

From the Podium

Post-abortion Mental Health Effects, Awareness, and Politics

Panel Discussion
October 9, 2008

The Family Research Council
801 G Street NW • Washington, DC 20001
800-225-4008 • www.frc.org



FAMILY RESEARCH
COUNCIL
801 G STREET NW
WASHINGTON DC
20001

(202) 393-2100

ORDER LINE:
1-800-225-4008

PD08K01

Table of Contents for Panel Presentations and Materials

- I. Abortion Trauma, Posttraumatic Stress Disorder (PTSD) & Complicated Grief – Vincent Rue, Ph.D.
 - “Abortion Trauma, PTSD & Complicated Grief” - PowerPoint presentation
 - “Post-abortion Syndrome: Diagnostic Criteria”
 - “Induced abortion and traumatic stress: A preliminary comparison of American and Russian women” - Study
 - “Posttraumatic Stress Disorder After Abortion”
- II. Abortion and Mental Health Research – Priscilla Coleman, Ph.D.
 - “Abortion and Mental Health Research” - PowerPoint presentation
 - “Abortion and Women’s Mental Health” - Summary page
- III. Psychiatric Clinical Perspective and Grassroots Efforts to Address Post-abortion Mental Health Effects – Martha Shuping, M.D.
 - “Abortion Recovery”
 - “Resources”
 - “Post-abortion Grief: Evaluating the Possible Efficacy of a Spiritual Group Intervention” - Study
- IV. Post-abortion effects and men – Catherine Coyle, R.N., Ph.D.
 - “Men and Abortion: A Review of the Research” – PowerPoint presentation
 - “Men and Abortion: A Summary of Research Findings” – Summary page
- V. Post-abortion awareness and politics Poll – David Reardon, Ph.D.
 - “Politics and Post-abortion Awareness Survey”
- VI. Political Perspective and the Freedom of Choice Act (FOCA) -Thomas McCluskey
 - “Freedom of Choice Act Would Harm Women and Remove a Lot of Freedoms” – *Insight* Paper
- VII. American Psychological Association (“APA”) Task Force Report on Abortion and Mental Health – Priscilla Coleman, Ph.D.
 - “APA Task Force Report on Abortion and Mental Health: A Violation of the Ethics of Science and a Breach of Public Responsibility” – PowerPoint presentation
 - “Does Abortion Cause Mental Health Problems? The Evidence Through an Objective Scientific Lens as Opposed to the APA’s Recent Analysis”

- VIII. Implications of the American Psychological Association Task Force Report on Abortion and Mental Health – Vincent Rue, Ph.D.
- “Advocacy vs. Science: Implications of the APA Task Force Report on Abortion” – PowerPoint presentation

Biographies of Panel Speakers

Vince Rue, Ph.D.

Director of the Institute for Pregnancy Loss in Jacksonville, Florida:

Dr. Rue is the Director of the Institute for Pregnancy Loss in Jacksonville, Florida, an independent non-profit research & treatment center. Dr. Rue received his Ph.D. in Child Development and Family Relations from the University of North Carolina in 1975. For 33 years Dr. Rue has been a practicing psychotherapist and has served on the faculty of California State University at Los Angeles and United States International University in San Diego. In 1981, Dr. Rue provided the first clinical evidence of postabortion trauma, identifying this psychological condition as "Postabortion Syndrome" in testimony before the U.S. Congress. In 1984, he published one of the first articles on abortion's impact on men and relationships and over the years has treated numerous women and men who have been traumatized by their abortion experience. During the Reagan Administration, Dr. Rue was a special consultant to the U.S. Surgeon General, Dr. C. Everett Koop, on abortion morbidity. In addition to his clinical work, Dr. Rue also serves as a litigation consultant assisting numerous offices of the state Attorneys General in abortion and family related statutory challenges. He is a Fellow of the American Academy of Experts in Traumatic Stress and a Member of the International Society for Traumatic Stress Studies, the Association for Psychological Science, and the American Psychological Association. He has lectured throughout the United States, and has also presented in North and South America, Europe and Asia. Dr. Rue has authored one book and numerous professional journal articles on the topic of postabortion trauma and has been the principal investigator of the International Pregnancy Loss Research Project. He is also the co-founder of two new online research and education-oriented post-abortion sites: abortionresearch.net and standapart.org.

Priscilla Coleman, Ph.D.

Associate Professor of Human Development and Family Studies at Bowling Green State University, Ohio:

Dr. Coleman is an Associate Professor of Human Development and Family Studies at Bowling Green State University. Dr. Coleman received her Ph.D. in Life-Span Developmental Psychology from West Virginia University in 1998. A major concentration of Dr. Coleman's research has been on the psychological outcomes of abortion, and her recent studies address the impact of abortion on interpersonal relationships (parenting and intimate partners). Additional research has focused on mother-child interaction, attachment, and the development of competency beliefs across the transition to parenting. The author of over 40 peer-reviewed articles, Dr. Coleman has published numerous studies in psychology and medical journals on the psychology of abortion, and she has presented her research to national and international audiences. Dr. Coleman has also served as an expert on state and civil cases related to the harmful effects of abortion, and she is on the editorial boards for two international medical journals.

Catherine Coyle, RN, Ph.D.

Co-Director of the Alliance for Post-Abortion Research & Training:

Catherine Coyle earned her doctorate in Educational Psychology (area of Human Development) at the University of Wisconsin. She is a registered nurse and holds a master's degree in clinical psychiatric nursing. She has taught at both Edgewood College and the University of Wisconsin in Madison. Dr. Coyle has developed a healing program for men who have been hurt by abortion and has scientifically documented its effectiveness. She is the author of the book, *Men and Abortion: A Path to Healing*, which is based on her research and is available from Life Cycle Books (1-800-214-5849). Dr. Coyle is an associate of the International Forgiveness Institute and continues to pursue research in the areas of both forgiveness and post-abortion trauma. She has published several papers and given numerous presentations concerning these topics. Contact via e-mail at: ctcoyle@abortionresearch.net

Dr. Coyle is on the advisory boards of the International Forgiveness Institute and the Care Net Pregnancy Center of Dane County, and is a board member of the Wisconsin Medical Society Foundation.

Martha Shuping, M.D.

Psychiatrist, Shuping & Associates, Winston-Salem, North Carolina:

Dr. Martha Shuping earned her M.D. degree from Wake Forest University School of Medicine, Winston-Salem, NC, in 1984. She completed a 4-year psychiatry residency at Wake Forest University Baptist Medical Center in 1988. She currently practices in Winston-Salem, NC. Dr. Shuping has had extensive experience in working with women who have had abortion issues. She has served as facilitator for the Rachel's Vineyard weekend retreats, and has trained professionals and peer counselors for abortion recovery programs in Europe, Asia, and throughout the U.S. She has taught continuing education workshops for physicians and nurses, and has also presented workshops on women's health after abortion at the United Nations. She has authored articles and books relating to abortion recovery, including *The Four Steps to Healing* (with Debbie McDaniel).

<http://www.postabortionhealing.net> .

David Reardon, Ph.D.

Director of the Elliot Institute, Springfield, Illinois:

David C. Reardon, Ph.D., director of the Elliot Institute, is a biomedical ethicist and a leading expert on the aftereffects of abortion on women, a field in which he has specialized since 1983. He is the author of numerous books and popular and scholarly articles on this topic.

His studies have been published in such prestigious medical journals as the British Medical Journal and the American Journal of Obstetrics and Gynecology, and have shown that, compared to childbirth, abortion is associated with higher rates of maternal death, subsequent substance abuse, clinical depression, and psychiatric hospitalization.

He is the author of numerous books on the effects of abortion on women, including, *Aborted Women, Silent No More*, and *Victims and Victors: Speaking Out About Their Pregnancies, Abortions, and Children Resulting from Sexual Assault*, with Julie Makimaa and Amy Sobie. He is also co-author of *Forbidden Grief: the Unspoken Pain of Abortion* with Dr. Theresa Burke.

Articles about Dr. Reardon and his work have appeared in numerous magazines and newspapers, including *Newsweek* and the *New York Times*.

Thomas McClusky

Vice President for Government Affairs, Family Research Council, Washington, D.C.:

As Vice President of Government Affairs for Family Research Council, Tom McClusky has represented the organization before Congress since 2003 on a variety of issues, including education policy, tax reform, faith-based initiatives, and the sanctity of marriage.

Mr. McClusky has a long history of both local and national campaign experience. His first job in Washington, D.C. was with the Republican National Committee as a political analyst. Following the 1992 elections, Mr. McClusky worked as a legislative/legal analyst for the multi-billion dollar Coastal Corporation.

In 1998, Mr. McClusky became Senior Policy Analyst for National Taxpayers Union and National Taxpayers Union Foundation (NTU/NTUF) where he worked on a daily basis with Members of Congress and their staff. While at NTUF he wrote a number of presidential candidate agenda reports which had a critical role in providing non-partisan fiscal perspectives on the 2000 election.

ABORTION TRAUMA, PTSD & COMPLICATED GRIEF

Vincent M. Rue, Ph.D.*
Institute for Pregnancy Loss
Jacksonville, Florida
E-mail: vincerue@bellsouth.net



Some disorders have to be
seen
to be believed

WHO TO BELIEVE?



Rue: Abortion Trauma, PTSD & Complicated Grief

3

Post-abortion Trauma

- is 27 years old
- continues to be politically incorrect in the USA
- is increasingly acknowledged by the public
- is denied by the media and abortion rights proponents
- is denied or minimized by American mental health organizations
- is more accepted by international mental health organizations

Rue: Abortion Trauma, PTSD & Complicated Grief

4

Basic Assumptions

- Abortion is an intentionally caused human death event. it can cause serious and lasting adverse mental health outcomes for many women and men
- The patient's perception of the abortion event is determinative
- If abortion is perceived as violating one's moral code or religious values, it is likely to precipitate significant intrapsychic conflict and present a risk to one's mental health.
- Individuals may be asymptomatic following an abortion, experiencing intense psychological sequelae months, years or even decades later.

Rue: Abortion Trauma, PTSD & Complicated Grief

5

Mental Health Realities of Abortion

- **Insufficient evidence confirming abortion's psychological safety**
- **No credible evidence documenting abortion's mental health benefits**
- **Abortion is contraindicated when undertaken for mental health reasons**
- **Abortion can place mental health at risk**
- **Untreated traumatic stress complicates and thwarts grief responses**

Rue: Abortion Trauma, PTSD & Complicated Grief

6

Continuum of Mental Health Risks from Induced Abortion

Postabortion Distress	Postabortion Anxiety & Mood Disorders (PAS or PTSD)	Postabortion Psychotic Disorders	Suicide or Homicide
-----------------------	---	----------------------------------	---------------------

Rue: Abortion Trauma, PTSD & Complicated Grief

7

When an abortion is traumatic, and cannot be openly acknowledged, publicly mourned or socially supported, the woman/man lives in isolation and dreaded silence. For such an individual, grief is "disenfranchised."

Postabortion Syndrome (PAS)

is a Type of Posttraumatic Stress Disorder

Traumatic Stressor (DSM-IV*)

- "the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others"
- "the person's response involved intense fear, helplessness, or horror"

*American Psychiatric Association, Diagnostic & Statistical Manual of Mental Disorders IV, 1987

Rue: Abortion Trauma, PTSD & Complicated Grief

10

PAS/PTSD Diagnostic Criteria

- Unwanted Re-experiencing
- Persistent Avoidance
- Increased Arousal (not present before the abortion)
- Significant Distress or Impairment in Functioning
- Symptom Duration: 1 month>

Rue: Abortion Trauma, PTSD & Complicated Grief

11

What Is Abortion Trauma?

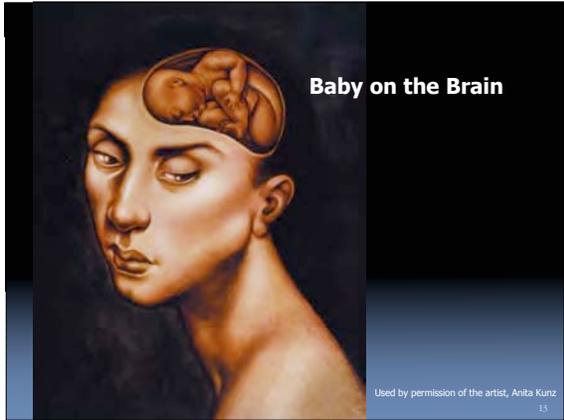


Polly Becker, WSJ 2008

- Overwhelming stress at the abortion clinic
- Participation in the intentional and actual death of my unborn child or later learning of this
- Feelings of fear, horror and helplessness

Rue: Abortion Trauma, PTSD & Complicated Grief

12



Epidemiology of PTSD

- Prevalence of trauma exposure is higher in men (%) M:F 61:51
- Women exposed to trauma are twice as likely to develop PTSD (20.4% vs. 8.2%)
- Lifetime prevalence of PTSD twice as high for women vs. men (10.4% vs. 5.0%)

Kessler, et al. *Arch Gen Psychiatry*. 1995; 52:1048.

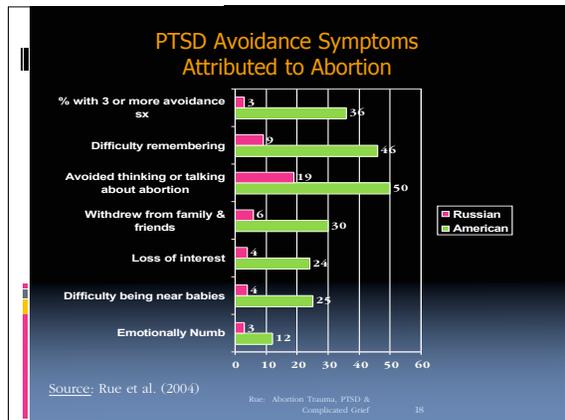
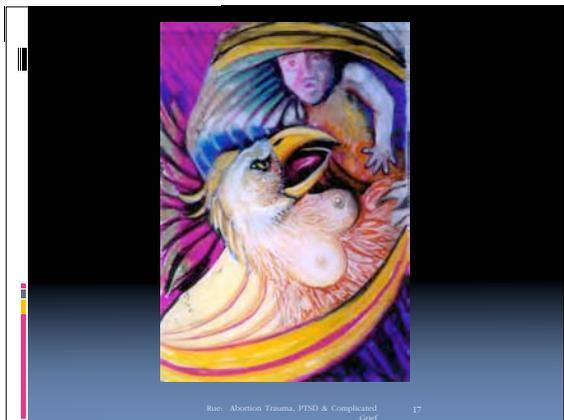
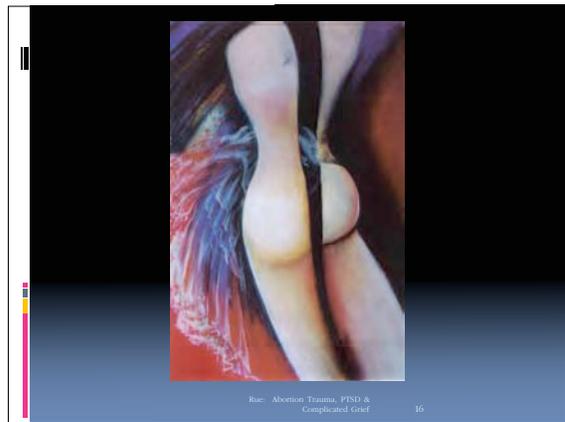
Rue: Abortion Trauma, PTSD & Complicated Grief

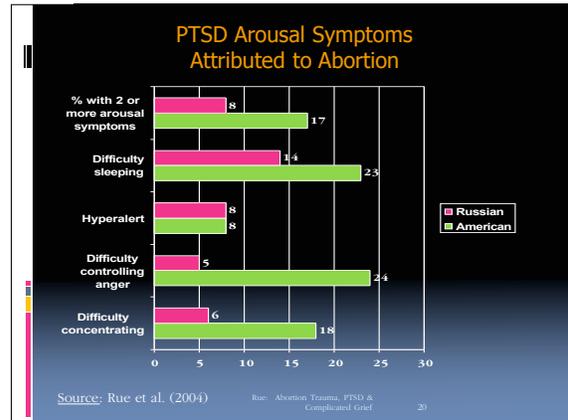
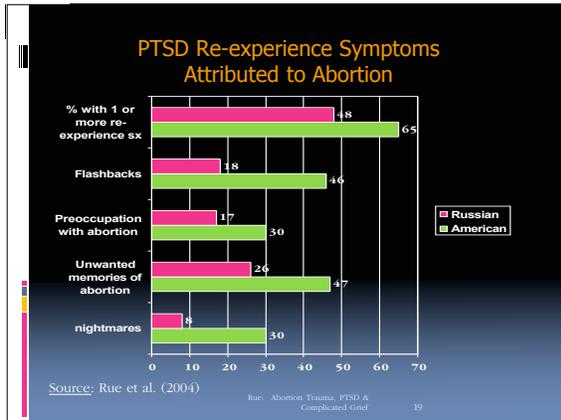
14

Trauma Can Produce Serious Psychological Disorders

Up to 50% of patients with PTSD go on to have a chronic course of this illness across their lifetime.

- Marshal et al. *Am. J. of Psych*. 2001, 158: 1982-1988





Cognitive Impact of Abortion Trauma – Shattered Assumptions

- The world is not benevolent
- The self is not innocent
- The world is not meaningful
- The self is not worthy

Rue: Abortion Trauma, PTSD & Complicated Grief 21

Abortion & Disrupted Cognitive Schema (TSI Belief Scale Scores)*

- 242 for battered women (Dutton, 1994)
- 244 for outpatients at mental health clinic (Pearlman & MacIan, 1992)
- 260 for women aborting (Rue et al., 2004)

*The higher the scores, the greater the cognitive disruption.

Rue: Abortion Trauma, PTSD & Complicated Grief 22

“THE TEARS FREELY FORM WHENEVER I AM ALONE . . . THEY COME OUT FROM HIDING, REVEALING THOUGHTS I DON’T YET KNOW I HAVE. BUT MY TEARS KNOW . . . AND THEY COME. THEY VISIT AT DARK AND THEY VISIT AT DAWN. I WONDER IF MY GUESTS WILL EVER LEAVE?”

Amy, 34 years old

Postabortion Syndrome:

*Diagnostic Criteria**

A. EXPOSURE TO TRAUMA: Both of the following are present:

- (1) the person has experienced, witnessed or was confronted with an abortion event which was perceived as traumatic and involving the actual and intentional death of the unborn child.
- (2) the person's response involved intense fear, helplessness, or horror so as to cause significant symptoms of re-experience, avoidance, increased arousal and impacted grief.

B. REEXPERIENCE: The abortion trauma is re-experienced in one or more of the following ways:

- (1) recurrent and intrusive distressing recollections of the abortion experience
- (2) recurrent distressing dreams of the abortion or of the unborn child (e.g. baby dreams or fetal fantasies)
- (3) acting or feeling as if the abortion event were recurring (includes reliving the experience, illusions, hallucinations, dissociative [flashback] episodes)
- (4) intense psychological distress at exposure to events that symbolize or resemble the abortion experience (e.g., medical clinics, pregnant mothers, babies, subsequent pregnancies), as well as experiencing anniversary reactions of intense grieving and/or depression on subsequent anniversary dates of the abortion or on the projected due date for delivery
- (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble as aspect of the abortion

C. AVOIDANCE: Persistent avoidance of stimuli associated with the abortion trauma or numbing of general responsiveness (not present before the abortion), as indicated by at least three of the following:

- (1) efforts to avoid thoughts, feelings or conversations as well as efforts to deny thoughts or feelings associated with the abortion or negative personal meaning derived from the experience
- (2) efforts to avoid information, activities, places, or people that arouse recollections of the abortion trauma
- (3) inability to recall an important aspect of the abortion trauma
- (4) markedly diminished interest or participation in significant activities
- (5) feeling of detachment or estrangement from others, including withdrawal in relationships and/or reduced communication
- (6) restricted range of affect, e.g., unable to have loving or compassionate feelings
- (7) sense of a foreshortened future, e.g., does not expect to have a career, marriage or future children, or a normal life span

D. ASSOCIATED FEATURES: Persistent symptoms of increased arousal (not present before the abortion trauma) as indicated by two or more of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger (e.g., at self, others, male partner, God, doctor)
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response to intrusive recollections of the abortion trauma
- (6) depression and/or suicidal thinking
- (7) persistent feelings of guilt about surviving when one's unborn child did not
- (8) significant symptoms of self devaluation and/or an inability to forgive one's self
- (9) secondary substance abuse
- (10) symptoms of eating disorder
- (11) loss of sexual interest or acting out with multiple sexual partners

E. DURATION: Symptoms in B, C, & D last more than 1 month

F. IMPAIRMENT: Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

G. ONSET:

- (1) Acute (if duration of symptoms is less than 3 months)
- (2) Chronic (if duration of symptoms is 3 months or more)
- (3) Delayed (if onset of symptoms is at least 6 months after the stressor)

*Developed by and revised by Vincent M. Rue, Ph.D. from diagnostic criteria for Posttraumatic Stress Disorder (DSM-IV: 309.81), American Psychiatric Association, **Diagnostic and Statistical Manual of Mental Disorders**, Washington, D.C.: APA, 1994, pp. 427-429. Postabortion Syndrome was first identified by Rue in 1981. While the American Psychiatric Association has not yet affirmed the existence of a clinical syndrome under the diagnosis of "Postabortion Syndrome," it has identified abortion as a type of "psychosocial stressor" (DSM III-R, p. 20, 1987). The most current diagnostic manual, DSM-IV, does not reference or include the diagnosis of "Postabortion Syndrome," but does identify the "death of a family member" as a type of psychosocial problem capable of causing PTSD.

Received: 2004.02.03
Accepted: 2004.04.22
Published: 2004.10.01

Induced abortion and traumatic stress: A preliminary comparison of American and Russian women

Authors' Contribution:

- A** Study Design
- B** Data Collection
- C** Statistical Analysis
- D** Data Interpretation
- E** Manuscript Preparation
- F** Literature Search
- G** Funds Collection

Vincent M. Rue^{1ABCDEF}, Priscilla K. Coleman^{2CDEF}, James J. Rue^{3AEF},
David C. Reardon^{4CDEF}

¹ Institute for Pregnancy Loss, Jacksonville, FL, U.S.A.

² Human Development and Family Studies, Bowling Green State University, Bowling Green, OH, U.S.A.

³ Sir Thomas More Clinic, Downey, CA, U.S.A.

⁴ Elliot Institute, Springfield, IL, U.S.A.

Source of support: Partial funding for this study was made possible by grants from the Trust Funds Foundation and the Alberto Vollmer Foundation.

Summary

Background:

Individual and situational risk factors associated with negative postabortion psychological sequelae have been identified, but the degree of posttraumatic stress reactions and the effects of culture are largely unknown.

Material/Methods:

Retrospective data were collected using the Institute for Pregnancy Loss Questionnaire (IPLQ) and the Traumatic Stress Institute's (TSI) Belief Scale administered at health care facilities to 548 women (331 Russian and 217 American) who had experienced one or more abortions, but no other pregnancy losses.

Results:

Overall, the findings here indicated that American women were more negatively influenced by their abortion experiences than Russian women. While 65% of American women and 13.1% of Russian women experienced multiple symptoms of increased arousal, re-experiencing and avoidance associated with posttraumatic stress disorder (PTSD), 14.3% of American and 0.9% of Russian women met the full diagnostic criteria for PTSD. Russian women had significantly higher scores on the TSI Belief Scale than American women, indicating more disruption of cognitive schemas. In this sample, American women were considerably more likely to have experienced childhood and adult traumatic experiences than Russian women. Predictors of positive and negative outcomes associated with abortion differed across the two cultures.

Conclusions:

Posttraumatic stress reactions were found to be associated with abortion. Consistent with previous research, the data here suggest abortion can increase stress and decrease coping abilities, particularly for those women who have a history of adverse childhood events and prior traumata. Study limitations preclude drawing definitive conclusions, but the findings do suggest additional cross-cultural research is warranted.

key words:

abortion • trauma • posttraumatic stress disorder • psychological sequelae • women's reproductive health

Full-text PDF:

http://www.MedSciMonit.com/pub/vol_10/no_10/4923.pdf

Word count:

4645

Tables:

7

Figures:

1

References:

50

Author's address:

Vincent M. Rue, Institute for Pregnancy Loss, 1574 Scottridge Lane, Jacksonville, FL 32259, U.S.A.,
e-mail: vincerue@bellsouth.net

BACKGROUND

Beyond politics, increasing public health concern is focusing on the adverse emotional outcomes women can experience following abortion [1–15]. Researchers on both side of the abortion debate agree that some women's mental health is negatively impacted by abortion and that more investigation is warranted to better assist those women and to prevent future harm to others.

Extensive research has documented how traumatic stress can significantly alter individuals' lives [16]. Traumatic stressors are strong predictors of PTSD. While the lifetime prevalence of PTSD has been estimated to be up to 12% of U.S. women [17], limited research has examined the role of induced abortion as a traumatic stressor.

Anxiety and depression have long been associated with induced abortion [18]. In a major review of the literature, anxiety symptoms were identified as the most common adverse postabortion response [19]. As an anxiety disorder, posttraumatic stress disorder (PTSD) can be identified with an overwhelming and life-threatening event and with an inability to process the trauma. Earlier research reported a connection between experiencing a traumatic abortion and the onset of posttraumatic stress related symptoms [20–24]. These studies were limited due to their reliance upon either case studies or small samples, with the exception of one larger study that reported a 1% incidence of PTSD following abortion [25]. The present study focused on the degree to which induced abortion was associated with posttraumatic stress and whether or not posttraumatic responses following abortion were evident in another culture.

Women's psychological responses to abortion are likely influenced by complex socio-cultural factors. In some nations the social environment surrounding abortion is defined by strong moral sanctions against it; whereas in other parts of the world abortion is a passively accepted medical practice. The present study represents an exploratory comparison of abortion reactions of American and Russian women. The comparison of these two groups is especially interesting because abortion continues to be a highly charged political issue in the United States since its legalization in 1973, while there has been very little political controversy about abortion in Russia following its legalization in 1955. For many years, Russian women have used abortion as one of their principle means of birth control due to the relative scarcity of other birth control options; although more restrictive policies are emerging [26–28].

Some research has suggested that PTSD is not just limited to Euro-Americans [29]. However, assessment of PTSD symptoms may vary widely due to ethnocultural influences [30–32]. While there is some evidence of PTSD following abortion in the U.S. [20–24], no equivalent research has been conducted with Russian women. Hence, the primary purpose of this research was to examine whether or not abortion was perceived as traumatic, and if so, whether or not its manifestations were equivalent to PTSD symptoms in both American and Russian women. The secondary purposes of this research included identifying demographic and pregnancy circumstances most predictive of possible negative outcomes, as well as evaluating the extent to which negative

responses could be due to cultural factors, rather than individual characteristics in American and Russian women.

MATERIAL AND METHODS

Participants

Women who had experienced a pregnancy loss (spontaneous abortion, induced abortion, stillbirth, or adoption) were asked to participate in a study of women's reactions to a pregnancy loss. Data were collected in 1994 at U.S. and Russian healthcare facilities (public and private hospitals, and health care clinics). All women between the ages of 18 and 40 were surveyed on a continuous basis until 992 women with at least one pregnancy loss had been identified. The sample used in the current study includes only those women who had one or more induced abortion and no miscarriages, stillbirths, or adoptions ($n=548$ or 55.2% of the larger sample). If multiple abortions were reported, the respondent was asked to identify and only report on the "most stressful" one. As to nationality, the sample used in the current study included 331 Russian and 217 American women.

At the time of their reported abortion experience, the mean age of the Russian women was 22.11 ($SD=5.80$) and for the American women, the mean age was 23.07 ($SD=5.71$). The mean age at the time the women completed the questionnaire was 28.24 ($SD=9.67$) for the Russians and 33.86 ($SD=8.85$) for the American. Among Russian women, the mean number of weeks pregnant at the time of the abortion was 6.75 ($SD=3.19$); whereas among the American women, the mean number of weeks pregnant was 10.07 ($SD=4.55$).

Procedure

Data were collected at one urban hospital in Russia and one urban hospital and two medical outpatient clinics in the United States. At the Russian national hospital, which specialized in women's health, all women seeking health care were asked by a staff physician to participate in the research. After several consultations with Russian physicians and demographers, as well as piloting the Russian version of the IPLQ, it was determined that the optimum form of data collection to ensure completeness and patient comprehension was to have staff doctors interview the patient/respondents. The considerable difficulty in translating the avoidance criteria of PTSD into Russian and concern regarding patient comprehension motivated the use of interviews as opposed to questionnaires in Russia. The participating Russian physicians were trained on the research purposes and particulars of using the IPLQ as an interview guide. Mental health facilities were purposefully excluded as data collection sites to prevent the selection of subjects from a "pathology-oriented" population.

In the U.S., each subject completed a written questionnaire. A study monitor at each of the three data collection sites was available to respond to any questions or concerns. In Russia, a staff physician interviewed each female patient and completed the questionnaire on her behalf in order to minimize cross-cultural misinterpretations of question wording. In all cases, respondents were informed of the following: (1) that their participation in the research was voluntary; (2) that all

responses were anonymous; (3) that they had the right to refuse participation and that non-participation would not influence their healthcare; (4) that they had the right to discontinue participation in the research at any point; and (5) that counseling was available afterwards if so requested. The administration time was 15 to 20 minutes. Due to funding and staff limitations, no data were collected on women who chose not to participate.

Measures

The two data collection instruments used were the Institute for Pregnancy Loss Questionnaire (IPLQ) and the standardized Traumatic Stress Institute's (TSI) Belief Scale - Version K originally developed by Pearlman [33]. The scale was subsequently revised to Version L [34] and has now been renamed the Trauma & Attachment Belief Scale [35,36]. A university-based human subjects review panel approved the use of the IPLQ and it was pre-tested using college age students.

The IPLQ included two major sections. The first section included demographic and background information. The latter included questions related to likely control variables including stressors that might pre- or postdate the abortion. The second section of the IPLQ presented subjects with a cognitive/emotional/behavioral checklist of positive and negative effects of abortion that had been previously reported in the literature. Subjects were asked to indicate whether or not they had experienced the various responses before and after the abortion, and whether or not they believed the abortion caused the items endorsed. Only those symptoms women specifically attributed to their abortions were reported here.

Items included in the second section of the IPLQ were drawn from a pool of variables identified by experts in the field of pregnancy loss with additional items culled from the research literature. The determination of which items to include was made by a panel of clinician raters for purposes of content validation. Thirty-one items pertaining to possible negative effects met the final selection criteria for inclusion in the cognitive/emotional/behavioral checklist, with 14 of these items indicative of PTSD symptomatology. On the 14-item PTSD scale, Cronbach's alpha was 0.89. Cronbach's alpha for the 17-item negative effects scale (all negative items minus the PTSD symptoms) was 0.87. For the three subscales of the PTSD measure, corresponding to symptoms of arousal (4 items), re-experience (4 items), and avoidance (6 items), Cronbach's alpha coefficients were found to equal 0.67, 0.74, and 0.81 respectively. The fourteen items on this scale correspond to the 14 symptoms of PTSD outlined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) [37]. In order to meet the DSM-IV criteria for PTSD diagnosis a person must endorse at least two symptoms of arousal, one re-experiencing symptom, and three avoidance symptoms for at least one month. Four positive outcome items were included as well: relief, improved self-image, improvement in partner relationships, and feeling more in control of one's life. These four items were included both to address response set bias and because they were repeatedly reported in the literature. Cronbach's alpha was found to equal 0.45 for the four-item positive response total scale.

A single item self-report measure of the level of stress experienced as a result of the abortion served as another outcome measure. The range of scores on this item was from 1 to 4, with lower scores indicative of minimal stress and higher scores suggesting overwhelming stress.

In addition to the IPLQ, the standardized Traumatic Stress Institute's (TSI) Belief Scale was employed. The TSI Belief Scale is intended to measure disruptions in beliefs about self and others that can arise from exposure to psychological trauma. The scale consists of 90 items and uses a 6-point Likert scale. The TSI Belief Scale is based on Constructivist Self Development Theory, integrating self psychology, object relations, interpersonal and social cognition theories [38,39]. Internal consistency reliability of the TSI Belief Scale was reported to be 0.98 (Cronbach's alpha). Subscale reliabilities ranged from 0.77 (other-control) to 0.91 (self-esteem); however, only total summed scores were used in this study [33]. The TSI Belief Scale has been used with a variety of populations and has reliably discriminated between trauma survivors and non-trauma survivors [33,34].

RESULTS

Various demographic and psychosocial background variables were assessed. In this sample, as to ethnicity, most of the women from the former Soviet Union identified themselves as Russian (78.2%); in the American sample, 59.4% were white, 24.9% Hispanic, and 10.1% black. Most Russian women worked full-time (63.4%) compared to 34.3% of the women in the American sample. In both cultures, the majority of women worked in the professional/ business sector (62% Russian v. 57.9% American). More Russian women were married (59.1%) compared to American women (49.1%), and Russian women had slightly more years of education than American women (48.9% had 16 years of education v. 42.9%). As to number of children, 52% of Russian women had none compared to 30.4% of American women.

Regarding the psychosocial variables, these data generally suggest that women in the Russian sample perceived their childhoods (8.5% Russian v. 51.6% American) and adolescence (74.2% Russian v. 36.6% American) to be happier than American women. American women were considerably more likely to report being physically or sexually abused before age 18 (42.3% American v. 11.4% Russian). When asked about religious convictions, 63.1% of the Russian sample and 89.4% of the American sample indicated having religious beliefs. The mean rating of the importance of these beliefs was 2.49 (SD=0.73) for the Russian sample and 1.49 (SD=0.71) for the American sample on a scale of 1 to 4, with scores closer to 1 suggesting more importance.

Table 1 contains the descriptive statistics for all the outcome measures for both the Russian and American samples. On a 1 to 4 scale, women in both countries generally reported their abortion experiences as stressful. Overall, when compared to Russian women, American women who chose to abort were more than twice as likely to experience negative psychological effects and report PTSD symptoms of arousal, re-experience, and avoidance, particularly the latter. Russian women only scored higher than American women on the TSI scale.

Table 1. Descriptive statistics for the outcome measures based on nationality.

