her records on my computer: "This student is dealing with depression, feelings of loss and isolation," read the assessment, "as well as

recovering from a recent medical problem." What? A "medical problem"? My first thought was, The therapist is protecting the student's confidentiality; my second, that the therapist perceived the abortion to be a minor event. Either way, it surprised me, and I made a mental note to find out what it was all about.

Now, all this was taking place in the days following Hurricane Katrina. As a provider of mental health services, I was bombarded with information about the anticipated psychological fallout of the disaster. Professional newsletters and Web sites were filled with grim predictions about expected rates of post-traumatic stress disorder, or PTSD, in survivors. Health-care professionals in every location were reminded of the importance of early diagnosis and treatment. They were urged to be on the lookout for "stress reactions": shock, anxiety, irritability, insomnia . . .

You might expect the target audience of this information campaign to have been limited to the survivors of the tragedy, but that would be incorrect. The American Psychological Association, for example, reached out to everyone—or at least, everyone who watches television: They warned on their Web site: Images of this catastrophe, even when viewed from far away, may cause feelings of "vulnerability."

On my campus, there was another angle: You may not have experienced this disaster firsthand, the counseling center's Web site pointed out, but you may be struggling with "issues highlighted in the aftermath of Katrina: inequity, race, social class, the inadequacy of our emergency preparedness and our institutional response." You may

therefore feel frustrated, angry, and helpless, so we welcome you to join us in a series of meetings focused on Katrina, where you can "work through" your thoughts and feelings.

It seemed as if, following this hurricane, my colleagues in the mental health field were determined to find each and every individual experiencing even the slightest distress, and to reassure them: *your reactions are normal, your tears and insomnia expected. You are not alone. Here are tips that will help you get through the days ahead, numbers you can call and a Web site you can visit, and here's when you need to speak with a professional.* And to the credit of many government and social service organizations and individuals, it seemed they wouldn't stop until the job was done.

In my opinion, it was overkill, but it was well intentioned. We in mental health know that for some people, trauma will have profound consequences. We have seen how depression, fear, guilt, flashbacks, and irritability can interfere with daily life. We know too well the toll it can take on relationships, work, and physical health. Some survivors may turn to self-destructive behaviors in an effort to dull the pain: drug use, alcohol, gambling. Some will attempt suicide; a few will succeed. We know, too, that reactions to trauma may be complex. Psychogenic amnesia exists—that's when people don't recall details because doing so would overwhelm them. A soldier may survive the battlefield or a woman a rape, and initially appear to cope well. Only later—maybe years later—may they begin to dwell on what happened, to obsess and dream about it. Finally, we understand that as a person ages, earlier traumas

will be reexamined and appraised from a new angle, depending on subsequent events: marriages, divorces, births, miscarriages, infertility, menopause, loss of loved ones.

Hurricanes and terrorist attacks make headlines; other traumas happen behind closed doors, and wounds are hidden due to shame and fear. This, we know, can be particularly destructive.

This is why psychology reaches out to survivors of trauma, because for many the process of speaking about it, sharing details, having an opportunity to openly grieve, mourn, question, and be angry, allows healing to begin. It's a process through which the victim should feel endorsed, and supported. Ideally, this work is done with others in the same position, people who have "been there." This can be enormously helpful, even lifesaving. And we need to identify the minority with more serious symptoms and bring them into the system for evaluation and treatment. It's a public health strategy, part of the ABCs of psychology.

Of course, not everyone who survives a traumatic event develops symptoms of a stress disorder. Most don't. But because we can't predict too well who will and who won't, we want to alert everyone, just in case, because when this occurs, it can be debilitating. It only makes sense.

That's why, when evaluating a new patient, we always consider the possibility of trauma or abuse in her past. If she has come in for ADD or Internet addiction, it makes no difference; we must ask: Have you been through any major trauma? Were you, or anyone in your family, the victim of sexual, physical, or emotional abuse? We do this because many people won't say unless specifically asked. And if we miss this portion of her history, it's a major oversight.

Now here's what I don't understand.

