IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF NORTH DAKOTA

SOUTHWESTERN DIVISION

MKB MANAGEMENT CORP, et al.

Plaintiffs,

-vs-

BIRCH BURDICK, et al.,

Defendants.

Declaration and Expert Report of Martha W. Shuping, M.D.

Civil No. 1:13-CV-071

Martha W. Shuping, M.D., declares and states the following:

DECLARATION OF MARTHA SHUPING, M.D.

I. PROFESSIONAL BACKGROUND AND CREDENTIALS

1. I am a medical doctor specializing in psychiatry licensed in the state of North Carolina licensed to practice in the state of North Carolina. I graduated from the Wake Forest University School of Medicine with the M.D. degree in 1984, and completed psychiatry residency at the Wake Forest University Baptist Medical Center in 1988. My Curriculum Vitae is attached as Exhibit A. I have been retained by the Office of the Attorney General, Civil Litigation Division as an expert witness on behalf of the State of North Dakota in defense of House Bill 1456.

2. Within my clinical experience, I have spoken with more than one thousand women who have requested help in regard to abortion related mental health problems. As a practicing psychiatrist, I have provided individual psychiatric treatment for many women with mental health problems associated with a past abortion. I have also conducted more than fifty abortion recovery weekends for groups of women who have requested help with emotional issues and psychiatric disorders associated with past abortions. I have treated many women who have experienced coerced, pressured, and forced abortions. I have treated women who have been victims of rape and incest, and have experience with women in these situations who have carried a pregnancy to term and with women in these situations who have chosen abortion. I have also treated women who have had abortions due to fetal abnormality, who subsequently experienced mental health problems associated with the abortion. I have treated women who have had mental health problems associated with miscarriages, stillbirths, and have also treated women with post-partum depression. I also have treated men and women with PTSD arising from various past traumatic experiences of various types including childhood physical abuse and childhood sexual abuse.

3. I have provided educational programs within the U.S. and in 15 countries in North America, South America, Europe and Asia, to train professional counselors, health professionals, and peer counselors to help women experiencing negative emotions and psychiatric disorders associated with past abortions. I have provided accredited continuing education for physicians, nurses and counselors on this subject.

4. I am a co-author of published research related to abortion and women's mental health. Because of my clinical experience with women experiencing abortion related mental health problems and also because of my knowledge of the abortion and mental health research, I was appointed by the President of Division 48 of the American Psychological Association to a task force with the purpose of establishing a research agenda in regard to abortion and mental health. As a member of this task force since April, 2013, I have been a participant in discussions with researchers of diverse backgrounds and viewpoints concerning abortion and mental health, specifically including members who are pro-choice and those who are pro-life in their personal views. The complete name of this task force is, American Psychological Association, Division 48, Society for the Study of Peace, Conflict, and Violence: Presidential Task Force for a Research Agenda on Abortion from a Peace Psychology Perspective (A.P.A. Div. 48 Task Force).

5. I have also had experience with women who are in the process of making decisions regarding their pregnancy. This experience includes psychiatric patients who have come to me as their treating psychiatrist, seeking assistance with their decision making in regard to an unintended pregnancy. This also includes volunteer work at a pregnancy resource center, Birthright, where I served as Assistant Director, then Executive Director, over a five year period, during which I provided some direct client services as well as training and supervision of volunteers, interns and staff. My experience also includes volunteer work as an abortion counselor during 1973 while a

university undergraduate student, serving at a clinic which provided counseling and referrals for abortion services.

6. I have been a registered participant at the United Nations Commission on the Status of women annual meetings in 2005, 2008, 2009, and 2011, and have been a workshop presenter during 2008, 2009, and 2011, on women's mental health and abortion. My CV is attached as Exhibit A.

7. The opinions provided herein, which are held to a reasonable degree of medical certainty, are based upon more than 25 years of experience as a psychiatrist, and the knowledge I have obtained through my education, training, research and consulting experience, voluntary experience, discussions with colleagues, attendance at conferences, and ongoing review of the medical and scientific literature, which includes but is not limited to published literature concerning mental health issues associated with post-partum depression, pregnancy loss (abortion, miscarriage, stillbirth and other perinatal losses), attachment including maternal-fetal attachment, posttraumatic stress, and complicated mourning. It would be impossible for me to provide a complete list of all sources which have contributed to formulating my opinion, but some of the most pertinent are discussed in my report and included in a list of citations following this report.

