Myth number five—actually, I'd like to do myth number nine: Post-abortion distress is a made-up, religious issue. Regardless of who or what one believes in, something or someone failed if the pregnancy was unintended. Abortion causes loss. The loss must be worked through. There are multiple losses; often the relationship terminates. Resolution involves what part she has in the loss, and the comment to me has been, "I've lied to myself, and now my life is a lie."

Thank you, and I'll wait for questions to give further information.

[The prepared statement of Ms. Roy follows:]

PREPARED STATEMENT OF CINNY ROY

As a professional counselor licensed in Ohio, I have been trained to assess clients. Assessment is used for the diagnosis and the diagnosis for the treatment plan. Very often a client's current behavior is driven by a crisis or trauma earlier in life. The crisis was not dealt with in a timely fashion, hence the need for counseling. It is important at the time of the crisis or trauma to process what has happened. Processing involves going through the stages of impact: what happened, how it affected the person, who is responsible, grieving the loss, identifying the impact to the client's life today, a period of stabilization and finally resolution. This is why grief and crisis counselors go to schools when a student dies. This is why chaplains and pastoral staff are at hospitals. They attempt to start the students, patients and families on the road to mental, spiritual, and emotional recovery.

Men and women come for counseling because they are stuck. The coping skills they developed over time aren't working anymore. Something has triggered or upset the way they have been living. The man or woman is feeling out of control and often does not recognize that the trauma or crisis of the past is bobbing closer to the surface. It is the job of the clinician to figure out with the client what is and what is not causing the problem that brought him or her in for help.

Beginning in 1997, I worked exclusively with women and became a specialist in abortion recovery. Recognizing that when a woman seeks help it is often more complicated than a single issue, I returned to university in 2000 and received a master's degree in counseling.

In 2003 the Eve Center was founded, a branch of the Center for Women's Ministries, Inc. headquartered in Bloomington Indiana. We provide free, faith based support by women to women seeking to regain their mental, emotional and spiritual health. The Eve Center trains women in lay counseling to assist on an array of topics such as:

- Abuse
- Boundaries and lifestyle choices
- Childlessness: infertility, adoption, single-no children, pregnancy loss due to abortion, STDs
- Codependency
- Death: husband, child, parent, close friend
- Depression
- Eating issues
- Fears and phobias
- Jail: families of inmates, inmate before and after release
- Illness and disability
- Loneliness
- Parenting: small children, teenagers, empty nest, single parenting, older parents
- Pregnancy
- Promiscuity
- Relationships: husband, parent, partner, children, co-worker, friends
- Self-esteem
- Sexuality
- Singleness

- Spirituality: personal image of God
- Suicide
- Woundedness from childhood

Because the Eve Center provides a safe, confidential environment exclusively for women, the response has been good. We receive calls for all of the above. Since we aren't a single issue organization, when a woman comes in, no one knows what concerns she brings. We provide anonymity. Because we have the highest standards of confidentiality and because of the broad menu of presenting problems, she experiences respect and protection during her sessions.

I had moved away from abortion recovery but found that working in women's issues I can't get away from it. Even if it isn't her primary presenting issue, there is a significant percentage of intakes with abortion checked as a concern.

Please see Attachment A. 23.3% of Eve Center closed out clients 7/1/04–12/31/05 voluntarily identified abortion as a cause for concern. This was prior to any Phase I marketing that the Eve Center was beginning support groups for abortion recovery in February 2006. This does not include statistics for current ongoing clients.

Please see Attachment B. Right now I am leading a group. These statistics are not included in Attachment A. They are volunteers at the Eve Center who said they want to recall and repair from their abortions. In the group we have four (4) women.

A second group has begun; two (2) participants are clients seen in one to one sessions; two (2) are new contacts since January 2006 to the Eve Center specifically asking for abortion recovery assistance.

