ABORTION MALPRACTICE: WHEN PATIENT NEEDS AND ABORTION PRACTICE COLLIDE

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In contemporary American life, legal remedy for harm or injury resulting from substandard or negligent medical care is commonplace. Too often the only arbiter between the needs and rights of the patient and the adequacy and standards of the health care services provided is medical malpractice litigation.

Because litigation mirrors contemporary social conflict, it provides an intense arena in which to scrutinize highly volatile issues. Nowhere is this more evident than in the fierce political controversy surrounding reproductive rights and induced abortion: "the heat of the conflict tends to melt the boundaries between demonstrated fact and personal belief."[i] Resistance to the reality that some women and men are psychologically harmed post-abortion is considerable, both in the courtroom and out.

Not all women who elect abortion have a traumatic response. Nor, however, is abortion such a benign psychological experience that women should be misinformed about its significant emotional risks for some individuals. The fact is, insufficient scientific data is available in this country to determine conclusively how many women and men are negatively impacted by abortion and which types of individuals are at risk compared to other possible alternatives. Though existing research has identifiable methodological weaknesses, in the aggregate, these studies suggest a *direction of harm* and a significant percent of individuals likely to be negatively impacted. Politics aside, some

women experience serious psychological harm post-abortion.

Recent publications in peer-reviewed professional journals have also documented the psychological risks of induced abortion, including the studies by Rue (1986), Hittner (1987), Zakus and Wilday (1987), Campbell, Franco and Jurs (1988), Ney and Wickett (1989), Rogers, Stoms and Phifer (1989), DeVeber, Ajzenstat and Chisholm (1991), Rogers (1991), El-Mallakh and Tasman (1991), Rue and Speckhard (1991), Angelo (1992), Speckhard and Rue (1992), Rosenfeld (1992), Franz and Reardon (1992), Speckhard and Rue (1993), Congelton and Calhoun (1993), Bagarozzi (1993), Bagarozzi (1994) and Ney (1994).[ii]

With increased recognition of the psychological harm abortion can cause some women, it is not surprising that more and more women are filing abortion malpractice suits in the U.S.[iii] This article will address the underlying reasons for these cases, provide a profile of a "typical plaintiff," and will offer recommendations that might better protect women from harm if they are considering an abortion.

THE NATURE OF THE ABORTION DECISION

The abortion decision is a unique one, complex in nature, necessitating due deliberation and the evaluation of considerable information, some of which may be emotionally trying. The U.S. Supreme Court has ruled: (1) that "abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of potential life" (*Harris v. McRae* 448 U.S. 297, 325 (1980); (2) that the decision whether or not to abort should be made "in light of all circumstances — psychological and emotional as well as physical — that might be relevant to the well being of the patient" (*Planned Parenthood v.*

Danforth 428 U.S. 52, 66 (1976); and (3) that the "medical, emotional and psychological consequences of an abortion are serious and can be lasting..." (*H. L. v. Matheson* 450 U.S. 411 (1981). Because of the medical, moral, societal and psychological controversies surrounding abortion, some states are now insisting that reasoned and deliberate abortion decision-making be legally mandated. In particular, women's "right to know" laws have been enacted that precisely determine the content of information and the timing as to when information should be made available before an abortion may be performed.[iv]

In the United States today, the following elements of informed consent have been mandated in a number of states: (1) the medical risks associated with pregnancy determination; (2) the probable gestational age of the unborn child; (3) the alternative risks associated with carrying to term; (4) the medical assistance benefits if childbirth were elected; (5) the father's liability for financial assistance; (6) the opportunity to review printed information descriptive of fetal development; and (7) some waiting period for deliberation, usually 24-48 hours. Additionally, a number of states now have parental consultation statutes requiring minors seeking abortions to involve their parents in their decision-making. This is to protect the adolescent from making a secret and hasty abortion-decision and to insure that her decision is truly informed and voluntary.

These informed consent requirements are additive in nature, insuring that the woman has more rather than less information. These requirements do not appear to restrict the patient's decision-making capacity — they enhance it. How is it possible for a woman to weigh the benefits and risks of electing an abortion if information regarding abortion alternatives are conspicuously absent in the "counseling process"? Indeed, if informed

consent is not obtained prior to an abortion, then grounds for medical malpractice litigation are warranted based on personal injury.[v]

Because the doctrine of informed consent is well established, courts and legislatures have consistently required physicians to provide a minimum of information to the patient prior to making a decision regarding treatment. This information is generally composed of a determined diagnosis, reasonable prognosis, the risks and benefits of proposed treatment and non-treatment, all of which should be provided in terms that the patient can comprehend. The practice of abortion has been an exception to this standard of care.