II. INTRODUCTION

8. I was retained by the Office of the Attorney General, Civil Litigation Division as an expert witness on behalf of the State of North Dakota in defense of House Bill 1456. In my opinion, within reasonable medical and scientific certainty, the provisions of HB 1456 are necessary to protect women from the well-substantiated increased risk of mental health, emotional and psychological problems and disorders associated with and caused by abortion, and in particular the adverse and profound adverse effects abortion has on the mental, emotional and psychological health and well-being of women.

9. I provide these opinions in opposition to Plaintiffs' Motion for Summary Judgment against enforcement of North Dakota House Bill 1456, now codified at North Dakota Century Code Sections 14-02.1-05.1 14-02.1-05.2 and 43-17-31. My understanding is that North Dakota's HB 1456 prohibits an abortion[1] if the unborn child[2] the pregnant woman is carrying has a detectable heartbeat, absent certain exceptions such as to prevent the death of a pregnant woman, to prevent a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman, or to save the life of an unborn child. In addition to the benefit of protecting human life, HB 1456 will directly benefit the emotional, mental and psychological well-being of women of

[1] In referring to an "abortion," I am referring to the definition found in N.D.C.C. § 14-02.1-02(1), and being an induced termination of a clinically diagnosed intrauterine pregnancy of a woman with knowledge that the termination will with reasonable likelihood cause the death of the unborn child.

[2] I may sometimes refer to the term "unborn child," which shall have the same meaning as that term is defined in N.D.C.C. § 14-02.1-02(18) to mean the offspring of human beings from conception until birth.

reproductive age in North Dakota. To the extent that fewer abortions occur, fewer women will be at risk for mental health, emotional and psychological problems, and fewer women will be at risk for problems in their relationships with their children and their partners. Women who choose abortions will do so before a detectable heartbeat is present which will serve to reduce mental health, emotional and psychological problems associated with and caused by abortion and will reduce the risk for problems in relationships with their children and their partners.

10. I have been requested to give an expert opinion on the effect of abortion on women's mental health, emotional and psychological well-being.

11. In rendering my expert opinion, I utilized and considered testimonials and information I have received from women who have had abortions that I have diagnosed and personally counseled and treated for mental health problems and disorders over the course of my 25 year psychiatric medical career.

12. In rendering my expert opinions, I have also reviewed and considered testimony of approximately 4,500 women who had abortions. These testimonials include both declarations under penalty of perjury and affidavits of women who have experienced abortions, and these also form a part of the basis of my expert opinion. It is customary, in the field of psychiatry, to utilize patient accounts in forming professional opinion, in addition to considering the published research. Patient accounts are used in diagnosis, of course, but are also sometimes quoted in published research for illustrative purposes. In addition, because these are sworn testimonies, they actually have a higher value for accuracy and reliability than some of the patient history, anecdotal data and opinion

surveys of women suffering from mental trauma that are customarily used by professionals in the field of psychiatry. The declarations and affidavits and that I reviewed and that were utilized and considered in rendering my opinions are as follows:

a. Statements from 96 women from North Dakota, South Dakota, Minnesota, and Montana, which have been submitted in some cases in the form of notarized affidavits, or in other cases as declarations. In regard to the North Dakota women, these include statements of six women within this group of 96 statements, identified by these names and Bates Numbers: Jody Clemens (Bates Nos. 1119-20), Ruth Ruch (Bates Nos. 1121-22), Terry Melby (Bates Nos. 1123-24), Erin Hill (Bates Nos. 1125-26), Rhonda Nygaard (Bates No. 1127), Kay Kiefer (Bates Nos. 1128-29). Many women have signed their full name and have given permission for their full name to be used, but some women have requested that only initials be used and for these women, the names have been redacted. In using material from these statements as examples below, I will state the actual name or initials according to what appears on the document and will reference the state they are from, or will refer to the "96 women" in considering this group of women as a whole. These statements of Ms. Clemens, Ms. Ruch, Ms. Melby, Ms. Hill, Ms. Nygard, and Ms. Kiefer are collectively attached as Exhibit B-1 and note the bates numbers that were assigned to them in discovery for this case. The other statements and affidavits that I used from the other women from North Dakota, South

Dakota, Minnesota and Montana are attached as Exhibits B-2 bates numbered 1576 to 1749.

b. A group of approximately 180 affidavits from post-abortive women excerpts of which were previously submitted to the U.S. Supreme Court within an amicus brief in regard to *Gonzales v. Carhart*, and which were cited in that decision. These excerpts and affidavits are attached to the Affidavit of Allen E. Parker, Jr., dated November 25, 2013, as Exhibits 2 and 3, bates 1138 through 1458. I understand this affidavit and these exhibits are being submitted by the State of North Dakota in response to the Plaintiffs' summary judgment motion.