Here are the effects shared by post-abortion women that persist since the time of their abortions. These are the same insidious reactions I've observed since starting abortion recovery work:

- Guilt
- Emotional numbing
- Dreams/nightmares
- Change in relationships
- Lower self-esteem/self hatred
- Dizziness/fainting
- Sleep disturbances
- Sexual problems
- Thoughts of harming children
- Can't forgive self
- Inability to concentrate
- Preoccupation with death
- Mood swings
- Depression
- Sadness
- Anxiety
- Suicidal ideation
- Start/increase alcohol, nicotine, drug use
- Loneliness
- Sense of loss
- Infertility
- Sighing
- Hostility toward men
- Desire to be pregnant
- Desire for others to abort
- Avoidance/fear of doctors
- Avoidance of OB/GYN appointments
- Crying spells
- Regret
- Anger/rage
- Helplessness
- Headaches
- Eating issues

- Panic feeling
- Inability to relax
- Marital stress
- Fatigue
- Inability to make decisions
- Inability to bond with children
- Overprotective of children
- Preoccupation with abortion or due date
- Loss of hope
- Deserving punishment
- Emotional shut down
- Less interest in previously enjoyed activities

Part of the code of counseling is to "do no harm" to the client. It is not my intent to cause distress for anyone. If a woman says she is fine with her decision to abort, that is good. It is preferable that she be well. There are many, many reasons a woman may have the aforementioned symptoms. But if in addressing the identified concerns of the client those concerns are not resolved, maybe the focus is incorrect. When the treatment does not resolve the pain, then maybe the diagnosis is wrong.

A cognitive disconnect takes place when the abortion procedure is over. Remember that trauma treatment is a process. The memory of the trauma of the abortion is boxed up and resolution is stunted. Because it is underground and not talked about, it leaks into other areas of her life. Hence the list of symptoms, many of which are criteria for diagnosis for post traumatic stress disorder, acute stress disorder, generalized anxiety disorder, anxiety disorder not otherwise specified, depressive disorder, increased Axis IV psychosocial and environmental problems and lower GAF ratings (global assessment of functioning).

Recall that when a crisis isn't processed, one tends to use one's subjective experiences to shape the memory. Hence perceptions become personal truths although the personal beliefs may not be truth at all. When one is left to "figure out" something with no benefit of counsel, one is left with a narrow and often incomplete or inaccurate memory. By going back to before the decision to abort was made, the woman or man is able to see at a distance all that took place, process what happened and resolve the trauma. Because this is a death issue, it is similar to complicated grief treatment.

My behavior could have been classified as obsessively driven, almost compulsively consumed with achievement. During the 1990's I was a superwoman of success: married with three children. I was a volunteer for Sunday school, bible study leader and women's group leader. At our children's school I regularly helped with classroom activities and was annual giving co-chair. In the community, I held leadership positions in the Junior League of Cincinnati and served on several non-profit boards. Somewhere I fit in jogging, playing golf and digging in the garden. I was a woman in motion. Friends would tell me I made them tired. My coping skills reached a point where they no longer worked effectively. I had assumed too many responsibilities. Whatever was driving the manic pursuit of acceptability was no longer manageable. I was going to crash interpersonally or intrapersonally. This happened to me in the spring and fall of '96. In pursuit of reparation, the cause for my struggle needed to be identified. When one can name the cause, techniques or stop sticks can be put in place. These prevention techniques prevent the triggers which ignite the cycle for which there hasn't been effective skills to prevent a crash, further trauma or new crisis.

The answer to what was driving my behavior had been impacting me for years. There had been a crisis, a trauma. While that crisis had been abated, the actions to avert the crisis had been more impacting than I realized. The crisis was this: I was "caught" having sex outside of marriage. The way I got caught was that I became pregnant. The assumed immediate solution was to move quickly to stop the panic and to prevent getting caught any further. The solution was an elective abortion. I did not pause to consider options. I was caught and I wanted out.

I crashed into my past in 1996, and broke isolation by telling someone I trusted. I reluctantly joined a recovery group, scared to death of all the emotions. My life has not been the same since. It became apparent, as is true of all the women I work with, that we stop, frozen in time when the abortion took place. The survival mode is so strongly in operation, it remains for years. As time slides by, the walls of suppression thin and for the first time a woman peers over at the devastation the abortion caused. We repackage the experience but now the walls have a leak and we

seek all kinds of ways to cement the walls back into place. With help I took down my walls brick by brick facing my choice then and how it impacted me for 20 years.