THE "TYPICAL" PLAINTIFF

In numerous cases in which we have either evaluated the patient, testified as expert witnesses, or consulted generally on a case, it is apparent to us that most plaintiffs have a number of factors in common.

1. Most were between 22 and 35 years of age, unmarried and had experienced both physical and emotional injuries post-abortion.
2. Most did not receive pre-abortion counseling, or if they did, it was so deficient as to be meaningless to the plaintiff at the time of the abortion.
3. Most of these women remembered signing "informed consent forms" but did not read or understand them.
4. Most were not given "options" counseling, nor the opportunity to ask questions privately.
5. Most had four to eight predisposing risk factors to post-abortion trauma that were unacknowledged or unexplored at the abortion clinic or minimized by either the abortion counselor or the physician.
6. Most experienced the staff and abortion-provider as insensitive to their special circumstances or emotional state.
7. Most felt ill-prepared for the emotional traumatization post-abortion and deceived by the abortion counselor regarding the developmental characteristics and humanity of the

fetus.

8. Most plaintiffs have suffered serious and significant emotional injury that has negatively impacted their primary relationships, subsequent parent-child interactions, and resulted in lowered self-esteem, the use of dysfunctional coping mechanisms (drinking, drugs, food, avoidance behaviors, emotional numbing) and experienced post-traumatic decline in overall functioning.
9. Most of these women all had first trimester abortions.
10. Most of these women had some pre-existing psy-chosocial stressors, most were competent and functioning individuals in society prior to their abortion traumatization.

The following cases are presented here by way of example of the degree and variance of post-abortion emotional injury.

CASE ONE

D. had a first trimester abortion to hide the fact that she was having sex with someone other than her mate. She felt she had no other choice. She did not receive any pre-abortion counseling. After the procedure she found herself thinking about the abortion hundreds of times during the day. When she had her menstrual period, she would save whatever blood clots that had passed into the toilet and place them in glass bottles every month. Every week since the abortion, this woman has had oral sex with her mate twice a week. Unknown to her sexual partner, she collects his semen in her mouth and goes to the bathroom immediately afterwards. There she spits it into a turkey baster and then inserts the semen into her vagina, hoping to become pregnant. In addition, she has nightmares and suffers from depression and unrelenting guilt.

CASE TWO

M. had a first trimester abortion. She had approximately five minutes of pre-abortion counseling.

After the abortion she returned to the abortion clinic for her follow-up visit. She reported that she was continuing to bleed and that the pain was severe. In her own words: "they wouldn't listen to me. They told me there was nothing wrong except rectum strain. I told them that I couldn't sleep and they gave me Halcium. I think they just wanted me to die in my sleep." For the next three months this woman was traumatized by her incomplete abortion. She had unrelenting pain, diarrhea, and kept smelling something rotten coming from her vagina. She continued bleeding. She felt she was going crazy because the smell was intermittent and the pain was overwhelming. Her mate discounted her feelings and called her names. The experience finally culminated in an emergency D&E abortion, at which time a fetal corpse was identified in her cervix and was removed.

CASE THREE

G. had a first trimester abortion. During pre-abortion counseling she asked if this was a baby and her counselor assured her "it is just a clump of tissue." Shortly afterwards she went home and took a shower. Afterwards she felt something strange and looked down at the bathroom floor: "I looked down and it had two eyes, the formation of a nose and a mouth; the rib cage was sticking out. It was all broken up. You could even see an arm. You could just see what it was." In her shock and panic, she quickly picked it up and took it into the kitchen and put it in the cupboard. Then she just started to shake and cry.

KNOWN DEFICIENCIES OF ABORTION COUNSELING

The two most common causes of action in abortion

malpractice are: (1) negligence in evaluating/screening a patient pre-abortion; and (2) lack of informed consent, which constitutes battery. Because abortion is a medical procedure, legally it is the physician's duty to evaluate, counsel and assess the patient beforehand.

Current abortion practice, though, severely limits physician-patient contact, and instead pre-abortion counseling is most typically delegated to the physician's agent, i.e., the abortion counselor. Nevertheless, it is the physician who actually performs the abortion, and it is always his/her ultimate responsibility to (a) protect the patient's health; (b) to see to it that the patient's decision is firm, freely made, and duly thoughtful; and (c) that her consent is truly informed.