c. Approximately 4,200 statements of post-abortive women, some in the form of notarized affidavits and others in the form of declarations that I have been asked to review. To identify these, real names will be used if permission was given to use full name, or if identifying data was redacted at the women's request for privacy, then initials will be used, and the group will be referenced as the "4200." Because of the volume of these statements it would be impossible to attach each and every statement to my declaration and therefore, I have only attached those that I have specifically referenced, which are representative and illustrative of these 4,200 statements in general and in total, These affidavits are attached to my declaration as Exhibit C and bates numbered 1750 to 1754.

d. Additional affidavits that have been obtained during the course of this litigation and disclosed to the Plaintiffs. These affidavits are attached as Exhibit D and bates numbered 1755 through 1793.

To refer collectively to all the documents included in a, b, c and d, nearly 4,500 in all, I will reference "the affidavits and declarations."

Also, because of the volume of the affidavits and declarations I reviewed and considered, it would be impossible to recite to each and every one of them with respect to the opinions I have rendered. Rather, I have cited to those affidavits and declarations that are representative and illustrative of the information contained in the affidavits and declarations in general and in total.

13. To be very clear, I cannot make a diagnosis on any woman from the statements I reviewed because the diagnosis would require a complete, individual psychiatric or psychological evaluation. However, these statements were utilized and considered in rendering my opinions, because they are examples of and wholly consistent with the testimonials and information I have received from the post-abortive women I have treated for mental health, emotional and psychological symptoms, problems and disorders over the course of my twenty-five year psychiatric career. Therefore, I utilized and considered these testimonials to avoid disclosure of my patients' personal information, yet show that post-abortive women I treat for mental health, emotional and psychological symptoms, problems and disorders have consistent stories and accounts of the mental, psychological and emotional problems encountered as the women in these testimonials. Further, these testimonials and statements noted are also illustrative of the mental health, emotional and

psychological symptoms, problems and disorders that have been identified in the published research. They provide additional weight and support for and are a part of the basis of my professional expert opinion. Finally, these testimonials allowed me to make some general observations.

14. In rendering my expert opinions, I have also reviewed and considered the deposition testimonies of Dr. Eggleston and Tammi Kromenaker taken on November 26, 2013. I understand these deposition transcripts are being submitted by the State of North Dakota in response to the Plaintiffs' motion for summary judgment. In rendering my expert opinions, I have also reviewed and considered statements assumed to be patients (also a partner and some family members) of the Red River Women's Clinic, which were disclosed in the discovery of this case by the Plaintiffs. These are unsigned (no names or initials); therefore I will refer to these individually by number and collectively as "Red River Women's Clinic patients." These statements were provided by the plaintiffs in discovery and the statements are attached hereto as Exhibit F and have bates number PL 624 to PL 675 that were assigned by Plaintiffs. At pages 55-57 of the deposition transcript of Tammi Kromenaker, (conducted on November 26, 2013), she stated that these statements came from "patient journals at our clinic" and further testified "We have patient journals throughout the clinic and patients or their support person who comes with will often be seen writing in them. The recovery room is where most of that writing occurs 'cause it's a more private space." However, she also testified, "There's no way to know the identity of a specific patient who wrote those."

15. Apparently the Red River Women's Clinic patients' statements were written in journals that are left at various places throughout the clinic, and the comments are written anonymously. From Ms. Kromenaker's testimony, the authorship of any of the comments cannot be known or discovered. Additionally, since they are not notarized documents and not declarations given under penalty of perjury, I would not assign to them the same weight compared to the declarations and affidavits. In writing a declaration or affidavit, there is some careful thought involved in choosing one's words accurately, and with the affidavit there is the additional step of proving one's identity before a magistrate, though preparation of either an affidavit or a declaration would indicate that the person has taken some time and considered their words carefully to give an accurate statement to be used for legal purposes. In contrast, it's not possible to know with certainty that the Red River Women's Clinic patients' statements were actually all written by patients (one appears to be written by a patient's partner, and one by a patient's mother), and if written by patients, many may have been written in the recovery room while the patient was perhaps still under the effects of anesthesia or pain.