After my recovery group I devoted my skills to becoming a specialist in the greater Cincinnati area for recovery from pregnancy loss due to abortion. Personally, I have had the honor to meet with and support several hundred women seeking to understand the impact mentally, physically, and spiritually of their choice to abort pregnancies.

Here are myths surrounding elective abortion:

Myth #1: It is a free choice.

Not one woman wakes up on a given day stretches and says to herself, "Gee I think I will choose to have an abortion today." The types of fear inducing thoughts women have when the pregnancy test is positive are "It will ruin my future," "I can't work and raise a baby," "The university won't let me have a leave from classes." Fear is an inadequate emotional state to be in when making any decision. Couple this emotionally heightened state with spoken and unspoken threats and there is a reduced margin for thoughtful, educated decision making to take place.

Over and over women tell how the ones they love give them no option but to abort: parents threaten to turn her out, her lover/husband will leave, her mom, aunt, sister, grandmother, and friends all pressure her to have the abortion. The woman makes the final decision. However the internal and external pressure is not a peaceful state in which to make such a choice. She feels slammed from one side knowing what the "church" and much of society says about sexual activity outside of marriage: to be caught is a bad thing. The way one is "caught" is by becoming pregnant. The price to get out of this predicament is to sacrifice either her lifestyle or her pregnancy. She blames herself, her partner blames her, society blames her and the church blames her. Nothing is "free" about this choice.

Myth #2A: Life goes back to the way it was.

In working with dysfunctional relationships, the one who is healing is changing. The dynamics of the relationship change. Often members in the family or relationship system do not want improvement, or don't see a need for change. He or she, the no change advocate, doesn't want the way life is to change and will apply pressure to the change agent/person to revert back to the dysfunctional but familiar roles in the relationship. Individuals would rather stay the same and expect others, no matter what the cost, to stay in the game living by the same rules. Having a baby changes the rules and patterns of a person or family's life. Abortion makes sure the life game does not change. Yet life never goes back to exactly the way it was before the abortion procedure.

Myth #2B: Life goes back to the way it was.

No matter how long a pregnancy lasts, the woman was pregnant. An abortion does not negate that fact. What happens is now the woman retains the memory. The pregnancy changed her physically, changed her identity to mother for forever, rocks her emotionally and spiritually.

Myth #3: Women take time and care to seek out advice to formulate the best plan for her.

The decision is made in a heightened alarmed state and self preservation is the driving component. Homeostasis: returning to what was previous is of paramount importance. Her pregnancy threatens her stability. The positive pregnancy test triggers immense out of control feelings. Survival instinct takes over and she moves to "lock and load" mentality. Little can be done to sway her from achieving her goal.

Myth #4: It is just tissue.

There is a universal law: no matter what position a woman takes regarding the beginning of life, we all know that the end result of a pregnancy is a baby. Pregnant = baby. This is simple, irrefutable fact. So the myth of "tissue" causes a cognitive snap as the woman tries to disconnect a life truth.

Myth #5: It is a women's issue.

Repeatedly the women tell me if their lover, boyfriend, husband had supported them, they would have considered seeing the pregnancy to term and examined in a less frantic, crisis mode options such as parenting or adoption, in the family as well as outside the family.

Men buy the lie pregnancy has nothing to do with them which in turn give a sense of permission not to be involved when a man's input is highly valuable.

Myth #6: You are not ready to be a parent.

Who is? The fact is physically and mentally there is a pregnancy imprint. This is referred to as "baby on the brain." The woman is a mother regardless of length of pregnancy.

Myth #7: It must be something else in your past that is causing your problems.

We have women who contact us having been through counseling and it hasn't helped. Because we ask the why questions we unearth the truth. We connect pregnancy history to current life impacting behaviors. When all other factors have been ruled out and still there is mental pain, and abortions as a complicating factor have not been visited, even she can draw the line between the dots.

Myth #8: "I'm fine with it."

Professionally as a therapist, the rule is to do no harm to the client. It is not my intent to cause distress for anyone. If a woman says she is fine with her decision to abort, that is good. It is preferable that she be well. There are many, many reasons a woman may have the aforementioned symptoms. But if in addressing the identified concerns of the client those concerns are not resolved, maybe the focus is incorrect. When the treatment does not resolve the pain, then maybe the diagnosis is wrong.

Myth #9: Post-abortion distress is a made up, religious issue.