Variable	Potential range	Russian (N=331)			American (N=217)		
		Observed range	M	SD	Observed range	M	SD
Negative effects	0–17	0–15	4.57	3.18	0–17	10.56	3.59
PTSD Total scores	0–14	0–13	3.42	3.21	0–14	8.95	3.84
PTSD Arousal	0–4	0–4	1.13	1.23	0–4	2.29	1.27
PTSD Re-experience	0–4	0–4	1.14	1.17	0–4	2.75	1.39
PTSD Avoidance	0–6	0–6	1.14	1.40	0–6	3.92	1.76
Disruption in cognitive schemas (TSI total scores)	90–540	115–383	274.61	38.33	127–399	258.65	56.57
Self-reported stress associated with the abortion	1–4	1–4	2.85	0.69	1–4	3.34	0.77
Positive effects after abortion	0–4	0–3	0.71	0.84	0–4	0.88	1.04

Table 2. Zero-order correlations reflecting associations between particular psychosocial stressors and outcome measures based on nationality (Russian data in bold).

	Harshly disciplined as a child	Abused as a minor	Parents divorced before 18	Unwanted Sexual contact before 18	Sexually abused by relative before age 18	Raped after age 18	Physically or emotionally abused after 18
Self-reported stress	0.03 0.04	0.01 0.08	0.03 0.12	0.12* –0.04	0.13* –0.06	0.01 0.10	0.01 0.00
TSI scores	0.07 0.10	0.02 0.05	0.10 0.01	0.03 0.11	0.12 0.01	0.09 0.18*	0.15* 0.14*
Negative effects Total scores	0.13* 0.01	0.08 0.04	0.07 0.06	0.16** 0.06	0.16** 0.04	0.22** 0.01	0.28** 0.01
PTSD Total scores	0.16** 0.00	0.07 0.04	0.11 0.05	0.11 0.06	0.01 0.03	0.21** 0.04	0.27** 0.01

* $p < 0.05$;** $p < 0.01$.

Table 2 provides zero-order correlations reflecting associations between particular psychosocial stressors and outcome measures based on nationality. Table 3 provides zero-order correlations among all the outcome measures conducted separately for the two samples. Significant correlations were detected between PTSD symptoms (total and subscale scores) and the other measures of negative effects in both samples. In addition, the subscales of the PTSD measure were significantly intercorrelated with data collected from the Russian and American samples.

Table 4 contains descriptive data for all the abortion context variables. In both countries, women perceived abortion as morally wrong in equal proportion. More Russian women than American women felt prepared for their abortion in that they were counseled on alternatives, felt the counseling they received was adequate, and found their partner

was supportive. On the other hand, more American women in this sample versus Russian women felt they needed more time to make their decision, felt pressured by others to abort, and were less sure of their decision at the time of the abortion.

Table 5 presents both positive and negative outcomes following abortion which were unrelated to PTSD. As for positive outcomes, few women in either country felt relief or more in control of their lives after their abortion; fewer still experienced relationship improvement or enhanced self-esteem after the procedure. On the other hand, the majority of women in both countries felt badly following their abortions, including feeling considerable guilt. American women were almost twice or more likely than their Russian counterparts to have sexual problems, overprotect their children, experience suicidal thoughts, report difficulty at work,

Table 3. Zero-order correlations among the outcome measures based on nationality (Russian data above the diagonal and American data below the diagonal).

	1	2	3	4	5	6	7
1. Self-reported stress associated with the abortion		0.25**	0.29**	0.30**	0.13*	-0.04	0.10
2. Negative effects after abortion	0.14*		0.71**	0.65**	0.61**	0.14*	0.41**
3. PTSD Arousal	0.04	0.68**		0.60**	0.55**	0.15**	0.40**
4. PTSD Re-experience	0.07	0.64**	0.63**		0.56**	0.08	0.47**
5. PTSD Avoidance	0.16*	0.70**	0.66**	0.61**		0.09	0.28**
6. Disruption in cognitive schemas (TSI total scores)	-0.01	0.31**	0.32**	0.25**	0.31**		-0.01
7. Positive effects after abortion	-0.19**	0.07	0.03	-0.006	0.01	-0.07	

* p<0.05;

** p<0.01.

Table 4. Single item frequencies for the abortion circumstance variables and the outcome measures based on nationality.

<i>Abortion-related variables</i>	Russian (N=331)			American (N=217)		
	Percent "yes"	Percent "no"	Percent "unsure"	Percent "yes"	Percent "no"	Percent "unsure"
Desired pregnancy	14.8	71.1	14.2	17.7	76.7	11.6
Pregnancy desired by partner	14.6	56.4	29	14	71.2	14.9
Received counseling beforehand	64	34.7	1.3	29.4	66.8	3.8
Needed more time to make decision	33.3	54.5	12.2	51.9	32.4	15.7
Counseled on alternatives	48.8	45.1	6.1	17.5	79.2	3.3
Felt pressured by others	37.2	54.9	7.9	64	28.5	7.5
Felt abortion was morally wrong	50.5	35.7	13.8	50.7	19.2	30
Had health complications afterwards	21.4	60.9	17.8	30.5	62.6	6.7
Believed in a woman's right to have an abortion	79	6.2	14.8	40.1	26.4	33.5
Received adequate counseling beforehand	63.4	30.5	6.0	10.8	84	5.2
Partner was supportive	50.7	41.1	8.3	23.8	64.3	11.9
Parents involved in the decision making	27.1	70.3	2.6	19.7	78.4	1.9
Parental involvement was helpful	23.1	72.6	4.3	12.4	79.7	7.9
Was not sure about the decision at the time	38	49.7	12.3	54.2	27.8	17.9
Received counseling afterwards	11.9	88.1	0	21	79	0
Effectiveness of counseling	80.6	19.4	0	78.8	21.2	0
Felt emotionally close or attached to the pregnancy, child	37.2	24	38.8	39.3	24.8	36

SR

Table 5. Percent positive and negative outcomes attributed to abortion by nationality.

	Russian	American
Relationship with partner improved	2.2%	0.9%
Felt better about myself	0.3%	0.9%
Felt relief	6.9%	13.8%
Felt more in control of my life	1.6%	3.7%
Felt badly	47.0%	53.9%
Thoughts of suicide	2.8%	36.4%
Difficulty at work	2.5%	11.5%
Increase in alcohol or drugs	4.4%	26.7%
Guilt	49.8%	77.9%
Fears concerning future pregnancy and parenting	34.9%	36.9%
Feelings of sadness and loss	38.6%	55.8%
Sexual problems	5.9%	24.0%
Felt overwhelmed	14.0%	30.4%
Overprotecting my child(ren)	6.2%	12.4%
Need help to deal with this loss	8.4%	29.0%
Relationship problems	6.8%	26.7%
Felt part of me died	33.6%	59.5%
Sadness at loss anniversaries	9.7%	39.2%
Unable to forgive self	10.9%	62.2%
Relationship ended with partner	7.8%	19.8%
Psychiatric hospitalization	0.9%	2.3%

increase their use of alcohol or drugs, have fears concerning future pregnancy and parenting, experience feelings of loss and sadness, report relationship problems, feel part of them died, feel sadness and loss at anniversaries (of due date or abortion date), and report the end of their relationship with their partner.

Figure 1 presents the posttraumatic stress related symptoms included in the IPLQ by diagnostic criteria for PTSD: arousal, avoidance and re-experience. For American women, the top 5 most commonly endorsed PTSD symptoms were the following: difficulty remembering, flashbacks, avoiding thinking or talking about the abortion, unwanted memories of the abortion, and difficulty concentrating. For Russian women, the top 5 most commonly endorsed PTSD symptoms included: unwanted memories of the abortion, difficulty sleeping, being hyperalert, having flashbacks, and avoiding thinking or talking about the abortion. Additional analysis revealed that 65% of American women and 13.1% of Russian women experienced multiple symptoms of in-

creased arousal, re-experiencing and avoidance. When the analysis was further restricted to only those symptoms the subjects attributed to their abortions, 14.3% of American and 0.9% of Russian women met the full diagnostic criteria for abortion-related PTSD (at least two symptoms of arousal, one re-experiencing symptom, and three avoidance symptoms persisting for at least one month).

Eight analyses of covariance (ANCOVAs) were conducted in an effort to compare American and Russian women with respect to positive and negative outcomes associated with the experience of an induced abortion. In each analysis, statistical controls were introduced relative to the number of abortions, amount of time elapsed since the pregnancy, the number of weeks pregnant at the time of the procedure, severe stress-related symptoms prior to the experience, and other stressors postdating the abortion in addition to demographic and psychosocial variables found to be significantly related to nationality. More specifically, these variables included the following: divorce, current marital status, number of children, employment, age, holding religious beliefs, the importance of religious beliefs held, self-reported happiness during childhood and adolescence, having experienced harsh discipline, sexual abuse, physical abuse, or parental divorce prior to age 18, having experienced unwanted sexual contact before age 18, having experienced physical or emotional abuse after age 18, and having been raped after age 18.

The results of these analyses are presented in Table 6. Compared to Russian women, American women reported significantly more negative effects, including more symptoms of PTSD (subscale scores and total scores), and higher levels of stress associated with the abortion experience. Russian women, on the other hand, reported significantly higher rates of disruption in cognitive schemata. No nationality differences were observed relative to positive effects. The amount of variance attributed to nationality on the tests that were significant ranged from 1% to 24%.

A series of eight multiple regression analyses were conducted for the Russian and American samples for the purpose of identifying possible demographic and pregnancy circumstance variables that were predictive of positive and negative outcomes. Controls were instituted for severe stress-related symptoms prior to the experience, other stressors postdating the abortion, and psychosocial history variables likely to have been associated with high levels of stress (harsh discipline, sexual abuse, physical abuse, or parental divorce prior to age 18, unwanted sexual contact before age 18, physical or emotional abuse after age 18, and rape after age 18). In each analysis, the control variables were entered into the first block, with the demographic and pregnancy-related variables entered into the second and third blocks respectively. Demographic variables included the following: age, marital status, history of divorce, number of children, employment, and education. The pregnancy circumstance predictors of interest included the following: number of weeks pregnant, time elapsed since the procedure, number of abortions, feelings of being bonded to the fetus, desire for the pregnancy, partner's desire for the pregnancy, partner's supportiveness of the decision, confidence in the decision, needing more time to decide, having received counseling beforehand, having received counseling afterwards, hav-

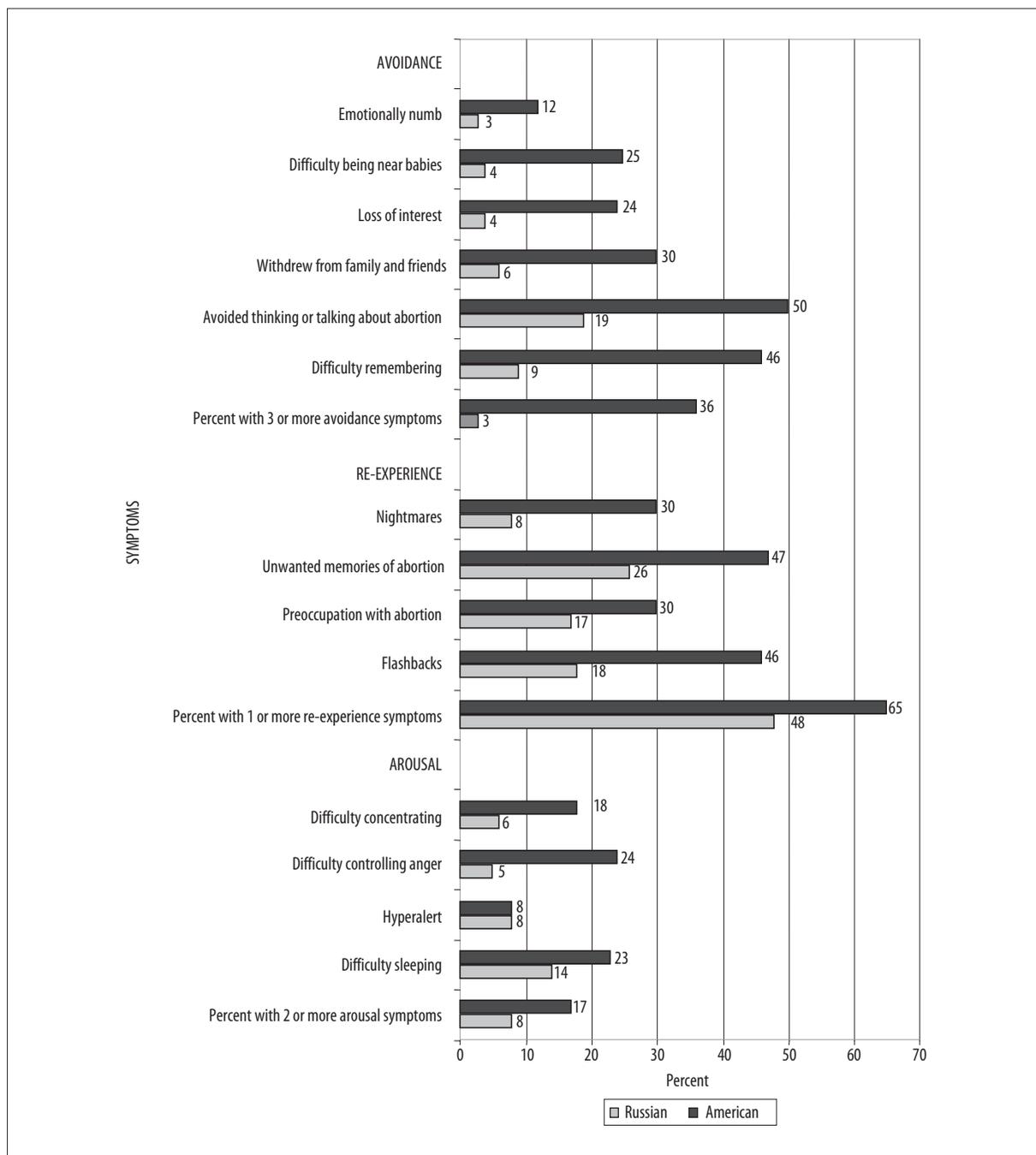


Figure 1. PTSD symptoms following abortion by nationality and percent.

ing felt pressure from others to abort, having felt abortion was morally wrong, believing in a woman’s right to have an abortion, having had health complications afterwards, and parental involvement in the decision.

Table 7 provides the outcomes of these analyses. Demographic predictors of negative psychological outcomes included being younger, more religious, and having more children in the Russian sample. Abortion circumstances predicting negative psychological outcomes in the Russian women included having bonded to the fetus, not believing in a woman’s right to abort, having a partner who desired the pregnancy, having experienced health complications, hav-

ing felt pressured into the decision, having experienced ambiguity surrounding the decision, not having received counseling before the procedure, and having been farther along in the pregnancy at the time of the abortion. Russian women experiencing more positive responses tended to be less religious, but there were no other significant demographic predictors of positive reactions. More time elapsed since the procedure and not having felt pressured into the decision were the only two abortion-circumstance variables associated with positive reactions in the Russian sample.

Using data generated from the American sample, demographic predictors of negative psychological outcomes in-

Table 6. Outcome comparisons based on nationality.

Outcome	F-test p-value	Potential range	Russian adjusted mean (SE), 95% CI American adjusted mean (SE), 95% CI	Partial Eta squared
Positive effects	0.23 p=0.630	0–4	0.75 (0.06), .63–0.88 0.81 (0.08), .65–0.97	0.00
Negative effects	119.09 p<0.0001	0–17	5.08 (0.22), 4.65–5.52 9.80 (0.29), 9.23–10.38	0.19
PTSD arousal subscale	25.16 p<0.0001	0–4	1.28 (0.08), 1.12–1.45 2.08 (0.11), 1.97–2.30	0.05
PTSD re-experience subscale	71.68 p<0.0001	0–4	1.24 (0.08), 1.07–1.40 2.62 (0.11), 2.40–2.83	0.12
PTSD avoidance subscale	160.07 p<0.0001	0–6	1.21 (0.11), 1.01–1.42 3.81(0.14), 3.54–4.09	0.24
PTSD total scores	112.03 p<0.0001	0–14	3.73 (0.23), 3.28–4.19 8.51 (0.31), 7.91–9.11)	0.18
Self-reported stress associated with the abortion	6.22 p=0.013	1–4	2.95 (0.05), 2.86–3.05 3.19 (0.06), 3.06–3.32	0.01
Disruption in cognitive schemas	13.61 p<0.0001	90–540	277.22 (3.12), 271.09–283.34 254.82 (4.12), 246.75–262.88	0.03

In every ANCOVA, controls were included for the number of abortions, the number of weeks pregnant, amount of time elapsed since the procedure, severe stress-related symptoms prior to the experience, other stressors pre- and post-dating the abortion, and psychosocial history variables (harsh discipline, sexual abuse, physical abuse, or parental divorce prior to age 18, unwanted sexual contact before age 18, physical or emotional abuse after age 18, and rape after age 18).

cluded being younger, a history of divorce, not having been employed full-time, and more years of education. Abortion circumstance variables that predicted negative psychological outcomes included having bonded to the fetus, not believing in a woman's right to have an abortion, not having been counseled before the abortion, having felt pressured into the decision, and having experienced more abortions. None of the demographic variables predicted positive adjustment reactions among the American women. Abortion circumstance predictors of positive reactions in the American women included believing in a woman's right to an abortion, not having needed more decision time, having a partner who did not desire the pregnancy, and being fewer weeks along at the time of the procedure.

DISCUSSION

Women from Russia and the U.S. were compared with respect to negative and positive outcomes after an induced abortion. Compared to Russian women, American women exhibited more negative effects, more symptoms of PTSD, and reported higher levels of stress associated with experiencing an abortion. However, the Russian women reported significantly higher rates of disruption in cognitive schemata. No nationality differences were observed relative to positive effects.

In the present study, American women were exposed to considerably more preabortion traumatic events than their Russian counterparts. The percentage of American women reporting preabortion trauma is high but roughly equivalent to an earlier study that found 40% of females reported unwanted sexual experiences prior to age 18 [40] and another which found 38% reported childhood emotional abuse

[41]. Approximately half of women who experience early childhood trauma also experience PTSD at some point [42]. Other research has confirmed that childhood traumata are more likely to result in subsequent high risk-taking behaviors, including a significantly higher number of abortions [43–45]. The findings here suggest that abortion may well exacerbate prior posttraumatic stress symptoms, even if in remission. Hence, an individual's trauma history should be fully explored in counseling prior to obtaining an abortion.

In this study, for Russian women, the least endorsed PTSD subscale was that of avoidance. This finding corroborates prior research that the PTSD subscale of avoidance is more difficult to assess in non Euro-American cultures, and that failure to diagnose PTSD is often due to lack of cultural comprehension of avoidance symptoms [29].

The TSI Belief Scale was used in this study to examine disruption of cognitive schemata relative to basic needs impacted by trauma: self/other-safety, self/other-trust, self/other-esteem, self/other-intimacy, and self/other-control. The higher the total score, the greater the degree of disrupted cognitive schemata. Numerous factors may explain why Russian women scored higher on this scale than American women, e.g., repeated exposure to abortion as birth control, or a combination of that with repeated and cumulative re-experiencing of other traumata in Russian life, i.e., severe economic shortages, exposure to criminal/gang violence, enduring regimes which were totalitarian and dehumanizing, and disintegration of family life.

Comparing the overall TSI score with other known populations of impacted individuals in the U.S. may help

Table 7. Results of multiple regression analyses.

Russian sample outcomes	Block variables	Change in r ²	Change in F
Negative effects	Block 2: Significant demographic predictors: • Younger age (p=0.001) • More children (p=0.010) • Religious (p=0.004)	0.07	3.62, p=0.001
	Block 3: Significant abortion-related predictors: • More bonded to fetus (p=0.010) • Not believing in a woman's right to abort (p<0.001) • Unsure of decision (p=0.020) • More weeks pregnant (p<0.001)	0.15	4.11, p<0.0001
PTSD Total scores	Block 2: Significant demographic predictors: • Younger age (p=0.010) • More children (p=0.031) • Religious (p=0.019)	0.04	2.35, p=0.024
	Block 3: Significant abortion-related predictors: • No counseling before abortion (p=0.031) • Having experienced health complications (p<0.001) • More weeks pregnant (p=0.001)	0.13	3.26, p<0.001
PTSD Arousal subscale scores	Block 2: Significant demographic predictors: • Younger age (p=0.001) • More children (p=0.042) • Religious (p=0.014)	0.06	3.08, p=0.004
	Block 3: Significant abortion-related predictors: • Having experienced health complications (p<.008) • Not believing in a woman's right to have an abortion (p=0.040) • Unsure of decision (p=0.024) • More weeks pregnant (p<0.001)	0.13	3.00, p<0.001
PTSD Re-experience subscale scores	Block 2: Significant demographic predictors: • None	0.02	1.28, p=0.260
	Block 3: Significant abortion-related predictors: • Partner desired pregnancy (p=0.026) • More bonded to fetus (p=0.022) • Having experienced health complications (p<0.002) • More weeks pregnant (p<0.001)	0.13	3.09, p<0.001
PTSD Avoidance subscale scores	Block 2: Significant demographic predictor: • More children (p=0.038)	0.04	1.91, p=0.068
	Block 3: Significant abortion-related predictors: • More bonded to fetus (p=0.033) • No counseling after abortion (p=0.018) • Having felt pressured (p=0.034) • Having experienced health complications (p=0.001)	0.10	2.26, p=0.003
Positive effects	Block 2: Significant demographic predictor: • Less religious (p=0.010)	0.03	1.58, p=0.14
	Block 3: Significant abortion-related predictors: • Not having felt pressured (p=0.004) • More years since abortion (p=0.041)	0.10	2.14, p=0.006
Disruption in cognitive schemas	Block 2: Significant demographic predictors: • None	0.01	0.37 p=.918
	Block 3: Significant abortion-related predictor: • No counseling before abortion (p=0.007)	0.08	1.55, p=.078
Self-reported stress associated with the abortion	Block 2: Significant demographic predictors: • Younger age (p=0.011) • Religious (p=0.002)	0.07	3.21, p=0.003
	Block 3: Significant abortion-related predictor: • More weeks pregnant (p<0.001)	0.10	2.04, p=0.01

SR

Table 7. Continued. Results of multiple regression analyses.

American sample outcomes	Block variables	Change in r ²	Change in F
Negative effects	Block 2: Significant demographic predictors: • Younger age (p=0.001) • History of divorce (p=0.004)	0.11	3.65, p=0.001
	Block 3: Significant abortion-related predictors: • None	0.08	1.04, p=0.418
PTSD Total scores	Block 2: Significant demographic predictors: • None	0.12	3.92, p=0.001
	Block 3: Significant abortion-related predictors: • More bonded to fetus (p=0.036) • Not believing in a woman's right to have an abortion (p=0.013)	0.12	1.74, p=0.039
PTSD Arousal subscale scores	Block 2: Significant demographic predictors: • None	0.09	2.79, p=0.009
	Block 3: Significant abortion-related predictor: • No counseling before abortion (p=0.036)	0.09	1.28, p=0.212
PTSD Re-experience subscale scores	Block 2: Significant demographic predictors: • Not being employed full-time (p=0.038) • More years of education (p=0.050)	0.14	5.06, p<0.001
	Block 3: Significant abortion-related predictors: • More bonded to fetus (p=0.001) • Not believing in a woman's right to have an abortion (p=0.006)	0.14	2.24, p=0.005
PTSD Avoidance subscale scores	Block 2: Significant demographic predictor: • More years of education (p=0.029)	0.09	2.94, p=0.006
	Block 3: Significant abortion-related predictor: • Not believing in a woman's right to have an abortion (p=0.046)	0.11	1.58, p=0.073
Positive effects	Block 2: Significant demographic predictors: • None	0.03	0.94, p=0.477
	Block 3: Significant abortion-related predictors: • Believing in a woman's right to have an abortion (p=0.001) • Not needing more time to decide (p=0.041) • Partner did not desire pregnancy (p=0.015) • Fewer weeks pregnant (p=0.006)	0.18	2.85, p<0.001
Disruption in cognitive schemas	Block 2: Significant demographic predictor: • History of divorce (p=0.040)	0.07	2.29, p=0.029
	Block 3: Significant abortion-related predictor: • Not believing in a woman's right to have an abortion (p=0.007)	0.10	1.45, p=0.118
Self-reported stress associated with the abortion	Block 2: Significant demographic predictors: • More years of education (p=0.044) • Younger age (p=0.041)	0.07	2.24, p=0.033
	Block 3: Significant abortion-related predictors: • More bonded to fetus (p=0.045) • Having felt pressured (p=0.021) • More abortions (p=0.030)	0.15	2.32, p=0.003

In every regression analysis, first block controls were included for severe stress-related symptoms prior to the experience, other stressors pre- and post-dating the abortion, and psychosocial history variables (harsh discipline, sexual abuse, physical abuse, or parental divorce prior to age 18, unwanted sexual contact before age 18, physical or emotional abuse after age 18, and rape after age 18).

provide a better understanding of the meaning of the cognitive disruption identified here. For example, the mean total TSI score in a study of battered women was 242 [46], and 244 in a population of outpatient mental health clients [33]. In the present study, American women who aborted had a mean total TSI score of 260 whereas Russian women had a mean total TSI score of 276.

The amount of variance attributed to nationality on the tests that were significant ranged from 1% to 24%, suggesting that most of the variability in women's responses to an abortion may be attributable to other personal or situational factors. Cultural factors may play a role in how stress is experienced and reported. More specifically, the higher rates of behavioral and emotional manifestations reported by the American women are perhaps consonant with a social en-

vironment that is more conflicted on the issue of abortion. On the other hand, in a cultural context wherein abortion is normative and a much less volatile social issue, women who do suffer from the experience, may be more inclined to deal with the stress on an intellectual or cognitive level. Russian women may also be more stress-experienced and less prone to verbalizing than American women given the harshness of economic, political and social conditions they have endured over the past decades.

Using multiple regression, several common variables were determined to be predictive of adverse psychological adjustment following abortion. In both the U.S. and in Russia, these predictive risk factors included: being younger, having bonded to the fetus, not believing in a woman's right to abort, having felt pressured into the decision, and not having received counseling before the procedure. Social policies in both countries that enhance informed consent and professional counseling opportunities for women seeking abortions would appear to be beneficial. Furthermore, public policies that increase the protections afforded younger women would also appear warranted.

Despite the strengths of the study, limitations are apparent. The data were derived through the exclusive use of retrospective self-report measures. As with most of the prior research on postabortion adjustment, self-selection precludes generalization of the results to the entire population of women having abortions, in either the U.S. or Russia. In the U.S., at least, it is known that many women will not report a prior abortion even on an anonymously submitted questionnaire [47]. Research has shown that women who conceal their abortion experience from others, compared to those who do not, are more likely to suppress thoughts of the abortion, experience more intrusive abortion-related thoughts, and feel greater psychological distress [48].

While this study is the first to survey postabortion women from two different cultures with the same instrument, the comparisons between American and Russian women must be cautiously interpreted due to several limitations. *First*, while the TSI scale has been validated among American women, we have no information about its validation among Russian women. *Second*, we have no information on the women who declined to participate. *Third*, while the mean age of women in both groups at the time of their abortions is similar, there was a five-year difference between the mean number of years that had elapsed between the abortion and the time each group responded to the survey (10.6 years for American women, 5.8 years for Russian women). Although it is unclear why this time discrepancy occurred, it may reflect some difference in the age groups served by the American and Russian health care institutions collecting the data or a cultural bias as to why and when women are willing to disclose information about a past abortion. If the experience of negative reactions to abortion or the willingness to disclose negative reactions increase over time, the longer period of time between the abortion and the data collection observed among the American women may play a role in explaining why the American women generally reported more negative reactions. This hypothesis is supported by evidence that negative reactions to abortion may increase over time [25,49,50]. Case reports have also shown that suppressed traumatic reactions to abortion can be triggered by later events, such as a subse-

quent birth or death [2,11]. The *fourth* limitation is that for the Russian women the hospital where the physician interviewed them was often the same site at where their abortions were performed. Being questioned about a past abortion in the facility where the abortion was performed may have resulted in stress that altered responses or increased the refusal rate. *Fifth*, while American women completed the questionnaire themselves, a physician interviewed the Russian women. The use of an orally presented questionnaire in Russia and a written questionnaire in the U.S. may have resulted in significant differences in the results that were not related to cultural factors but to the administrative mode.

CONCLUSIONS

In conclusion, this study provides increased insight into the manifold reactions of women to induced abortion while also identifying convergent predictors of adverse psychological adjustment following abortion in two diverse cultures. This study furthers our understanding of traumatic responses across cultures, and in particular, suggests that for some women, abortion is a traumatic stressor capable of causing PTSD symptoms. Finally, the results also significantly expand our knowledge of risk factors associated with negative postabortion outcomes, and therefore may help to improve preabortion screening and counseling.

Acknowledgements

The authors gratefully acknowledge the generous assistance of Suzi Tellefsen, Susan Stanford-Rue, Ph.D, Frida Rotlewicz, Ph.D, Anne Speckhard, Ph.D, B. Hudnall Stamm, Ph.D, Cui Xinja, M.D, Teri Reisser, M.A, Paul Reisser, M.D, Svetlana Sysoeva, M.D, Nina Kirbasowa, M.D, Michael Mannion, S.T.D, Kerry Cielinski, Ph.D, Eugenia Riordan Mule, Alexander Rodriguez, Nancy Austin & Elizabeth Blake.

REFERENCES:

1. Thorp JM, Hartman KE, Shadigian EM: Long-term physical and psychological health consequences of induced abortion: Review of the evidence. *Ob Gyn Survey*, 2002; 58: 67-69
2. Burke T, Reardon DC: *Forbidden grief: the unspoken pain of abortion*. Springfield (IL): Acorn Books, 2002
3. Coleman PK, Reardon DC, Rue VM, Cogle JR: State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over four years. *Amer J Ortho*, 2002; 72: 141-52
4. Coleman PK, Reardon DC, Rue VM, Cogle JR: A history of induced abortion in relation to substance abuse during pregnancies carried to term. *Amer J Ob Gyn*, 2002; 187: 1673-78
5. Reardon D, Ney P: Abortion and subsequent substance abuse. *Amer J Drug Alcohol Abuse*, 2000; 26: 61-75
6. Reardon DC, Cogle JR: Depression and unintended pregnancy in the National Longitudinal Survey of Youth: A cohort study. *BMJ*, 2002; 324: 151-52
7. Reardon DC, Cogle JR, Rue VM et al: Psychiatric admissions of low income women following abortion and childbirth. *Can Med Assoc J*, 2003; 168: 1252-56
8. Ostbye T, Wenghofer E, Woodward C et al: Health services utilization after induced abortions in Ontario: A comparison between community clinics and hospitals. *Amer J Med Quality*, 2001; 16: 99-106
9. Rue V, Speckhard A: Post abortion trauma: Incidence and diagnostic considerations. *Med & Mind*, 1992; 6: 57-74
10. Russo N, Denious J: Violence in the lives of women having abortions. *Prof Psych*, 2001; 32: 142-50
11. Stotland N: Abortion: Social context, psychodynamic implications. *Am J Psychiatry*, 1998; 155: 964-67

12. Cougle JR, Reardon DC, Coleman PK: Depression associated with abortion and childbirth: A long term analysis of the NLSY cohort. *Med Sci Monit*, 2003; 9(4): CR157–CR164
13. DePuy C, Dovitch D: *The healing choice*. New York, Fireside, 1997
14. Ring-Cassidy E, Gentles I: *Women's health after abortion: The medical and psychological evidence*. Toronto: De Veber Institute, 2002
15. Soderberg H, Janzon L, Sjoberg N: Emotional distress following induced abortion: A study of its incidence and determinants among adoptees in Malmo, Sweden. *Eur J Obstetr Gyn Reprod Biol*, 1998; 79: 173–78
16. Litz B, Roemer L: Post-traumatic stress disorder: An overview. *Clin Psych & Psychotherapy*, 1996; 3: 153–68
17. Resnick H, Kilpatrick D, Dansky B et al: Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *J Consult Clin Psychol*, 1993; 61: 984–91
18. Illsley R, Hall MH: Psychological aspects of abortion: A review of issues and needed research. *Bull World Health Organ*, 1976; 53: 83–106
19. Bradshaw Z, Slade P: The effects of induced abortion on emotional experiences and relationships: A critical review of the literature. *Clin Psych Rev*, 2003; 23: 929–58
20. Bagarozzi D: Post traumatic stress disorders in women following abortion: Some considerations and implications for marital/couple therapy. *Int J Family Marriage*, 1993; 1: 51–68
21. Congleton GK, Calhoun LG: Postabortion perceptions: A comparison of self-identified distressed and non-distressed populations. *Int J Soc Psychiatry*, 1993; 39: 255–65
22. Barnard C: *The long-term psychosocial effects of abortion*. Jacksonville (Florida): Institute for Pregnancy Loss, 1990
23. Hanley D, Piersma H, King D et al: Women outpatients reporting continuing post-abortion distress: A preliminary inquiry. Paper presented at the annual meeting of the International Society for Post-Traumatic Stress Studies, Los Angeles, 1992
24. Pope L, Adler N, Tschann J: Postabortion psychological adjustment: Are minors at increased risk? Unpublished paper, Exhibit 2, Affidavit of Nancy E. Adler, Ph.D. in North Florida Women's Health and Counseling Services, Inc, et al. v. State of Florida, et al. In the Circuit Court of the Second Judicial Circuit in and for Leon County, Tallahassee, Florida, 1999
25. Major B, Cozzarelli C, Cooper ML et al: Psychological responses of women after first-trimester abortion. *Arch Gen Psych*, 2000; 57(8): 777–84
26. Vishnevsky AG: Family, fertility and demographic dynamics in Russia: Analysis and forecast. In: DaVanzo J, editor. *Russia's demographic "crisis"*. Santa Monica, CA: Rand Conference Proceedings, 1996; 1–35
27. Vikhlayeva EM, Nikolaeva E: Epidemiology of abortions in Russia. *Entre Nous Cph Den*, 1996; 34–35: 18
28. Parfitt T: Russia moves to curb abortion rates. *Lancet*, 2003; 362: 968
29. Marsella AJ, Friedman MJ, Gerrity ET, Scurfield RM: Ethnocultural aspects of ptsd: Some closing thoughts. In: Marsella AJ, Friedman MJ, Gerrity ET, Scurfield RM, editors. *Ethnocultural aspects of posttraumatic stress disorder: Issues, research and clinical applications*. Washington, DC: American Psychological Association, 1996; 529–38
30. Frey C: Post traumatic stress disorder and culture. In: Yilmaz AT, Weiss MG, Riecher-Rossler A, editors. *Cultural psychiatry: Euro-international perspectives*. Basel, Switzerland: Karger, 2001; 103–16
31. Kleber RJ, Figley CR, Gersons BP, editors: *Beyond trauma: Cultural and social dynamics*. New York, Plenum, 1995
32. Resick PA: *Stress and trauma*. London: Psychology Press, 2001
33. Pearlman L, Maclann P: *The TSI Belief Scale: Normative Data from Four Criterion Groups*. Unpublished manuscript. South Windsor, CT: Traumatic Stress Institute, 1992
34. Pearlman LA: Psychometric review of TSI Belief Scale Revision L. In: Stamm BH, editor. *Measurement of stress, trauma and adaptation*. Lutherville, Md.: Sidran Press, 1996
35. The TSI Belief Scale was recently renamed the Trauma, Attachment & Belief Scale as described at <http://www.tsicaap.com/research.htm> and is being made available through Western Psychological Services
36. Pearlman LA: *Traumatic Stress Institute Belief Scale. Revision L*. Unpublished. Copyright Western Psychological Services, Los Angeles, 2000
37. American Psychiatric Association: Diagnostic criteria for posttraumatic stress disorder. In: *Diagnostic & statistical manual of mental disorders IV*. Washington, D.C.: American Psychiatric Press, 1994; 427–28
38. Janoff-Bulman R: *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press, 1992
39. McCann I, Pearlman L: *Psychological trauma and the adult survivor: Theory, therapy and transformation*. New York: Brunner/Mazel, 1990
40. Kellogg ND, Huston RL: Unwanted sexual experiences in adolescents. *Clin Ped*, 1995; June: 306–12
41. Walker EA, Koss MP, Katon WJ: Medical sequelae of sexual and physical victimization of women. *NASPOG Annual Meeting Abst*, 1995; 5: 77–78
42. Kessler RC, Sonnega A, Bromat E et al: Post-traumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry*, 1995; 52: 1048–60
43. Walker EA et al: Costs of health care utilization by women HMO members with a history of childhood abuse and neglect. *Arch Gen Psychiatry*, 1999; 56: 549–55
44. Walker EA, Katon WJ: Research the health effects of victimization: The next generation. *Psychosom Med*, 1996; 58: 16–17
45. Green BL, Schnurr PP: Trauma and physical health. *Clin Qrtly Nat Center for Post-Traumatic Stress Disorder*, 2000; 9: 3–5
46. Dutton M et al: Battered women's cognitive schemata. *J Traumatic Stress*, 1994; 7: 237–55
47. Jones EF, Forrest JD: Under reporting of abortion in surveys of U.S. women: 1976 to 1988. *Demography*, 1992; 29: 113–26
48. Major B, Gramzow RH: Abortion as a stigma: cognitive and emotional implications of concealment. *J Person Soc Psychol*, 1999; 77(4): 735–45
49. Miller WB: An empirical study of the psychological antecedents and consequences of induced abortion. *J Soc Iss*, 1992; 48: 67–93
50. Miller WB, Pasta DJ, Dean CL: Testing a model of the psychological consequences of abortion. In: Beckman LJ, Harvey SM, editors. *The new civil war: The psychology, culture, and politics of abortion*. Washington: American Psychological Association, 1998

Posttraumatic Stress Disorder After Abortion

Martha Shuping, M.D. (April 17, 2007)

Research shows that a high percentage of women are likely to have some symptoms of posttraumatic stress after abortion. Even those having only some symptoms but not meeting all criteria may still experience significant distress. They will continue to remain at risk for developing full criteria posttraumatic stress disorder when exposed to other stresses later in life. Those who develop posttraumatic stress disorder often have symptoms that are very long-term, and this disorder is a predictor of poor general health. Comparisons with other groups give an indication of the magnitude of the stress that many women experience from abortion.