There are over a million abortions in the United States each year, and 52 percent are in women under twenty-five.¹ Most women having early abortions do not seem to have lasting emotional difficulties,² but many do. Even the study quoted by Planned Parenthood, in support of their statement that "most women do not experience psychological problems or regrets two years after their abortion"³ indicates that after two years 28 percent of women reported more harm from the abortion than benefit, 19 percent would not make the same decision under the same circumstances, 20 percent were depressed, and 1 percent had post-traumatic stress disorder.⁴ College campuses must be reeming with these women. The study also reported that younger age predicted a more negative response to induced abortion, and that with the passing of time, negative emotions like sadness and regret *increased*, and decision satisfaction *decreased*. That is, more women reported sadness and regret two years following an abortion than one month after the event.

Now, I don't know if Kelly will end up with long-term symptoms or not, but why is there an *assumption* she'll be fine? Why does student health not schedule a postabortion follow-up, to check on how she is coping?⁵ Why are women like Kelly sent home from Planned Parenthood knowing what to do in case of fever or heavy bleeding, but without a number to call or a Web site to visit if she is distressed?⁶ And why, if she is seen in the future at the campus counseling center, will she surely be asked whether she was ever beaten or neglected by her parents, but not if she ever had an abortion?⁷

Let's say for the sake of argument that we dismiss

the women with “only” sadness and regret, and consider a conservative estimate of 1 percent of women with post-traumatic stress disorder. Still, with over one million abortions annually, that’s more than ten thousand women a year. Since the *Roe v. Wade* decision in 1973, that’s a total of 420,000 women in the United States who may have PTSD related to abortion.⁸

Where are these women? Where do they go to talk? What number do they call, what Web site do they visit?

Some of them are logged on to *afterabortion.com*, “a neutral, non-political, non-religion based, non-judgmental place for women to communicate with each other after an abortion.”⁹ This is a remarkable site. Women from the United States, Canada, England, Ireland, Australia, Sweden, and elsewhere are here, providing to one another what psychology does not: a forum to share experiences, a place to find validation, support, and advice. “You can always come to this site,” one member tells another, “because we are in different time zones. So when you need to talk, there’s almost always someone, somewhere available.” “Regardless of whether your abortion was 3 weeks ago, 3 years ago, or 30 years ago,” the home page states, “you can find other women who understand.”

It’s a busy place: there are almost 90,000 threads, over 600,000 posts, and 1,000 new posts are added daily. There are chat rooms and on-line recovery groups. It’s like a twenty-four-hour hotline, or a never-ending group therapy session. One of their rules: no discussion about politics or morality.

One support board is for women who are seriously grieving: “Here you can discuss the intense feelings of loss,

regret and despair that linger when you have an abortion and later either regret it or are feeling haunted by the what-ifs.” The thread titles are filled with urgency: “Need help—NOW!!!”; “I’m losing it . . .”; “Suffocating”; “Can’t breathe”; “Tears won’t stop”; “Oh man can it get any worse?”; “Sad Scared Alone”; “Breakdown”; “Someone please please help”; “Numb”; “Why?????????”; “Can’t do this anymore.” It goes on and on; there are over seven-hundred threads here.

PTSD is diagnosed when specific symptoms are present following an intensely distressing event. Typically, the traumatizing event is military combat, rape, assault, kidnapping, an accident, a natural disaster, war, or torture. But it could also involve seeing someone severely injured or killed. The immediate response involves intense fear, helplessness, or horror.

Following the event, some—but not all—people re-experience it in dreams, flashbacks, or on the incident’s anniversary. The re-experiencing causes severe distress. Some victims feel numb, detached from reality and other people. They may not be able to recall details of the event, or they may be unable to forget them. Some will avoid thoughts, activities, or places that remind them of the event. They may be excessively moody or angry, overly sensitive, and unable to sleep or concentrate. When a survivor of a traumatic event has suffered for at least one month with re-experiencing, avoidance of stimuli, and hyperarousal, she qualifies for a diagnosis of post-traumatic stress disorder. When these symptoms occur following an abortion, some have called the condition post-abortion stress syndrome (PASS).¹⁰

Many women on afterabortion.com write about the people, places, or things that remind them of their abortion, causing deep pain; these are “triggers.” Sensitive to the need of members to share experiences, but mindful of the possibility their entries will cause distress to others, the site uses “trigger warnings.” Members are advised:

A trigger warning serves as a heads up that the post contains some possibly upsetting material. Trigger warnings include, but are not limited to, pregnant women, children, clinic protestors, insensitive people . . . anniversaries, etc. Many of the ladies (and guys!) here are feeling down and can be easily upset. Trigger warnings are advanced warning NOT to read if you're feeling sensitive or easily upset. If you feel your post may be upsetting to others, you may add a trigger warning. On occasion a moderator may add one for you, if they determine that it's necessary.