Regardless of who or what one believes in, something or someone failed if the pregnancy was unintended. Abortion causes loss. The loss must be worked through. There are multiple losses; often the relationship terminates. Resolution involves what part she has in the loss, denial, depression, anger, mourning and acceptance. And regardless of belief system, this is shaken. I have yet to meet someone who doesn't have any belief system: characterized by belief in self, system, whatever. Something failed that brings the decision to abort the pregnancy. The comment to me has been "I lied to myself and now my life is a lie."

Myth #10: Professionals know how to work with post-abortion women.

No they don't. They haven't got a clue. Counselors, lay, pastoral and professional, aren't trained in grief work. Those who have a course or continuing education credit still do not know how to assist someone who took a life, coerced or not. Remember the universal law: no matter what position a woman takes regarding the beginning of life, we all know that the end result of a pregnancy is a baby. Pregnant = baby. Therefore a life was taken and counselors do not have training in resolution of this death issue.

Myth #11: Abortion is rare.

It has become the standard not the exception. The website of the Alan Guttmacher Institute, affiliate of pro-choice Planned Parenthood Federation of America states 24% of all pregnancies (excluding miscarriages) end in abortion. Teens are more likely than older women to delay having an abortion until after 15 weeks of pregnancy, when medical risks associated with abortion increase significantly (Source: *http://www.agi-usa.org/pubs/fb—induced—abortion.html*) The abortion ratio is the proportion of pregnancies (excluding miscarriages) ending in abortion. In 2000, the abortion ration was 25%, meaning that one-quarter of all U.S. pregnancies ended in abortion. On the basis of current rates, one in three women (33.3%) will have had an abortion by the age of 45.

Source: *http://www.guttmacher.org/in-the-know/incidence.html*

As to "scope"; the abortion industry needs to be held to the highest standard possible.

Currently, it is more like an adolescent than an adult in behavior and procedure.

- Require face-to-face appointments with the licensed doctor prior to the invasive surgical procedure just like any other elective or life saving surgery
- Require a thorough intake procedure for any preexisting medical and psychological factors which can complicate and damage the patient and signature that it has been reviewed by the doctor performing the surgery
- Require parental notification for unmarried minors to custodial parent or guardian
- Require a trained guardian ad litem or advocate with therapeutic background be available to any minor proceeding to court for judicial permission to proceed with an abortion outside of parental notification
- Require school guidance counselors, nurses and health providers to have advocate information in print available

- Require all abortion offices to be licensed by the state as a medical clinic
- Require abortion offices to have a contract with emergency services that are not more than five miles away.
- Require that a post surgery report be given to the patient at the time of discharge with the signature of attending nurse, doctor, and health assistant AND referral information for a follow up appointment with an OB/GYN

The purpose of these points is to expand the professionalism of this business. As a woman, I require the respect and professionalism I deserve if I were to choose to be a return patron of the abortion industry.

In conclusion, here are three (3) websites for further understanding of the impact of abortion to women.

- *www.afterabortion.org*
- *www.projectgrace.com*
- *www.abortionfacts.com*

Thank you for the privilege to speak to you this afternoon.

Attachment A
Eve Center Client Statistics – Intake forms for closed clients 7/1/04 – 12/31/05

Abuse – sexual 25	Depression 64	Husband 31	Promiscuity 14	Spirituality 28
Abuse - physical 13	Divorce 25	Illness/Disability 13	Relationships 43	Anxiety 46
Alcohol/drugs 16	Eating issues 19	Jail 4	Self-esteem 48	Singleness 18
Childlessness 5	Fear/phobia 26	Parenting 33	Aging parents 12	Sexuality 8
Death 20	Finances 44	Pregnancy 11	Pregnancy loss 4	Sexuality 9
Abortion 27*	Employment 28	Incomplete form 3		Completed forms 116*
Other (handwritten in): Emotional/verbal abuse 6 Codependency Boundaries STDs Rape 2	 OCD Mother Panic disorder Suicide 2 School	 Anger 2 Abandonment Adoption Loneliness Miscarriage 3	 Housing Cutting 3 Stillbirth	
* 23.3% clients voluntarily identified abortion as a cause for concern.				