Post-abortive women have higher trauma scores compared to women in a battered women's shelter.¹

American and Russian women who had experienced abortion in their past were studied regarding effects of abortion. On a test to measure the effects of trauma, the Traumatic Stress Institute's (TSI) Belief Scale was used. In a study of battered women, the average (mean) score was 242, and in a population of outpatient mental health patients, the score was 244. For U.S. women who had aborted, the average score was 260, and for Russian women who had aborted, the average score was 276.

65% Experience Multiple Symptoms of Posttraumatic Stress after Abortion.² In the above study of post-abortive women, 65% of the American women were found to have multiple symptoms of posttraumatic stress disorder. 14.3% of the American women reported all the symptoms necessary for the diagnosis of posttraumatic stress disorder. In another study, 19% of post-abortive women met diagnostic criteria for posttraumatic stress disorder, with about half the women having many, but not all, the symptoms.³

Posttraumatic stress disorder prevalence in other groups: To help understand the meaning of these numbers, it may help to look at the prevalence of posttraumatic stress disorder in other populations. "The most recent National Comorbidity Survey Report, published in 2005 on a newer sample, estimated lifetime prevalence of PTSD among adult Americans at 6.8%."⁴

The United States Department of Veteran's Affairs, reporting on The National Vietnam Veterans Readjustment Survey, says that 15.2% of all male Vietnam veterans and 8.1% of all female Vietnam veterans received diagnoses of Posttraumatic Stress Disorder at the time of the Survey (1986-88).⁵ This study found "an additional 22.5% of men and 21.2% of women have had partial Posttraumatic Stress Disorder at some point in their lives." Those with "partial posttraumatic stress disorder" are considered to have experienced "clinically serious stress reaction symptoms" even though not meeting all the diagnostic criteria.

All trauma is cumulative—each new stress continues to add to the burden of trauma carried by a person. If a person has some symptoms of trauma but not enough to meet diagnostic criteria for posttraumatic stress disorder, later additional trauma may cause symptoms to worsen or new symptoms to develop so that the person later meets criteria for diagnosis. One report stated that it is "probable that any individual could develop posttraumatic stress disorder regardless of other risk-factors once the trauma load reaches a certain threshold."⁶ Another report concluded, "Cumulative trauma continued to affect psychiatric symptom levels a decade after the original trauma events."⁷

Effects of trauma are often very long-lasting. An important study of posttraumatic stress in the general population (The National Comorbidity Study) showed that "more than one third of people with posttraumatic stress disorder fail to recover even after many years."⁸

Posttraumatic stress disorder is predictive of poor health. This was the conclusion in a study that controlled for a "wide range of variables predictive of poor health."⁹

Types of symptoms and some examples:

1) **Re-experiencing the trauma:** Trauma may be re-experienced by distressing dreams, distressing memories, or experiencing intense distress when encountering anything that reminds the person of the trauma.¹⁰ A woman experiencing posttraumatic stress after an abortion may experience severe anxiety when she is around a pregnant woman or a newborn baby since these can be reminders of the abortion.¹¹

2) **Increased arousal:** There is increased arousal so that sleep may be disturbed.¹² A large study of 57,000 women with no known history of sleep problems showed that women were more likely to be treated for sleep disorders after having an abortion compared to giving birth. Those women who had abortions were almost twice as likely to be treated for sleep disorders in the first six months after the pregnancy ended compared to women who continued the pregnancy and gave birth. Many studies show that trauma victims experience sleep difficulties.¹³

The diagnostic manual lists other symptoms of arousal including irritability or anger outbursts.¹⁴ This may explain why women with a past abortion have higher risk of child abuse and domestic violence.^{15,16,17,18,19}

3) **Avoidance** may take the form of efforts to avoid activities, places or people that may cause people to remember the trauma.²⁰ If a particular type of music was playing during a woman's abortion, she may want to avoid that type of music. Or she may avoid going for routine gynecological care because the thought of the examination may make her remember the abortion. Many women have reported avoiding babies or pregnant women. A woman whose story is told in *Forbidden Grief* stated she had quit a job she liked because she could not bear to be around a pregnant co-worker because of the pregnancy.²¹

Other forms of avoidance can involve shutting down the emotions ("restricted range of affect")²² which may affect marital or family relationships if the woman is not able to feel loving feelings.²³

There may also be an effort to avoid thoughts or feelings connected to the trauma. Dr. Coleman suggests, "Alcohol and drugs, which are readily accessible in our society, may be used as a means for effectively suppressing or blunting painful memories."²⁴

Strong link between posttraumatic stress disorder and substance abuse shown in many studies:

In a review article, Dr. Priscilla Coleman writes: "There is strong evidence for an association between PTSD and substance use disorders."^{25,26,27,28,29,30} "A general population study published in 1995 revealed a 7.6% lifetime rate of drug abuse or dependence for women without a history of PTSD and 26.9% lifetime rate of drug abuse or dependence among women with a history of PTSD. Recent research has indicated that the onset of PTSD typically precedes the onset of substance use disorders, suggesting a causal relation."^{30,31} "In a study of over 1000 young adults, Chilcoat and Breslau found that PTSD was associated with a more than 4-fold increased risk of drug abuse and dependence 3 to 5 years after an initial assessment."³² "The authors suggested that drug abuse or dependence in persons with PTSD might be a result of their efforts to self-medicate."

REFERENCES:

1. Rue VM, Coleman PK, Rue JJ, Reardon DC. Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. *Medical Science Monitor*. 2004; 10(10):SR5-16.
2. Ibid.
3. Barnard C. *The Long-Term Psychological Effects of Abortion*. 1990. Portsmouth, N.H.: Institute for Pregnancy Loss.
4. National Center for PTSD Fact Sheet. United States Department of Veterans Affairs. Available from: http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_epidemiological.html (Accessed April 13, 2007)
5. Ibid.
6. Neuner F, Schauer M, Karunakara U, Klaschik C, Robert C, Elbert T. Psychological trauma and evidence for enhanced vulnerability for posttraumatic stress disorder through previous trauma among West Nile refugees. *BMC Psychiatry*. 2004;4:34. Published online 2004 October 25. doi: 10.1186/1471-244X-4-34. (Accessed April 13, 2007).

7. Mollica RF, McInnes K, Poole C, Tor S. Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *British Journal Psychiatry*, 1998 Dec;173:482-8.
8. Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. *Archives General Psychiatry* 1995;Dec 52(12):1048-60.
9. Lauterbach D, Vora R, Rakow M. The relationship between posttraumatic stress disorder and self-reported health problems. *Psychosomatic Medicine*. 2005 Nov-Dec 67(6):939-47.
10. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. (*DSM-IV*TM). Washington, DC: American Psychiatric Association; 1994:424-429.
11. Burke T, Reardon DC. *Forbidden Grief: The Unspoken Pain of Abortion*. 2002. Springfield: Acorn Books.
12. Diagnostic and Statistical Manual of Mental Disorders, op. cit.
13. Reardon DC, Coleman PK. Relative treatment rates for sleep disorders and sleep disturbances following abortion and childbirth: a prospective record based study. *Sleep*. 2006;29(1):105-106.
14. Diagnostic and Statistical Manual of Mental Disorders, op. cit.
15. Benedict, et al., Maternal Perinatal Risk Factors and Child Abuse. *Child Abuse and Neglect*. 1985;9:217-224.
16. P.G. Ney, "Relationship between Abortion and Child Abuse," *Canadian Journal of Psychiatry*, 24:610-620, 1979.
17. Reardon, *Aborted Women - Silent No More*. Chicago: Loyola University Press. 1987:129-30.
18. Burke T, Reardon DC, op. cit.
19. Priscilla K. Coleman, Vincent M. Rue, Catherine T. Coyle, Charles D. Maxey: Induced Abortion and Child-Directed Aggression Among Mothers of Maltreated Children. *The Internet Journal of Pediatrics and Neonatology*. 2007. Volume 6 Number 2.
20. Diagnostic and Statistical Manual of Mental Disorders, op. cit.
21. Burke T, Reardon DC, op. cit.
22. Diagnostic and Statistical Manual of Mental Disorders, op. cit.
23. Burke T, Reardon DC, op. cit.
24. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34.
25. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34. Ibid., citing Kessler RC, Sonnega A, Bromet E, *et al*. Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry* 1995; 52: 1048-1060. 7.
26. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34, citing Brady KT, Back SE, Coffey SF. Substance abuse and posttraumatic stress disorder. *Current Directions in Psychological Science* 2004; 13:206-209.
27. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34, citing Chilcoat HD, Breslau N. Posttraumatic Stress Disorder and Drug Disorders. *Arch Gen Psychiatry* 1998; 55: 913-917.
28. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34, citing Jacobsen LK, Southwick SM, Kosten TR. Substance Use Disorders in Patients with Posttraumatic Stress Disorder: A Review of the Literature. *Am J Psychiatry* 2001; 158(8): 1184-1190
29. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34, citing Saxon AJ, Davis TM, Sloan KL, *et al*. Trauma, Symptoms of Posttraumatic Stress Disorder, and Associated Problems Among Incarcerated Veterans. *Psychiatr Serv* 2001; 52: 959-964.
30. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34, citing Armony JL, LeDoux JE. How the brain processes emotional information. In Yehuda R & McFarlane AC Eds, *Psychobiology of posttraumatic stress disorder*. New York, Academy of Sciences 1997; 259-270.
31. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34, citing Chilcoat HD, Breslau N. Posttraumatic Stress Disorder and Drug Disorders. *Arch Gen Psychiatry* 1998; 55: 913-917.
32. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34, citing Saxon AJ, Davis TM, Sloan KL, *et al*. Trauma, Symptoms of Posttraumatic Stress Disorder, and Associated Problems Among Incarcerated Veterans. *Psychiatr Serv* 2001; 52: 959-964.
32. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Current Women's Health Reviews*. 2005;1(21):21-34, citing Chilcoat HD, Breslau N. Posttraumatic Stress Disorder and Drug Disorders. *Arch Gen Psychiatry* 1998; 55: 913-917.

Abortion and Mental Health Research



Priscilla Coleman, Ph.D.

Associate Professor of Human Development and Family Studies
Bowling Green State University
(pcolema@bgnnet.bgsu.edu)

1

Basic statistics

- Worldwide, the lifetime average is 1 abortion per woman.
- By age 45, more than 35% of U.S. women have had at least one abortion.



2

A rapidly progressing literature



- The world literature on abortion and mental health has grown considerably in the past several decades and the scientific rigor of the published studies has increased substantially.
- Identification of risk factors for adverse post-abortion adjustment and specific negative psychological consequences have been the focus of most of the research.

3

Risk factors for adverse psychological effects of abortion



4

Risk factors for adverse psychological effects of abortion

- Pregnancy is initially intended
- Unstable or immature partner relationships
- Being unmarried or poor
- Feelings of having been forced into abortion by significant individuals or by life circumstances
- Pre-abortion ambivalence or decision difficulty
- Low confidence related to coping with the abortion
- Compromised self-esteem

5

Risk factors for adverse psychological effects of abortion

- Non-supportive partner, family members, or friends
- Conservative views of abortion
- Second trimester abortions
- Pronounced maternal orientation
- Pre-existing emotional problems or unresolved trauma
- Prior abortions
- A negative relationship with one's mother
- Timing during adolescence

6

Adverse psychological effects of abortion: a synopsis of the literature



Adverse psychological effects of abortion: a synopsis of the literature

- Research indicates 20-30% of women experience adverse, prolonged post-abortion reactions.
- With 1.3 million U.S. abortions performed annually - a minimum of 260,000 new cases of mental health problems surface each year.



Adverse psychological effects of abortion: a synopsis of the literature

Latest research has many strengths:

- More longitudinal or prospective studies
- Larger samples
- Controls for prior mental health and other variables serving to equate abortion and no abortion groups
- Use of medical claims data
- Employment of unplanned pregnancy delivered as a comparison group

Adverse psychological effects of abortion: a synopsis of the literature

The most sophisticated studies employ nationally representative samples and numerous controls for personal and situational factors that may differ between women choosing to abort or deliver.

These studies have clearly demonstrated that abortion significantly increases risk for **depression, anxiety disorders, sleep problems, suicide ideation, suicide, and substance abuse.**

Adverse psychological effects of abortion: a synopsis of the literature

When compared to unintended pregnancy carried to term and other forms of perinatal loss, abortion poses more significant mental health risks.



Results of recent studies from around the globe



New Zealand



In 2006 researcher David Fergusson reported that women who aborted were at a significantly higher risk for mental health problems compared to those who delivered and were never pregnant. By age 25:

- 42%: Major depression
- 39%: Anxiety
- 27%: Suicidal ideation
- 6.8%: Alcohol dependence

13

New Zealand

In his article, Dr. Fergusson challenged the American Psychological Association's conclusion that: "*Well-designed studies of psychological responses following abortion have consistently shown that risk of psychological harm is low.*"



14

Norway



A Norwegian Sociologist, Willy Pedersen recently published two studies linking abortion to mental health problems.

Data for both studies was from the Young in Norway Longitudinal Study, which is nationally representative and included over 700 respondents.

15

Norway

Women with an abortion history were nearly 3 times as likely as their peers without an abortion experience to report significant depression after the researcher controlled for parental education level, parental smoking habits, parental support, and prior history of depression.

16

Norway

Women who aborted had increased risk of nicotine dependence: 400%, alcohol problems: 180%, marijuana use: 360%, and other illegal drugs: 670% compared to other women after controlling for social background, parental and family history, smoking, alcohol and drug use, conduct problems, depression, schooling, and career variables.



17

South Africa

Suliman and colleagues (2007) employed clinician-administered interviews and self-report measures in assessments of 151 women recruited from private abortion clinics.

The authors of this longitudinal study concluded "*The prevalence of PTSD after termination was 17.5% and 18.2% at one and three months respectively.*" Presence of these clinical levels of PTSD was not predicted by baseline (prior to the abortion) levels of depression, state anxiety, self-esteem, and functional disability.

18

United States: Rees & Sabia



Rees and Sabia (2007) employed a large representative sample of U.S. women who had recently given birth, the Fragile Families and Child Wellbeing Study, to examine the extent to which abortion increases risk for Major Depression.

19

United States: Rees & Sabia

Women who had an abortion were at a higher risk for major depression compared to women who had not become pregnant.

The difference could not be explained by race, ethnicity, age, education, household income, number of children, or prior depression.

After adjusting for these factors, abortion was associated with more than a two-fold increase in the likelihood of having depressive symptoms at second follow-up.

20

United States: Coleman, Coyle, Shuping & Rue

We recently analyzed data from the National Co-morbidity Survey, which provides the most comprehensive epidemiological data on the prevalence of psychological disorders in the U.S.



21

United States: Coleman, Coyle, Shuping & Rue

Abortion made a significant contribution independent of 22 personal history and socio-demographic control variables to the following disorders. Increased risk estimates were from 44% to 167%.

- **Anxiety Disorders:** Panic Disorder, Panic Attacks, PTSD, Agoraphobia with Panic Disorder, Agoraphobia without Panic Disorder
- **Substance Abuse Disorders:** Alcohol Abuse with or without Dependence, Alcohol Dependence, Drug Abuse with or without Dependence, and Drug Dependence.
- **Mood Disorders:** Bipolar Disorder, Major Depression without Hierarchy, Major Depression with Hierarchy.

22

United States: Coleman, Coyle, Shuping & Rue

Abortion contributed significant independent effects to many disorders above and beyond that of other stressful life experiences including frequent demands from relatives, a history of miscarriage/stillbirth, rape, abuse of various forms, a life threatening accident, difficulty paying bills, and health problems.

In fact, abortion made a significant independent contribution to more mental health outcomes than rape, sexual abuse in childhood, physical assault in adulthood, physical abuse in childhood, and neglect.

23

Conclusion



Our findings and those of several other research groups indicate it is false and misleading to suggest to women that abortion has no significant mental health risks, much less is "psychologically safer" than carrying to term.

24

**DOES ABORTION CAUSE MENTAL HEALTH PROBLEMS?
THE EVIDENCE THROUGH AN OBJECTIVE SCIENTIFIC LENS
AS OPPOSED TO THE APA'S RECENT ANALYSIS**

Priscilla K. Coleman
Bowling Green State University

I. Background for understanding causality when studying human behavior

Due to the inherent complexity of human psychological health outcomes, such as depression and suicidal behavior, identification of a single, precise causal agent applicable to all cases is not possible. Every mental health problem is determined by numerous physical and psychological characteristics, background, and current situational factors subject to individual variation. Further, any one cause (e.g. abortion) is likely to have a variety of effects (e.g., anxiety, depression, suicidal behavior) based on the variables involved.

A *risk factor* refers to any variable that has been established to increase the likelihood of an individual experiencing an adverse outcome. Risk factor data are used in medicine and psychology for the explicit purposes of understanding etiology, warning patients of risks associated with various medical interventions, and development of effective prevention and intervention protocols to maximize health.

Assessment of degree of risk is often expressed in terms of *absolute risk*, which relates to the chance of developing a disease over a time-period (e.g., a 10% lifetime risk of suicide) or in terms of *relative risk*, which is a comparison of the probability of an adverse outcome in two groups. For example, abortion would be considered an increased risk for suicide if the relative risk is significantly higher for women who abort compared to women who give birth or never have children.

Determination of causality technically requires an experimental design in which there is random assignment of large groups to expected cause conditions (e.g., abortion, no abortion/delivery, no abortion/no pregnancy). However, as is true with numerous variables of interest in psychology and medicine, it is not ethical nor is it practically feasible to implement such a study. When scientists are not able to control or manipulate the variable of interest, risk factors for negative outcomes are established over time through the two primary scientific steps described below.

1. Analysis of each individual study. Each individual study published in a peer-reviewed journal is examined to assess the quality of evidence suggestive of a causal link between abortion and negative outcomes. The following three criteria are applied when the variable of interest such as abortion can not be manipulated.

- a. Abortion must be shown to precede the mental health problem (referred to as *time precedence*). This is typically accomplished with longitudinal or prospective data collection in which testing occurs over an extended period of time following the abortion.
- b. Differences in abortion history (abortion, no abortion) must be systematically associated with differences in mental health status (*covariation*).
- c. Finally, all plausible alternative explanations for associations between abortion and mental health must be ruled out using a method of control. Typically third variables

predictive of both the choice to abort and mental health (e.g. income, previous psychological problems, exposure to domestic violence etc.) are statistically removed from the analyses. Identifying, measuring, and statistically controlling for known predictors of abortion would go a long way to help establish causality; however there are many other means for achieving the same goal of infusing control. Additional control techniques include: (1) matching groups on all variables known to be related to abortion and the outcome measures; (2) measuring potential confounding variables and introducing them as additional variables to assess their independent effects; (3) identifying and selecting homogeneous populations to draw the pregnancy outcome groups.

2. Integrative analysis. After evaluating individual studies for causal evidence linking abortion to decrements in mental health, scientists assess the consistency and magnitude of associations between abortion and particular mental health problems across all available studies. This integrative process represents the second step for determining whether or not abortion is a substantial contributing factor for severe depression and other mental health problems.

a. *Consistency* refers to repeated observation of an association between abortion and mental health across several studies using different people, places, and circumstances tested at distinct points in time. When results become generalized in this manner, the probability that an association would be due to chance is dramatically reduced.

b. *Magnitude* (or strength of effect) refers to whether the associations between abortion and various mental health problems are slight, moderate, or strong. Strong associations across various studies are more likely causal than slight or modest associations. This point has been illustrated with the high risk ratios for the association between exposure levels of smoking and incidence of lung cancer.

II. The tables below provide an overview of the studies related to abortion and suicide ideation and suicide, abortion and substance use/abuse, abortion and depression, and abortion and anxiety. The arrangement of the data in the tables offers guidance regarding the extent to which the conditions for causality have been met.

Table 1: Scientific Studies Identifying Abortion as a Risk Factor in Suicidal Ideation and Suicide

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
1. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. <i>Journal of Child Psychology and Psychiatry</i> , 47, 16-24.	√	√	√ Those who delivered and were never pregnant used as comparison groups. Controlled for maternal education, childhood sexual abuse, physical abuse, child neuroticism, self-esteem, grade point average, smoking, prior history of depression, anxiety, prior history of suicide ideation, living with parents, living with partner	√ 27% of women who aborted reported experiencing suicidal ideation This effect was significant at the >.001 level, meaning there was on a 1 in 1000 chance that the result was due to chance. The risk was 4 times greater for women who aborted compared to never pregnant women and more than 3 times greater than women who for women who delivered
2. Gilchrist, A. C. et al (1995). Termination of pregnancy and psychiatric morbidity. <i>British Journal of Psychiatry</i> 167, 243	√	√	√ Comparisons included women who were refused abortion and women who chose abortion but changed their minds	√ Among women with no history of psychiatric illness, the rate of deliberate self-harm was significantly higher (70%) after abortion than childbirth
3. Gissler, M. et al. (1996). Suicides after pregnancy in Finland, 1987-94: Register linkage study. <i>British Medical Journal</i> , 313, 1431-4.	√	√	√ Compared women who aborted to those who delivered, miscarried, and the general population	√ Suicide rate was nearly 6 times greater among women who aborted compared to women who gave birth
4. Gissler, M., et al. (2005). Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. <i>European Journal of Public Health</i> , 15, 459-463.	√	√	√ Compared women who aborted to those who delivered, miscarried, and were not pregnant Distinguished level of risk associated with suicide and other forms of death.	√ Abortion was associated with a 6 times higher risk for suicide compared to birth.
5. Reardon, D.C., et al. (2002). Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study. <i>Southern Medical Journal</i> , 95,834-41.	√	√	√ Use of homogenous population. Controlled for prior psychiatric history, age, and months of eligibility for state medical coverage	√ Suicide risk was 154% higher among women who aborted compared to those who delivered
6. Rue, V.M., Coleman, P. K., Rue, J. J., & Reardon, D.C. (2004). Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. <i>Medical Science Monitor</i> 10, SR 5-16.	√	√	√ Controlled for stressors pre-and post-abortion, demographic and psycho-social variables (harsh discipline, sexual, physical, and emotional abuse, parental divorce, etc.)	√ 36.4% of the American women and 2.8% of the Russian women respectively reported suicidal ideation.

**Table 2: Scientific Studies Identifying Abortion
as a Risk Factor in Substance Use/Abuse**

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
1. Amaro H., Zuckerman B, & Cabral H. (1989). Drug use among adolescent mothers: profile of risk. <i>Pediatrics, 84, 144-151.</i>	√	√	√ Other forms of perinatal loss as comparison groups	√ Adolescent drug users when compared to nonusers were significantly more likely to report a history of elective abortion (33% vs. 16.3%). No associations were identified between drug use and parity or other forms of perinatal loss (miscarriage /stillbirth).
2. Coleman, P. K. (2006). Resolution of Unwanted Pregnancy During Adolescence Through Abortion versus Childbirth: Individual and Family Predictors and Consequences. <i>Journal of Youth and Adolescence.</i>	√	√	√ Demographic, educational, psychological, and family variables found to predict the choice to abort Exclusive focus on unwanted pregnancies	√ After implementing controls, adolescents with an abortion history, when compared to adolescents who had give birth were 6 times more likely to use marijuana.
3. Coleman, P. K., Reardon, D. C., Rue, V., & Cogle, J. (2002). History of induced abortion in relation to substance use during subsequent pregnancies carried to term. <i>American Journal of Obstetrics and Gynecology, 187, 1673-1678.</i>	√	√	√ Results were stratified by potentially confounding factors (marital status, income, ethnicity, and time elapsed since a prior abortion or birth)	√ Compared with women who had previously given birth, women who aborted were significantly more likely to use marijuana (929%), various elicited drugs (460%), and alcohol (122%) during their next pregnancy. Differences relative to marijuana and use of any elicited drug were more pronounced among married and higher income women and when more time had elapsed since the prior pregnancy. Differences relative to alcohol use were most pronounced among the white women and when more time had elapsed since the prior pregnancy.
4. Coleman, P. K., Reardon, D. C., & Cogle, J. (2005) Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy. <i>British Journal of Health Psychology, 10, 255-268.</i>	√	√	√ Other forms of loss Age Marital status Trimester in which prenatal care was sought Education Number in household	√ No differences were observed in the risk of using any of the substances measured during pregnancy relative to a prior history of miscarriage or stillbirth. A prior history of abortion was associated with a significantly higher risk of using marijuana (201%), cocaine-crack (198%), cocaine-other than crack (406%), any illicit drugs (180%), and cigarettes (100%).

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
5. Reardon, D. C., Coleman, P. K., & Cogle, J. (2004) Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study. <i>Am. Journal of Drug and Alcohol Abuse</i> , 26, 369-383.	√	√	Age Ethnicity Marital status Income Education Pre-pregnancy self-esteem and locus of control	√ Compared to women who carried an unintended first pregnancy to term, those who aborted were 100% more likely to report use of marijuana in the past 30 days and 149% more likely to use cocaine in the past 30 days (only approached significance). Women with a history of abortion also engaged in more frequent drinking than those who carried an unintended pregnancy to term. Except for less frequent drinking, the delivery group was not significantly different from the no pregnancy group
6. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. <i>Journal of Child Psychology and Psychiatry</i> , 47, 16-24.	√	√	√ Those who delivered and were never pregnant used as comparison groups. Controlled for maternal education, childhood sexual abuse, physical abuse, neuroticism, self-esteem, grade point average, smoking, prior history of depression, anxiety, suicide ideation, living with parents, living with partner	√ 6.8% indicated alcohol dependence, and 12.2% were abusing drugs. By age 25.
7. Hope, T. L., Wilder, E. I., & Watt, T. T. (2003). The relationships among adolescent pregnancy, pregnancy resolution, and juvenile delinquency, <i>The Sociological Quarterly</i> , 44, 555-576.	√	√	√ Controls for a wide range of socioeconomic and demographic variables likely to influence juvenile delinquency.	√ Compared to adolescents who ended their pregnancies through abortion, those who keep their babies experienced a dramatic reduction in smoking and marijuana use
8. Pedersen, W. (2007). <i>Addiction</i> . Childbirth, abortion and subsequent substance use in young women: a population-based longitudinal study, 102 (12), 1971-78.	√	√	√ Controls for social background, parental and family history, smoking, alcohol and drug use, conduct problems, depression, schooling, and career variables. Comparison groups included those who had never been pregnant and those who delivered.	√ Elevated rates of substance use (nicotine dependence: 400% increased risk; alcohol problems: 180% increased risk; Cannabis use: 360% increased risk; and other illegal drugs: 670% increased risk) compared to other women

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
9. Reardon D.C., Ney, P.G. (2002) Abortion and subsequent substance abuse. <i>American Journal of Drug and Alcohol Abuse</i> , 26, 61-75.	√	√	Controlled for substance use prior to the abortion and age	<p data-bbox="1268 201 1295 237">√</p> <p data-bbox="1040 243 1524 453">Women who aborted a first pregnancy were 5 times more likely to report subsequent substance abuse than women who carried to term and 4 times more likely to report substance abuse compared to those who had a non-voluntary pregnancy loss</p>
10. Yamaguchi D, & Kandel D. (1987). Drug use and other determinants of premarital pregnancy and its outcome: A dynamic analysis of competing life events. <i>Journal of Marriage and the Family</i> , 49, 257-270.	√	√		<p data-bbox="1268 459 1295 495">√</p> <p data-bbox="1040 501 1524 621">The use of illicit drugs other than marijuana was 6.1 times higher among women with a history of abortion when compared to women without a history.</p>

**Table 3: Scientific Studies Identifying Abortion
as a Risk Factor in Depression**

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
1. Bradley, C.F. (1984) Abortion and subsequent pregnancy. <i>Canadian Journal of Psychiatry</i> , 29, 494.	√	√	√ Women with and without a history of abortion had similar demographic characteristics, obstetric experiences, and attitudes about labor and birth.	√ Women, who aborted, when compared to women without a history of abortion, were significantly more likely to report depressive affect during pregnancy and in the postpartum period.
2. Coleman, P.K., & Nelson, E.S. (1998). The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. <i>Journal of Social and Clinical Psychology</i> , 17, 425-442.	√	√	√ Compared men and women with abortion experience. Time elapsed since abortion	√ Depression increased after abortion: female: 56.7%; male: 25.9%
3. Coleman, P. K., Reardon, D. C., Rue, V., & Cogle, J. (2002). State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over four years. <i>American Journal of Orthopsychiatry</i> , 72, 141-152	√	√	√ Comparison groups likely very similar except for the abortion experience Controls for pre-pregnancy psycho-logical difficulties, age, and months of eligibility	√ Across the 4-yr, the abortion group had 40% more claims for neurotic depression than the birth group
4. Congleton, G. & Calhoun, L. (1993). Post-abortion perceptions: A comparison of self-identified distressed and non-distressed populations. <i>International Journal of Social Psychiatry</i> , 39, 255-265	√	√	√ Compared women who self-identified as distressed and non-distressed only.	√ Depression reported in 20% of women who aborted.
5. Cogle, J., Reardon, D. C., & Coleman, P. K. (2003). Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort. <i>Medical Science Monitor</i> , 9, CR105-112	√	√	√ Controlled for prior psychological state and several other variables: age, race, marital status, divorce history, education, and income (stratification by ethnicity, current marital status, and history of divorce)	√ Women whose 1 st pregnancies ended in abortion were 65% more likely to score in the "high-risk" range for clinical depression. Differences between the abortion and birth groups were greatest among the demographic groups least likely to conceal an abortion (White: 79% higher risk; married: 116% higher risk; 1 st marriage didn't end in divorce: 119% higher risk).