16. It is also unclear how many were written before the abortion vs. after the abortion. Originally, at page 56 of the deposition transcript, in response to the question "So these are…patients that have already had an abortion?" Ms. Kromenaker testified, "yes," then later clarifying as above that the journals are throughout the clinic, but often women choose to write in the recovery room. However, from my reading of the statements, in some statements the writer indicates she is waiting for her abortion, while in others the writer states she is in recovery, and in many statements it is not clear whether the

statement is being given before or after the abortion. In terms of using these statements to better understand whether abortion improves women's mental health or whether abortion worsens women's mental health, they are of limited usefulness since some were written before, rather than after the abortion, and it's not definitely possible to tell which were before and which after. In either case, it is more important to consider the longer term effects of the abortion, rather than only the first thirty minutes after the abortion.

17. Thus, in my opinion, these the Red River Women's Clinic patients' statements are limited in their usefulness, but nevertheless, I have reviewed and considered them in rendering my expert opinions and will discuss their content and give my expert opinion in regard to their content further below.

III. NO MENTAL HEALTH BENEFITS FROM ABORTION

18. Dr. David M. Fergusson of New Zealand is a researcher who was invited to serve as a member of the APA Div. 48 Task Force on abortion research, on which he served for approximately six months during 2013. It is well known that his personal views are "pro-choice," and he served on the APA Div. 48 Task Force as a "pro-choice" member, since there was desire to have balance among membership in order to try to avoid bias and to consider all viewpoints in regard to the research. I know from serving with him, through personal communication between myself and Dr. Fergusson within the Task Force, that he is certainly pro-choice.

19. Dr. Fergusson has expressed concern that there has been very little published research on the mental health benefits of abortion, if any. "Few reviews have considered the extent to which abortion has therapeutic benefits that mitigate the mental health risks

of abortion" (Fergusson et al., 2013). With this in mind, he undertook a meta-analysis of eight studies that included several different mental health outcomes. A meta-analysis pools and re-analyzes data from several studies, and can provide a conclusion that is more reliable than the individual studies.

20. Fergusson's recent study was specifically to consider the "hypothesis that abortion reduces rates of mental health problems in women having unwanted or unintended pregnancy." His results showed: "There was consistent evidence to show that abortion was not associated with a reduction in rates of mental health problems," and the results were statistically significant.

21. He states: "For all analyses considered, there is no evidence to suggest that rates of mental health problems were lower in women having abortion than in comparison groups of women having unwanted pregnancy. This conclusion held for all studies, all authors, and all outcomes considered, irrespective of variations in study quality….." (Fergusson et al., 2013).

22. His conclusion: "There is no available evidence to suggest that abortion has therapeutic effects in reducing the mental health risks of unwanted or unintended pregnancy."

23. Based on the foregoing and on my own clinical experience and my own extensive review of the literature, to a reasonable degree of medical and scientific certainty, I conclude and it is my opinion there are no mental health, emotional and psychological benefits from abortion.

IV. ABORTION HAS A PROFOUND AND SIGNIFICANT ADVERSE EFFECT UPON THE MENTAL HEALTH, EMOTIONAL AND PSYCHOLOGICAL WELL-BEING OF WOMEN

24. In my opinion, to a reasonable degree of medical and scientific certainty, the overwhelming preponderance of scientific and medical evidence demonstrates abortion is a substantial contributing factor and cause of increasing the risk of mental health, emotional and psychological problems for women that have had an abortion, and in turn abortion has a profound and significant adverse effect on women's mental health, emotional and psychological well-being. Therefore, in my opinion HB 1456 protects women from these adverse effects of an abortion and in turn promotes the health, safety and well-being of women, along with protecting the life of unborn children and health and well-being of their families, and is medically and scientifically sound and reasonable. Along with my own clinical experience and my own extensive review of literature, further supporting information for these opinions is presented below.

(A) Suicide after abortion:

25. The following studies and literature support my opinion that women that have abortion have an increased risk of suicide and suicidal thoughts.

26. A large record-based study in Finland reported a higher rate of suicide after abortion. Women who had an abortion had a 650% higher risk of death from suicide compared to women who carried to term. This study linked actual death certificates to medical records (Gissler et al., 1996).

27. The higher suicide rates after abortion persist for several years and are highest for younger women. This was seen in a large study of more than 173,000 California

Medicaid records in which the increased rate of suicide persisted for the 8 years studied, and which was not explained by prior mental illness (at least not during the year preceding the target pregnancy) (Reardon et al., 2002).

28. A records based U.K. study comparing suicide attempts before and after abortion indicated the increase in suicide rates after abortion was not related to prior suicidal behavior but was most likely related to adverse reactions to the abortion (Morgan et al., 1997). The rate of attempted suicide remained level or decreased before and after pregnancies that resulted in giving birth. But following abortion, the suicide rate increased from a normal baseline to a significantly higher rate.