** This is prior to any Phase I marketing that the Eve Center was beginning support group for abortion recovery in February 2006. It does not include data for current ongoing clients seen one to one sessions.

House Judiciary Committee Constitutional Oversight Witness: Cinny Roy
3/2/06 Scope and Myths of Roe v. Wade

Attachment B
Eve Center Recovery Group Intake Responses prior to start of program

Women in abortion recovery group Winter 2006	abortions	miscarriages	Live births	Tubal
1	2	0	3	0
2	1 (set of twins)	0	5	1
3	1	1	2	0
4	2	0	2	0
Total	7	1	12	1

Reasons for abortion
• He would not help, support, he abandoned me. Embarrassed, forgot to take birth control, weak, financial fears
• Abused, advised by my mother and husband
• Not married, father of child did not want it, worried about parent's humiliation and my own
• Was not married, did not have a job, was pressured by boyfriend and family members to have an abortion

Place #1 by any that applied to you in the past 6 months considering this abortion	Place #2 by the THREE things that you have experienced the most intensely in recent weeks when considering this abortion.	
Guilt	Moodiness 2,2	Crying spells 1,1,1
Dreams/nightmares 2	Depressed 1	Regret 2,1,1
Change in relationships 1,1	Sad 1,1,2,1	Anger/rage 2
Lower self-esteem 1,1,1,1	Suicidal ideas 2	Headaches
Dizziness/fainting	Sedatives	Eating issues
Sleep disturbances 1	Alcohol/drugs	Panic feeling 1,1,1
Can't make friends	Loneliness 1,1	Unable to relax
Sexual problems 2	Sense of loss 1,1,1	Marital stress 2
Child abuse	Infertility	Fatigue 1,1,1
Unforgiveness 1	Anxiety 1,1	Sighing 1,1
Can't concentrate 1,1,1	Hostility at men 1,1,1	Attracted to women
Preoccupation with death 2	Desire to be pregnant	Unable to bond with children
Self-hatred 1	Desire for others to abort	Preoccupation with abortion date or due date
Uncomfortable around pregnant women/babies	Avoid/fear OB/GYN or doctors	Emotionally numb 1,2,1,1
Other: upset stomach, muscle tenseness		

Attachment C

This is information assembled by Dr. David Reardon, the Elliot Institute: PO Box 7348, Springfield, IL 62791-7348. Additional material is posted at www.afterabortion.org

Fact Sheet Courtesy of the Elliot Institute, PO Box 73478 Springfield, IL 62791-7348

A List of Major Psychological Sequelae of Abortion

REQUIREMENT OF PSYCHOLOGICAL TREATMENT:

In a study of post-abortion patients only 8 weeks after their abortion, researchers found that 44% complained of nervous disorders, 36% had experienced sleep disturbances, 31% had regrets about their decision, and 11% had been prescribed psychotropic medicine by their family doctor. (2) A 5 year retrospective study in two Canadian provinces found significantly greater use of medical and psychiatric services among aborted women. Most significant was the finding that 25% of aborted women made visits to psychiatrists as compared to 3% of the control group. (3) Women who have had abortions are significantly more likely than others to subsequently require admission to a psychiatric hospital. At especially high risk are teenagers, separated or divorced women, and women with a history of more than one abortion. (4)

Since many post-aborted women use repression as a coping mechanism, there may be a long period of denial before a woman seeks psychiatric care. These repressed feelings may cause psychosomatic illnesses and psychiatric or behavioral in other areas of her life. As a result, some counselors report that unacknowledged post-abortion distress is the causative factor in many of their female patients, even though their patients have come to them seeking therapy for seemingly unrelated problems. (5)

POST-TRAUMATIC STRESS DISORDER (PTSD or PAS): A major random study found that a minimum of 19% of post- abortion women suffer from diagnosable post-traumatic stress disorder (PTSD). Approximately half had many, but not all, symptoms of PTSD, and 20 to 40 percent showed moderate to high levels of stress and avoidance behavior relative to their abortion experiences. (6) Because this is a major disorder which may be present in many plaintiffs, and is not readily understood outside the counseling profession, the following summary is more complete than other entries in this section. PTSD is a psychological dysfunction which results from a traumatic experience which overwhelms a person's normal defense mechanisms resulting in intense fear, feelings of helplessness or being trapped, or loss of control. The risk that an experience will be traumatic is increased when the traumatizing event is perceived as including threats of physical injury, sexual violation, or the witnessing of or participation in a violent death PTSD results when the traumatic event causes the hyperarousal of "flight or fight" defense mechanisms. This hyperarousal causes these defense mechanisms to become disorganized, disconnected from present circumstances, and take on a life of their own