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
6. Cozzarelli, C. (1993). Personality and self-efficacy as predictors of coping with abortion. <i>Journal of Personality and Social Psychology</i> , 65, 1224-1236.	√	√		√ 3 weeks after the abortion, depression was higher than general population norms, but lower than psychiatric norms.
7. Fayote, F.O., Adeyemi, A.B., Oladimeji, B.Y. (2004). Emotional distress and its correlates. <i>Journal of Obstetrics and Gynecology</i> , 5, 504-509.	√	√	√ Used a matched control group	√ Previous abortion was significantly associated with depression among the pregnant women
8. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. <i>Journal of Child Psychology and Psychiatry</i> , 47, 16-24.	√	√	√ Those who delivered and were never pregnant used as comparison groups. Controlled for maternal education, childhood sexual abuse, physical abuse, child neuroticism, self-esteem, grade point average, smoking, prior history of depression, anxiety, prior history of suicide ideation, living with parents, living with partner	√ 42% of the women who had aborted reported major depression by age 25.
9. Harlow, B. L., Cohen, L. S., Otto, M. W., Spiegelman, D., & Cramer, D. W. (2004). Early life menstrual characteristics and pregnancy experiences among women with and without major depression: the Harvard Study of Mood and Cycles. <i>Journal of Affective Disorders</i> , 79, 167-176.	√	√	√ Employed demographic controls (age, age at menarche, educational attainment, and history of marital disruption)	√ Compared to women with no history of induced abortion, those with two or more were 2-3 times more likely to have a lifetime history of major depression at study enrollment. When only antecedent induced abortions were compared to no history of abortion, there was a three fold increase risk of developing depression later in life.
10. Major, B. et al. (2000). Psychological responses of women after first trimester abortion. <i>Archives of General Psychiatry</i> , 57, 777-84.	√	√	√ Controls for demographic characteristics, medical complications, and prior mental health	√ Two years post-abortion, 28% were not satisfied with their decision, 31% would not have the abortion again, and 20 % were depressed. Younger age and having more children pre-abortion predicted more negative post-abortion outcomes.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
11. Major, B. Cozzarelli, C., Sciacchitano, A.M., Cooper, M. L., Testa, M., & Mueller, P. M. (1990). Perceived social support, self-efficacy, and adjustment to abortion. <i>Journal of Personality and Social Psychology</i> , 59, 186-197.	√	√		√ Immediately after abortion Mild depression 21% Moderate depression 11% Severe depression 4%
12. Miller, W. B., Pasta, D. J., & Dean, C. L. (1998). Testing a model of the psychological consequences of abortion. In L. J. Beckman and S. M. Harvey (eds.), <i>The new civil war: The psychology, culture, and politics of abortion</i> . Washington, DC: American Psychological Association.	√	√	√	√ 2 weeks post-abortion: 29.5% felt some guilt, 36.6% experienced some depression, 30.4% reported mood problems, 17.3% reported decreased relationship satisfaction, and 26.9% reported decreased interest in sex. 6-8 weeks post-abortion: 35.9% felt some guilt, 35.9% experienced some depression, 30% reported mood problems, 22% reported decreased relationship satisfaction, and 26% reported decreased interest in sex.
13. Pedersen W. (2008). Abortion and depression: A population-based longitudinal study of young women. <i>Scandinavian Journal of Public Health</i> , 36 (4):424-8.	√	√	√ Controlled for parental education level, parental smoking habits, parental support, and prior history of depression.	√ Women with an abortion history were nearly 3 times as likely as their peers without an abortion experience to report significant depression
14. Pope, L. M., Adler, N. E., & Tschann, J. M. (2001). Post-abortion psychological adjustment: Are minors at increased risk? <i>Journal of Adolescent Health</i> , 29, 2-11.	√	√	√ Compared current sample results with those reported in other studies using similar samples..	√ 19% experienced moderate to severe levels of depression 4 weeks post-abortion.
15. Reardon, D. C., & Cogle, J. (2002) Depression and Unintended Pregnancy in the National Longitudinal Survey of Youth: A cohort Study. <i>British Medical Journal</i> , 324, 151-152.	√	√	√ Confined analyses to unintended pregnancy aborted or delivered. Controls for the following: prior psychiatric state, family income. Education, race, age at first pregnancy Stratified by marital status	√ The percentage of women who carried to term considered to be in the high-risk range for depression was 22.7% compared to 27.3% of women who aborted (OR=1.54) Among married women, the percentage of women who carried to term considered to be in the high-risk range for depression was 17.3% compared to 26.2% of women who aborted (OR=2.38)

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
16. Reardon, D. C., Cogle, J., Rue, V. M., Shuping, M., Coleman, P. K., & Ney, P. G. (2003). Psychiatric admissions of low-income women following abortion and childbirth. <i>Canadian Medical Association Journal</i> , 168, 1253-1256.	√	√	√ Comparison groups are likely very similar except for the abortion experience. Controls for pre-pregnancy psychological difficulties, age, and months of eligibility Extended time frame	√ Across the 4-yr, the abortion group more claims for depressive disorders compared to the birth group, with the percentages equaling 90%, 110%, and 200% for depressive psychosis, single and recurrent episode, and bipolar disorder respectively.
17. Rees, D. I. & Sabia, J. J. (2007) The relationship between abortion and depression: New evidence from the Fragile Families and Child Wellbeing Study. <i>Medical Science Monitor</i> , 13(10), 430-36.	√	√	√ A number of controls were incorporated: race, ethnicity, age, education, household income, number of children, prior depression.	√ Women who had an abortion between the first and second data collection waves were at a significantly higher risk for reporting symptoms of major depression compared to women who had not become pregnant. After adjusting for controls, abortion was associated with more than a two-fold increase in the likelihood of having depressive symptoms at second follow-up.
18. Schmiede, S., & Russo, N. F. (2005). Depression and unwanted first pregnancy: Longitudinal cohort study. <i>British Medical Journal</i> .	√	√	√ Age Age at first pregnancy 1992 marital status Education Family income	√ Percent of women exceeding the depression cut-off score on the Center for Epidemiological Studies depression scale after an abortion: Married White women: 16% Married Black women: 24% Unmarried White women: 30% Unmarried Black women: 38% Non-Catholic: 27% Catholic: 20%
19. Slade, P., Heke, S., Fletcher, J., & Stewart, P. (1998). A comparison of medical and surgical methods of termination of pregnancy: Choice, psychological consequences, and satisfaction with care. <i>British Journal of Obstetrics and Gynecology</i> , 105, 1288-95.	√	√		√ 1 month post-abortion: Cases of depression: 9%

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
20. Söderberg H, Janzon L and Sjöberg NO (1998). Emotional distress following induced abortion. A study of its incidence and determinants among abortees in Malmö, Sweden. <i>European Journal of Obstetrics and Gynecology and Reproductive Biology</i> 79, 173-8	√	√	Utilized a case control data analysis strategy	50-60% of the women experienced emotional distress of some form (e.g., mild depression, remorse or guilt feelings, a tendency to cry without cause, discomfort upon meeting children), classified as severe in 30% of cases. 76.1% said that they would not consider abortion again (suggesting indirectly that it was not a very positive experience).
21. Suri, R, Altshuler, L., Hendrick, V. et al. (2004). The impact of depression and fluoxetine treatment on obstetrical outcome. <i>Archives of Women's Mental Health</i> , 7, 193-200.	√	√	.	46 women with a history of depression had a significantly higher mean number of prior therapeutic abortions than 16 women without a history of depression (.78 vs. .31). The mean number of prior pregnancies and spontaneous abortions did not differ.
22. Urquhart D.R., & Templeton, A. A. (1991). Psychiatric morbidity and acceptability following medical and surgical methods of induced abortion. <i>British Journal of Obstetrics and Gynecology</i> , 98, 396-399.	√	√	.	Clinically significant feelings of depression at 1 month post-abortion by 10% of the sample.

**Table 4: Scientific Studies Identifying Abortion
as a Risk Factor in Anxiety Disorders**

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
1. Broen, A.N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2004). Psychological impact on women of miscarriage versus induced abortion: A 2 year follow-up study. <i>Psychosomatic Medicine</i> , 66, 265-271.	√	√	√ Number of children Marital status Vocational status	√ 10 days after the pregnancy ended, 30% of those who had an abortion scored high on measures of avoidance or intrusion, which includes symptoms such as flashbacks and bad dreams. 2 years after the pregnancy ended, nearly 17% of 80 women who had an abortion scored highly on a scale measuring avoidance symptoms, compared with about 3% of those who miscarried.
2. Broen, A.N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2005). Reasons for induced abortion and their relation to women's emotional distress: a prospective, two-year follow-up study. <i>General Hospital Psychiatry</i> , 27, 36-43.	√	√	√ Marital status Psychiatric history	√ Male pressure on women to abort was significantly associated with negative abortion-related emotions in the two years following an abortion. Pre-abortion psychiatric history was not significantly related to immediate negative abortion related emotion or with negative emotional responses measured at 2 years out. 23.8% of the sample scored high on The Impact of Events Scale (a measure of stress reactions after a traumatic event) 10 days after the abortion, 13.3% at 6 months, and 1.4% after 2 years.
3. Coleman, P.K., & Nelson, E.S. (1998). The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. <i>Journal of Social and Clinical Psychology</i> , 17, 425-442.	√	√	√ Gender: Compared men and women with abortion experience. Time elapsed since abortion	√ Anxiety increased after the abortion: female: 13.3%; male: 9.7%
4. Cogle, J., Reardon, D. C., Coleman, P. K., & Rue, V. M. (2005). Generalized anxiety associated with unintended pregnancy: A cohort study of the 1995 National Survey of Family Growth. <i>Journal of Anxiety Disorders</i> , 19, 137-142	√	√	√ All women were experiencing an unintended pregnancy Stratification by ethnicity, current marital status, and age.	√ The odds of experiencing subsequent Generalized Anxiety was 34% higher among women who aborted compared vs. delivered. Greatest differences among the following demographic groups: Hispanic: 86% higher risk, Unmarried at time of pregnancy: 42% higher risk; under age 20: 46% higher risk.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
5. Fayote, F.O., Adeyemi, A.B., Oladimeji, B.Y. (2004). Emotional distress and its correlates. <i>Journal of Obstetrics and Gynecology</i> , 5, 504-509.	√	√	√ Used a matched control group	√ Previous abortion was significantly associated with anxiety among the pregnant women
6. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. <i>Journal of Child Psychology and Psychiatry</i> , 47, 16-24.	√	√	√ Those who delivered and were never pregnant used as comparison groups. Controlled for maternal education, childhood sexual abuse, physical abuse, child neuroticism, self-esteem, grade point average, smoking, prior history of depression, anxiety, prior history of suicide ideation, living with parents, living with partner	√ 39% of post-abortive women suffered from anxiety disorders by age 25.
7. Lauzon, P., Roger-Achim, D., Achim, A., & Boyer, R. (2000). Emotional distress among couples involved in first trimester abortions. <i>Canadian Family Physician</i> , 46, 2033-2040.	√	√	√ Random sample of the general population of reproductive age used as the control group	√ Before the abortion, 56.9% of women and 39.6% of men were much more distressed than their respective controls. Three weeks after the abortion, 41.7% of women and 30.9% of men were still highly distressed.
8. Major, B., & Gramzow, R. H. (1999). Abortion As stigma: Cognitive and emotional implications of concealment. <i>Journal of Personality and Social Psychology</i> , 77, 735-745.	√	√	.	√ Two years after abortion: Intrusive thoughts - quite a bit: 3% - some intrusive thoughts: 62%
9. Sivuha, S. Predictors of Posttraumatic Stress Disorder Following Abortion in a Former Soviet Union Country. <i>Journal of Prenatal & Perinatal Psych & Health</i> , 17, 41-61 (2002).		√	.	√ 35% of women had some posttraumatic consequences of abortion (elevated avoidance, intrusion, or hyper-arousal scores) 46% of women had evidence of PTSD, exceeding the cut-offs for intrusion and avoidance subscales. 22% of women experienced PTSD, exceeding the cut-offs on all 3 subscales.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
10. Suliman et al. (2007). Comparison of pain, cortisol levels, and psychological distress in women undergoing surgical termination of pregnancy under local anaesthesia vs. intravenous sedation. <i>BMC Psychiatry</i> , 7 (24), p.1-9.	√	√	√ Baseline levels of depression, state anxiety, self-esteem, and functional disability.	√ The percentages of women experiencing PTSD symptoms after abortion were 17.5% and 18.2% at one and three months respectively.
10. Pope, L. M., Adler, N. E., & Tschann, J. M. (2001). Post-abortion psychological adjustment: Are minors at increased risk? <i>Journal of Adolescent Health</i> , 29, 2-11.	√	√	√ Compared current results with those in other studies using similar samples.	√ Impact of Events Scale – Intrusion Subscale Score = 13.46, which is similar to adults experiencing a recent parental bereavement.
11. Rue, V. M., Coleman, P. K., Rue, J. J., & Reardon, D. C. (2004). Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. <i>Medical Science Monitor</i> 10, SR 5-16.	√	√	√ Controls for severe stress symptoms prior to the abortion, other stressors pre-and post-abortion, several demographic variables, psychosocial variables (harsh discipline, abuse, parental divorce, etc).	√ The percentages of Russian and U.S. women who experienced 2 or more symptoms of arousal, 1 or more symptom of re-experiencing the trauma, and 1 or more experience of avoidance (consistent with DSM-IV diagnostic criteria for PTSD) were equal to 13.1% and 65% respectively.
12. Slade, P., Heke, S., Fletcher, J., & Stewart, P. (1998). A comparison of medical and surgical methods of termination of pregnancy: Choice, psychological consequences, and satisfaction with care. <i>British Journal of Obstetrics and Gynecology</i> , 105, 1288-1295.	√	√		√ 1 month post-abortion: Cases of anxiety: 27%
13. Williams, G. B. (2001). Short-term grief after an elective abortion. <i>Journal of Obstetrics, Gynecologic, and Neonatal Nursing</i> , 30, 174-183.	√	√	√ Controlled for other forms of loss and psychiatric history. Control group with no abortion history.	√ Women with a history of elective abortion experienced more grief in terms of loss of control, death anxiety, and dependency than controls.
14. Urquhart D.R., & Templeton, A. A. (1991). Psychiatric morbidity and acceptability following medical and surgical methods of induced abortion. <i>British Journal of Obstetrics and Gynecology</i> , 98, 396-399.	√	√	.	√ Clinically significant feelings of anxiety at 1 month post-abortion by 10% of the sample.

Abortion Recovery

Family Research Council

October 9, 2008

Martha Shuping, M.D.

I've been asked to speak as a psychiatrist concerning the numerous grassroots abortion recovery programs that exist to help women, men, and families heal after abortion. If you've already been involved with the growing abortion recovery movement, you can readily understand why a psychiatrist might be involved in abortion recovery. For those who are only now learning about abortion recovery, I'll explain the connection by starting with a true story of one of my first patients.

I graduated medical school and started residency in psychiatry in 1984. During that first year, during my first two months on a psychiatric inpatient unit, I had a patient who had recently obtained an abortion. She had been a happily married stay-at-home-mom with a couple of kids already, in a comfortable home, with an upper middle class lifestyle. She was happy when she found out she was pregnant again, and had already given her heart to the new baby on the way. But her husband felt he had no room in his life for another child, and he asked her to abort. When she hesitated to terminate the life a baby she already loved, he persuaded her to go with him to talk to their pastor, who took his side.

After the abortion took place, my patient became severely depressed, unable to function in her role as mom and homemaker, and she ended up being admitted to the hospital. When I talked to her at the time of admission, she identified the abortion as the cause of her problems.

When I discussed the case with my supervisor, wanting to know how to help my patient, I was told that she was suffering from a chemical imbalance and that she would probably stop obsessing about the abortion as soon as the medication took effect.

Looking back, I realize that if my patient had identified a rape, or domestic violence, or childhood sexual abuse as a contributing cause of her serious symptoms, there would have been no shortage of support groups, treatment protocols, books or journal articles, even in the mid-1980's. Using Google Scholar today, you can search for publications on these topics from that time period and find thousands of hits specifically dealing with treatment issues and treatment protocols. If my patient had been depressed following a rape, the treatment team would likely have believed her when she attributed her symptoms to the rape, and would likely have been prepared with treatment options that offered more than medication only.

But in the case of abortion, it was very different. The fact that she attributed her symptoms to the abortion was of no consequence—her thoughts merely reflected a chemical imbalance. I received no guidance on psychotherapeutic approaches to her self-identified issue, and no books or articles were suggested to guide me. Indeed, even today, the professional literature is very limited in regard to treatment approaches for grief and trauma issues after abortion. Professional societies have been committed to the fiction that women do not suffer from their abortions; if there is no problem, there is no need for treatment protocols or treatment guidelines on how to help with this issue.

In the case of this patient, her emotional pain was extreme, and she specifically wanted help with her abortion issues. I was able to make contact with one of the earliest grassroots post-abortion support groups—Women Exploited by Abortion, WEBA. My supervisor gave permission for a support group leader to visit our patient, to give her the help she wanted, that we were not prepared or equipped to provide.

That experience led me to seek out peer counselors, support group leaders, their books, their workshops and conferences, so that I could know at least as much as the nonprofessional helpers if I were called upon to help in future cases--as I have been many times.

The plain truth is this. Although some individual professionals do help women and men to deal with the impact of abortion in their lives, the professional societies have abdicated in this arena creating a vacuum, an absence of help, which has been filled by the women themselves. Women suffering from after-effects of abortion have risen in a huge grassroots movement to help others without waiting for help that has not been forthcoming from the professional societies.

Even today, after 35 years of legal abortion, there is little to be found in the professional literature about mental health treatment for those affected by abortion. One of the very few studies related to treatment is by Susan Layer and colleagues, published in 2004 in *Research on Social Work Practice*.¹ This study evaluated three spiritually based post-abortion grief group interventions, drawing from three faith-based programs in Florida, two non-denominational Christian and one Catholic. The results, which were statistically significant, indicated that these faith-based group programs were effective in reducing shame and in reducing symptoms of Posttraumatic Stress Disorder.

In addition to obtaining quantitative data, the researchers invited women to give feedback as to which aspects of the programs were believed by the participants to have been particularly helpful. The researchers stated that a prominent theme throughout this qualitative data was forgiveness and reconciliation, which included the women extending forgiveness toward themselves and forgiveness toward others involved in the abortion, in addition to reconciliation with God.

For those without experience within the abortion recovery movement, the concept of forgiveness toward others may be surprising. Why would a woman find this important to her healing? Who is being forgiven and why? A true story about an abortion experience will make this clear.

My friend was 17 years old, and engaged to be married. Her fiancée was employed in the military and was away at training when she discovered she was pregnant. She concealed the pregnancy for as long as she was able. When her mother found out, the mother made an appointment at an abortion clinic. My friend, still in high school and not employed, was told that she could not live at home and continue with this pregnancy. She sought help from a pro-life crisis pregnancy service but was not able to find alternative living arrangements in time. The day arrived, and her mother drove her to the clinic. My friend says she looked the doctor in the eye and told him she did not give consent for this abortion. She wanted her baby.

My friend was tied down and drugged, and her first baby was aborted against her expressed wishes because her mother wanted the abortion and had paid for it.

The situation of women being coerced or pressured into abortions of wanted babies is not at all unusual or infrequent. In a 2004 study by Rue and colleagues in *Medical Science Monitor*, 64% of American post-abortive women reported having been pressured in regard to their abortion decision.² This situation is so common, it has been mentioned in both an abortion providers' textbook³ and in a 1993 Planned Parenthood Fact Sheet,⁴ which identify coercion or perceived coercion as a risk factor for having adverse mental health consequences after abortion.

Since it is clear that abortion providers acknowledge that forced or coerced abortions occur and that they are detrimental to women's mental health, one might hope that screening to prevent coerced abortions would be taking place routinely. There is no evidence that this is the case, and in fact, there are many reports to the contrary. The Elliot Institute's report on *Forced Abortion in America*⁵ available at www.unfairchoice.info/ gives more information on this subject, but from my experience, I would say it is probably the tip of the iceberg.

By way of comparison to another serious problem affecting many women, consider the issue of domestic violence. Today, in 2008, it is a standard of care that when domestic violence is suspected, physicians are to interview the woman privately, apart from her husband or partner, to determine whether the woman is being beaten or harmed. One can readily find journal articles telling physicians to screen for domestic violence, and studies can be found evaluating which questions should be asked and in what manner they should be asked in order to elicit information that will lead to women being helped with their domestic violence situations. However, in regard to coerced abortions, a similar screening process does not seem to be taking place, nor is this discussion taking place within professional journals or professional societies.

Returning to my friend and to the issue of forgiveness, one can understand the strained relationship she experienced with her mother and with other adult family members who had endorsed the forced abortion, a strain that continued for more than a decade. My friend's first marriage and her relationships with subsequent children suffered from the isolation and from the mental health problems that followed the abortion. Only after many years did she participate in an abortion recovery weekend retreat that led to profound healing in regard to the abortion, and which included forgiveness of her mother and other family members.

Considering what my friend experienced, one can imagine that forgiveness of her mother was not an easy task for her, and facilitation by others in a structured program as well as the resources of her religious faith proved helpful to her. It is not likely that she could have accomplished this on her own; indeed, she had not been able to for more than a decade.

A motto of the Rachel's Vineyard program which my friend attended has always been, "No one is forced to do anything, but the more you do, the more you heal." No one is pressured to forgive when they are not ready to do so, or to engage in any actions or exercises against their wishes. However, the program provides a safe environment where women and men can share freely about their abortion experiences, and make peace with their past and their future.

Today, the abortion recovery movement has come a long way since the early days of WEBA. Numerous choices are available, for example, once a week support groups, or programs complete in one weekend. Choices of location could be conveniently close to home or a hundred miles away for a feeling of greater privacy.

Abortion Recovery InterNational,⁶ ARIN, is an important resource for those looking for healing after abortion. The organization serves as a network of recovery, research, awareness and educational resources that provide information concerning post-abortion issues. The ARIN Directory⁷ is an online, international listing of abortion recovery centers and programs providing opportunities for healing to those who are hurting after abortion. The directory serves 30,000 people annually.

Stacey Massey, President of ARIN, says that there are more than 1500 healing programs currently offered throughout the U.S. This includes a wide range of options. For example, many pregnancy resource centers (in the past often referred to as crisis pregnancy centers) offer abortion recovery programs in addition to their pregnancy related services. Pregnancy resource centers affiliated with the national organization Care Net provided abortion recovery services to 13,000 women and men in 2006 alone. Heartbeat International estimates that their affiliate centers are serving 8,000 to 10,000 clients annually.

But in addition to the abortion recovery programs associated with pregnancy resource centers, there are many independent abortion recovery ministries, and also programs that affiliate with national organizations such as Rachel's Vineyard.⁸ Many Catholics are aware of the Catholic network of programs and individual counseling options under the umbrella of Project Rachel.⁹

The existence of so many programs demonstrates both that large numbers of women and men are coming forward to ask for help with abortion issues, and that help for anyone is only a phone call or a mouse click away.

The Rachel's Vineyard retreat, a copyrighted, trademarked, program using a specific format, is widely available throughout the United States as well as at international locations on six continents, providing 600 weekend retreats per year. The program has spread quickly, because as women are helped, they want to bring this help to others. A unique feature of this program is that it is presented by team which includes a mental health professional, a minister or priest, and lay volunteers, some of whom have had abortions themselves. Both men and women are welcome, and couples sometimes choose to go through the weekend together.

The retreat has been translated into Spanish, Chinese, and Russian, with other languages near completion, and is also available in non-denominational as well as Catholic formats.

An outcome study of Rachel's Vineyard was conducted by me and presented at the Rachel's Vineyard international leader's conference in 2004.¹⁰ Two hundred and forty one past retreat participants from 22 states completed a survey about their experience. They were asked to rate the program, using negative numbers if the program harmed them, giving a zero if the program neither harmed nor helped, or using numbers 1 through 5 to show the degree of benefit they had obtained. There were no negative numbers and no zeros. The average rating was 4.75.

Considering that published studies indicate an increased risk of suicide after abortion, one concern among sponsoring faith-based organizations has been: Is this program safe for vulnerable men and women? We asked survey participants about their prior mental health for the period after their abortion until the time of the retreat, and found that 70% had required prior mental health treatment, with 65% admitting to suicidal thoughts, 17% admitting to suicide attempts, and 48% reporting problems with substance abuse. So this was a group which had experienced some significant

problems during the time period from the abortion until the retreat, but at the same time, there was no one who rated the retreat as having caused harm, and the benefit was perceived as very high.

Additionally, for 58.9% of those responding, more than one year had passed since their retreat, with the average time being 3.1 years post retreat. An additional 33.2% were responding at a time from one to ten months after their retreat, with the average for this group being 4.8 months. This indicates that those responding continued to feel that the retreat had given them significant benefit, even after many months or even years had passed. The healing is not something temporary, but something enduring with benefit that is sustained over time.

The Rachel's Vineyard retreat, like many of the abortion recovery programs, is rooted in the Christian faith and Christian Scriptures. This is appropriate for many participants, considering Layer's study which indicated that 86% of the women in her study reported that "their religious beliefs played a strong to very strong role" in their experience of healing. Layer also cites a 2001 Gallup poll indicating that 70% of Americans identify themselves as Christian, reinforcing the appropriateness of faith-based Christian programs for many.

Many individuals also find it helpful to be able to share their grief with others who have had similar experiences, as well as to engage in exercises to process grief. Here are some comments from women who have attended the Rachel's Vineyard retreats (comments which participants have written in their evaluations and for which permission given to share with others):

"At the end of the retreat, I felt relief and hope."

"I felt so safe in sharing my experience and emotions. It was exactly what I needed."

"This retreat touched a part of me that I didn't even realize was there. I feel healed from the inside out."

"To any woman considering the need to reconcile their abortion, the retreat is a wonderful gift you could give to yourself. You are able to experience the sadness, grief and shame in the company of others feeling very much the same. You are able to turn pain into hope."

For those who are hesitant to connect with others for their healing, there are self-help books that can help people to begin to address this issue. The paperback book, *The Four Steps to Healing*¹¹ was written by Debbie McDaniel and me to help those who needed to explore the issue privately at home as their first step. Other options include checking out websites such as www.abortionrecovery.org or www.rachelsvineyard.org to look for resources or to email your questions to someone who can help.

In Layer's study nearly half the participants stated initially that only two or fewer others knew of their abortion. But after completion of the intervention, 80% expressed willingness to tell others about their abortion if it would help another person. The decrease in shame experienced by the participants in Layer's study removes a barrier to disclosing the abortion to others.

In fact, many women and men who have experienced healing after abortion want to help others. One significant area often revolves around informed consent. A retreat participant told me, "I received better informed consent when my dog had surgery compared to what I received when I had my abortion." In the study by Rue and colleagues, 84% of American post-abortive women said they did not receive adequate counseling beforehand.

Those who experienced a relative lack of information in making their decision or who made the decision without adequate counseling want to make sure that others are fully informed before an irrevocable choice is made. So, many post-abortive women choose to serve as volunteers at pregnancy care centers where they can help with information and counsel that may otherwise be lacking.

Others choose to tell their stories in public gatherings through the Silent No More Awareness Campaign or through Operation Outcry. By telling their stories, they are giving information about abortion to young women among the general public who may not yet have had an abortion, so that information is accessible in advance of a crisis pregnancy. In addition, telling stories publicly helps to let other post-abortive women know they are not alone, and to know that help is available. One of my friends, who had years of psychiatric treatment following her abortion, found out about abortion recovery through the Operation Outcry TV program Faces of Abortion. She was then able to access further information and find healing through a weekend retreat.

The women of Operation Outcry take the additional step of writing their testimony in a Declaration format that can be used as legal testimony in legislative hearings and in court cases. The testimony of 180 post-abortive women was submitted to the Supreme Court as part of an amicus curiae brief filed by the Justice Foundation in the partial birth abortion case, *Gonzales v. Carhart*. The Supreme Court alluded to the women's testimonies in its decision. For the first time, the Supreme Court recognized that "some women come to regret their choice to abort the infant life they once created and sustained," and that some women experience severe depression, grief and sorrow following abortion.

In *Gonzales*, the Court highlighted the importance of informed consent, confirming that "The state has an interest in ensuring that so grave a choice is well informed," and stating that it is "self-evident" that women would experience even a greater degree of grief and sorrow to learn "only after the event" information concerning the details of the procedure and the effects on her baby.

The *Gonzales* decision was cited in a recent 8th Circuit Court of Appeals decision which upheld a South Dakota informed consent statute, and which specifically referenced the testimony of the Operation Outcry women regarding the adverse effects of abortion that they had experienced. The South Dakota law requires that women be informed that abortion terminates the life of a unique living human being, and that abortion is associated with increased risk of depression, psychological distress, suicidal ideation and suicide.

More than 3000 women have signed Declarations to date and many more are mobilizing and speaking out. The women of Operation Outcry have adopted the song "Million Voices," by Barlow Girl, as their theme: "With a million voices breaking silence... they'll remember we were here."¹² Post-abortive women are finding their voices, and making a difference. As they gain momentum, one million voices may be just the beginning.

Author Contact Information:

Martha Shuping, M.D.

Email: rachelnetwork@sprynet.com

Author's websites: <http://www.postabortionhealing.net> <http://www.rachelnetwork.org>

REFERENCES:

1. Layer S, Roberts C, Wild K, Walters J. *Postabortion Grief: Evaluating the possible efficacy of a spiritual group intervention*. Research on Social Work Practice. Vol. 14, No.5, 344-350 (2004) DOI: 10.1177/1049731504265829 <http://rsw.sagepub.com/cgi/content/abstract/14/5/344> (Abstract accessed 9/13/08).
2. Rue VM, Coleman PK, Rue J, Reardon DC. *Induced abortion and traumatic stress: A preliminary comparison of American and Russian women*. Medical Science Monitor 10(10): SR5-16 (2004).
3. Planned Parenthood Federation of America, *Fact Sheet: The Emotional Effects of Induced Abortion* (PPFA Communications Division, FS-A4, revised 1993).
4. Baker A., et al., *Informed Consent, Counseling, and Patient Preparation*, in *A Clinician's Guide to Medical and Surgical Abortion*, ed. Maureen Paul, et. al., (New York: Churchill Livingstone, 1999) 29.
5. *Forced Abortion in America*, The Elliot Institute, available at www.afterabortion.org and www.unfairchoice.info/ (Accessed 10/7/08).
6. Abortion Recovery InterNational www.abortionrecoveryinternational.org
7. Abortion Recovery Directory www.abortionrecovery.org
8. Rachel's Vineyard Ministries www.rachelsvineyard.org
9. Project Rachel <http://www.hopeafterabortion.com/>
10. Shuping, M. *Rachel's Vineyard Outcome Study*, Presented at Rachel's Vineyard International Leader's Conference, Greensboro, North Carolina, June, 2004.
11. Shuping M, McDaniel D, *The Four Steps to Healing*, (2007). High Point: Tabor Garden Press. (ISBN-10: 0972876944).
12. Barlow Girl, *Million Voices*, Word Music, 2007.

Resources

Abortion Recovery International: www.abortionrecoveryinternational.org

Abortion Recovery Directory: www.abortionrecovery.org

Care Net: <http://www.care-net.org/>

Forced Abortion in America, The Elliot Institute, available at www.afterabortion.org and www.unfairchoice.info/

The Four Steps to Healing (2007) Shuping, M., McDaniel D. Tabor Garden Press.
<http://postabortionhealing.net> (ISBN-10: 0972876944)

National Helpline for Abortion Recovery: 1-866-482-LIFE.

Heartbeat International: <http://www.heartbeatinternational.org/>

Operation Outcry: <http://www.operationoutcry.org/>

OptionLine: <http://optionline.org/> 1-800-395-HELP

Project Rachel: <http://www.hopeafterabortion.com/>

Rachel Network: <http://rachelnetwork.org/>

Rachel's Vineyard Ministries: www.rachelsvineyard.org

Silent No More Awareness Campaign: <http://www.silentnomoreawareness.org/>

Victims of Choice: <http://www.victimsofchoice.org/>

Postabortion Grief: Evaluating the Possible Efficacy of a Spiritual Group Intervention

Susan Dyer Layer

Cleora Roberts

Kelli Wild

Jan Walters

University of South Florida

Objective: Although not every woman is negatively affected by an abortion, researchers have identified a subgroup of women susceptible to grief and trauma. The primary providers for postabortion grief (PAG) groups are community faith-based agencies. Principle features of PAG are shame and post-traumatic stress disorder (PTSD) symptoms. *Method:* This study measured the efficacy of a spiritually based grief group intervention for women grieving an abortion. Thirty-five women completed the Impact of Event Scale-Revised (IES-R) and the Internalized Shame Scale (ISS) pre- and postintervention along with posttest open-ended questions. *Results:* Postintervention measures indicated significant decrease in shame ($p < .000$) and PTSD symptoms ($p < .002$). More than 80% reported their religious beliefs and the spiritual intervention played a strong to very strong role in the group. *Conclusion:* Social workers need to screen for PAG with a postabortive woman and when appropriate refer her to agencies offering such groups.

Keywords: postabortion grief; spirituality; group intervention; shame; faith-based agencies

Although the literature indicates the majority of women who have abortions do not experience significant emotional problems (e.g., Major et al., 2000; Mueller & Major, 1989; Russo & Zierk, 1992), researchers have identified a subgroup of women who are negatively affected by the abortion experience (e.g., Barnard, 1990; Ney, Fung, Wickett, & Beaman-Dodd, 1994; Peppers, 1987; Zeanah, Dailey, Rosenblatt, & Saller, 1993). Some studies negating the prevalence of postabortion grief (PAG) are compromised by high attrition rates (e.g., Major et al., 2000; Mueller & Major, 1989) and assessments done immediately after the abortion (e.g., Major, Mueller, & Hildebrandt, 1985; Mueller & Major, 1989). PAG is largely unrecognized and untreated, and those who experience grief from an abortion find themselves alone in their mourning. PAG is a “complicated mourning” resulting from the perceived loss of a child (Speckhard & Rue, 1993). Unlike most forms of grief, PAG is elusive; there is no body, no burial, no photos, and no outpouring of sym-

pathy for comfort or closure (Harvath, 1990). This lack of recognition conveys to the woman that her PAG is unjustifiable, which over time perpetuates her silence and delays her mourning (Freed & Salazar, 1993; Speckhard & Rue, 1993). Furthermore, with the confusing political rhetoric and heated debate over abortion, the individuals negatively affected by an abortion have received little attention in the area of treatment in published research. Consequently, empirical studies assessing PAG intervention have not been reported.

This article addresses the deficit in the literature by describing the outcomes of a spiritually based intervention designed to address PAG. The literature identifies a clinical range of PAG symptoms with some exhibiting acute stress or post-traumatic stress disorder (PTSD) and/or grief with psychotic features (e.g., Burke & Reardon, 2002; Speckhard & Rue, 1993). Of those seeking help for PAG at the faith-based agencies in the current study, the most commonly reported symptoms mirror a PTSD profile with pervasive shame and guilt, and avoidance-type behavior. This internalized grief typically leads to avoidance-type behaviors in which the woman may avoid contact with newborns, omit an abortion history in medical exams, or avoid any discussion addressing abortion. It is common for these women to delay seeking help several years after their abortion (Burke & Reardon, 2002; Harvath, 1990). Research

Authors' Note: We would like to honor the courageous women who participated in our study; may their stories bring immeasurable hope to others. We would also like to thank our families for their loving support and encouragement, Michelle Trotter for her keen and discerning mind, and more importantly Jesus who gave us the fortitude and endurance to complete this research project.