Reading the board on triggers provides a glimpse of the agony that an ordinary day can bring some women who have had abortions. Maternity stores, baby clothing, strollers, and cribs; kittens, puppies, a pregnant friend, a child calling “Mommy”; the abortion date, the due date, Mother’s Day; a happy family, a kite, a song, biology class, a museum exhibit, a pro-life demonstration, a bumper sticker, menstruation, the sound of a vacuum cleaner. Many are young women in high school or college. They describe being “triggered” by a movie or TV show they are watching with their parents or boyfriend, and having to hide their sorrow

and rage. No wonder they log on to this site—to find an international sisterhood, company for their misery.

And they really are there for each other—listening, soothing, and sending hugs. Here’s how they sound: “Yes, I too had the same thing, same vision, same, same, same. . . . O hun, I can see why that is so upsetting. . . . You have every right to feel upset and angry. . . . I can totally relate. . . . yep, me too!! Horrible isn’t it? . . . The only advice I can give is chocolate. Lots and lots of chocolate. . . . my heart is with you. . . . Oh sweetie, I am so sorry for what you are going thru, I’d be crying too. . . . PM or email me anytime. . . . (((((hugs)))))) . . . I hope you are OK. . . . You poor thing. But you are strong and we are all here for you. . . . Hang in there, ok? . . . I’ve noticed that drinking warm milk when I’m really upset sometimes helps to calm me down. . . .”

For anyone still wondering how an abortion might, for some, fall into the category of a traumatic event, read on. But be advised, the material you are about to read has been given a “trigger warning.” It will be difficult to absorb, even for those who are not survivors of trauma.

The following phrases are from a message board whose topic is medical abortion, the kind Kelly had. Posting here are women who saw a fetus in the blood clots and tissues they passed—a tiny head, the beginnings of arms and legs. They had not been warned of this possibility beforehand. Listen to them speak: “It’s been a year and a half, but I can still remember how it looked and felt. . . . I held my baby in my hand. . . . white, like mucus I thought at first until I looked closer and my mind accepted what I was seeing. Head, eyes, nose, arms, fingers. . . . I cried over it,

kissed it . . . *sigh* that was the worst part of all . . . I remember seeing the embryo . . . clear as day, I knew what she was. I couldn't fool myself. I stared at her for the longest time . . . felt like eternity. I will never forget that sight as long as I live. . . ."

"I saw every little feature perfectly . . . it was very, very tiny . . . just stared at it . . . was in shock . . . shut off my thinking . . . it was surreal . . . like I was trapped in a horror movie . . . can't lose the image . . . won't stop replaying in my mind . . . haunting me . . . horrifying . . . reminded every day . . . it's what I see when I go to bed . . . can never un-see what I saw . . . see it every day in my mind . . . can't lose the image . . . don't know how to deal with this . . . haven't told anybody . . . horrifying . . . nightmares . . . lots of nightmares . . ."

One woman wrote, "I can't even believe I'm typing these words." And I couldn't believe I was *reading* them: ghastly accounts of seeing the fetus and not knowing what to do. "I had to dispose of it myself and I couldn't think of anywhere to bury it that I could be sure an animal wouldn't dig it up . . . didn't know what to do . . . should I save it . . . bury it . . . flush it . . . didn't want to flush it, . . . couldn't think of what else to do . . . was so horrified, I couldn't move . . . I was guilt-ridden for years about putting it in the toilet, but I didn't know what else to do . . . wish someone had said there was a chance I would see it clearly and that I should prepare myself for what I was going to do . . . left mine in a cardboard dish . . . wrapped her in a piece of tissue and put her in the bedpan . . . wish I'd taken her and buried her properly . . . wish I would have buried mine,

but I was too young and too stupid . . . if only . . . can't forget just flushing my baby away . . . I will never forgive myself for this, never ever. . . ."