Attachment C

resulting in abnormal behavior and major personality disorders. As an example of this disconnection of mental functions, some PTSD victim may experience intense emotion but without clear memory of the event; others may remember every detail but without emotion; still others may reexperience both the event and the emotions in intrusive and overwhelming flashback experiences. (7)

Women may experience abortion as a traumatic event for several reasons. Many are forced into an unwanted abortions by husbands, boyfriends, parents, or others. If the woman has repeatedly been a victim of domineering abuse, such an unwanted abortion may be perceived as the ultimate violation in a life characterized by abuse. Other women, no matter how compelling the reasons they have for seeking an abortion, may still perceive the termination of their pregnancy as the violent killing of their own child. The fear, anxiety, pain, and guilt associated with the procedure are mixed into this perception of grotesque and violent death. Still other women, report that the pain of abortion, inflicted upon them by a masked stranger invading their body, feels identical to rape. (8) Indeed, researchers have found that women with a history of sexual assault may experience greater distress during and after an abortion exactly because of these associations between the two experiences. (9) When the stressor leading to PTSD is abortion, some clinicians refer to this as Post-Abortion Syndrome (PAS).

The major symptoms of PTSD are generally classified under three categories: hyperarousal, intrusion, and constriction.

Hyperarousal is a characteristic of inappropriately and chronically aroused "fight or flight" defense mechanisms. The person is seemingly on permanent alert for threats of danger. Symptoms of hyperarousal include: exaggerated startle responses, anxiety attacks, irritability, outbursts of anger or rage, aggressive behavior, difficulty concentrating, hypervigilence, difficulty falling asleep or staying asleep, or physiological reactions upon exposure to situations that symbolize or resemble an aspect of the traumatic experience (eg. elevated pulse or sweat during a pelvic exam, or upon hearing a vacuum pump sound.)

Intrusion is the reexperience of the traumatic event at unwanted and unexpected times. Symptoms of intrusion in PAS cases include: recurrent and intrusive thoughts about the abortion or aborted child, flashbacks in which the woman momentarily reexperiences an aspect of the abortion experience, nightmares about the abortion or child, or anniversary reactions of intense grief or depression on the due date of the aborted pregnancy or the anniversary date of the abortion.

Constriction is the numbing of emotional resources, or the development of behavioral patterns, so as to avoid stimuli associated with the trauma. It is avoidance behavior; an attempt to deny and avoid negative feelings or people, places, or things which aggravate the negative feelings associated with the trauma. In post-abortion trauma cases, constriction may include: an inability to recall the abortion experience or important parts

Attachment C

of it; efforts to avoid activities or situations which may arouse recollections of the abortion; withdrawal from relationships, especially estrangement from those involved in the abortion decision; avoidance of children; efforts to avoid or deny thoughts or feelings about the abortion; restricted range of loving or tender feelings; a sense of a foreshortened future (e.g., does not expect a career, marriage, or children, or a long life.); diminished interest in previously enjoyed activities; drug or alcohol abuse; suicidal thoughts or acts; and other self-destructive tendencies.

As previously mentioned, Barnard's study identified a 19% rate of PTSD among women who had abortions three to five years previously. But in reality the actual rate is probably higher Like most post-abortion studies, Barnard's study was handicapped by a fifty percent drop out rate. Clinical experience has demonstrated that the women least likely to cooperate in post-abortion research are those for whom the abortion caused the most psychological distress. Research has confirmed this insight, demonstrating that the women who refuse followup evaluation most closely match the demographic characteristics of the women who suffer the most post-abortion distress. (10) The extraordinary high rate of refusal to participate in post-abortion studies may interpreted as evidence of constriction or avoidance behavior (not wanting to think about the abortion) which is a major symptom of PTSD.