Research on Social Work Practice, Vol. 14 No. 5, September 2004 344-350
DOI: 10.1177/1049731504265829
© 2004 Sage Publications

indicates individuals appearing at higher risk for PAG include adolescents (e.g., Campbell, Franco, & Jurs, 1988; Franz & Reardon, 1992), women who have second trimester abortions (e.g., Rosenfeld, 1992), abortions for medical concerns (e.g., Donnai & Harris, 1981; Furlong & Black, 1984; Rosenfeld, 1992; Zeanah et al., 1993), and coercive abortions (e.g., Zakus & Wilday, 1987). These risk factors need to be addressed in the initial assessment if an abortion history is confirmed (for review of PAG clinical symptoms, see Burke & Reardon, 2002, and Speckhard & Rue, 1993).

SPIRITUALITY AND RELIGION

Over the past 5 years, public policy and social work have joined the medical community in the recognition and acceptance of holistic care (Canda, 1997; Hodge, 2001). Such care involves addressing the client's spiritual and religious orientation. In social work practice, Canda (1997) depicted spirituality as "the gestalt of the total process of human life and development, encompassing biological, mental, social, and spiritual aspects" (p. 302) and religion as "the patterning of spiritual beliefs and practices into social institutions, with community support and traditions maintained over time" (p. 303). Martin and Martin (2002) distinguish the Black American's experience of spirituality as "one's personal and communal ties to an invisible supernatural realm" (p. 4) and religiosity as "a religious institution or denomination" (p. 4). Throughout history, spirituality and religion have played vital roles in shaping the Black American (e.g., Gilkes, 1995; Martin & Martin, 2002) and Latino (e.g., Falicov, 1998; Sandoval, 1995) familial and cultural values. With the expedient Latino population growth, Latinos are projected to become the majority of Catholics by 2013 (Sandoval, 1995). Faith-based "charitable choice" legislation in the past 5 years has further integrated social services and religious institutions against poverty and other community problems.

Within the Christian religion there exists a myriad of denominations with distinct religious practices, beliefs, and ceremonies. With exception of a few, the majority of Christians believe that Jesus is the son of God and is the ultimate source for comfort, hope, and/or forgiveness in times of distress. For the purpose of our research, the participating Christian faith-based agencies were unified in the core beliefs that the Trinity of God comprises Jesus the son of God, the Holy Spirit, and the Father God and that the Bible is the inerrant word of God. With 7 of 10

Americans reporting Christianity as their religious preference and almost one half describing themselves as evangelical (e.g., Gallup Poll, 2001), it is important that social workers are knowledgeable about this belief system.

FAITH-BASED AGENCIES AND PAG SERVICES

Faith-based agencies using a Christian belief system offer PAG group interventions. Across the country, faith-based PAG groups are within access of any major city, yet little is known or written about them. In the literature, secular treatments may consist of individual therapy using cognitive reframing within an interpersonal forgiveness model with postabortion men (e.g., Coyle & Enright, 1997) or psychoanalytical techniques (e.g., Joy, 1985) have been described as beneficial in alleviating PAG. Similar to the spiritually based PAG groups, the secular interventions typically follow a grief resolution and forgiveness format. The key difference is the inclusion or exclusion of spirituality. The PAG groups offered are community outreaches by the Roman Catholic Church and nondenominational faith-based agencies, both following a Christian belief system.

The unique value of the psychoeducational postabortion spiritual groups is that the members share and validate the loss, provide peer support, offer unconditional acceptance, and integrate spirituality into the healing process (e.g., Freed & Salazar, 1993). The group members become a community for the women to openly mourn and process their grief in a safe, accepting environment. These PAG groups are offered in a scheduled format with some later forming into self-help groups. Similar to other support groups, facilitators are typically trained professionals or volunteers with professional supervision.

Although Catholics and nondenominational churches differ in their ceremonies and rules, the unifying elements in the Christian belief system is found in the belief of the Trinity and sovereignty of God. The overall curriculum of the Catholic and nondenominational PAG interventions was similar as both reviewed the grief stages, integrated applicable Biblical scriptures and stories, and participated in mourning exercises and memorials.

The primary purpose of the current study was to determine if a spiritually based grief group intervention decreases shame and other symptoms related to PTSD in women who are experiencing PAG. A second purpose

was to identify specific aspects of the intervention that may have been helpful or not helpful for a woman with PAG.

METHOD

Between January and October 2000, a pretest-posttest design was administered to measure changes in shame and other symptoms related to PTSD in a convenience sample of 35 women with PAG participating in a spiritually based group intervention. The participants were drawn from three faith-based nonprofit agencies in three counties of Florida. Of the three faith-based agencies, one was Catholic based with the other two being nondenominational. Prior to the intervention, the participants were given an explanation about the study, an opportunity to ask questions, referrals to licensed clinicians for individual counseling if needed, and the Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1997) and the Internalized Shame Scale (ISS) (Cook, 1988) revised pretest. At the conclusion of the group intervention, evaluative qualitative data were collected from the women in addition to the IES-R and ISS posttest quantitative data. To ensure anonymity of responses, the women were asked to put their mother's birth date on the pre- and postquestionnaire.

Description of the Intervention

At the initial assessment, prior to entering the group, the spiritual/religious nature and purpose of the group was fully discussed allowing the individual the right to refuse the intervention if the religious orientation of the group made her uncomfortable. Women who had an abortion in the previous year typically would be referred for individual counseling. The concern would be that an individual with acute stress symptoms may minimize or discount her grief when hearing longer standing PTSD symptoms of the group members. The group interventions were offered either in an 8-week (19 participants) format meeting once a week for 2 hours or in a weekend format (16 participants) meeting 8 hours per day for 2 days. The weekly groups typically ranged in size from 4 to 8 individuals with the weekend group as large as 13. As with standards for group work practice, the facilitator described her role as a guide in the group process and reviewed rules stressing confidentiality and respect for one another. The participants learned about the grieving process and its different stages, participated in mourning rituals, and read scripture from the Bible addressing the

hurt, anger, and guilt as well as the loving, forgiving nature of God (for intervention review, see Freed & Salazar, 1993).

Sample

The participants were nonpregnant women between the ages of 18 and 65 years. Of the original 38 participants, three participants (8%) did not complete the intervention, bringing the total to 35. The reasons given for discontinuing the intervention by the participants were a physical injury, change of work shift, and conflicting schedule. The participants were referred to the grief group as follows: by a clinician ($n = 1$ or 3%), by a social service agency ($n = 1$ or 3%), by an Alcoholics Anonymous sponsor ($n = 1$ or 3%), by churches ($n = 13$ or 35%), by crisis pregnancy center staff ($n = 9$ or 24%), by a friend ($n = 6$ or 16%), by media ($n = 4$ or 11%), and by other ($n = 3$ or 8%) sources in the community. Twelve participants (34%) were enrolled in the Catholic spiritual intervention and 23 participants (66%) in a nondenominational spiritual intervention. Sixteen participants (46%) were in the weekend format, and 19 participants (54%) were in the 8-week series intervention.

Additional biopsychosocial data about the women and their abortion experience would have been helpful. However, these data were not collected for two reasons: (a) It was found that expanding the length of the research questionnaire might discourage some participants from volunteering to participate, and (b) participants' anonymity may have been compromised by asking questions that could identify them (e.g., the oldest woman in the group, a woman of ethnic minority).

Instruments

The 22-item IES-R was used to measure posttraumatic symptoms. The recent revised scale included seven more questions to measure for hyperarousal symptoms associated with PTSD with the Avoidance Subscale and Intrusion Subscale remaining almost identical to the original IES-R. By adding the Hyperarousal Subscale, it was felt the IES-R would provide a more sensitive measure of PTSD symptoms as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (DSM IV; Weiss & Marmar, 1997). Furthermore, the instructions were modified, and participants now report the degree of "distress" rather than "frequency" of PTSD responses. The IES-R subscales have coefficient alphas ranging from .79 to .91 and test-retest correlation coefficients of .57 to .94. The responses range from 0 (*not at all*) to 4

(*extremely*) on each of the statements, yielding a score, range from 0 to 88, the higher the score, the greater the trauma. This scale may be used for any life event, and the IES has been used to assess the intrusive and avoidance symptoms of PTSD (Weiss & Marmar, 1997) and in PTSD related to PAG (Barnard, 1990).

The 35-item ISS (Cook, 1988) measures shame requiring the participant to respond from 0 (*never*) and 4 (*almost always*) as to the frequency of feeling or experiencing the description in the statement. The total score ranges from 0 to 140, the higher the score, the greater the shame. This scale has been used previously with a clinical sample of abused or neglected children, individuals with substance abuse problems, and female victims of domestic violence yielding an internal consistency reliability coefficient of .93. Internal consistency was also demonstrated with nonclinical samples of male and female undergraduates and adults. In both samples, reliability coefficients of .95 were achieved (e.g., Cook, 1988).

At posttest, 11 qualitative, open-ended questions were administered addressing the helpfulness of specific techniques in the intervention and the role of the participants' religious beliefs. These questions yielded additional insight in understanding the significance or insignificance of one's religious beliefs in PAG resolution.

RESULTS

Data analysis revealed a dramatic reduction in shame and posttraumatic stress in the study participants. A matched pairs *t* test analysis of the pre- and posttest of the ISS showed significant reduction of shame ($p < .000$). The mean pretest ISS score decreased from 62.63 ($SD = 30.39$) to 42.57 ($SD = 26.59$) ($t = 5.864$, $df = 34$, $p = .000$) at posttest. The mean revised IES score, measuring PTSD symptoms decreased from 30.28 ($SD = 21.93$) at pretest to 21.06 ($SD = 18.52$) posttest, which was also statistically significant ($t = 3.348$, $df = 34$, $p < .002$). In examining the three subscale scores of intrusion, avoidance, and hyperarousal, it was shown that there was no significant change in intrusive thoughts ($p = .574$). The Avoidance Subscale and Hyperarousal Subscale, however, showed significant improvement at the .001 level. These subscales indicate that the women improved by lessening the use of avoidance techniques and were less hypervigilant as it related to the abortion experience. However, they did not experience fewer intrusive thoughts.

Separate analyses were done for the 16 women in the weekend intervention and the 19 women in the 8-week

intervention to determine if one intervention was more effective in reducing shame and PTSD symptoms. The interventions were effective in reducing shame scores for the weekend group, pretest ISS $M = 59.69$, $SD = 26.85$ and posttest $M = 41.56$, $SD = 31.08$, $t = 3.39$, $df = 15$, $p < .01$, and for the weekly series, pretest $M = 65.12$, $SD = 33.60$ and posttest $M = 43.42$ ($SD = 22.99$, $t = 4.81$, $df = 18$, $p < .001$). However, only the 8-week intervention led to a significant reduction in IES-R scores from a pretest mean of 31.95 ($SD = 24.39$) to a posttest mean of 18.16 ($SD = 15.95$), resulting in a *t* value of 3.51, $df = 18$, $p < .01$. In contrast, the weekend participants did not experience a significant reduction in IES-R scores with a pretest mean of 28.31 ($SD = 19.20$) and a posttest mean of 24.50 ($SD = 21.18$), resulting in a *t* value of 1.09, $df = 15$, $p > .05$. These data indicate that symptoms of PTSD are more enduring and less responsive to an intensive intervention.

The revised version of the IES was chosen for the current study as it includes the hyperarousal symptoms that we felt would make it a more sensitive measure of change. The significant reduction in the Hyperarousal Subscale validated the decision to use the IES-R. A disadvantage of the revised version, however, is that clinical cut points have not been established, making it difficult to assess clinically significant change. We maintain that the drop in average IES-R scores from 30.28 to 21.06 was a meaningful reduction in distress based on the following rationale. According to Barnard (1990), persons who score an average of 1 on each of the 15 IES items (total score of 15) have been considered distressed. If we extrapolate to the revised 22-item scale, a total score of 22 would be considered distressed. In the current sample, the pretest average of 30 would represent elevated distress, and the posttest average of 21 would fall slightly below this cut point. More interesting, Barnard's sample of 77 postabortive women (Barnard, 1990) scored an average of 21.8 on the 15-item IES-R or 1.45 per item that is nearly identical to the 1.38 per item (30.28 divided by 22 items) in the current study.

Content Analysis of Qualitative Data

A content analysis of the open-ended questions assessed various features of the spiritually based intervention and provided richness to the overall data. Two researchers developed themes in the responses then worked independently to categorize each response into a theme. Interrater agreement was 95%. When the participants expressed more than one response to an item, the researchers broke up the comments into meaningful segments, and each segment was counted individually. Of the

items, five addressed the effectiveness of the group intervention, and three assessed the presence of clinical features associated with PAG. The items assessing intervention efficacy and PAG features are as follows:

- What was the most helpful for you about the group? The majority of subjects cited the validation they received from others with PAG and participation with grieving rituals such as writing letters to their babies, reading affirming Biblical scripture, and the use of visualizations as most helpful.
- What specific exercises or subject discussions in the intervention helped you the most? Similar to question four responses, the participants cited the use of affirming Biblical scripture, grieving rituals, and group discussion as most helpful.
- What role did your religious belief have in the group process? More than 80% reported that their religious belief and the spiritually based intervention played a strong to very strong role in resolving their PAG. Only 2 participants stated religion played no role at all.
- What did you consider the least helpful in the group intervention? One participant felt it was “too religious,” and another felt the facilitator was too directive. Of the remaining, 85% of participants left this question blank ($n = 14$) or wrote “nothing” ($n = 18$), indicating all was helpful.
- What suggestions would you make to improve the helpfulness of the group? Ten participants suggested one of the following: less facilitator dialogue, more solitude time for reflection in the weekend format, better advertisement of the group, overnight onsite accommodation for weekend retreat (some centers provide this), writing abortion story the night before the first session, and an ongoing support group. This question was left blank by 24% of participants, and 44% wrote “nothing” could have improved their group experience.

Three questions identified clinical features of PAG with the last two addressing the shame component a postabortion grief woman associates to the abortion experience.

- What thoughts or feelings had you experienced before joining the group as it related to your abortion? In response to this question, four themes emerged: 46% of participants stated that they experienced fear, depression, and/or isolation following their abortion. Guilt and shame were themes recorded by 40% of the women, and 25% reported comments that reflected feelings of denial following their abortion. Last, self-loathing and self-destructiveness were experienced by 25% of the women. More interesting, participants noted a sense of heightened moodiness and depression during the weeks preceding the start of the group. This is perhaps triggered by emerging issues related to their abortion experience that have been buried. In these cases, individual sessions prior to the group addressing these fears and anxiety related to these abortion memories may be helpful.
- Do you now plan to share with anyone about your abortion experience? One unexpected finding, given the predominance of the PAG features just mentioned, was a sense of altruism following the intervention. Of the women, 80% described a willingness to share their abortion experience with another struggling with PAG if they felt it would help that individual.
- Before the group intervention, how many people did you tell about your abortion? This increased sense of altruism postintervention takes on a greater significance when considering that prior to the intervention almost one half of the partici-

pants reported two or fewer people knew about their past abortion.

Finally, a prominent theme throughout the qualitative data was the women’s reported facilitation of forgiveness and reconciliation. This occurred in relationship to others involved in the abortion decision, toward themselves personally, and with God following completion of this spiritually based group intervention.

Therapeutic Role of Religion

A significant majority of the women (86%) reported that their religious beliefs played a strong to very strong role in the treatment process. When working with those who espouse a Christian faith, the current study supports the value of integrating spirituality into PAG intervention. The group facilitators observed that many of the participants accepted God’s forgiveness but struggled with the issue of self-forgiveness. From extensive clinical experience with this population, Freed and Salazar (1993) found that the lack of self-forgiveness is a common obstacle and, if not reconciled, will disrupt the process to PAG resolution. Forgiveness has to go beyond an intellectual exercise for a person of faith; it has to be a heartfelt choice made by the individual in relationship with God (Freed & Salazar, 1993).

Similar to the Alcoholics Anonymous Twelve-Step program, the integral part in the treatment philosophy of PAG is forgiveness and reconciliation with a higher power. The PAG curriculum focused on the sovereign, compassionate, and forgiving nature of Jesus, a core Christian belief, which assists an individual in forgiving others and eventually themselves. More than one half of the women reported that the validation from sharing similar grief was helpful; however, the majority of the women (86%) reported their religious beliefs playing a strong to very strong role in their “healing”:

“It would not have been helpful to go through this process without believing in God’s sovereignty.”

“Our common belief in Christ bonded us together as a group. The scriptures brought strength and healing.”

“Helped me accept God’s forgiveness.”

“It (religion) played a role in learning to forgive myself.”

“It (religion) is the backbone for all healing.”

DISCUSSION AND APPLICATION TO SOCIAL WORK PRACTICE

The current study indicated significant improvement in the level of shame and avoidance associated with

PTSD for women with PAG, using a spiritually based group intervention. It also provided qualitative data specifying what aspects of the PAG intervention benefited the participants most. Although the sampling size was small, these scores along with the qualitative data indicated that certain aspects of the group intervention created positive therapeutic changes for the women.

Some limitations of the research include the small size, lack of biopsychosocial information, and lack of a control group. Additional biopsychosocial information on participants would have been helpful in elucidating other variables that may have influenced the PAG. As the literature discusses, there are stressors, such as a mental health history or a coercive abortion, that may place the individual at higher risk for PAG.

On completion of the group intervention, the majority of participants indicated that their religious beliefs played a very strong role in resolving their PAG. However, a direct inquiry of their views regarding religion and spirituality prior to the group would have provided additional useful information. It would have been useful to understand the participant's meaning or understanding of spirituality or religion. This would have better enabled us to determine if those coming to the group would identify an already developed sense of spirituality, a desire for growth in that area, or perhaps would not identify spirituality as relevant in their lives at all. Although we are aware of participants coming from all of these categories who benefited from the group, we cannot correlate posttest scores with this aspect, nor can we determine if the group enhanced an already developed sense of spirituality or rather initiated the development of this sense.

A baseline control group measure would have been useful in determining if PAG lessens over time. Based on the qualitative data, it is highly improbable that the improved responses were due to the passage of time for the following reason: Most of the women described their PAG as "deeply buried" and reported feeling "numb" prior to the intervention (E1). Without a secular PAG intervention for comparison, we could not specifically measure the efficacy of the spiritual content. Was it the group process or the spirituality that generated the positive outcomes? From the qualitative data, 86% of the participants reported obtaining most benefit from the spiritually based exercises and discussions indicating the inextricability of spirituality from the therapeutic process. Longitudinal study assessing long-range effects of a spiritually based PAG group is needed.

Less than 5% of the women in the current study were referred from professionals outside religious networks in the community. Independent abortion providers rarely

provide or advertise PAG services (Burke & Reardon, 2002). Therefore a nonreligious person seeking PAG help would have difficulty in finding a non-faith-based PAG group in the community. It is imperative within our profession that we acknowledge the current literature that indicates that there are individuals who suffer from PAG and receive training in this unique form of grief. It should be routine while gathering biopsychosocial information to inquire if the individual has had a direct or indirect experience with abortion. Finally considering the limitations set by managed health care, it is essential that social workers integrate other lower cost interventions for the client. Most faith-based agencies provide the PAG groups at a nominal fee and/or on a sliding scale basis.

In summary, the current study demonstrated that a time-limited, spiritual group intervention resulted in clinically significant improvement in reduction of shame and PTSD for women experiencing PAG. The actual percentage of women negatively affected by an abortion remains unknown. Some women with symptoms of PAG would not be amenable to a spiritual intervention. For the women in the current study, however, improvement in well-being was achieved, and many attributed their satisfaction to the use of spirituality in the healing process.

REFERENCES

- Barnard, C. (1990). The long term psychosocial effects of abortion. *Dissertation Abstracts International*, 51(08), 4038A. (UMI No. 9100897)
- Burke, T., & Reardon, D. C. (2002). *Forbidden grief*. Springfield, IL: Acorn Books.
- Campbell, N. B., Franco, K., & Jurs, S. (1988). Abortion in adolescence. *Adolescence*, 23(92), 813-823.
- Canda, E. R. (1997). Spirituality. In R. L. Edwards (Ed.), *Encyclopedia of social work, 19th edition, 1997 supplement* (pp. 299-309). Washington, DC: NASW Press.
- Cook, D. R. (1988). Measuring shame: The Internalized Shame Scale. *Alcoholism Treatment Quarterly*, 4, 197-215.
- Coyle, C. T., & Enright, R. D. (1997). Forgiveness intervention with postabortion men. *Journal of Consulting and Clinical Psychology*, 65, 1042-1046.
- Donnai, P., & Harris, C. (1981). Attitudes of patients after genetic termination of pregnancy. *British Medical Journal*, 282, 621-622.
- Falicov, C. (1998). *Latino families in therapy: A guide to multicultural practice*. New York: Guilford.
- Franz, W., & Reardon, D. (1992). Differential impact of abortion on adolescents and adults. *Adolescence*, 27, 105, 161-172.
- Freed, L., & Salazar, P. Y. (1993). *A season to heal: Help and hope for those working through post abortion stress*. Nashville, TN: Thomas Nelson.
- Furlong, R. M., & Black, R. B. (1984). Pregnancy termination for genetic indications: The impact on families. *Social Work in Health Care*, 10, 17-34.

- Gallup Poll. (2001). Gallup Poll topics a-z. Available at www.gallup.com/poll/indicators/inreligion2.asp
- Gilkes, C. (1995). The storm and the light: Church, family work, and social crisis in the African-American experience. In N. Ammerman & W. Roof (Eds.), *Work, family, and religion in contemporary society* (pp. 177-198). New York: Routledge.
- Harvath, S. (1990). *Dear children . . . A story of post abortion healing* [Video]. (Available from Liguori Publications, One Liguori Drive, Liguori, MO 63057-9999)
- Hodge, D. R. (2001). Spiritual assessment: A review of major qualitative methods and a new framework for assessing spirituality. *Social Work, 46*, 203-214.
- Joy, S. (1985). Abortion: An issue to grieve? *Journal of Counseling and Development, 63*, 375-376.
- Major, B., Cozzarelli, C., Cooper, L., Zubek, J., Richards, C., Wilhite, M., et al. (2000). Psychological responses of women after first trimester abortion. *Archives of General Psychiatry, 57*, 777-784.
- Major, B., Mueller, P., & Hildebrandt, K. (1985). Attributions, expectations, and coping with abortion. *Journal of Personality and Social Psychology, 44*(3), 585-599.
- Martin, E., & Martin, J. (2002). *Spirituality and the Black helping tradition in social work*. Washington, DC: NASW Press.
- Mueller, P., & Major, B. (1989). Self-blame, self-efficacy, and adjustment to abortion. *Journal of Personality and Social Psychology, 57*, 1059-1068.
- Ney, P. G., Fung, T., Wickett, A. R., & Beaman-Dodd, C. (1994). The effects of pregnancy loss on women's health. *Social Science Medicine, 38*, 1193-1200.
- Peppers, L. (1987). Grief and elective abortion: Breaking the emotional bond? *Omega, 18*, 1-12.
- Rosenfeld, J. A. (1992). Emotional responses to therapeutic abortion. *American Family Physician, 45*, 137-140.
- Russo, N. F., & Zierk, K. L. (1992). Abortion, childbearing, and women's well-being. *Professional Psychology and Research Practice, 23*, 269-280.
- Sandoval, M. (1995). Hispanics in the United States: Between conquest and liberation. In A. Pineda & R. Schreiter (Eds.), *Dialogue rejoined* (pp. 9-22). Collegeville, MN: Liturgical Press.
- Speckhard, A. C., & Rue, V. M. (1993). Complicated mourning: Dynamics of impacted post abortion grief. *Pre- and Perinatal Psychology Journal, 8*, 5-32.
- Weiss, D., & Marmar, C. (1997). The Impact of Event Scale-Revised. In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399-411). New York: Guilford.
- Zakus, G., & Wilday, S. (1987). Adolescent abortion option. *Social Work in Health Care, 12*, 77-91.
- Zeanah, C. H., Dailey, J. V., Rosenblatt, M. J., & Saller, D. N. (1993). Do women grieve after terminating pregnancies because of fetal anomalies? A controlled investigation. *Obstetrics Gynecology, 82*, 270-275.

Men and Abortion

A Review of the Research

October 2008
Washington, DC
Catherine T. Coyle, RN, PhD



Review of the Research

- 31 scholarly papers since the legalization of abortion in 1973
- Studies are based on only 23 independent samples
- Seven samples were recruited in countries other than the United States (UK, Canada, Sweden, South Africa, Belgium & Greece)
- Studies tended to be descriptive rather than explanatory

(Coyle, 2007. Men and abortion: A review of empirical reports. *Internet Journal of Mental Health*.)

Strengths & Limitations

STRENGTHS:

- Raised awareness
- Suggestions for counseling

LIMITATIONS:

- Small sample size
- Usually assessed at time of abortion
- Inadequate clinical assessment
- Lack of control groups
- No attention given to men who chose not to participate

Studies of Therapeutic Abortion



Blumberg et al. (1975)
Depression 82%

Jones et al. (1984)
Depression 50% Guilt 33%

White van-Mourik et al. (1992)
Depression 47% Relief 32%
Failure 26% Fear 37% Anger 33%
Withdrawn 32% Guilt 26%
Concentration problems 41%

Robson (2002)
Traumatic re-experience.

Quantitative Studies

Buchanan & Robbins (1990)

Among adult men, a history of abortion during adolescence was more distressing than adolescent fatherhood.

Robbins & Streetman (1994)

Men with abortion history were less likely to have completed college.



Quantitative Studies (cont.)

Lauzon et al. (2000)

- 17.6% believed abortion negatively affected relationship with partner
- 30% would have liked counseling
- 21% of those who were with partners during procedure reported it as being traumatic

Coleman & Nelson (1998)

- regret 51.6%
- sadness 45.2%
- depression 25.8%
- longing for the fetus 33%

Quantitative Studies (cont.)

Men with abortion history were more likely to:

- endorse sex with more than one partner and with strangers
- be willing to engage in sex without love
- engage in impersonal sexual behaviors
- have more sex partners in past year
- have sex with a casual acquaintance or friend



Coleman, Rue, Spence & Coyle (2008)

Qualitative Studies

Rothstein (1977a, 1977b, 1978, 1991)

- 20% expressed interest in counseling
- 86.7% believed they were being helpful to partners in some way
- men expected relationship problems and struggled with guilt and anxiety
- negative impact on sexual relationships

Kero et al. (1999, 2000, 2004)

- ambivalence pre and post-abortion

Qualitative Studies (cont.)

Myburgh et al. (2001a, 2001b)

- powerlessness
- emotional turmoil related to relationship problems
- men involved in abortion need counseling

Poggenpoel & Myburgh (2002)

- adolescent males experienced guilt, grief, helplessness, social pain, psychological pain, spiritual pain, and overwhelming thoughts about the abortion and the future

Qualitative Studies (cont.)

Reich & Brindis (2006)

- Men felt excluded from the abortion decision and a significant number did not confide in anyone

Naziri (2006)

- ___ of the men disagreed with the abortion decision and responded with anger
- Even couples who agreed to abort experienced stress on their relationships

Qualitative Studies (cont.)



75% disagreed that abortion is easy for men.

40% to 63% reported lingering & disturbing thoughts or dreams.

Most men who sought counsel did so from a male friend.

25% of a post-abortion sample believed abortion had contributed to the end of relationships with partners.

Shostak (1979, 1983)

Shostak & McLouth (1984)

Intervention Studies

Gordon (1978), Gordon & Kilpatrick (1977)

Men struggled with anxiety, helplessness, guilt, responsibility, and regret.

Counseling was associated with a significant decrease in anxiety.

Coyle & Enright (1997)

Post-abortion men evidenced clinical levels of anxiety prior to treatment.

Forgiveness therapy was associated with significant reductions in anxiety, anger, & grief.

Clinical Reports

Mattinson (1985)

delayed grief reactions

Holmes (2004)

sleep disturbance, somatic complaints, rumination about the fetus, worthlessness, threat to belief system

Berger (1994)

Abortion may be a factor in the etiology of male homosexuality.

Clinical Reports (cont.)

Speckhard & Rue (1993)

Rue (1996)

- threats to masculinity
- feelings of failure
- guilt
- grief
- trauma reactions
- relationship difficulties



Men & Miscarriage or Stillbirth



- Men avoided talking about their loss
- Men felt misunderstood and neglected by both family & community
- A common coping strategy was to ignore things, try to forget, and carry on as normal

Men demonstrate lower “active grief” scores but higher “difficulty coping” and “despair” scores than those of women when dealing with pregnancy loss.

(Pudffoot & Johnson, 1999)



www.abortionresearch.net

n= 198

Ave. age = 38 (range 18-71)

Ave. time lapse = 14.8 years
(range < 1 mo – 46 years)

77.9% from United States

85.3% Caucasian

82.1% Christian

49.7% had undergrad degree

13.6% married at time of abortion

48.1% liberal views pre-abortion



Alliance for Post-Abortion Research & Training

www.abortionresearch.net

Grief 89%

Guilt 85%

Helplessness 83%

Relationship Problems 82%

Anger 80%

Persistent Thoughts 71%

High or Overwhelming Stress 71%

Would not choose abortion in the future 89%

Common Findings

- Tend to defer decision and repress emotions
- More emotionally trying than expected
- Ambivalence (relief, anxiety, grief, guilt, helplessness)
- Need and/or desire counseling
- Perceived role/Preferred coping style
- Relationship difficulties



“Whether or not the creator-father continues as parent, indeed, his part in the creation of a new life signifies an elemental reality which no legal, social, or medical act (such as abortion) can truly alter... It is the biological act which sets in motion the forces that will in time alter consciousness, self-perception, and even attitudes toward the outside world.”

Colman & Colman (1981). *Earth Father, Sky Father: The Changing Concept of Fathering*

Men and Abortion: A Summary of Research Findings

Since the legalization of abortion in 1973, a limited number of scholarly papers have been published concerning the potential effects of elective abortion on men. Some of the findings from these reports include the following:

- Most men who experience abortion do not perceive it to be a benign experience.^{1 2 3}
- Men dealing with abortion may need, desire, and/or benefit from counseling.^{4 5 6 7}
- Men experience ambivalent emotions in response to abortion including relief, anxiety, grief, depression, guilt, powerlessness and anger.^{8 9 10}
- Men tend to defer the abortion decision to their partners.^{11 12}
- Men tend to repress their own emotions in an attempt to support their partners.^{13 14 15}
- Men's relationships may be strained by and fail after abortion.^{16 17 18}
- Men may experience sexual problems following abortion.^{19 20 21 22}
- Men's masculine identity may be threatened by abortion.^{23 24 25}
- Men who experience abortion may be more stressed than men who experience unplanned pregnancy and fatherhood.²⁶

Resources for men can be found at the following websites:

**www.lifeissues.org/men/MAN/index.html
(Men and Abortion Network - M.A.N.)**

**www.fatherhoodforever.org
www.menandabortion.info**

¹ Shostak, A. (1979). Abortion as fatherhood lost: Problems and reforms. *Family Coordinator*, 28 (4), 569-574.

² Shostak, A. (1983). Men and abortion: Three neglected ethical aspects. *Humanity & Society*, 7 (1), 66-85.

³ Shostak, A. & McLouth, G. (1984). Men and abortion: Lessons, losses and love. New York: Praeger.

⁴ Rothstein, A. (1977). Men's reactions to their partners' elective abortions. *American Journal of Obstetrics and Gynecology*, 128 (8), 831-837.

⁵ Lauzon, P., Roger-Achim, D., Achim, A. & Boyer, R. (2000). Emotional distress among couples involved in first-trimester induced abortions. *Canadian Family Physician*, (46), 2033-2040.

⁶ Gordon, R.H. (1978). Efficacy of a group crisis-counseling program for men who accompany women seeking abortion. *American Journal of Community Psychology*, 6 (3), 239-246.

⁷ Coyle, C.T. & Enright, R.D. (1997). Forgiveness intervention with post-abortion men. *Journal of Consulting and Clinical Psychology*, 65 (6), 1042-1046.

⁸ Gordon, R.A. & Kilpatrick, C. (1977). A program of group counseling for men who accompany women seeking legal abortions. *Community Mental Health Journal*, 13 (4), 291-295.

⁹ Coleman, P.K. & Nelson, E.S. (1998). The quality of abortion decisions and college students' reports of post-

-
- abortion emotional sequelae and abortion attitudes. *Journal of Social and Clinical Psychology*, 17 (4), 425-442.
- ¹⁰ Kero, A., Lalos, A., Hogberg, U. & Jacobsson, L. (1999). The male partner involved in legal abortion. *Human Reproduction*, 14 (10), 2669-2675.
- ¹¹ Shostak, A. & McLouth, G. (1984).
- ¹² Gordon, R.A. & Kilpatrick, C. (1977).
- ¹³ Gordon, R.A. & Kilpatrick, C. (1977).
- ¹⁴ Robson, F.M. (2002). "Yes! - A chance to tell my side of the story. ": A case study of a male partner of a woman undergoing termination of pregnancy for foetal abnormality. *Journal of Health Psychology*, 7 (2), 183-193.
- ¹⁵ Shostak, A. & McLouth, G. (1984).
- ¹⁶ Shostak, A. & McLouth, G. (1984).
- ¹⁷ Myburgh, M., Gmeiner, A. & van Wyk, S. (2001). The experience of biological fathers of their partners' termination of pregnancy. *Health SA Gesondheid*, 6 (1), 28-37.
- ¹⁸ Naziri, D. (2007). Man's involvement in the experience of abortion and the dynamics of the couple's relationship: A clinical study. *The European Journal of Contraception and Reproductive Health Care*, 12 (2), 168-174.
- ¹⁹ Rothstein, A. (1977). Abortion: A dyadic perspective. *The American Journal of Orthopsychiatry*, 47 (1), 111-118.
- ²⁰ White-van Mourik, M.C., Connor, J.M. & Ferguson-Smith, M.A. (1992). The psychological sequelae of a second-trimester termination of pregnancy for fetal abnormality. *Prenatal Diagnosis*, 12 (3), 189-204.
- ²¹ Berger, J. (1994). The psychotherapeutic treatment of male homosexuality. *American Journal of Psychotherapy*, 48 (2), 251-261.
- ²² Coleman, P.K., Rue, V.M., Spence, M. & Coyle, C.T. (2008). Abortion and the sexual lives of men and women: Is casual sexual behavior more appealing and more common after abortion? *International Journal of Clinical and Health Psychology*, 8 (1), 77-91.
- ²³ Speckhard, A. & Rue, V. (1993). Complicated Mourning: Dynamics of impacted post abortion grief. *Journal of Prenatal and Perinatal Psychology*, 8 (1), 5-32.
- ²⁴ Holmes, M.C. (2004). Reconsidering a "woman's issue." One man's postabortion experiences. *American Journal of Psychotherapy*, 58 (1), 103-115.
- ²⁵ Rue, V.M. (1996). The effects of abortion on men. *Ethics and Medics*, 21 (4), 3-4.
- ²⁶ Buchanan, M. & Robbins, C. (1990). Early adult psychological consequences for males of adolescent pregnancy and its resolution. *Journal of Youth and Adolescence*, 19 (4), 413-424.