THE ABORTION COUNSELOR

Abortion counseling in most countries suffers from obvious and serious conflicts of interest and procedural inadequacies. Abortion counseling between physician and patient is largely non-existent. Instead, the patient is "counseled" by someone other than a physician, i.e., his agent, who most typically is not professionally trained and who receives "on the job training." In the U.S. abortion counselors as a "profession" are unlicensed and are unregulated in 95% of the States. "Professional background is considered less important than such personal attributes as warmth, caring, empathy and *a commitment to the pro-choice cause*."[vi]

Counselor-bias can clearly be a negative force in the counseling process, particularly if the situation is compounded by a conflict of interest, e.g., pecuniary benefit in the outcome, namely, abortion.

All too often the abortion counselor has only a high school diploma, has herself had one or two abortions, and feels compelled to assist others by affirming the abortion decision. She thereby affirms her own

decision, unknown to her and her client. Because she may be in denial about the emotional aftereffects of her own abortion, she is either unaware of post-abortion emotional trauma because she needs to be, or is simply uninformed.

One abortion counselor worked two days at the clinic and the remainder of her work-week as a bartender at a "biker's bar." Another abortion counselor, when asked at her deposition when human life began, responded: "it begins at birth." Sadly, this kind of counselor and counseling may be more the rule than the exception.

DURATION OF PRE-ABORTION COUNSELING

Contemporary abortion counseling is so time-limited and volume-oriented as to make it impossible to be tailored to the unique needs and circumstances of the individual patient. Indeed, thorough, thoughtful and deliberative pregnancy-outcome decision-making is handicapped by existing abortion counseling procedures.

Several empirical studies in the U.S. have indicated the deficiencies of current abortion counseling practices with the majority of respondents reporting insufficient information provided by the abortion counselor, insensitive, unhelpful abortion clinic personnel with respect to providing assistance in decision-making, and the provision of misinformation, thereby contributing to increased anxiety, confusion, and levels of post-abortion depression and hostility.[vii]

Clearly, effective counseling that is empathic, durational and substantive in content benefits women considering abortion as a solution to an undesired pregnancy. On the other hand, biased "counseling" which is of 5-15 minutes duration, outcome-oriented, deficient of sufficient information and not allowing for multiple visits or time to deliberate is harmful to women

considering abortion.

NATURE OF PRE-ABORTION COUNSELING

Current standards of care for abortion counseling have appropriately been criticized in the U.S. on at least three counts: (1) the health profession inadequately fulfills women's needs for abortion counseling; (2) current laws, by not mandating or regulating the practice of abortion counseling, thus undermines maternal health; and (3) abortion counseling must of necessity expand and include assistance in remediating post-procedural problems.[viii]

The value of nondirective crisis pregnancy counseling was underscored by Cook. She reported: "When women may act only within a short span of gestation, they may be denied the opportunity to consider their options fully and take necessary steps for continuation or termination. Women could thereby be denied the choice to continue a pregnancy and give birth. The agendas of both antichoice and prochoice activists may be served by affording women opportunities for nondirective counseling and planning, and not obliging them to make their decisions in haste."[ix]

INFORMATION DEFICIENCIES

It is a tragic reality that abortion clinics go to great lengths to disguise, minimize, deny, disavow or dissuade their patients' concerns about the humanity of the fetal child.

Not offering a woman the opportunity to receive fetal information is also not following good counseling procedures, for in the absence of such procedures a directive counseling environment is created. In the absence of an opportunity to receive fetal information, the woman's attention is focused on the limited information which the counselor chooses to disclose,

and her decision is thereby directed by the limited information she receives. In such a directive counseling situation, the woman is denied the opportunity to consider thoroughly all her options, as information that would allow such has been withheld by the counselor.

In addition, many women are not familiar with the facts of fetal development but would consider information on fetal development to be important in making their abortion-decision because they would not wish to have an abortion if their unborn child were sufficiently developed to have readily identifiable arms, legs, a beating heart, etc.

The provision of information on fetal development further insures that, in deciding whether or not to have an abortion, a woman has an opportunity to use her own personal values, including her view of the time at which human life begins. If she is informed about fetal development and concludes that the unborn child is indeed a human life, then given her legal options, she can act accordingly in light of her own values. If she concludes that either the product of conception or the aborted material is not human, and decides to abort it, then she will have minimized the risk of future potential psychological harm arising from post-operative reflection prompted by obtaining fetal information not made available to her before it took place.