29. There are reports of attempted or completed suicides coinciding with the anniversary date of the abortion or expected due date of the aborted child (Tischler, 1981; Reardon , Strahan, Thorp, & Shuping, 2004). This would tend to indicate a possible causal relationship between the abortion and the suicide or attempted suicide.

30. Risk of death by suicide is reduced in women who carry a pregnancy to term. In the Finland study, women giving birth had a suicide rate about half that of the general population of Finnish women" (Gissler et al., 1996).

31. Several studies have shown carrying a pregnancy to term and giving birth are associated with a reduced risk of suicide (Appleby, 1991; Appleby et al., 1995; Drower & Nash, 1978; Jansson, 1965).

32. "In one study of women with prior psychiatric problems, none of those who carried to term subsequently committed suicide over an eight-to-thirteen year follow up, while five per cent of those who aborted subsequently committed suicide" (Reardon, et

al., 2004). A study of Canadian women also showed that women with previous psychiatric problems had a higher suicide rate after abortion (Greenglass, 1976).

33. Teens are at much higher risk of a suicide attempt after abortion. Researchers at University of Minnesota found suicide attempts increased ten-fold for teens who were post-abortive in the preceding 6 months (Garfinkel et al., 1986). Fergusson et al. (2006) found that 50% of post-abortive teens (15-18 years) had suicidal thoughts and behaviors, double the rate for pregnant but never aborted, and double the rate of never pregnant girls.

34. There is a much higher rate of suicide in post-abortive women compared to women who have given birth. Women who have given birth have a suicide rate that is below the community baseline. Even in women with prior mental illness, it still holds that those who have abortions have higher rates of suicide, while those who give birth have the lowest rate of suicide, lower than the non-pregnant baseline.. The data consistently show that the risk of suicide is less after giving birth, and higher after abortion.

35. Based on the foregoing, within reasonable medical and scientific certainty, it is my opinion that women having abortions are at increased risk of suicide and suicidal thoughts, compared to baseline community rates of suicide, and compared to other pregnancy outcomes, and women giving birth are at decreased risk of suicide compared to baseline community rates of suicide and compared to other pregnancy outcomes.

(B) Researchers on both sides agree: Some women have problems after abortion.

36. Researchers on both sides of the abortion issue agree that some women have mental health problems after abortion. For example, in 1992, the Journal of Social Issues

dedicated an entire issue to research relating to the psychological effects of elective abortion. In an overview of the contributor's papers the editor, Dr. Gregory Wilmoth (1992), concluded: "There is now virtually no disagreement among researchers that some women experience negative psychological reactions postabortion" [after abortion].

37. *A Clinician's Guide to Medical and Surgical Abortion* ("*Clinician's Guide*") is a medical textbook written by leading abortion providers (Paul, et al., 1999) for the purpose of training abortion providers. This textbook bears the logo of the National Abortion Federation on its cover. A chapter on counseling in *Clinician's Guide* identifies a number of "negative reactions" that some women experience after abortion, including: depression, guilt, shame, regret, and grief. (Baker, 1999).

38. According to *Clinician's Guide*, symptoms of depression include the following (as well as several other symptoms):

a. "crying frequently."

b. "suicidal ideation" (suicidal thoughts and behaviors).

c. "performing poorly at work or school."

d. "losing interest in enjoyable activities."

e. "feeling worthless."

39. According to *Clinician's Guide,* symptoms of "severe guilt" include the following symptoms, below. Note that although these are listed as symptoms of "severe guilt" in the textbook, in fact, the symptoms identified in "b" through "d" below are also symptoms of Posttraumatic Stress Disorder which will be discussed further below. (American Psychiatric Association, 2013).

a. "Engaging in self-punishing behaviors such as substance abuse, indiscriminate sex, and

b. "Nightmares about killing or saving babies."

c. "Blocking out the experience."

d. "Avoiding anything that triggers memories of the event."

e. "Fearing God's punishment."

f. "Interpreting any misfortune, illness or accident as signs of God's punishment."

40. According to *Clinician's Guide*, symptoms of shame include the following, listed below. Note that although "self-destructive behavior" is listed in the textbook as a symptom of "shame," it is also a symptom of Posttraumatic Stress Disorder as we will discuss in another section.

a. "Relentless thoughts of being a bad person."

b. "Engaging in self-destructive behaviors."

c. "Inordinate fear of anyone finding out about the abortion."

d. According to Clinician's Guide, symptoms of regret include:

e. "Believing a different decision would have resulted in a more desirable outcome."

f. "Dwelling only on negative consequences attributed to the abortion decision."