Politics and Post-Abortion Awareness Survey
95% Confidence Limits are +/- 4%
National Survey of a Random Sample of Residential Phone Numbers

General Findings

- Approximately 85 percent of American adults believe negative emotional problems after an abortion are common to very common. Over 60% of those identifying themselves as very pro-choice also believe post-abortion emotional problems are common to very common.
- When negative emotional reactions occur, 84% believe the reactions are moderately to very severe.
- Only 15 percent of those polled believed that abortion generally makes women's lives better. Over half believe it generally makes women's lives worse.
- About half stated that it is common or very common for women to feel pressured into unwanted abortions. Only 14% believe that pressured or coerced abortions are rare.
- 80% believe abortion doctors should screen for women feeling pressured into unwanted abortions.
- 70% believe abortion doctors should screen for risk factors that identify women who are more likely to experience emotional problems after an abortion.
- 71% believe more research into the negative emotional effects should be of medium to high priority, with 41% rating it as of high priority. 11% believe there should be no more research done on this issue.
- Those who identify themselves as strongly pro-choice are evenly split regarding how common and severe negative post-abortion reactions are, but over 60% believe doctors should screen for women being pressured into unwanted abortions.
- Those who identify themselves as strongly pro-life are most likely to consider negative reactions to be very common and very severe and to support more research and requirements for pre-abortion screening for coercion and risk factors.
- Those who have the least affiliation with either a pro-life or pro-choice view, tend to have a significantly more negative view of abortions effects than those who are pro-choice, but not as negative as for those who are pro-life. Over 80% of this "middle" group support requiring doctors to screen for coercion and 70% support pre-abortion screening for other risk factors for negative reactions.

Methodology

This poll was conducted Feb 4 and Feb 5 of 2008 by In Touch Systems (GoInTouch.com) using the automated, recorded polling services of DialingServices.com and a national random sample drawn from InfoUSA's compiled list of all "white page" listed residential numbers in the United States. A total of 10,690 calls reached a voice response, and 626 respondents completed the poll.

As with all telephone surveys, the results may be affected by omission of persons who do not have a residential phone (due to either poverty or reliance on a cell phone), omission of persons who have unlisted numbers, and by overrepresentation of persons with more time or interest in answering polls.

Script and Results for Politics and Post-Abortion Awareness Poll

95% Confidence Limits are +/- 4%

Hello, we are taking a nationwide opinion poll regarding abortion and politics. This poll has been commissioned by the Elliot Institute. We would appreciate your participation.

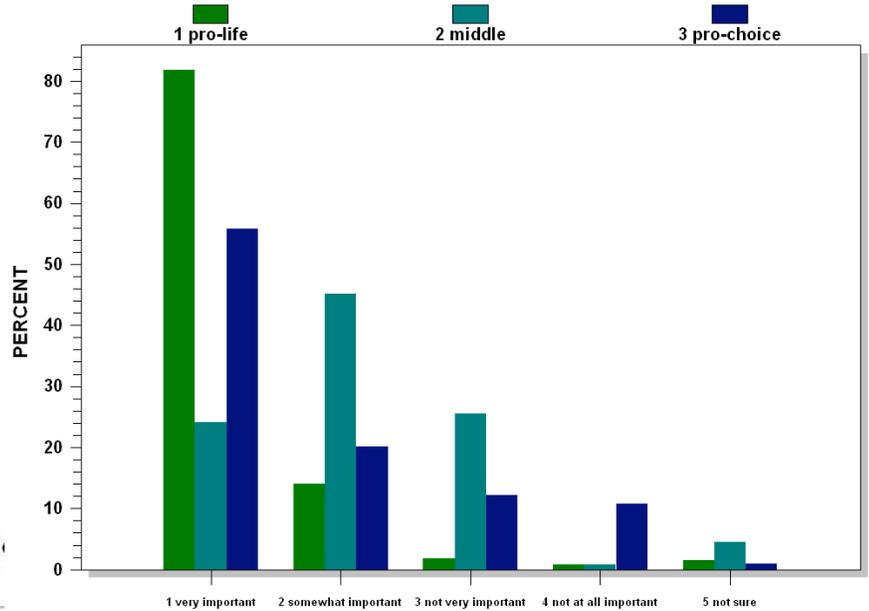
If you are over 18 years of age, please press 1 to continue -- or please give the phone to an adult in your home and ask them to press 2 to repeat this introduction. At any time you may press the pound or star key to repeat the question.

First, In terms of the way it impacts your vote for elected officials, how important is a candidate's position on abortion? If very important, press 1. If somewhat important, press 2. If not very important, press 3. If NOT AT ALL important, press 4. If you are not sure, press 5. Press the star key to repeat the question.

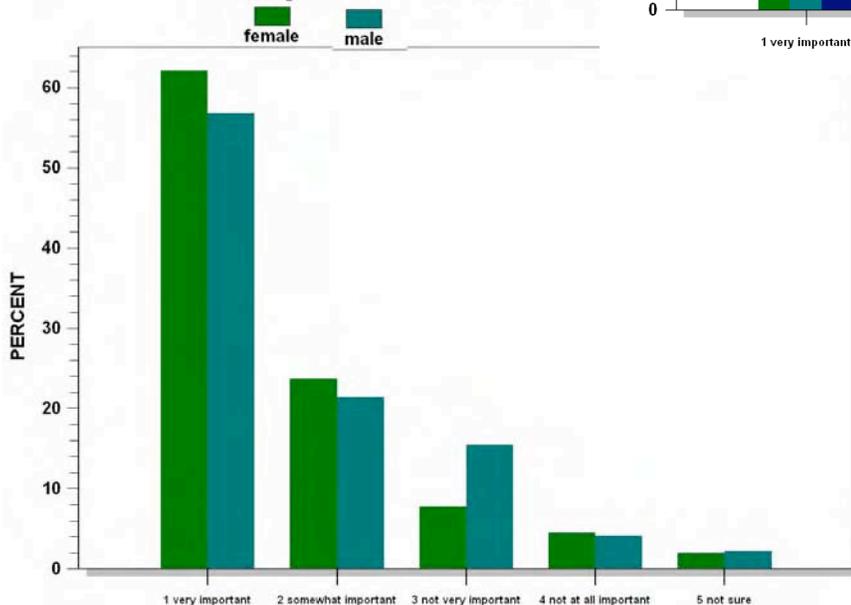
In all graphs, the view of the respondents (pro-life, middle, or prochoice) is drawn from question 5.

Candidate's Position	Percent
1 very important	60.2%
2 somewhat important	22.9%
3 not very important	10.5%
4 not at all important	4.3%
5 not sure	2.1%
Total n=621	100.0%

How Important is Candidates Postion?



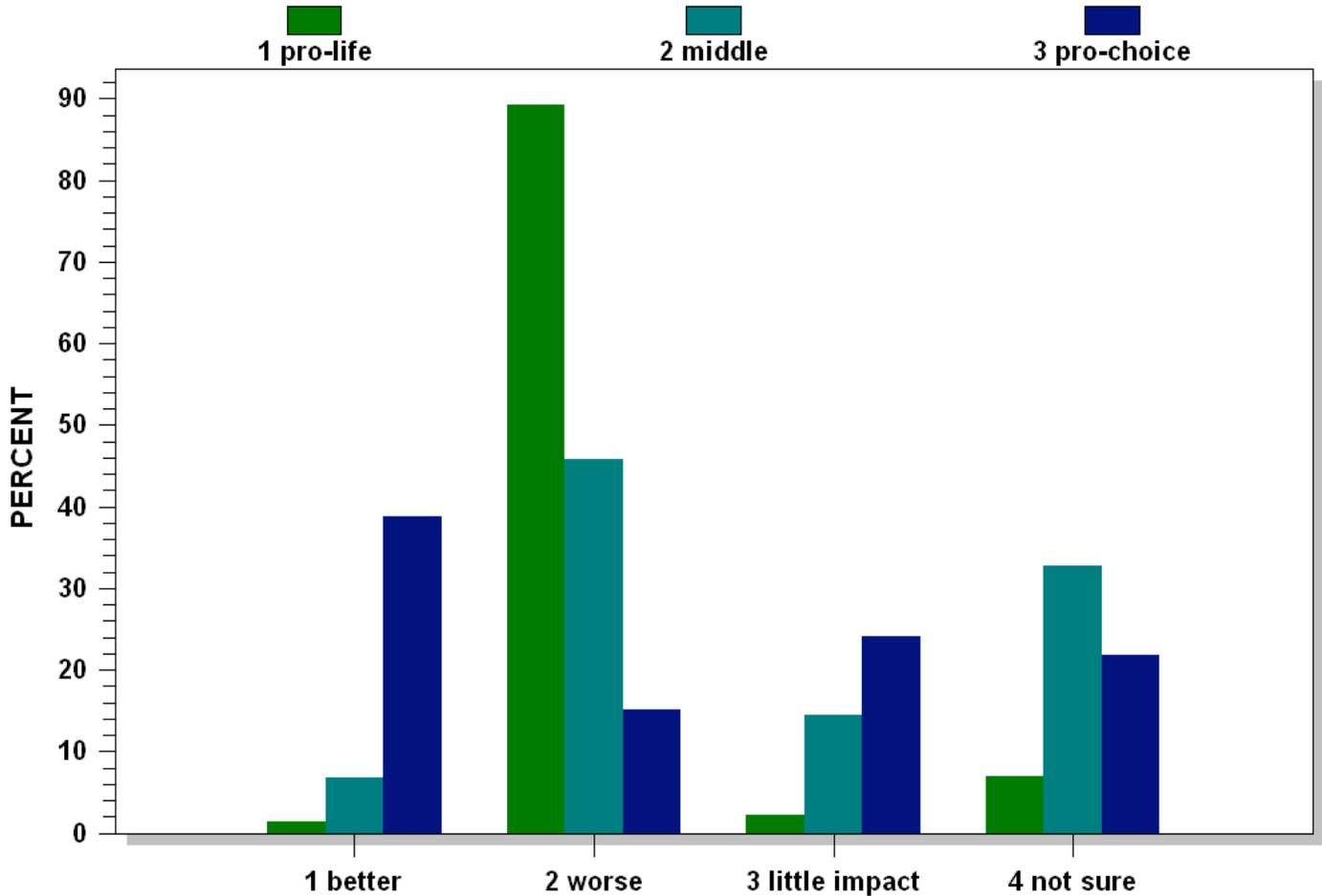
How Important is Candidates P



Question two: When a woman has an abortion, do you think it generally makes her life better, worse, or does it have little impact? If better, press 1. If worse, press 2. If little impact, press 3. If you are not sure, press 4. Press the star key to repeat the question.

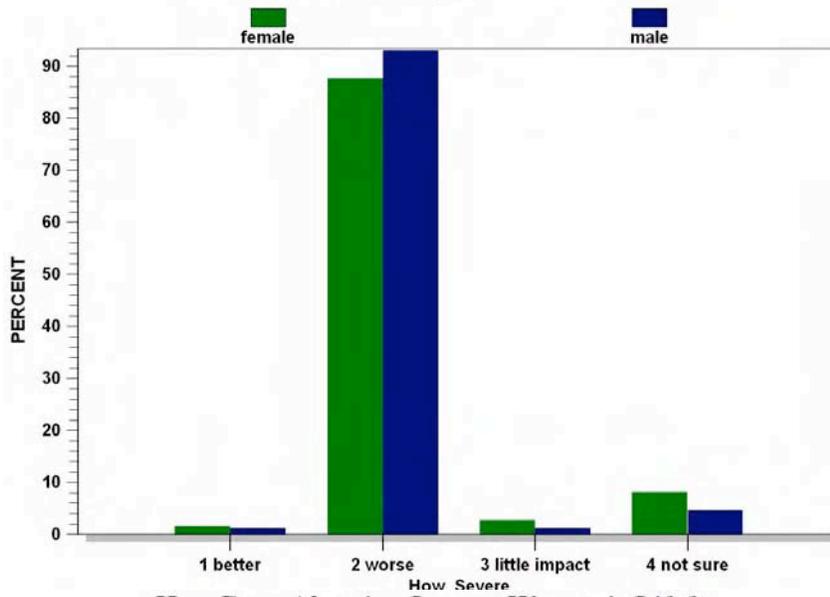
Impact on Life	Percent
1 better	15.4%
2 worse	54.5%
3 little impact	12.3%
4 not sure	17.8%
Total n=618	100.0%

How Does Abortion Impact Woman's Life? Better, Worse, or Little Impact



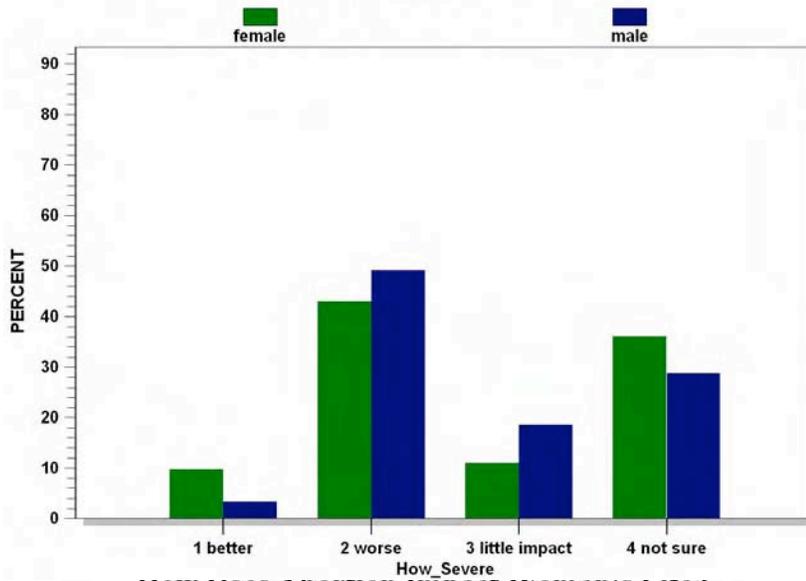
How Does Abortion Impact Woman's Life?

View=1 pro-life



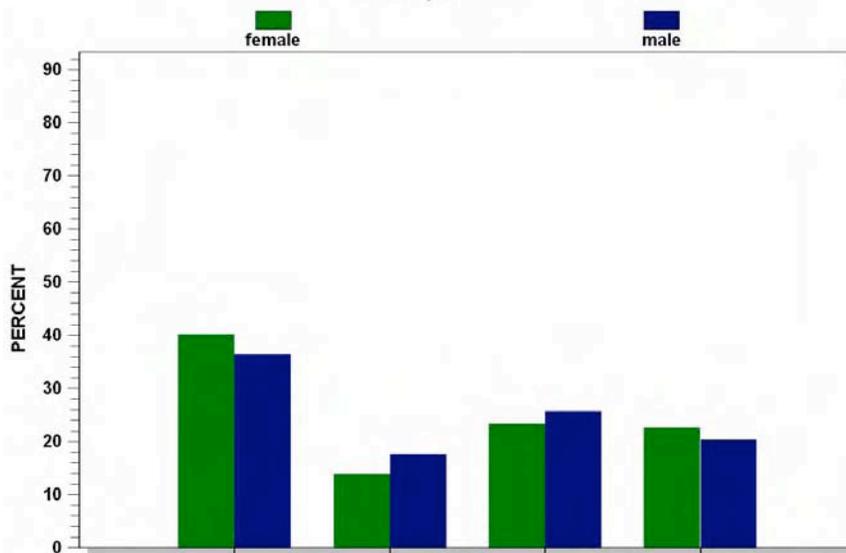
How Does Abortion Impact Woman's Life?

View=2 middle



HOW DOES ADORTION IMPACT WOMAN'S LIFE ?

View=3 pro-choice



How many women have emotional problems following an abortion? Please answer this question using a scale from 1 to 9 where a 1 means that NO women suffer emotional problems following an abortion and 9 means that ALL women suffer emotional problems following an abortion. Please touch the appropriate number on your telephone keypad. Remember this is a scale where 1 means that NO women suffer emotional problems following an abortion and a 9 means that ALL women suffer emotional problems following an abortion.

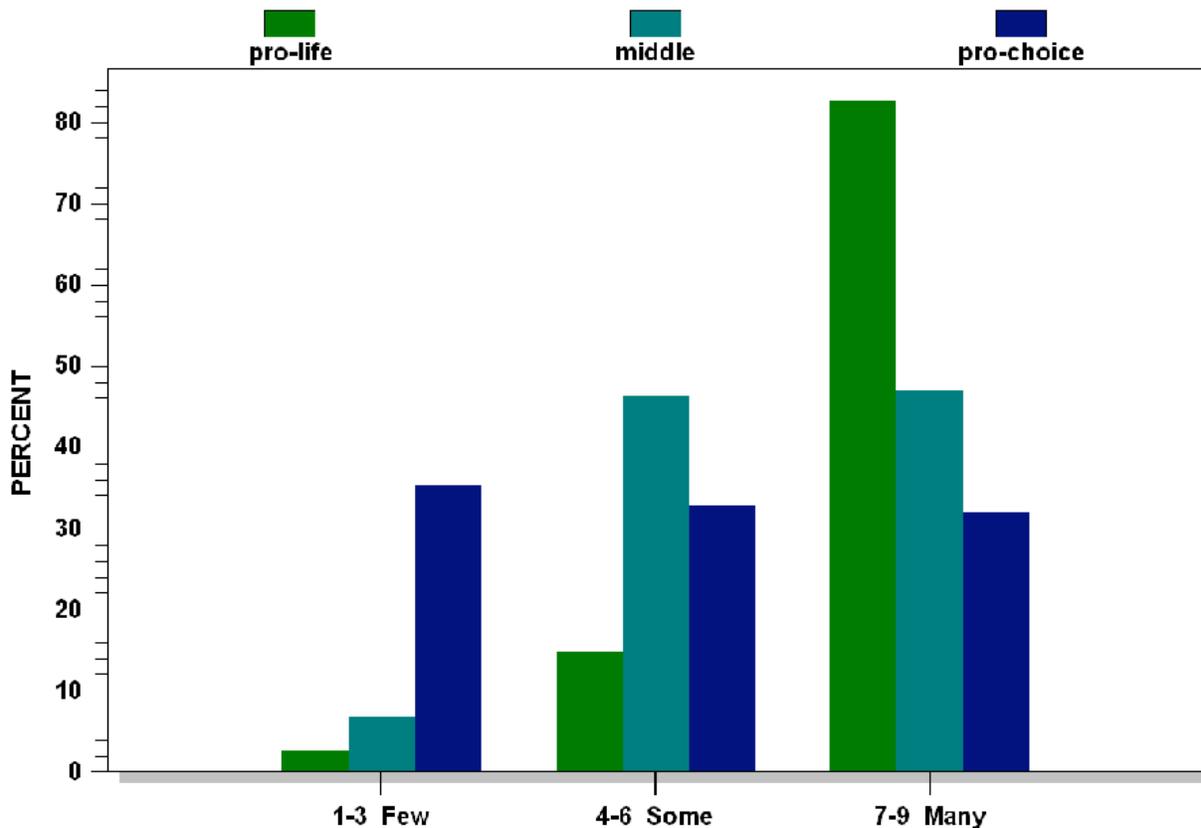
How Many	Frequency	Percent	Cum Percent
1 No Women	24	3.9%	3.9%
2	36	5.8%	9.6%
3	32	5.1%	14.8%
4	36	5.8%	20.5%
5	93	14.9%	35.5%
6	43	6.9%	42.4%
7	73	11.7%	54.1%
8	75	12.0%	66.1%
9 All Women	211	33.9%	100.0%
Total	623	100.0%	100.0%

The graph below shows that pro-life and middle oriented persons were significantly more likely to believe reactions are common than pro-choice persons. Pro-choice persons are evenly split between few, some, and many women having problems.

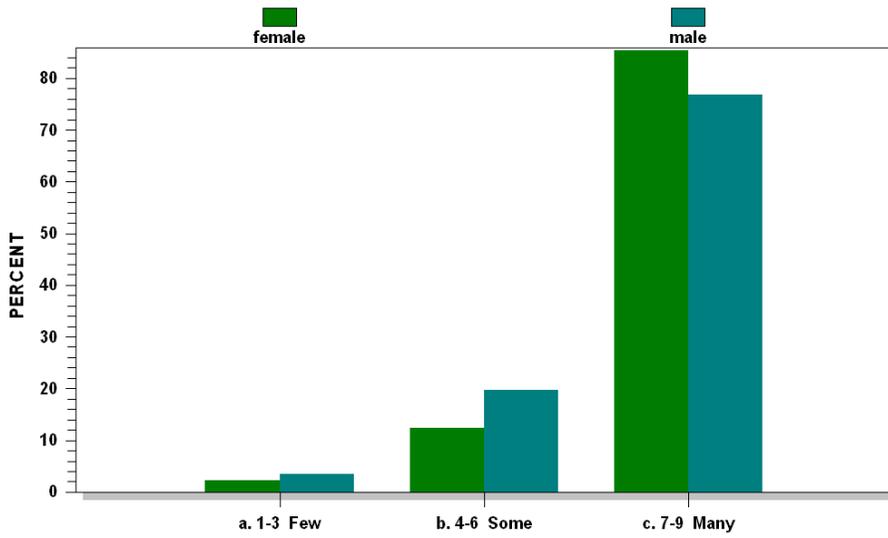
The three graphs on the following page show that in all three view groups, women are more likely than men to believe negative reactions are common.

How Common Are Emotional Reactions?

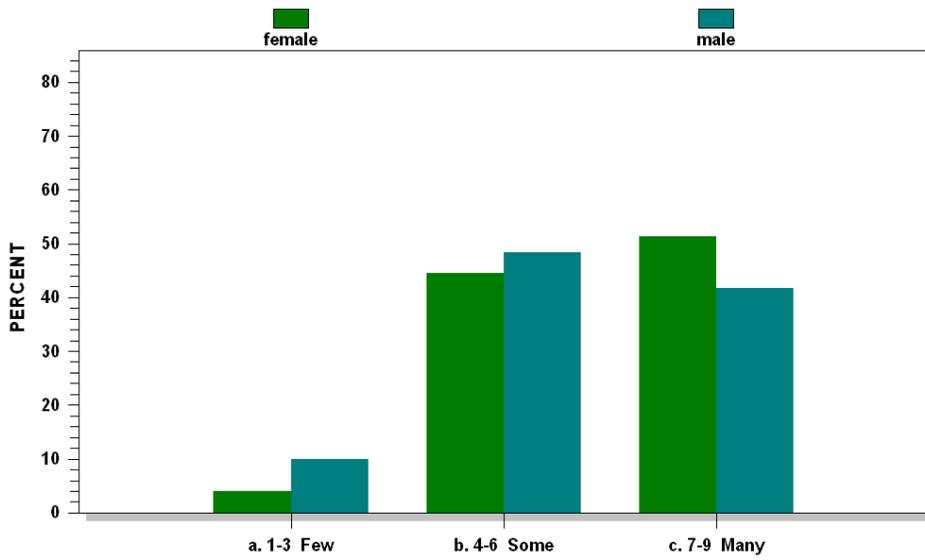
1=No Women Have to 9=All Women Have



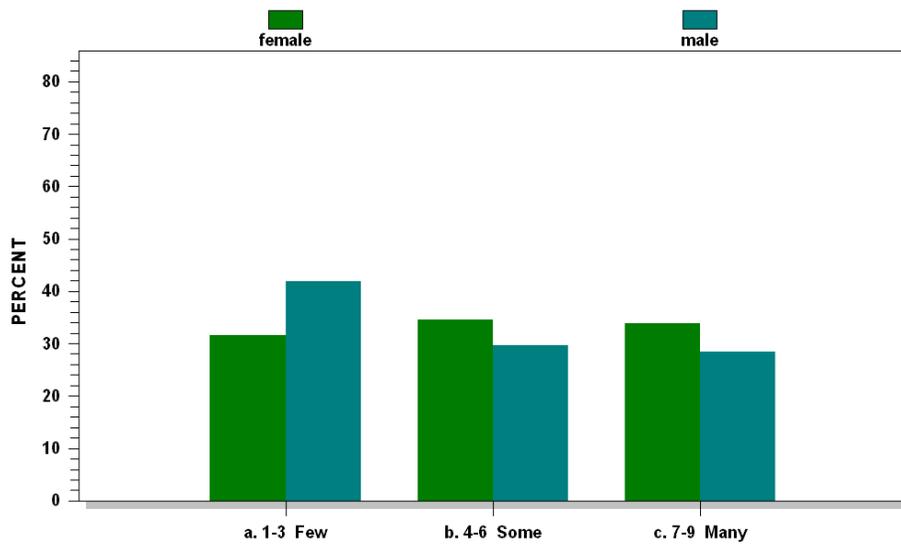
1=No Women Have to 9=All Women Have
view=1 pro-life



1=No Women Have to 9=All Women Have
view=2 middle

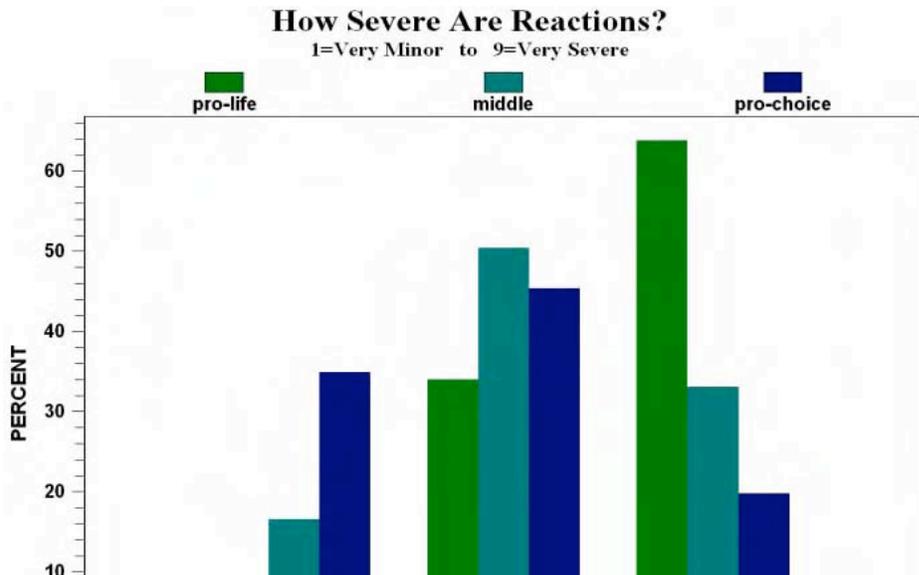
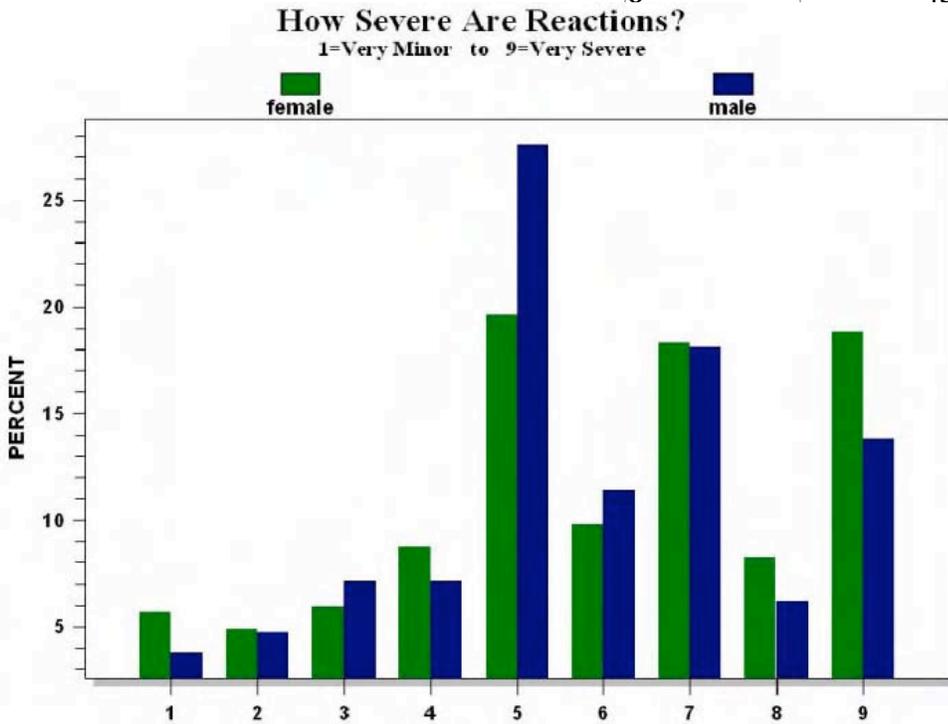


1=No Women Have to 9=All Women Have
view=3 pro-choice



Okay... When women do experience emotional problems after an abortion, how severe are they for most women? Please use a scale from 1 to 9 where a 1 means that the emotional problems are very minor and a 9 means that they are very severe.

How Severe	Frequency	Percent	Cum Percent
1 No Women	30	5.0%	5.0%
2	29	4.8%	9.9%
3	38	6.4%	16.2%
4	49	8.2%	24.4%
5	134	22.4%	46.8%
6	62	10.4%	57.2%
7	109	18.2%	75.4%
8	45	7.5%	82.9%
		17.1%	100.0%
		100.0%	100.0%

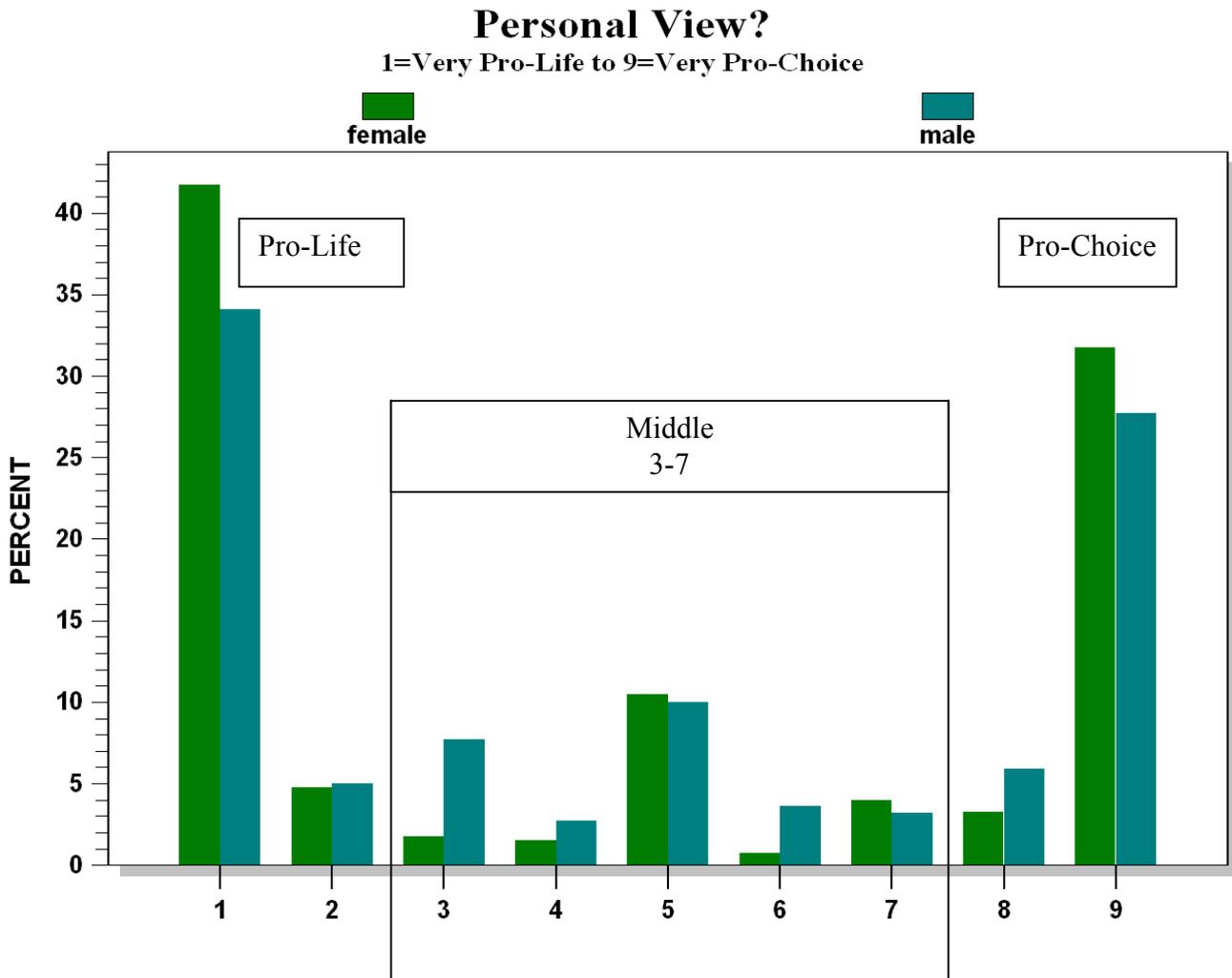


Regarding the political issue of abortion, on a scale of 1 to 9 where 1 is very pro-life and 9 is very pro-choice, how would you rate your personal view on abortion.

[pause two seconds] Please touch the appropriate number on your telephone keypad. Remember, a 1 means very pro-life and 9 is very pro-choice. 5 is neutral.

For analyses sorted by political view on abortion this question was used to segregate respondents by group using 1-2 for “pro-life” (n=272), 3-7 for “middle” (n=134) and 8-9 for “pro-choice” (n=214).