If information causes discomfort or dissonance, this does not mean it is antithetical to the doctrine of informed consent. According to U.S. Supreme Court Chief Just Rehnquist and Justice White: "It is in the very nature of informed consent provisions that they may produce some anxiety in the patient and influence her in her choice. This is in fact their reason for existence, and — provided that the information required is accurate and non-misleading — it is an entirely salutary reason."[x]

DECISION-MAKING AND NON-EVALUATING

One of the most important roles of the abortion counselor is to ascertain whether or not a woman's decision is indeed her own, made with sufficient information and reflection, made voluntarily, and without undue pressure or coercion. In addition the counselor should obtain a psychosocial as well as a medical history, and accordingly assess the risk for any post-abortion negative emotional adjustment.

The current nature of pre-abortion counseling virtually insures the impossibility of achieving its objectives. This is so because of: (a) the lack of professional education and training on the part of the counselor; (b) the severe time-constraints placed upon the session (5-15 minutes); (c) often the reliance upon group versus individual counseling; (d) the absence of objective information; (e) the non-exploration of alternatives; (f) the absence of information on fetal development; (g) the conflict of interest for the abortion counselor; and (h) the counselor's biases.

PREDISPOSING RISK FACTORS FOR POST-ABORTION TRAUMA

Research evidence is clear that certain women are predisposed to significant negative post-abortion adjustment. Existing biased abortion counseling places maternal health of these women at risk. These women are in need of *more* counseling, *more* information, exploration, and deliberation-time, and *more* assistance than others.

Abortion traumatization may in many cases be prevented or remediated if women who give evidence of documented risk factors receive adequate counsel to make a decision that fits their unique psychological and social needs.

In the current marketplace of abortion practice, nowhere is the disparity between the patient's best

interests and the reality of care provided more evident than in the abortion "counseling" provided. Sadly, in this examiner's opinion, it is normative today for *all* women seeking abortions to be treated *identically*. Women that need special attention and time are treated the same way as everyone else. Individual evaluation of patient needs tends to be more the ideal than the reality of contemporary abortion practice.

Empirical evidence suggests emotional harm from abortion is probable when the following risk factors are present:

1. prior history of mental illness
2. immature interpersonal relationships
3. unstable, conflicted relationships with one's partner
4. history of a negative relationship with one's mother
5. ambivalence regarding abortion
6. religious or cultural background hostile to abortion
7. single status, especially if one has not borne children
8. age, particularly adolescents versus adult women
9. second-trimester versus first-trimester abortions
10. abortion for genetic reasons, i.e., fetal anomaly
11. pressure or coercion to abort
12. prior abortion
13. prior children
14. maternal orientation
15. biased pre-abortion counseling

An example of inadequate abortion counseling is illustrated by Donna M., who came to the Institute for emotional and behavioral evaluation pending a medical malpractice suit against her abortion-provider. Because information about gestation and fetal characteristics was not made available, her traumatization was worsened post-abortion. She recalls: "... I guess I was a little bit naive. You know, three months, you look at yourself and say, ‘I don't look any bigger,' and I hadn't gained any weight, and I felt, you know, what could be really inside of you?" Prior to her abortion she failed to keep two appointments at the clinic, expressed

considerable ambivalence and moral conflict with the decision, felt pressure to abort by her social worker, and possessed ten of fifteen risk factors for post-abortion traumatization, none of which were considered in her pre-abortion counseling. Clinical evaluation of this patient's functioning supported the impact of Post-Abortion Syndrome (PAS),[xi] a type of Post-traumatic Stress Disorder, in her life and the painful reality of post-traumatic decline since her pregnancy termination.

Women who are emotionally traumatized by their abortions, and perhaps physically traumatized as well, are frequently overwhelmed by the depths of emotions that the abortion experience evokes. The factors of being surprised and overwhelmed by the intensity of the emotional and physical response to the abortion experience frequently act upon the post-abortive woman in a manner which causes her to resort to the defenses of repression and denial.

Women who repress or deny their emotional responses to the abortion trauma are more likely to re-experience that trauma in memory at a later time.[xii] When denial breaks and painful symptoms cause significant suffering, it is far more likely at this point that a woman will consider bringing a lawsuit against her abortion provider.

In the case of PAS, re-experience of the abortion event can occur in nightmares or any events during the day associated with childbearing or with abortion. One woman reported a recurring nightmare in which she dreams that her aborted baby is pointing a gun at her and she wakes up in a sweat just before the trigger is pulled.