41. According to *Clinician's Guide*, "symptoms of unresolved grief include engaging in thoughts and behaviors that perpetuate a strong emotional investment in the pregnancy or that prevent the redirection of emotional energy into moving forward with life."

42. The symptoms identified above are all symptoms that have been reported to me on numerous occasions by the women who come to me seeking help for mental health, emotional and psychological problems and disorders that they identify and I diagnose as being associated with their abortion.

(C) Risk factors for mental health, emotional and psychological problems after abortion.

43. Researchers on both sides of the abortion issue also agree that there are a number of well established "risk factors," supported by numerous studies, which are "predisposing factors" (the term used in *Clinician's Guide*) for mental health, emotional and psychological problems after abortion. Women who have these risk factors are more vulnerable to mental health, emotional and psychological problems after abortion. The textbook *Clinician's Guide* gives a list of factors that may predict increased risk of negative outcomes after abortion. I hold this opinion that there is agreement on many of these risk factors through having done extensive literature searches and reading studies by researchers on either side of the issue and it is very clear that there is agreement on a number of pre-existing conditions that if present places a woman at increased risk for mental health, emotional and psychological problems after abortion. I have also discussed the topic of risk factors within the A.P.A., Division 48, Task Force, on which I am a current member. The *Clinician's Guide* lists 14 such risk factors and cites some of the studies which established these particular risk factors.

44. A newer textbook, *Management of unintended and abnormal pregnancy: Comprehensive Abortion Care* ("*Comprehensive Abortion Care*"), by many of the same authors and many of the same editors (Paul, et al., 2009) lists 18 risk factors, including the same or similar risk factors from the earlier textbook, with some additional risk factors listed, in a chapter on counseling (Baker & Beresford, 2009). Note that this textbook also bears the logo of the National Abortion Federation on its cover. Below is a listing of 15 risk factors selected from *Comprehensive Abortion Care* which are extremely important in understanding the mental health, emotional and psychological effects that many women experience after abortion. There are additional risk factors that are also well established and agreed upon by researchers from both sides which will be discussed further below.

a. "Commitment and attachment to the pregnancy."

b. "Perceived coercion to have the abortion."

c. "Significant ambivalence about the abortion decision."

d. "Putting great effort into keeping the abortion a secret for fear of stigma."

e. "Advanced stage of pregnancy."

f. "Preexisting experience of trauma."

g. "Past or present sexual, physical, or emotional abuse."

h. "Unresolved past losses and perception of abortion as a loss."

i. "Fetal Abnormality or other medical indications for the abortion."

j. "Intense guilt and shame before the abortion."

k. "An existing emotional disorder or mental illness prior to the abortion."

l. "Appraisal of abortion as extremely stressful before it occurs."

m. "Expecting depression, severe grief or guilt, and regret after the abortion."

n. "Belief that abortion is the same act as killing a newborn infant."

o. "Lack of emotional support and receiving criticism from significant people in their lives."

45. Additional information on these and other established risk factors are included within the declaration of Dr. Priscilla Coleman, particularly in Exhibit D which is dated December 2, 2013 and is being submitted by the State of North Dakota in response to Plaintiffs' motion for summary judgment (I will refer to this report as the "Coleman Report"). I agree with the risk factors that Dr. Coleman has identified and will refer to some of these further below.

(D) Maternal – child attachment during pregnancy (prenatal bonding)[3]

(1) Introduction

46. Most people have some understanding of mother-child bonding during pregnancy. Popular magazines, baby books and websites tell parents that bonding begins in the womb, and that bonding can be enhanced by talking to the baby, singing to the baby, or by other parental actions (Babycentre, 2011). Medical journals are also giving the same advice to health care professionals working with pregnant women, that prenatal bonding can be enhanced by these activities (Verny, 1984).

[3] In discussing mother-child bonding occurring during pregnancy, I will use the terms "maternal-fetal attachment," "maternal-fetal bonding," "prenatal bonding or attachment," or "maternal-child bonding during pregnancy" interchangeably, since they appear to be used interchangeably within the published literature irrespective of the age of the unborn child. I will use these terms to refer to bonding that takes place between a woman and her unborn child.