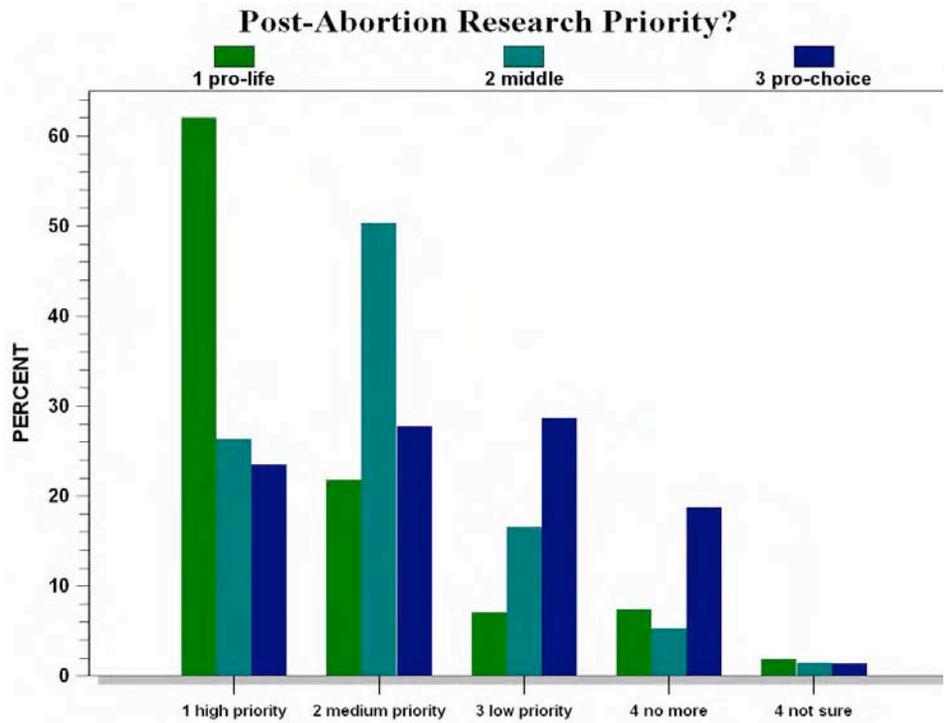
Personal View	Frequency	Percent	Cum Percent
1 (pro-life)	242	39.0%	39.0%
2 (pro-life)	30	4.8%	43.9%
3 (middle)	24	3.9%	47.7%
4 (middle)	12	1.9%	49.7%
5 (middle)	64	10.3%	60.0%
6 (middle)	11	1.8%	61.8%
7 (middle)	23	3.7%	65.5%
8 (pro-choice)	26	4.2%	69.7%
9 (pro-choice)	188	30.3%	100.0%
Total	620	100.0%	100.0%



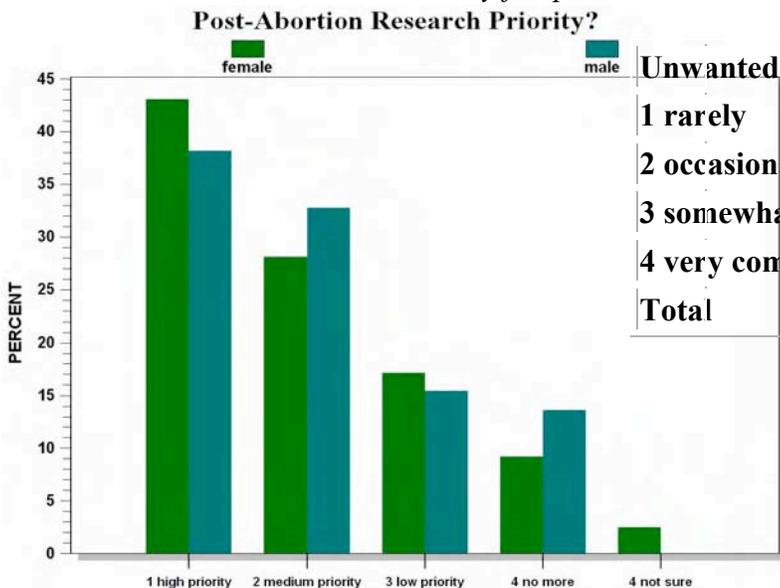
We're not going to use the 1 to 9 scale any more... Recent studies have shown that after an abortion some types of women are significantly more likely to experience negative emotional problems, such as grief, depression, substance abuse, or suicidal tendencies. These negative reactions appear to impact millions of women. Knowing this, Should more research on women's emotional reactions to abortion be a (1) a high priority, (2) a medium priority (3) a low priority, or (4) should no more research be done.

More Research	Frequency	Percent	Cum Percent
1 high priority	257	41.3%	41.3%
2 medium priority	185	29.7%	71.1%
3 low priority	103	16.6%	87.6%
4 no more	67	10.8%	98.4%
5 not sure	10	1.6%	100.0%
Total	622	100.0%	100.0%

*If a high priority, press 1
 If a medium priority, press 2
 If a low priority, press 3
 If no more research should be done, press 4.
 If you are not sure, press 5*



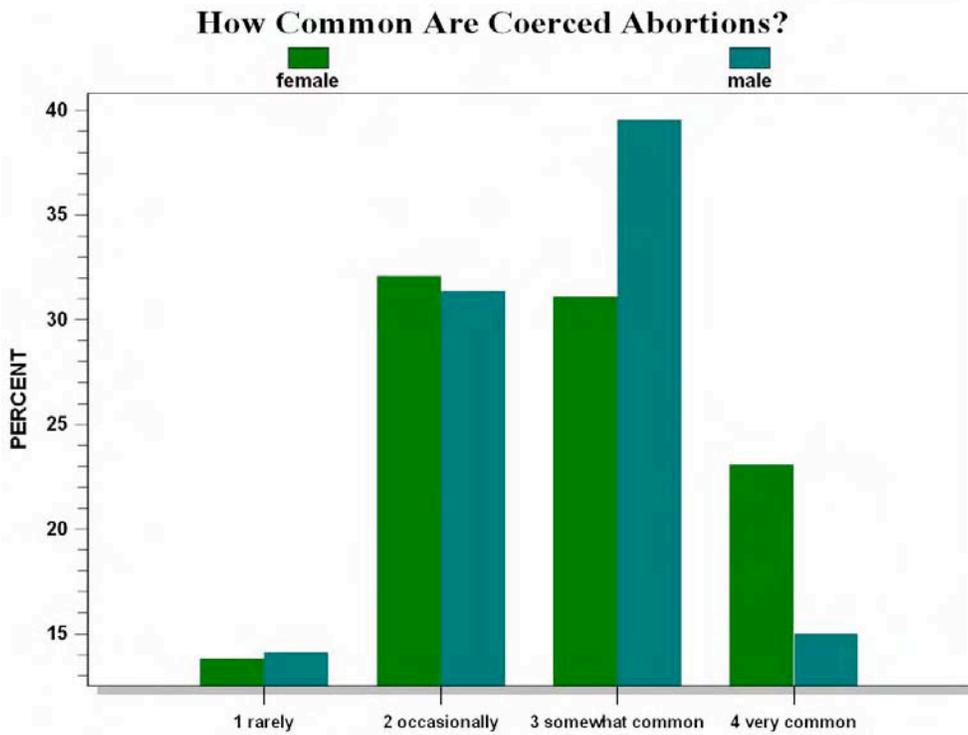
Some women have said that they felt pressured or coerced by their parents or male partners to undergo



Unwanted Abortions	Frequency	Percent	Cum Percent
1 rarely	86	13.9%	13.9%
2 occasionally	197	31.8%	45.7%
3 somewhat common	211	34.1%	79.8%
4 very common	125	20.2%	100.0%
Total	619	100.0%	100.0%

"unwanted abortions"? Do you believe this problem of "unwanted abortions" happens rarely, occasionally, is somewhat common, or is very common?

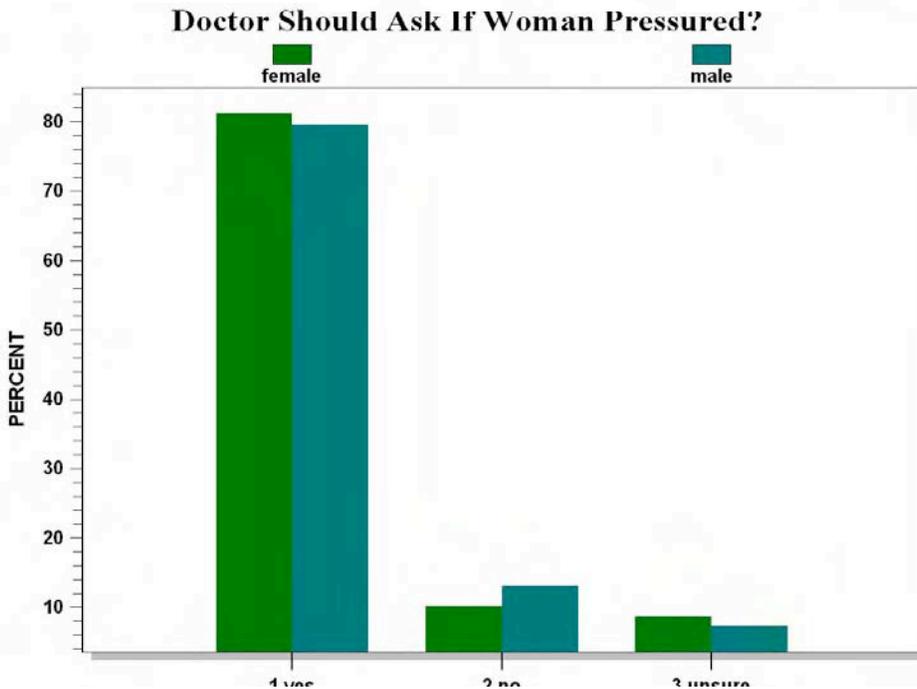
If rarely, press 1
If occasionally, press 2
If somewhat common, press 3
If very common, press 4



Women who feel pressured to have unwanted abortions are at much higher risk of experiencing more severe grief, guilt, depression and other psychological problems following an abortion. Do you believe abortion providers should ask if a woman is feeling pressured into an unwanted abortion?

Ask if Pressured	Frequency	Percent	Cum Percent
1 yes	505	80.7%	80.7%
2 no	70	11.2%	91.9%
3 unsure	51	8.1%	100.0%
Total	626	100.0%	100.0%

If yes, press 1
 If no, press 2
 If you are not sure, press 3



Do you believe abortion providers should ask about risk factors that can help identify if a woman is more likely to experience emotional problems after an abortion?

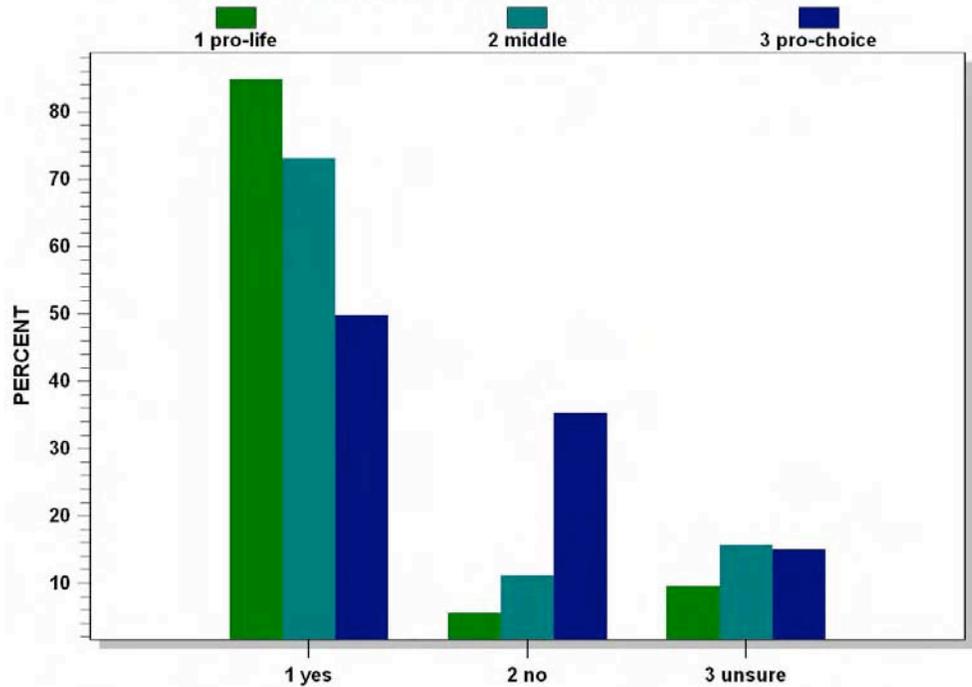
If yes, press 1

If no, press 2

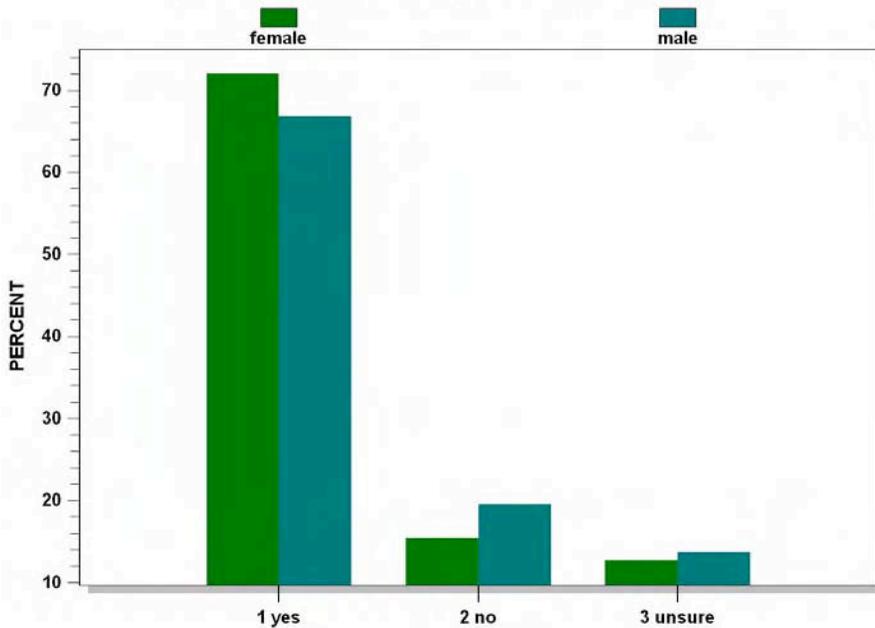
If you are not sure, press 3

Ask About Risk Factors ?	Frequency	Percent	Cum Percent
1 yes	438	70.2%	70.2%
2 no	105	16.8%	87.0%
3 unsure	81	13.0%	100.0%
Total	624	100.0%	100.0%

Doctor Should Ask About Risk Factors?



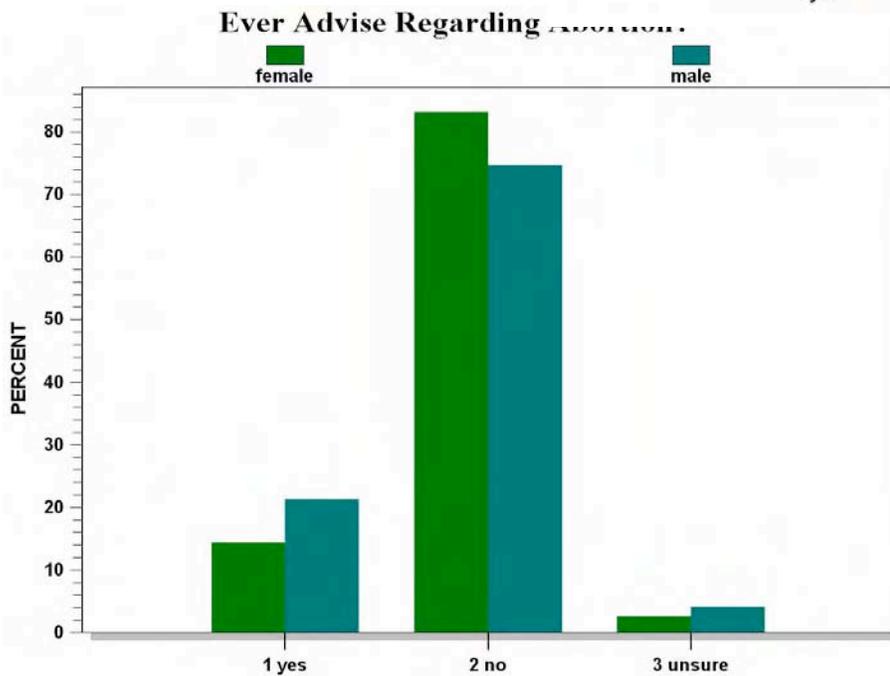
Doctor Should Ask About Risk Factors?



Have you ever been involved in advising someone to have an abortion?

If yes, press 1.
 If no, press 2.
 If unsure, press 3.

Advised to have Abortion	Frequency	Percent	Cum Percent
1 yes	105	16.8%	16.8%
2 no	500	80.1%	97.0%
3 unsure	19	3.0%	100.0%
Total	624	100.0%	100.0%

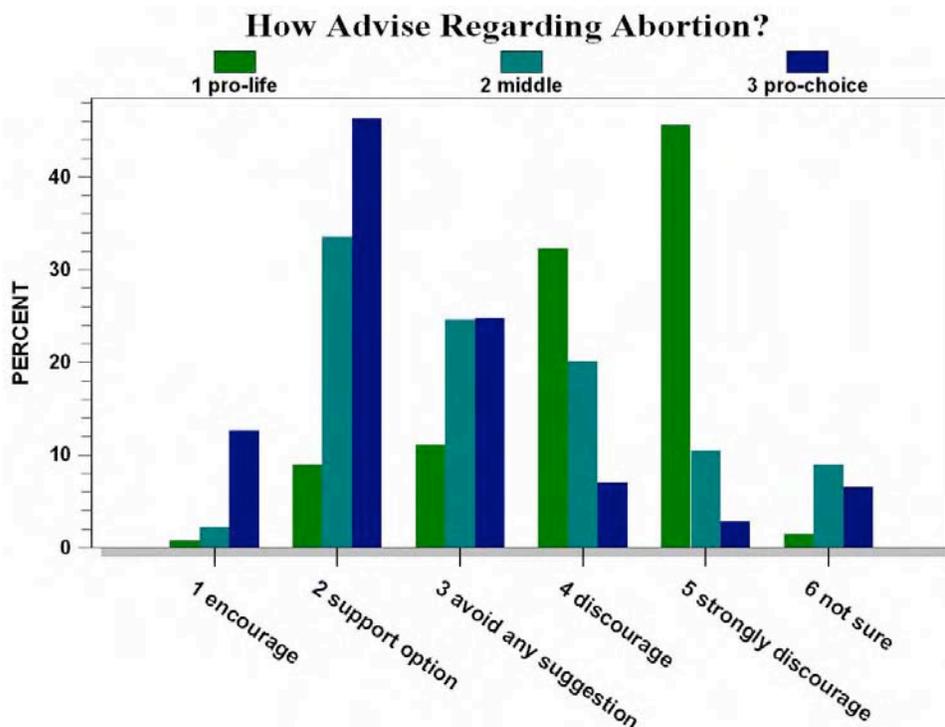
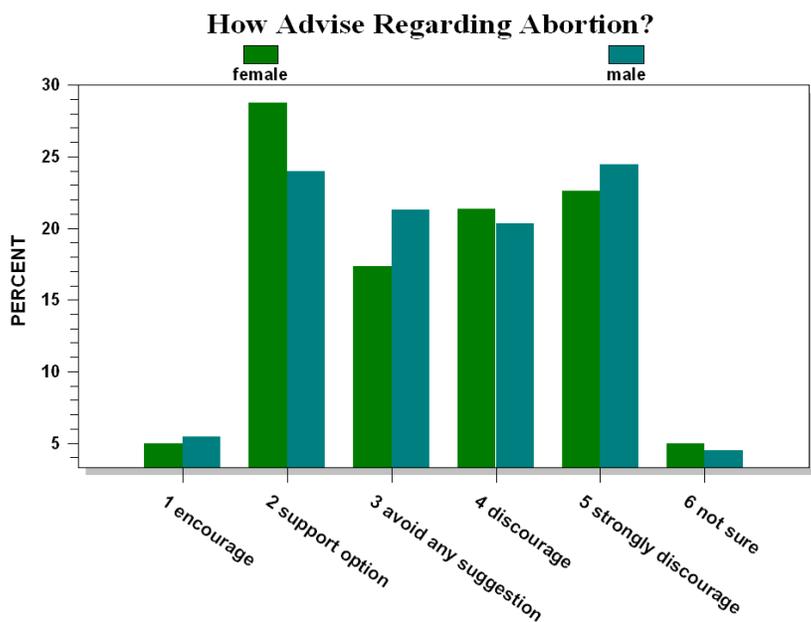


21% of men reported having advised someone to have an abortion compared to 14% of women.

Imagine that an unmarried friend or family member told you she was pregnant, but she could not expect any support from her male partner. How would you advise her?

- If you would encourage abortion, press 1.
- If you would support the option of abortion, press 2.
- If you would avoid making any suggestion, press 3.
- If you would discourage abortion, press 4.
- If you would strongly discourage abortion, press 5.
- If you are not sure, press 6

No Support from Partner	Frequency	Percent	Cum Percent
1 encourage	32	5.1%	5.1%
2 support option	169	27.1%	32.2%
3 avoid any suggestion	117	18.8%	51.0%
4 discourage	131	21.0%	72.0%
5 strongly discourage	145	23.2%	95.2%
6 not sure	30	4.8%	100.0%
Total	624	100.0%	100.0%



Are you likely to vote the 2008 Presidential election?

If yes, press 1

If no, press 2

If you are not sure, press 3

Likely to Vote	Frequency	Percent	Cum Percent	
Yes	595	95.2%	95.2%	
No	17	2.7%	97.9%	
Not Sure	13	2.1%	100.0%	
Total	625	100.0%	100.0%	

Looking back to 2004, did you vote for Republican George W. Bush, Democrat John Kerry, some other candidate, or did you not vote?

If you voted for Bush, press 1.
 If you voted for Kerry, press 2.
 If you voted for another candidate, press 3.
 If you did not vote press 4.
 If you are not sure, press 5

2004 Election	Frequency	Percent	Cum Percent	
Bush	315	50.4%	50.4%	
Kerry	217	34.7%	85.1%	
Other	41	6.6%	91.7%	
did not vote	41	6.6%	98.2%	
not sure	11	1.8%	100.0%	
Total	625	100.0%	100.0%	

2004 Election	1 pro-life	2 middle	3 pro-choice	TOTAL
1 Bush	210	52	50	312
Row %	67.3	16.7	16.0	100.0
Col %	77.2	38.8	23.5	50.4
2 Kerry	30	50	134	214
Row %	14.0	23.4	62.6	100.0
Col %	11.0	37.3	62.9	34.6
3 Other	13	12	16	41
Row %	31.7	29.3	39.0	100.0
Col %	4.8	9.0	7.5	6.6
4 did not vote	15	13	13	41
Row %	36.6	31.7	31.7	100.0
Col %	5.5	9.7	6.1	6.6
5 not sure	4	7	0	11
Row %	36.4	63.6	0.0	100.0
Col %	1.5	5.2	0.0	1.8
TOTAL	272	134	213	619
Row %	43.9	21.6	34.4	100.0
Col %	100.0	100.0	100.0	100.0

If you are older than 18 and younger than 30, press 1.

If you are 30 to 45 years of age, press 2

If you are 46 to 60, press 3.

If you are over 60, press 4.

If you are under 18, press 5.

To have these choices repeated, press the star key.

Age	Frequency	Percent	Cum Percent	
18-29	59	9.5%	9.5%	
30-45	134	21.5%	30.9%	
46-60	205	32.9%	63.8%	
over 60	222	35.6%	99.4%	
under 18	4	0.6%	100.0%	
Total	624	100.0%	100.0%	

Age	1 pro-life	2 middle	3 pro-choice	TOTAL
age 18-29	19	18	21	58
Row %	32.8	31.0	36.2	100.0
Col %	7.0	13.4	9.9	9.4
age 30-45	56	40	37	133
Row %	42.1	30.1	27.8	100.0
Col %	20.7	29.9	17.4	21.5
age 46-60	92	35	77	204
Row %	45.1	17.2	37.7	100.0
Col %	33.9	26.1	36.2	33.0
over 60	103	39	77	219
Row %	47.0	17.8	35.2	100.0
Col %	38.0	29.1	36.2	35.4
under 18	1	2	1	4
Row %	25.0	50.0	25.0	100.0
Col %	0.4	1.5	0.5	0.6
TOTAL	271	134	213	618
Row %	43.9	21.7	34.5	100.0
Col %	100.0	100.0	100.0	100.0

What is your educational background?

- For High School, press 1
- For Some College, press 2
- For College degree, press 3
- For Post-Graduate Degree, press 4

To have these choices repeated, press the star key.

Education	Frequency	Percent	Cum Percent	
High School	161	26.0%	26.0%	
Some College	149	24.0%	50.0%	
College Degree	182	29.4%	79.4%	
Post-College Degree	128	20.6%	100.0%	
Total	620	100.0%	100.0%	

Education	1 pro-life	2 middle	3 pro-choice	TOTAL
college degree	68	34	78	180
Row %	37.8	18.9	43.3	100.0
Col %	25.4	25.8	36.4	29.3
high school	81	35	42	158
Row %	51.3	22.2	26.6	100.0
Col %	30.2	26.5	19.6	25.7
post-college degree	46	31	51	128
Row %	35.9	24.2	39.8	100.0
Col %	17.2	23.5	23.8	20.8
some college	73	32	43	148
Row %	49.3	21.6	29.1	100.0
Col %	27.2	24.2	20.1	24.1
TOTAL	268	132	214	614
Row %	43.6	21.5	34.9	100.0
Col %	100.0	100.0	100.0	100.0

If you are Male, press 1. If you are Female, press 2. To have these choices repeated, press the star key.

Gender	Frequency	Percent	Cum Percent	
Male	221	35.3%	35.3%	
Female	405	64.7%	100.0%	
Total	626	100.0%	100.0%	

(BRANCH BASED ON MALE OR FEMALE)

(FEMALE)

If you have NEVER had an abortion, press 1

If you have had two or more abortions, press 2

If you have had one abortion, press 3

(one second pause) Press the star key to repeat these choices.

(one second pause) To skip this question, press 4

Female Had Abortion	Frequency	Percent	Cum Percent	
1 abortion	19	4.7%	4.7%	
2 or more abortions	32	7.9%	12.6%	
no abortions	333	82.4%	95.0%	
Skip	20	5.0%	100.0%	
Total	404	100.0%	100.0%	

(IF Never had abortion, 1, go to THANK YOU & Goodbye....)

.(IF FEMALE AND HAD ABORTION, otherwise go to goodbye)

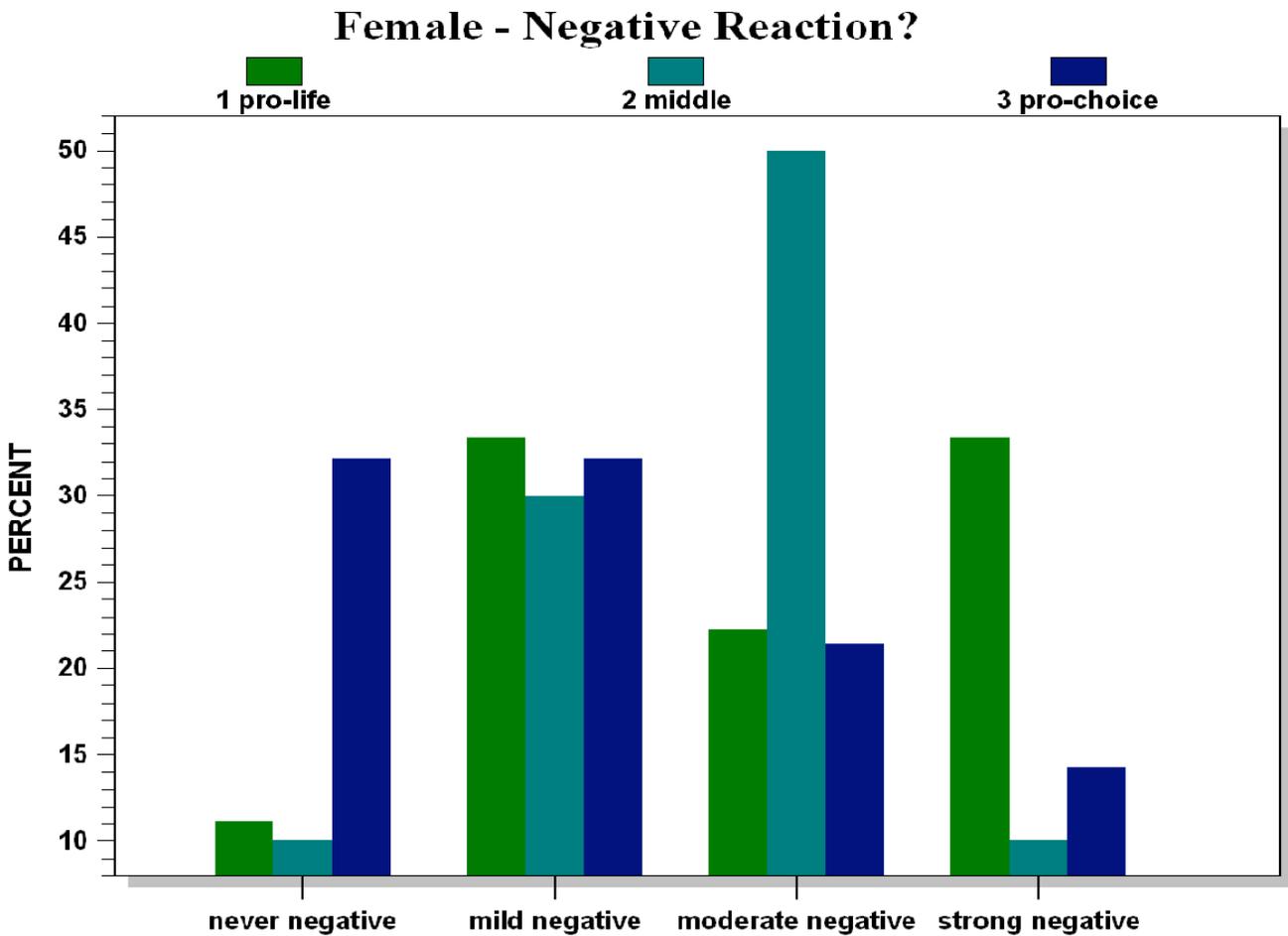
Press 1 if you have ever had strong negative emotional reactions to your abortion.

Press 2 if you have had moderate negative reactions

Press 3 if you have had only mild negative emotional reactions

Press 4 if you have never had any negative reactions to your abortion

Female Reaction	Frequency	Percent
strong negative	11	17.0%
moderate negative	13	27.7%
mild negative	15	31.9%
never negative	8	23.4%
Total	47	100.0%



(MALE) *Have you ever been the male partner in a pregnancy that was aborted?*

If yes, press 1

If no, press 2

If you are uncertain, press 3

(one second pause) Press the star key to repeat this question.

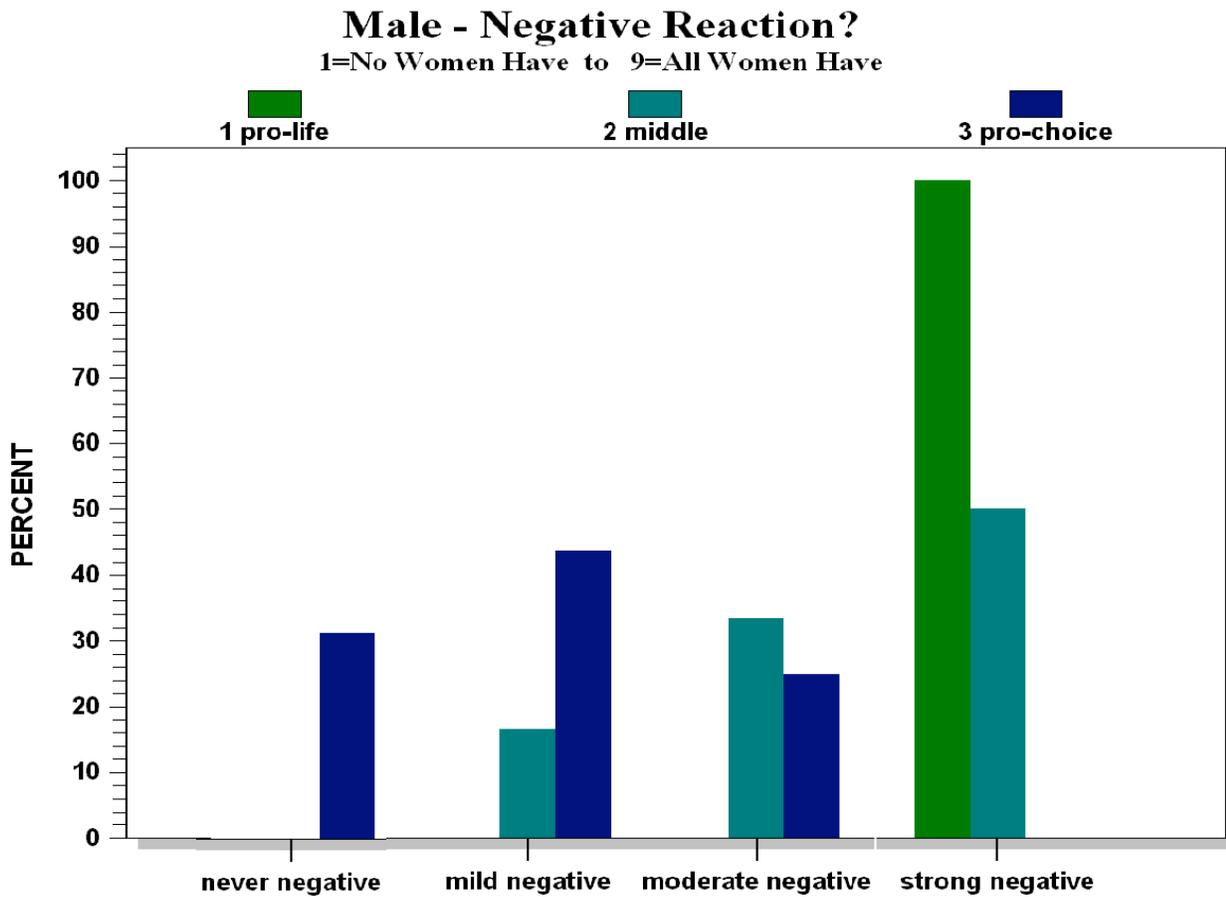
(one second pause) To skip this question, press 4

(IF Never had abortion, 2, go to THANK YOU & Goodbye....)