For many women, the onset or accurate identification of PTSD symptoms may be delayed for several years. (11) Until a PTSD sufferer has received counseling and achieved adequate recovery, PTSD may result in a psychological disability which would prevent an injured abortion patient from bringing action within the normal statutory period. This disability may, therefore, provide grounds for an extended statutory period.

SEXUAL DYSFUNCTION: Thirty to fifty percent of aborted women report experiencing sexual dysfunctions, of both short and long duration, beginning immediately after their abortions. These problems may include one or more of the following: loss of pleasure from intercourse, increased pain, an aversion to sex and/or males in general, or the development of a promiscuous life-style. (12)

SUICIDAL IDEATION AND SUICIDE ATTEMPTS: Approximately 60 percent of women who experience post-abortion sequelae report suicidal ideation, with 28 percent actually attempting suicide, of which half attempted suicide two or more times. Researchers in Finland have identified a strong statistical association between abortion and suicide in a records based study. The identified 73 suicides associated within one year to a pregnancy ending either naturally or by induced abortion. The mean annual suicide rate for all women was 11.3 per 100,000. Suicide rate associated with birth was significantly lower (5.9). Rates for pregnancy loss were significantly higher. For miscarriage the rate was 18.1 per 100,000 and for abortion 34.7 per 100,000. The suicide rate within one year after an abortion was three times higher than for all women, seven times higher than for women carrying to term, and nearly twice as high as for women

Attachment C

who suffered a miscarriage. Suicide attempts appear to be especially prevalent among post-abortion teenagers.(13)

INCREASED SMOKING WITH CORRESPONDENT NEGATIVE HEALTH EFFECTS: Post-abortion stress is linked with increased cigarette smoking. Women who abort are twice as likely to become heavy smokers and suffer the corresponding health risks. (14)

Post-abortion women are also more likely to continue smoking during subsequent wanted pregnancies with increased risk of neonatal death or congenital anomalies. (15)

ALCOHOL ABUSE: Abortion is significantly linked with a two fold increased risk of alcohol abuse among women. (16) Abortion followed by alcohol abuse is linked to violent behavior, divorce or separation, auto accidents, and job loss. (17) (see also New Study Confirms Link Between Abortion and Substance Abuse)

DRUG ABUSE: Abortion is significantly linked to subsequent drug abuse. In addition to the psycho-social costs of such abuse, drug abuse is linked with increased exposure to HIV/AIDS infections, congenital malformations, and assaultive behavior. (18)

EATING DISORDERS: For at least some women, post-abortion stress is associated with eating disorders such as binge eating, bulimia, and anorexia nervosa. (19)

CHILD NEGLECT OR ABUSE: Abortion is linked with increased depression, violent behavior, alcohol and drug abuse, replacement pregnancies, and reduced maternal bonding with children born subsequently. These factors are closely associated with child abuse and would appear to confirm individual clinical assessments linking post-abortion trauma with subsequent child abuse. (20)

DIVORCE AND CHRONIC RELATIONSHIP PROBLEMS: For most couples, an abortion causes unforeseen problems in their relationship. Post-abortion couples are more likely to divorce or separate. Many post-abortion women develop a greater difficulty forming lasting bonds with a male partner. This may be due to abortion related reactions such as lowered self-esteem, greater distrust of males, sexual dysfunction, substance abuse, and increased levels of depression, anxiety, and volatile anger. Women who have more than one abortion (representing about 45% of all abortions) are more likely to require public assistance, in part because they are also more likely to become single parents. (21)

REPEAT ABORTIONS: Women who have one abortion are at increased risk of having additional abortions in the future. Women with a prior abortion experience are four times more likely to abort a current pregnancy than those with no prior abortion history. (22)

Attachment C

This increased risk is associated with the prior abortion due to lowered self esteem, a conscious or unconscious desire for a replacement pregnancy, and increased sexual activity post-abortion. Subsequent abortions may occur because of conflicted desires to become pregnant and have a child and continued pressures to abort, such as abandonment by the new male partner. Aspects of self-punishment through repeated abortions are also reported. (23)

Approximately 45% of all abortions are now repeat abortions. The risk of falling into a repeat abortion pattern should be discussed with a patient considering her first abortion. Furthermore, since women who have more than one abortion are at a significantly increased risk of suffering physical and psychological sequelae, these heightened risks should be thoroughly discussed with women seeking abortions.