47. Consider first the risk factor of "commitment and attachment to the pregnancy." See also Exhibit D of the Coleman Report noting the 18 studies under the heading "Commitment to the Pregnancy," which serve as additional evidence that commitment to the pregnancy is a risk factor for problems after an abortion. Experts on both sides recognize that if a woman is committed to the pregnancy and if she has in fact "attached" (bonded) to her unborn child, that she is more vulnerable to having psychological, emotional and mental health distress after an abortion. When a woman has bonded to her baby but then has an abortion, it is my opinion, the woman will experience distress at the loss of her child, and research confirms that. However, at face value, it is a jarring concept to think that women are aborting an unborn child to which they are "committed and attached." It is important to consider the reasons that women abort babies to whom they have already bonded, and to consider how this affects women in the short term and in the long term. In my opinion, this situation occurs very frequently, that women experience attachment to their children but nonetheless obtain abortions. In my opinion, the loss of children through abortion in the presence of maternal bonding is a major source of many of the mental health symptoms, problems and disorders that that many women experience after abortion.

48. In professional literature, maternal-fetal attachment has been defined as "the extent to which women engage in behaviors that represent affiliation and interaction with the unborn child." (Cranley, 1981). This definition indicates that there can be varying degrees of attachment.

49. The reality of prenatal bonding is widely accepted in the medical and scientific literature. A PubMed search on maternal – fetal attachment shows hundreds of published articles, and similarly, a PubMed search on prenatal bonding also reveals hundreds of articles on this topic. These articles do not question whether or not prenatal bonding exists, but rather, examine what factors may enhance bonding, or consider factors that may decrease bonding. But there is no question that mother-child bonding occurs during the prenatal period. Many reports over the past 68 years have repeatedly concluded that attachment begins during pregnancy, and often very early in pregnancy, shortly after conception. (Deutsch, 1945; Bibring, 1961; Benedek, 1970; Klauss & Kennel, 1976; Peppers & Knapp, 1980; Condon, 1986; Borg & Lasker, 1989; Gilbert & Smart, 1992; Rando, 1993; Muller, 1996; Speckhard, 1997).

50. But does prenatal bonding take place in women seeking abortions? In legal testimony given in 1996 (published in 1999), Dr. Anne Speckhard stated, regarding the issue of attachment in regard to the wantedness vs. unwantedness of the pregnancy: "Psychological attachment is common in pregnancy, beginning for some women even in early pregnancy. As a human process, attachment occurs irrespective of perceived wantedness of the pregnancy. The basis of maternal attachment is both psychological and physical. On the psychological level attachment relies upon the images a woman is forming of her fetal child, images which invoke protective responses within her. The protective urges of maternal attachment form often irrespective of the pregnancy having been intended or wanted."

51. Published research shows that even in women seeking abortion, maternal attachment to the unborn child has been demonstrated. For example an Australian study of women attending an abortion clinic revealed that 40% of the women reported talking to their unborn child, and 30% endorsed "patting my tummy affectionately." (Allanson & Astbury, 1996). Additionally, 50% of the women stated that they had thought about whether it was a boy or a girl, and 50% also stated that they had "thought or daydreamed about what kind of mother I would be." These thoughts and behaviors indicate attachment to the unborn child.

52. More recently, a Swedish study collected information from 499 women who had requested abortion (Stalhandske, et al., 2012). Sixty seven percent of these women "thought of the pregnancy in terms of a child." This was one of several "existential components" that "correlated to difficulty in making the abortion decision and poor psychological wellbeing after the abortion." It is worth noting that 97% of the women in this study were still within their first trimester at the time of the abortion, thus, it is seen that this bonding takes place early in pregnancy among women seeking abortions.

53. In addition to asking questions that could be answered as "yes" or "no" and questions using a numerical rating scale, women were invited to comment in their own words. One woman stated, "Immediately when I found out I was pregnant, I felt like a mother. It felt like I had some kind of affinity with the child, and now afterwards, it feels empty," (Stalhandske, et al., 2012) indicating that this mother experienced maternal-child attachment very early in pregnancy, at the time she first discovered the pregnancy.

54. Another woman stated, "I lit a candle for the little one and asked for forgiveness," which is another example of maternal-fetal bonding since there would be no need to light a candle "for the little one" or ask forgiveness, unless the woman experienced the existence of some relationship that was being affected by the abortion (Stalhandske et al., 2012). Almost half of the women reported that they had done some special action such as asking for forgiveness following the abortion. The authors particularly noted that Swedish society is very secular, with only one third of Swedes considering themselves "religious," and with only 2% holding the belief that abortion is never justifiable, indicating a much higher level of support for abortion among their population compared to other western countries including the U.S.. Nevertheless, a high percentage of Swedish women in this study reported attachment to the unborn child and felt a need for "special acts."