Male Partner	Frequency	Percent	Cum Percent	
1 yes	26	11.9%	11.9%	
2 no	186	85.3%	97.2%	
3 uncertain	5	2.3%	99.5%	
4 skip	1	0.5%	100.0%	
Total	218	100.0%	100.0%	

(IF MALE INVOLVED IN ABORTION, 1, ask following, otherwise go to goodbye)
Press 1 if you have ever had strong negative emotional reactions regarding the abortion.
Press 2 if you have had moderate negative reactions
Press 3 if you have had only mild negative emotional reactions
Press 4 if you have never had any negative reactions to the abortion

Male Reaction	Frequency	Percent
strong negative	6	24.0%
moderate negative	6	24.0%
mild negative	8	32.0%
never negative	5	20.0%
Total	25	100.0%



THANK YOU for your participation. GOOD-BYE

FREEDOM OF CHOICE ACT WOULD HARM WOMEN AND REMOVE PROTECTIONS

Tom McClusky

“A government may not (1) deny or interfere with a woman’s right to choose – (A) to bear a child; (B) to terminate a pregnancy prior to viability; or (C) to terminate a pregnancy after viability where termination is necessary to protect the life or health of the woman; or (2) discriminate against the exercise of the rights set forth in paragraph (1) in the regulation or provision of benefits, facilities, services, or information. This act applies to every Federal, State, and local statute, ordinance, regulation, administrative order, decision, penalty, practice, or other action enacted, adopted, or implemented before, on or after the date of enactment of this act.” – Text of H.R. 1964 and S. 1173, introduced on April 19, 2007.

“The Freedom of Choice Act (FOCA) would sweep away hundreds of anti-abortion laws, policies” – National Organization of Women web site.¹

“The legislation (FOCA) would invalidate existing and future laws that interfere with or discriminate against the exercise of the rights protected. It also would provide an individual aggrieved by a violation of the act a private right of civil action in order to obtain appropriate relief.” – Planned Parenthood web site.²

“Nancy Keenan, president of NARAL Pro-Choice America, joined pro-choice members of Congress and activists at a Capitol Hill press conference to introduce legislation that would codify Roe v. Wade into law and guarantee a woman’s right to choose in all 50 states.” – NARAL Pro-Choice America (formerly called the National Association for the Repeal of Abortion Laws) press release, April 19, 2007.³



FAMILY RESEARCH
COUNCIL
501 G STREET NW
WASHINGTON DC
20001

(202) 393-2100

ORDER LINE:
1-800-225-4008

¹ “Freedom of Choice Act Would Guarantee Roe Protections in U.S. Statutes.” <<http://www.now.org/issues/abortion/070430foca.html>>.

² “Support the Freedom of Choice Act.” <<http://www.plannedparenthood.org/issues-action/abortion/freedom-of-choice-act/articles/support-foca-14393.htm>>

³ “One Day after Supreme Court Sides with Bush, Pro-Choice Leaders Take Action to Protect a Woman's Right to Choose” <http://www.prochoiceamerica.org/news/press-releases/2007/pr04192007_foca.html>.

When the Freedom of Choice Act (FOCA – H.R. 1964 and S.1173) was introduced on April 19, 2007, pro-abortion groups like Planned Parenthood, NARAL and NOW were on the podium with the sponsors, Senator Barbara Boxer (D-Calif.) and Representative Jerry Nadler (D-N.Y.). It was the day after the Supreme Court decision, *Gonzales v. Carhart*, which upheld a very limited ban on partial-birth abortions⁴ and the participants, while upset over that decision, sensed brighter days ahead. The Democrats had just taken over both chambers of Congress, and one of the leading Democratic presidential contenders, Senator Hillary Clinton (D-N.Y.), was an original cosponsor of FOCA. They knew that FOCA was not simply a bill to “codify” the *Roe v. Wade* and *Doe v. Bolton* decisions that legalized abortion in all of the United States. The legislation, if enacted, would effectively overturn hundreds of state laws that protect the rights of women, parents, children and health care personnel. The legislation is so important to those on the pro-abortion side that when the other leading Democratic presidential contender, Senator Barack Obama (D-Ill.), addressed a Planned Parenthood event on July 17, 2007, he told the audience of pro-abortion advocates and donors, “*The first thing I will do as President is sign the Freedom of Choice Act.*”⁵ His statement garnered a standing ovation.

First, let’s review the history of FOCA. The Freedom of Choice Act was first introduced in November 1989 by Representative Don Edwards (D-Calif.) and Senator Alan Cranston (D-Calif.). The legislation seemed to be a response to the *Webster* decision⁶ from February of that year. *Webster* was the first Supreme Court decision that broadened the restrictions that could be put on the use of tax money to pay for abortions. FOCA quickly became a tool for pro-abortion politicians to declare their fealty to the abortion cause. When pro-abortion President Bill Clinton took office in 1993, Planned Parenthood had high hopes for the passage of FOCA.⁷ The bill ended up being stuck in the Senate with the opposition led by Senator Obama’s predecessor, Carol Moseley Braun (D-Ill.),⁸ based on concerns that it did not go far enough. The opposition argued that “the bill allows the states to discriminate against young and poor women seeking an abortion”⁹ by ensuring conscience protections for health care personnel, not *requiring* states to fund abortions and allowing for parental consent in cases of minors seeking an abortion. The Senate version of the bill, S.25, explicitly stated that, “Nothing in this Act shall be construed to prevent a State from protecting

⁴ “(A)n abortion in which a physician deliberately and intentionally vaginally delivers a living, unborn child's body until either the entire baby's head is outside the body of the mother, or any part of the baby's trunk past the navel is outside the body of the mother and only the head remains inside the womb, for the purpose of performing an overt act (usually the puncturing of the back of the child's skull and removing the baby's brains) that the person knows will kill the partially delivered infant, performs this act, and then completes delivery of the dead infant” - Page 117 STAT. 1201. Public Law 108-105.

⁵ “Barack Obama Addresses Planned Parenthood.” <<http://www.youtube.com/watch?v=uUI99id2SvM>>.

⁶ U.S. Supreme Court, *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989)

⁷ Burke, Denise. “The Freedom of Choice Act: Endangering Women and Silencing the Voices of Everyday Americans.” Americans United for Life. <<http://www.aul.org/FOCA>>.

⁸ “Freedom of Choice Act in Peril.” Editorial. *New York Times* 17 July 1993.

⁹ “Senator Carol Mosley-Braun Withdraws Support of Abortion Rights Bill.” *Jet* 26 July 1993.

unwilling individuals or private health care institutions from having to participate in the performance of abortions to which they are conscientiously opposed; prevent a State from declining to pay for the performance of abortions; or prevent a State from requiring a minor to involve a parent, guardian, or other responsible adult before terminating a pregnancy.”¹⁰ At the time, both NARAL and *The New York Times*, two strong supporters of abortion on demand, supported the Senate “compromise.” It comes as no surprise, though, that they seem to have no problem with the current bill omitting the “compromise” language of 1993 and, instead, inserting a provision that says state and federal governments may not “discriminate against the exercise of the rights set forth in the regulation or provision of benefits, facilities, services, or information.”¹¹ Thus, the state and federal government must use taxpayer funds to pay for abortions at all stages of pregnancy. Not to do so would be discriminatory toward abortion “rights” as stated in the legislation.

Some of the supporters of the “Freedom of Choice Act” state that it merely codifies *Roe v. Wade*. This could not be further from the truth. As the American Civil Liberties Union said in its *Reproductive Rights Update* from December 20, 1991, “This [FOCA] bill prohibits such restrictions as parental notification and consent, as well as the requirement that all abortions be performed in a hospital, spousal consent, waiting periods ...” If FOCA were to pass both chambers of Congress and be signed by a pro-abortion President (President George W. Bush would certainly veto FOCA if it were to reach his desk), it would single-handedly overturn countless laws that have passed in the states in relation to abortion.

Many of the organizations that support the federal FOCA argue that removing state restrictions on abortion will actually decrease the number of abortions. According to NARAL, seven states¹² have codified abortion on demand as defined by *Roe v. Wade* and *Doe v. Bolton*. In Maryland, Freedom of Choice-type legislation has been on the books since 1991. Since that time, Maryland law has provided for abortion on demand even late in pregnancy, granted abortionists immunity from legal action, allowed abortionists the discretion to perform abortions on minors without notifying a parent, and denied health care workers the right to refuse to make abortion referrals as a matter of conscience.¹³ This has not led to a reduction of abortions in the state, but appears to actually have had the adverse effect of increasing the abortion rate in Maryland. According to Planned Parenthood’s Alan Guttmacher Institute, the abortion rate in the United States has declined nine percent since 2000 to 19.4 abortions per 1,000 women of reproductive age in 2005. By contrast, the state of Maryland produced a rate of 31.5 abortions per 1,000 women of reproductive age, an increase of eight percent

¹⁰ S. 25, 104th Congress, “The Freedom of Choice Act.” Senate Majority Leader George Mitchell (D-Maine), sponsor.

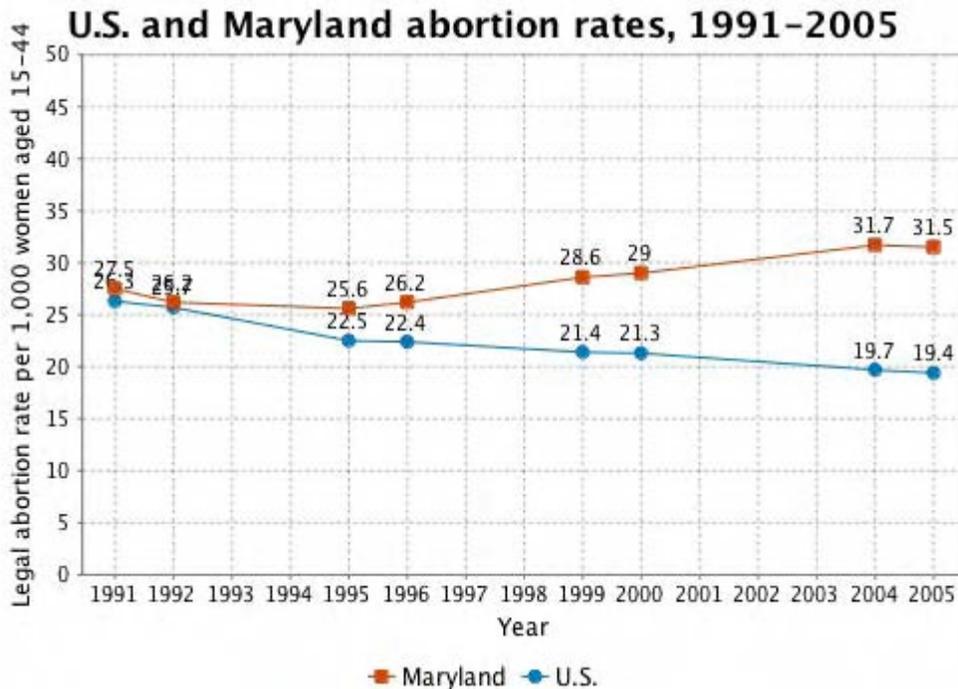
¹¹ S. 1173, 110th Congress, “The Freedom of Choice Act.” Senator Barbara Boxer (D-Calif.), sponsor.

¹² California, Connecticut, Hawaii, Maine, Maryland, Nevada and Washington.

¹³ “Abortion in Maryland Fact Sheet.” Maryland Right to Life. <<http://www.mdrtl.org/Abortion.aspx>>.

since 1991.¹⁴ Pro-abortion advocates argue that eliminating laws designed to protect women, parents, children and health care providers will make abortion “safe, legal and rare.” While it is highly questionable whether such actions make abortion safer, allowing for unrestricted abortions only increases the likelihood of abortion, certainly not making it rarer.

In 1991, Maryland’s abortion rate was similar to the national average of 26.3 abortions per 1,000 women of reproductive age. As seen in the Guttmacher Institute’s own chart (see below), while Maryland’s abortion rate has steadily increased since the enactment of its FOCA-type law in 1991, the national abortion rate has had an equally steady decrease.



Source: Guttmacher Institute

One explanation of the decline in the national rate for abortions is the increased number of incremental laws addressing the abortion issue in each state since the *Webster* decision.¹⁵ The enactment of a federal Freedom of Choice Act would be a federalist’s nightmare, overturning hundreds of state laws that have been enacted through legislation and statewide initiative and ballot referendums. If FOCA is passed, it would automatically overturn¹⁶:

¹⁴ “State Facts about Abortion: Maryland.” Guttmacher Institute.

<<http://www.guttmacher.org/pubs/sfaa/maryland.html>>.

¹⁵ New, Michael. “Analyzing the Effect of State Legislation on the Incidence of Abortion among Minors” Heritage Foundation 5 Feb 2007.

¹⁶ See Addendum 1

- State abortion reporting requirements in all 50 states
- Forty-four states' laws concerning parental involvement
- Forty states' laws on restricting later-term abortions
- Forty-six states' conscience protection laws for individual health care providers
- Twenty-seven states' conscience protection laws for institutions
- Thirty-eight states' bans on partial-birth abortion
- Thirty-three states' laws on requiring counseling before an abortion
- Twenty-eight states' laws requiring a waiting period before an abortion, and
- Sixteen states' laws concerning ultrasounds before an abortion

The passage of FOCA would not only force the issue of taxpayer funded abortions on both the federal and state governments, but would also overturn the wishes of all 50 state legislatures and millions of people in the states. Many of these laws are hugely popular. For example, Florida's 1994 amendment requiring parental notification was approved in a referendum with 65 percent of the vote. In an October 2007 Harris poll, 38 percent of the respondents wanted no change in current abortion laws, while 42 percent wanted to see laws that made it *tougher* for a woman to get an abortion. Only 16 percent of respondents wanted the government to make it easier for a woman to get an abortion.¹⁷

The abortion industry already handsomely rewards its supporters in Congress with millions of dollars in campaign donations. In return, enactment of the Freedom of Choice Act by a pro-abortion Congress (which we currently have) and a pro-abortion President would lead to the biggest payoff in history for those who profit from abortions. All of this would come at taxpayer expense, with the federal and state governments losing the power to decide which legislative path they wish to pursue—one of promoting abortion or promoting life. Ironically, the Freedom of Choice Act would remove any concept of "choice" from the equation, by eliminating the right of states and U.S. citizens to have a say in the debate.

Tom McClusky is Vice President of Government Affairs for Family Research Council. All state law information in the addendum was compiled by Laura Myers, Government Affairs Researcher for Family Research Council.

¹⁷ "The Harris Poll." Poll. October, 2007 <<http://www.pollingreport.com/abortion.htm>>.

ADDENDUM 1

FREEDOM OF CHOICE ACT:

“A government may not (1) deny or interfere with a woman’s right to choose – (A) to bear a child; (B) to terminate a pregnancy prior to viability; or (C) to terminate a pregnancy after viability where termination is necessary to protect the life or health of the woman; or (2) discriminate against the exercise of the rights set forth in paragraph (1) in the regulation or provision of benefits, facilities, services, or information.”

“This act applies to every Federal, State, and local statute, ordinance, regulation, administrative order, decision, penalty, practice, or other action enacted, adopted, or implemented before, on or after the date of enactment of this act.”

This Act would gut state laws regulating abortion:

1. **Parental Involvement Laws:**

Currently, 24 states have active Parental Consent Laws. AL, AZ, AR, ID, IN, KY, LA, MA, MI, MS, MO, NC, NC, OH, PA, RI, SC, TN, TX, VA, WI, and WY. 3 states, AK, CA, and NM, have had enforcement of their Parental Consent Laws permanently enjoined by court order.

13 states have active Parental Notification laws. CO, DE, FL, GA, IA, KS, MD, MN, NE, OK, SD, UT, and WV. 4 states, IL, MT, NV, and NJ have had enforcement of their Parental Notification laws enjoined by court order.

2. **Later-term Abortion Restriction Laws:**

Many states restrict abortions after a certain point in the pregnancy. These restrictions vary. States usually impose restrictions after fetal viability, in the third trimester, or after a specific number of weeks. Currently 36 states have active restrictions on later-term abortions. AL, AZ, AR, CA, CT, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MO, MT, NE, NV, NY, NC, ND, OK, PA, RI, SC, SD, TN, TX, VA, WA, WI, and WY. 4 states, DE, MN, OH, and UT have had enforcement of their late term abortion restriction laws permanently enjoined by court order.

3. **Conscience Protections for Individual Health care providers:**

46 states allow individual health care providers to refuse to perform abortions. AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, and WY.

4. **Conscience Protections for Institutions:**

27 states provide conscience protections for any institution. AZ, AR, CO, DE, FL, GA, HI, ID, KS, KY, LA, ME, MD, MA, MI, MS, MO, NE, NM, NC, ND, OH, SD, TN, VA, WA, and WI. 15 states limit conscience protections to private institutions. AK, IL, IN, IA, MN, MT, NE, NJ, OK, OR, PA, SC, TX, UT, and WY. 1 state, CA, limits conscience protections to religious institutions.

5. **State Abortion Reporting Requirements:**

46 states require that hospitals, physicians, and facilities providing abortions report those procedures to the state. AL, AK, AZ, AR, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MA, MI, MN, MS, MO, MT, NE, NV, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, and WY. 3 states voluntarily report abortions to the state. MD, NH and NJ. CA has had enforcement of its reporting law permanently enjoined by court order.

6. Partial Birth Abortion Bans:

14 states have active partial-birth abortion bans (the definition of partial-birth abortion varies by state). GA, IN, KS, LA, MS, MT, NM, ND, OH, OK, SC, SD, TN, and UT. In 7 of these states (IN, MS, MT, OK, SC, SD and TN), the ban is presumably unenforceable under *Stenberg v. Carhart*, according to the Guttmacher institute. 17 states have had their partial birth abortion bans permanently enjoined by order of court. AL, AK, AZ, AS, FL, ID, IL, IA, KY, MI, NE, NJ, RI, VA, WV, and WI.

7. Counseling Before Abortion Requirements:

33 states require that women be given counseling before an abortion. The content and method of counseling varies by state. The states that require counseling before an abortion: AL, AK, AR, GA, ID, KS, KY, LA, MI, MN, MS, NE, ND, OH, OK, PA, SC, SD, TX, UT, VA, WV, WI, CA, CT, DE, FL, IN, ME, MO, NV, RI, and TN.

8. Waiting Period Before Abortion Requirements

24 states require that women wait a certain amount of time between the counseling and the abortion (the specific length of waiting period varies by state). AL, AR, FL, GA, ID, IN, KS, KY, LA, MI, MN, MS, MO, ND, OH, OK, PA, SC, SD, TX, UT, VA, WV, and WI. 4 states (MA, MT, DE, and TN) have had their waiting period laws permanently enjoined by court order.

9. Ultrasound Requirements

16 states have some requirements concerning ultrasounds before abortions. The requirements vary from state to state. AL, AZ, AR, FL, GA, ID, IN, LA, MI, MS, OH, OK, SC, UT, and WI.

APA Task Force Report
on Abortion and Mental
Health: A Violation of the
Ethics of Science and a
Breach of Public
Responsibility

Priscilla K. Coleman, Ph.D.
Bowling Green State University



Mission of the APA

"To advance the
creation, communication
and application of
psychological knowledge
to benefit society and
improve people's
lives."



Mission of the APA?



*The APA has indeed
"created"
knowledge.....politically
driven as opposed to
being scientifically
derived from an
extensive peer-reviewed
literature.*

Aims of this Presentation

- Comment on the lack of objectivity in the development and conduct of the Task Force, selection of studies, analysis of the literature, and conclusions drawn.
- Shed light on the essential elements for evaluating the science objectively.



Insufficient Information on the Development and Conduct of the Task Force

The following questions remain unanswered:

- What was done to assure that the representatives did not all hold similar ideological biases?
- What was the process for selecting and securing reviewers?
- How was reviewer feedback incorporated into revising the document?

Disclosure of this information is vital for credibility and accountability purposes and was not offered.

Selective Reporting of Literature Reviews



Selective Reporting of Literature Reviews

An analysis of a review by Bradshaw and Slade (2003) in the APA Report ignores a central statement from the abstract of the review:

"Following discovery of pregnancy and prior to abortion, 40–45% of women experience significant levels of anxiety and around 20% experience significant levels of depressive symptoms. Distress reduces following abortion, but up to around 30% of women are still experiencing emotional problem after a month."

Selective Reporting of Literature Reviews

There is a claim that other literature reviews such as two that we recently published (Coleman et al., 2005; Coleman, 2006) and a very strong quantitatively based one by Thorp and colleagues (2003) are incorporated into the Report. However the conclusions of these reviews are ignored and no explanation is provided.

Thorp et al. (2003) employed strict inclusion criteria related to sample size and length of time before follow-up and concluded that induced abortion increased the risk for "mood disorders substantial enough to provoke attempts of self-harm."

Avoidance of Quantification

The authors of this report avoid quantification of the adverse effects of abortion. This is a glaring omission of potentially very useful, summary information.



Avoidance of Quantification

- ❑ The authors note "Given the state of the literature, a simple calculation of effect sizes or count of the number of studies that showed an effect in one direction versus another was considered inappropriate."
- ❑ There are too few studies to quantify effects yet a sweeping definitive statement indicating an absence of ill-effects is considered justified! This contradiction is indefensible.
- ❑ Had quantification of risk been conducted the conclusion would had to have been that abortion increases risk for a variety of mental health problems.

Deceptive Strategy to Justify Ignoring Studies Indicating Negative Effects

According to the report "The TFMHA evaluated all empirical studies published in English in peer-reviewed journals post-1989 that compared the mental health of women who had an induced abortion to the mental health of comparison groups of women (N=50) or that examined factors that predict mental health among women who have had an elective abortion in the United States (N=23)."

Note the 2nd type of study is conveniently restricted to the U.S. resulting in elimination of at least 40 studies, most of which identified ill effects. As a reviewer, I summarized the international studies and sent a table of them to the APA, which was entirely ignored.

Methodologically-Based Selection Criteria are Not Employed.

If the Task Force members were interested in providing an evaluation of the strongest evidence, more stringent criteria should have been used than simply publication of empirical data related to induced abortion, with at least one mental health measure in peer-reviewed journals in English on U.S. and non-U.S. samples (for one type of study).

The absence of methodologically-based selection criteria that reflect knowledge of this literature is shocking.

Sample size/characteristics/representativeness, type of design, employment of control techniques, discipline published in, etc. are logical places to begin.

Shifting Standards of Evaluation Based on Congruence with a Pro-Choice Agenda

- There are numerous examples in the APA report of studies with results suggesting no negative effects of abortion being reviewed less stringently than studies indicating adverse effects.
- The positive features of the studies suggesting abortion is a benign experience are highlighted while the positive features of the studies revealing adverse outcomes are downplayed or ignored.
- The studies demonstrating negative effects clearly have many strengths, which outweigh the limitations since they were published in competitive peer-reviewed journals.

Shifting Standards of Evaluation Based on Congruence with a Pro-Choice Agenda

The same standards and criteria are simply not applied uniformly and objectively in the report. I wrote several pages in my review... pointing out examples of the blatantly biased survey of the literature.



Cultural Stigmatization Model in Women's Abortion-related Stress is Unsupported

Cultural stigmatization as a primary variable related to negative post-abortion emotional outcomes is a theme that factors heavily into the APA report. Very few studies have been conducted to support the claim that ill-effects are culturally constructed.



Cultural Stigmatization Model in Women's Abortion-related Stress is Unsupported



In fact, many studies indicate that internalized beliefs regarding the humanity of the fetus, moral, religious, and ethical objections to abortion, and feelings of bereavement/loss most clearly distinguish between those who suffer and those who do not.

Conclusion Derived Inappropriately

The APA Task Force concluded: *"The best scientific evidence published indicates that among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy."*

This does not follow from the literature reviewed and it inappropriately rests on one study with many methodological flaws by Gilchrist et al. (1995) published in the U.K.

Conclusion Derived Inappropriately

Reliance on one study to draw a definitive conclusion stands in direct contrast to accepted scientific protocol as described by the Task Force on Statistical Inference affiliated with the APA Board of Scientific Affairs.

Wilkinson and colleagues (1999) specifically stated in the *American Psychologist*: *"Do not interpret a single study's results as having importance independent of the effects reported elsewhere in the relevant literature...the results in a single study are important primarily as one contribution to a mosaic of study effects"*

Is Reflection and a Retraction Possible?



With objection from researchers, professionals, and the public, perhaps the APA will take an honest look.

Sadly, history suggests just the opposite.....more concerted effort to distort and mislead in order to promote pro-choice ideology and insure the practice of abortion continues unhindered despite the enormous costs.

ABORTION AND WOMEN'S MENTAL HEALTH

Priscilla K. Coleman, Ph.D.

Bowling Green State University

- The world literature on abortion and women's mental health has grown considerably over the past several decades and the scientific rigor of the published studies has increased substantially.^{1,2,3} Identification of risk factors for adverse outcomes and exploration of a wide range of negative psychological consequences have been the focus of most of this research.
- Numerous studies have identified the demographic, individual, relationship, and situational characteristics that place women at risk for psychological disturbance in the aftermath of abortion. Among the most thoroughly substantiated risk factors are the following:
 - Perceptions of the inability to cope with the abortion⁴
 - Low self-esteem⁵
 - Difficulty with the decision^{6,7}
 - Emotional investment in the pregnancy^{8,9}
 - Perceptions of one's partner, family members, or friends as non-supportive⁴
 - Timing during adolescence or being unmarried^{7, 10, 11, 12}
 - Pre-existing emotional problems or unresolved traumatization¹³
 - Involvement in violent relationships^{14,15}
 - Traditional sex-role orientations¹⁶
 - Conservative views of abortion and/or religious affiliation^{7,17}
 - Pregnancy is intended^{18,19, 20}
 - Second trimester²¹
 - When women are involved in unstable partner relationships^{17,22}
 - Feelings of being forced into abortion by one's partner, others, or by life circumstances¹⁹
 - Pre-abortion ambivalence or decision difficulty.^{7,12}
- Studies with nationally representative samples and a variety of controls for personal and situational factors that may differ between women choosing to abort or deliver indicate abortion significantly increases risk for the following mental health problems:
 - Depression^{23, 24, 25, 26}
 - Anxiety^{24,25}
 - Substance abuse^{24,28,29,30}
 - Suicide ideation and behavior ^{24,31,32}
- Abortion is associated with a higher risk for negative psychological outcomes when compared to other forms of perinatal loss and with unintended pregnancy carried to term.^{27,28,30,33,34,35}
- There is consensus among most social and medical science scholars that a minimum of 20 to 30% of women who abort suffer from serious, prolonged negative psychological consequences^{1,12,36,37} yielding at least 260,000 new cases of mental health problems each year.
- Adjustment to abortion is a highly individualized experience as Goodwin and Ogden³⁸ recently noted "women's responses to their abortion do not always follow the suggested reactions of grief, but are varied and located within the personal and social context"
- Women who suffer from mental health problems associated with abortion may find a path to healing through conventional therapeutic interventions or through faith-based counseling. Unfortunately very little research has been conducted to assess the efficacy of various treatment protocols.

1. Bradshaw, Z., & Slade P. (2003). The effects of induced abortion on emotional experiences and relationships: A critical review of the literature. *Clinical Psychology Review, 23*, 929-958.
2. Coleman, P. K., Reardon, D.C., Strahan, T., & Cogle, J. (2005). The psychology of abortion: A review and suggestions for future research. *Psychology & Health, 20*, 237-271.
3. Thorp, J., Hartmann, K., & Shadigan, E (2003). Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence. *Obstetrical and Gynecological Survey, 58*, 67-79.
4. Major, B. Cozzarelli, C., Sciacchitano, A. M., Cooper, M. L., Testa, M., & Mueller, P. M. (1990). Perceived social support, self-efficacy, and adjustment to abortion. *Journal of Personality and Social Psychology, 59*, 186-197.
5. Cozzarelli, C., Karrasch, A., Sumer, N., & Major, B. (1994). The meaning and impact of partner's accompaniment on women's adjustment to abortion. *Journal of Applied Social Psychology, 24*, 2028-2056.
6. Bracken, M. B. (1978). A causal model of psychosomatic reactions to vacuum aspiration abortion. *Social Psychiatry, 13*, 135-145.
7. Osofsky, J. D., & Osofsky, H. J. (1972). The psychological reaction of patients to legalized abortion. *American Journal of Orthopsychiatry, 42*, 48-60.
8. Lyndon, J., Dunkel-Schetter, C., Cohan, C. L., & Pierce, T. (1996). Pregnancy decision making as a significant life event: A commitment approach. *Journal of Personality and Social Psychology, 71*, 141-151.
9. Remennick, L. I., & Segal, R. (2001). Sociocultural context and women's experiences of abortion: Israeli women and Russian immigrants compared. *Culture, Health, And Sexuality, 3*, 49-66.
10. Campbell, N., Franco, K. & Jurs, S. (1988). Abortion in adolescence. *Adolescence, 23*, 813-823.
11. Franz, W., & Reardon, D. (1992). Differential impact of abortion on adolescents and adults. *Adolescence, 27*, 161-172.
12. Adler, N. E. (1975). Emotional responses of women following therapeutic abortion: How great a problem? *Journal of Applied Social Psychology, 6*, 240-259.
13. Speckhard, A., & Rue, V. (1992). Postabortion syndrome: An emerging public health concern. *Journal of Social Issues, 48*, 95-119.
14. Allanson, S., & Astbury, J. (2001). Attachment style and broken attachments: Violence, pregnancy, and abortion. *Australian Journal of Psychology, 53*, 146-151.
15. Russo, N., & Denious, J. E. (2001). Violence in the lives of women having abortions: Implications for policy and practice. *Professional Psychology Research and Practice, 32*, 142-150.
16. Gold, D., Berger, C., & Andres, D. (1979). *The abortion choice: Psychological determinants and consequences*. Montreal: Concordia University, Department of Psychology.
17. Soderberg, H., Janzon, L., & Slosberg, N-O. (1998). Emotional distress following induced abortion: A study of its incidence and determinants among adoptees in Malmo, Sweden. *European Journal of Obstetrics, Gynecology, and Reproductive Biology, 79*, 173-178.
18. Ashton, J. (1980). The psychosocial outcome of induced abortion. *British Journal of Obstetrics and Gynecology, 87*, 1115-1122.
19. Friedman, C., Greenspan, R., & Mittleman, F. (1974). The decision-making process and the outcome of therapeutic abortion. *American Journal of Psychiatry, 131*, 1332-1337.
20. Miller, W. B. (1992). An empirical study of the psychological antecedents and consequences of induced abortion. *Journal of Social Issues, 48*, 67-93.
21. Athanasiou, R., Oppel, W., Michelson, L., Unger, T., & Yager, M. (1973). Psychiatric sequelae to term birth and induced early and late abortion: A longitudinal study. *Family Planning Perspectives, 5*, 227-231.
22. Llewellyn, S. P., & Pytches, R. (1988). An investigation of anxiety following termination of pregnancy. *Journal of Advanced Nursing, 13*, 468-471.
23. Cogle J., Reardon, D.C., & Coleman, P. K. (2003). Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort. *Medical Science Monitor, 9*(4), CR105-112.
24. Fergusson, D. M., Horwood, J., Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry, 47*, 16-24.
25. Pedersen W. (2008). Abortion and depression: A population-based longitudinal study of young women. *Scandinavian Journal of Public Health, 36* (4):424-8.
26. Rees, D. I. & Sabia, J. J. (2007) The Relationship Between Abortion and Depression: New Evidence from the Fragile Families and Child Wellbeing Study. *Medical Science Monitor, 13*(10), 430-436.
27. Cogle, J., Reardon, D.C., Coleman, P. K. (2005). Generalized anxiety associated with unintended pregnancy: A cohort study of the 1995 National Survey of Family Growth. *Journal of Anxiety Disorders, 19* (10), 137-142.
28. Coleman, P. K. (2006). Resolution of unwanted pregnancy during adolescence through abortion versus childbirth: Individual and family predictors and psychological consequences. *Journal of Youth and Adolescence, 35*, 903-911.
29. Pedersen, W. (2007). Addiction. Childbirth, abortion and subsequent substance use in young women: a population-based longitudinal study, *102* (12), 1971-78.
30. Reardon, D. C., Coleman, P. K., & Cogle, J. (2004) Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study. *American Journal of Drug and Alcohol Abuse, 26*, 369-383.
31. Gissler, M. et al. (1996). Suicides after pregnancy in Finland, 1987-94: Register linkage study. *British Medical Journal, 313*, 1431-4.
32. Gissler, M., et al. (2005). Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. *European Journal of Public Health, 15*, 459-463.
33. Broen, A. N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2004). Psychological impact on women of miscarriage versus induced abortion: A 2-year follow-up study. *Psychosomatic Medicine, 66*(2), 265-271.
34. Broen, A. N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2005). The course of mental health after miscarriage and induced abortion: A longitudinal, five-year follow-up study. *BMC Medicine, 3*, 18.
35. Coleman, P. K., Reardon, D. C., & Cogle, J. R. (2005). Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy. *British Journal of Health Psychology, 10*(2), 255-268.
36. Major, B., & Cozzarelli, C. (1992). Psychological predictors of adjustment to abortion. *Journal of Social Issues, 48*, 121-142.
37. Zolse, G., & Blacker C. V. R. (1992). The psychological complications of therapeutic abortion. *British Journal of Psychiatry, 160*, 742-749.
38. Goodwin P, Ogdan J. Women's reflections about their past abortions: an exploration of how emotional reactions change over time. *Psychology and Health 2007; 22*: 231-248.

ADVOCACY vs SCIENCE

IMPLICATIONS OF THE APA TASK FORCE REPORT ON ABORTION

Vincent M. Rue, Ph.D.
 Institute for Pregnancy Loss
 Jacksonville, FL
 vincerue@bellsouth.net

American Psychological Association - *A History of Advocacy & Incredibility*



- Hodgson v Minn. – APA Amicus Brief (1989)
- Planned Parenthood v Casey – APA Amicus Brief (1992)
- Redefining Child Sexual Abuse – APA Psych Bull. (1998)

“MANUFACTURING UNCERTAINTY”



Ideology vs. Science

In 1969, long before Roe v. Wade, the APA approved a resolution affirming abortion is a woman’s civil right. Thus whatever science concludes about the mental health risks of abortion is simply irrelevant.



Div 35 of the APA Psychology of Women

“Our purpose is to promote feminist scholarship and practice, and to advocate action toward public policies that advance equality and social justice. We are a voice of feminist issues within organized psychology!”

Implications:

1. For women who are considering abortion
2. For women emotionally injured from abortion
3. For health care professionals who treat women



Implications . . .

4. For those who pressure women to abort
5. For society
6. For future scientific efforts