Re-experience also occurs in PAS women in the form of preoccupation in their waking and sleeping moments with thoughts about pregnancy in general, and the aborted child in specific. Such preoccupation frequently

becomes most intense on subsequent anniversary dates of the abortion or on anniversaries of the projected due-date of the aborted child.

PAS re-experience also occurs in the form of flashbacks to the abortion experience. As one woman described her flashbacks, "Every time my period comes around and I see blood, I just start shaking. There it all is again in front of me."

It has been the author's experience in counseling hundreds of women that many encounter guilt, anxiety, loss, and depression now associated with Post-Abortion Syndrome. This condition was worsened because they received inadequate and misleading information prior to their abortion. All too often we have heard: "If I knew then what I know now, I would never have allowed myself to get into this mess."

VICTIMS NO LONGER

While some find their lives filled with daily emotional torture from their abortions, others may be living marginally and unconnected to their abortion feelings. For these women it may be too difficult or threatening to face the unacknowledged pain of their abortion experience. These women believe feelings buried by design are best left buried.

For this reason, denial is common among women who have elected abortion. In particular, some women may minimize or deny: (a) that they have experienced an emotional injury, especially when they "chose" to have the procedure; (b) that they feel grief and/or were traumatized; (c) the extent of their emotional suffering from the abortion, particularly when this is minimized by society, friends, and family; (d) that they have had multiple abortions because of the shame and guilt attached to these experiences and because of unmastered unconscious repetition compulsions; (e) the

extent of psychological disruption the abortion caused in their psyches and lives because they "deserved" it as warranted punishment; and (f) the need for treatment because the media and many professionals minimize the painful reality of post-abortion trauma.

Consequently, the story of the after-effects of abortion is largely untold and unknown. While appearing "invisible" at the societal level, the story is very visible at the personal level where rhetoric collides with reality and where women live out the consequences of their decisions.

It is recommended that the following necessary changes be instituted to enable enhanced informed consent and remediate deficient standards of abortion counseling:

- Counseling for women considering abortion should only be undertaken by professionals who are trained and who possess a minimum of a master's degree in the mental health field.
- Counseling for women considering abortion should include complete, full and factual information regarding fetal development, all possible pregnancy outcome alternatives and appropriate referral sources, risks and benefits of each alternative, and risks of non-treatment.
- All women seeking abortion should be required to attend a minimum of three individual counseling sessions of one-hour duration before being able to provide their informed consent for the procedure.
- There should be a minimum waiting period of at least one week before being able to provide their assent to abortion.
- All psychological risks of abortion should be explained and carefully evaluated according to each person's individual background and emotional status.
- Adolescents should be required to obtain the consent

of their parents in order to obtain an abortion, or in the event of severe family dysfunction and/or abuse, an alternative method of evaluation may be substituted, e.g., a juvenile court may appoint an independent social worker to provide a psychosocial assessment of the individual and her circumstances.

- All women seeking an abortion should be fully appraised of their legal rights to carry to term and their right to obtain financial assistance from the child's father.
- All women seeking an abortion should have the right to unbiased professional counseling and a full opportunity to discuss any and all information concerning their crisis pregnancy and possible outcome, as well as be afforded the opportunity to ask questions freely and privately.
- All women considering an abortion should be provided with the opportunity to view a video-presentation that is scientifically accurate that depicts human fetal development. In addition, all women should be afforded the opportunity to view a video-presentation that depicts both sides of the scientific controversy over Post-Abortion Syndrome.
- Abortion counseling should *not* be undertaken by any provider who has any financial interest in the outcome of the pregnancy decision-making process.
- Each State should be required by law to compile health statistics on abortion, including morbidity and mortality, and these statistics should be annually forwarded according to federal regulations to the Centers for Disease Control.

NOTES

i. N. Stotland, "The Myth of the Abortion Trauma Syndrome" in *Journal of the American Medical Association* 268 (1992) 2078.