NOTES:

1. An excellent resource for any attorney involved in abortion malpractice is Thomas Strahan's Major Articles and Books Concerning the Detrimental Effects of Abortion (Rutherford Institute, PO Box 7482, Charlottesville, VA 22906-7482, (804) 978-388.) This resource includes brief summaries of major finding drawn from medical and psychology journal articles, books, and related materials, divided into major categories of relevant injuries.

2. Ashton,"They Psychosocial Outcome of Induced Abortion", British Journal of Ob&Gyn., 87:1115-1122, (1980).

3. Badgley, et al.,Report of the Committee on the Operation of the Abortion Law (Ottawa:Supply and Services, 1977)pp.313-321.

4 R. Somers, "Risk of Admission to Psychiatric Institutions Among Danish Women who Experienced Induced Abortion: An Analysis on National Record Linkage," Dissertation Abstracts International, Public Health 2621-B, Order No. 7926066 (1979); H. David, et al., "Postpartum and Postabortion Psychotic Reactions," Family Planning Perspectives 13:88-91 (1981).

5 Kent, et al., "Bereavement in Post-Abortive Women: A Clinical Report", World Journal of Psychosynthesis (Autumn-Winter 1981), vol.13,nos.3-4.

6. Catherine Barnard, The Long-Term Psychological Effects of Abortion, Portsmouth, N.H.: Institute for Pregnancy Loss, 1990).

7. Herman, Trauma and Recovery, (New York: Basic Books, 1992) 34.

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Attachment C

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Attachment C

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Mr. CHABOT. Thank you very much. I know 5 minutes can go very quickly, so hopefully we'll be able to probe into some of the points that you might have wanted to get into, but may not have had the time to complete.

Ms. ROY. With respect to the Chair, it's fine.

Mr. CHABOT. Okay. Thank you.

Dr. O'Connor, you're recognized for 5 minutes. Could you turn the mike on there? Could you turn the mike on?

Ms. ROY. Press your "talk" button.

TESTIMONY OF KAREN O'CONNOR, PROFESSOR, AMERICAN UNIVERSITY

Ms. O'CONNOR. I have a problem, I guess. Okay. I don't know what this says about women and mechanical stuff, but hopefully I could start over.

Good afternoon, Chairman Chabot, Representative Nadler, Members of the Subcommittee, and distinguished guests. It is truly an honor for me to be before you testifying today about the significant implications of *Roe v. Wade* and *Doe v. Bolton* for both American women and their families. With new membership on the Supreme Court and several critical legal tests on the horizon, reproductive rights and reproductive freedoms in the United States are truly at a major crossroads.

It's important to remember, however, that abortion regulations and restrictions are not rooted in ancient theory or common law; despite the fact that abortion was common throughout history, no government—be it local, State, or national—attempted to regulate the practice until well into the 19th century. As Justice Blackmun wrote so eloquently in *Roe v. Wade*, "at common law, at the time of the adoption of our Constitution, and throughout the major portion of the 19th century . . . a woman enjoyed a substantially broader right to terminate a pregnancy than she does in most States today." Indeed, in 1812, a Massachusetts court found that an abortion performed before "quickening," defined as the time when a woman begins to feel movement in utero, usually between the 16th and 18th week of pregnancy, was not punishable at law.

The first abortion restrictions that were enacted in the United States came as State statutory creations that marked a shift away from the common law. In 1821, Connecticut became the first State to criminalize abortion after quickening. By 1840, eight other States had enacted statutory abortion restrictions. Other States followed quickly, and by 1910, every State except Kentucky had made abortion a felony.

By the early 1970's, however, following the lead of the American Colleges of Gynecologists and Obstetricians and the American Law Institute, 14 States liberalized their abortion statutes to permit abortion in limited circumstances: when the woman's health was in danger, when the woman herself was the victim of rape or incest, or when there was a likelihood of a fetal abnormality. Still, only four States—Alaska, Hawaii, New York, and Washington—had decriminalized the provision of abortion for any reason during the early stages of pregnancy.

The fact that abortion was illegal in all but a few States prior to *Roe*, however, did not mean that women were not obtaining the