As a psychiatrist, what do I learn from this Web site? First, I see in these women what I see in many of my patients—exceptional strength and courage. They continue to function, even with their hideous flashbacks and raw emotions. Somehow they go to school and work, cook meals, drive carpool. To me, they are heroines, no less than anyone else who gets up each day with a broken spirit and heart and finds a way to survive.

Second, many women here have textbook cases of PTSD. Some have severe cases, and would benefit from therapy and medication. A few are hopeless and suicidal, and sound to me to be in need of hospitalization.

It's disturbing that these women are neglected by mainstream mental health. I am dismayed to learn they have nowhere to turn but a Web site. I am alarmed that girls and women being prepared for abortion are left unaware of the possible scenarios ahead of them. It's fine to reassure that the majority will do OK, but since when, in medicine, do we omit giving a heads-up regarding worst-case scenarios, however unusual? When I prescribe a medication with a one-in-a-thousand chance of causing a dangerous rash, my patient must be made aware of the risk. Isn't it a matter of informed consent?

I remind you that most of the million abortions performed each year are on single women under the age of twenty-five.¹¹ It's bad enough that we have no campus outreach to them, like we do for victims of abuse or date

rape. What's worse is when one of these women does walk through our doors for help with depression, an eating disorder, or insomnia, we don't routinely ask, "Have you ever been pregnant?" and we're satisfied to assume her symptoms are due to other stressors in her life: school, finances, conflict with parents.

The woman herself may not know—or want to know—the source of her pain: she may genuinely believe her symptoms "came out of nowhere." Didn't everyone say that following the abortion she'll feel relieved, that the sadness will be short-lived, that there are essentially no long-lasting effects? If there are others like her, where are the posters and fliers on campus, affirming her feelings and listing times and locations of support groups? And finally, if she sought help at the counseling center and the professional with a degree *didn't even ask about it*, doesn't all this support her denial: My crying spells, insomnia, and falling grades aren't related to my abortion . . . right?

"I meet young women who dissolve into tears at the mention of a previous abortion," wrote a women's-health nurse for students at a large urban university.¹² In her article "The 'A' Word," she described how her patients felt so stigmatized and traumatized that they couldn't even *say* "abortion." Of course, *she* bothered to ask—as a nurse, it's routine. So why isn't it for campus therapists?

Because it's not politically correct. Campus counseling doesn't want to take the risk of suggesting that abortion can be traumatic—that's a word reserved for victims of rape, abuse, harassment, or natural disasters. So while everyone is bewildered at the mental health crisis on our cam-

puses, not one voice suggests that perhaps the aftermath of abortion contributes to the staggering statistics. I see no attention given to the topic in the journal or annual meetings of the American College Health Association, or in the book out of Harvard mentioned earlier about the campus mental health crisis.¹³ Neither do I find "The 'A' Word" anywhere on the American Psychiatric Association's Web site focused on college mental health issues.¹⁴

One woman, who was shocked at the lack of "emotional aftercare" following her abortion, put it well: "When I got my abortion, I was really mad at the feminists. You gave me this choice—great! But then I'm on my own afterwards? What's up with that?" A coordinator of a Reproductive Rights Action League explained, "There have been moments where the movement has been scared to say that abortion may have emotional effects."¹⁵

Moments? What an understatement! In nearly every medical, mental health, and women's health organization, the denial of the trauma of abortion is entrenched dogma: the experience is just not that big a deal.¹⁶

Shock, denial, numbness, distressing memories, flashbacks, avoidance, irritability, poor concentration, nightmares? These don't occur following abortion. So concluded a psychologist involved in the study done by Surgeon General Koop on the health effects of abortion, at the request of President Reagan. "We searched and searched and searched," he said, and there was "no evidence at all for the existence of the 'postabortion syndrome' claimed by some right-to-life groups."¹⁷ The surgeon general himself may have seen it differently: in a letter to the president he stated