ii. V. Rue, "Abortion in Relationship Context" in *International Review of Natural Family Planning* 19/2 (1986) 95-121; A. Hittner, "Feelings of Well-Being Before and After an Abortion" in *American Mental Health Counselors Association Journal* 9/2 (1987) 98-104; G. Zakus and S. Wilday, "Adolescent Abortion Option" in *Social Work in Health Care* 12/4 (1987) 77-91; N. Campbell, K. Franco and S. Jurs, "Abortion in Adolescence" in *Adolescence* 23/92 (1988) 813-23; P. Ney and A. Wickett, "Mental Health and Abortion: Review and Analysis" in *Psychiatric Journal of the University of Ottawa* 14 (1989) 506-16; J. Rogers, G. Stoms, and J. Phifer, "Psychological Impact of Abortion" in *Health Care for Women International* 10 (1989) 347-76; L. DeVeber, J. Ajzenstat, and D. Chisholm, "Postabortion Grief: Psychological Sequelae of Induced Abortion" in *Humane Medicine* 7 (1991) 203-09; J. Rogers, "Utilization of Data in the Ongoing Public Debate Over Abortion" in *Family Perspective* 25/3 (1991) 179-99; R. El-Mallakh and A. Tasman, "Recurrent Abortions in a Bulimic: Implications Regarding Pathogenesis" in *International Journal of Eating Disorders* 10/2 (1991) 215-19; V. Rue and A. Speckhard, "Postabortion Trauma: Incidence and Diagnostic Considerations" in *Medicine and Mind* 6/1 (1991) 57-74; E. J. Angelo, "Psychiatric Sequelae of Abortion: the Many Faces of Post-Abortion Grief" in *Linacre Quarterly* 59/2 (1992) 69-80; A. Speckhard and V. Rue, "Postabortion Syndrome: an Emerging Public Health Concern" in *Journal of Social Issues* 42/3 (1992) 95-119; J. Rosenfeld, "Emotional Responses to Therapeutic Abortion" in *American Family Physician* 45/1 (1992) 137-40; W. Franz and D. Reardon, "Differential Impact of Abortions on Adolescents and Adults" in *Adolescence* 27/105 (1992) 162-72; A. Speckhard and V. Rue, "Complicated Mourning and Abortion" in *Journal of Pre- and Peri-Natal Psychology* 8/1 (1993) 5-32; G. Congleton and L. Calhoun, "Post-Abortion Perceptions: a Comparison on Self-Identified Distressed and Non-Distressed Populations" in *International Journal of Social Psychiatry* 39/4 (1993) 255-65; D. Bagarozzi, "Post-traumatic Stress Disorders in Women Following Abortion: Some Considerations and Implications for Marital/Couple Therapy" in *International Journal of Family and Marriage* 1 (1993) 51-68; D. Bagarozzi, "Identification, Assessment, and Treatment of Women Suffering from Post-traumatic Stress After Abortion" in

Journal of Family Psychotherapy 5/3 (1994) 25-54; P. Ney et al., "The Effects of Pregnancy Loss on Women's Health" in *Social Science Medicine* 38/9 (1994) 1193-1200.

iii. See D. Reardon, *Abortion Malpractice* (Dallas: Life Dynamics 1994).

iv. In the U.S., the States of Ohio, Pennsylvania, North Dakota, South Dakota, Utah, Montana, Mississippi and Indiana have enacted statutes that expressly proscribe the nature and content of informed consent in pre-abortion counseling and decision-making.

v. J. Stuart, "Abortion and Informed Consent: a Cause of Action" in *Ohio Northern University Law Review* 14/1 (1987) 1-20.

vi. U. Landy, "Abortion Counseling — A New Component of Medical Care" in *Clinics in Obstetrics and Gynecology* 33 (1986) 37.

vii. C. Barnard, *The Long Term Psychological Effects of Abortion* (Portsmouth: Institute for Abortion Recovery and Research 1990); and H. Vaughan, *Canonical Variates of Post Abortion Syndrome* (Portsmouth: Institute for Abortion Recovery and Research 1990).

viii. T. Steinberg, "Abortion Counseling: To Benefit Maternal Health" in *American Journal of Law and Medicine* 15 (1989) 483.

ix. R. Cook, "Abortion Laws and Policies: Challenges and Opportunities" in *International Journal of Gynecology and Obstetrics* (1989, supplement 3) 61-87 at 74.

x. B. White and R. Rehnquist, Dissenting Opinion in *Thornburgh v. American College of Obstetrics and Gynecologists* 84-495 (1985) 16.

xi. For a more detailed exposition of PAS see V. Rue, "Postabortion Syndrome: a Variant of Posttraumatic Stress Disorder" in P. Doherty, ed., *Post-Abortion Syndrome* (Dublin: Four Courts Press 1995) 15-28; and V. Rue, "The Psychological Aftermath of Induced Abortion" in M. Mannion, ed., *Post-abortion Aftermath* (Kansas City: Sheed and Ward 1994) 5-43.

xii. A. Speckhard, *Psycho-Social Stress Following Abortion* (Kansas City: Sheed and Ward 1987).