55. The authors concluded that "women's experiences of abortion can include…feelings of attachment to the foetus….." (Stalhandske et al., 2012). The authors pointed out their study supports previous findings "that women who terminate a pregnancy can describe feelings of maternal attachment to their pregnancies" (Stalhandske et al., 2012, citing: Halldén et al., 2005; Allanson & Astbury, 1995). Prenatal bonding can and does take place in a sizable number of those women seeking abortions, and this recent study confirms that the presence of the attachment is associated with poor psychological outcomes (which confirms what was stated by Baker & Beresford, 2009, that attachment to the pregnancy is a risk factor for mental health problems after abortion.).

56. Rue et al. (2004) in a study of post-abortive women from a general gynecology population found that 37% of Russian women and 39% of American women reported they had felt emotionally close to or attached to the pregnancy / child, and only 24% of each group said they experienced "no bonding," while the remainder were "unsure."

57. While it is impossible to know the precise number of women who have undergone abortions and at the same have experienced some bonding to their unborn child, clearly a substantial number report experiencing bonding.

58. Consider also the statements of women concerning their personal experience of prenatal bonding prior to abortion. MKK is a woman who had an abortion in Rapid City, South Dakota, in 1978. See Exhibit B-2, Bates 1711. In her 2005 affidavit she stated, "Even though my abortion was in the first few weeks of pregnancy, there was still a connectiveness with the baby within me. Whether a physically formed baby is visible or not it is a real baby and we (mother and baby) were connected." This is similar to the statements of many women in my clinical experience.

59. Joanna (pseudonym) is a woman I know who has given me permission to tell her abortion story. Joanna was 16 years old when she became pregnant. She said, "I knew it was a baby. I was excited about the baby. I wanted the baby, and mom was getting excited, too." She was trying to make a plan for her baby's future, considering various options including possibly adoption though she reported that she was trying to figure this out on her own with "no counseling whatsoever." While she was still trying to find options, her boyfriend's father made the appointment for the abortion. She said that "at the time of the abortion, I wanted the baby." But she also says, "I didn't feel I had any

choice." After a visit to a doctor to initiate an abortion procedure, she was taken home where she passed her baby in the toilet. "There the baby was, a perfect little baby boy. I thought, oh, my God, what have I done." This example is one of numerous of reports I have heard from women in my clinical experience, indicating prenatal bonding prior to an abortion. Clearly, the fact of an abortion taking place cannot be assumed to mean that no maternal-child attachment took place, nor does it mean that the mother did not want the baby. One could attempt to make the case that Joanna is "different" from other women seeking abortions in that she "wanted" the baby who was aborted, but in reality, that makes her very similar to numerous women I know who had abortions that they didn't want and in many cases tried to avoid.

60. In my opinion, there is clear evidence that maternal – child attachment or bonding is experienced by a significant number of women even those who obtain induced abortions, and even during early pregnancy, within the first trimester.

(2) Long duration of attachment to aborted child

61. Speckhard (1997) states that "the attachment to the developing fetus/embryo may persist despite its death," which can include miscarriage, stillbirth or abortion.

62. In a study by Dykes et al. (2011, first published online in 2010), women at the age of menopause were asked to discuss their thoughts and feelings concerning their past abortions that had taken place decades earlier. All the women in this study reported that they continued to think about the child they had aborted many years previously, expressing long lasting attachment and unresolved grief. This study clearly shows that

maternal-child bonding can persist for decades after an abortion. Some examples (using pseudonyms as given in the published study):

a. Jenny said, “I’ve always thought of him … wondering how old he’d be, I do wonder about that child” (Dykes et al., 2011).

b. Elaine said, "This child of mine would have been (number of years) this month," referring to the expected due date she had been given for her pregnancy. She said, "I still think about this baby…I don't think I'll ever forget if I live to be a hundred" (Dykes et al., 2011).

c. Tina reported “wondering what it would have been like now, how old would it have been” (Dykes et al., 2011).

63. MKK (SD, also quoted above) had reported bonding prior to the abortion, but the attachment also persisted for years. Twenty-seven years after her abortion, she reported continuing to think about her aborted child: "I often wonder if it was a girl or a boy." See Exhibit B-2, Bates 1711.

64. CL, who had an abortion in South Dakota in 1984, and signed a declaration in 2008, stated, 24 years after the abortion, "I think about the child I aborted almost every day." See Exhibit B-2, Bates1715-16.

65. Debbie L. Otto (real name) had an abortion during 1975, and later signed an affidavit in 2001 in Montana, in which she referred to her two living daughters then stated: "I've never quit thinking about my other baby [her aborted baby] who would be 25 ½ by now - I've had nightmares and depression…Abortion not only kills a baby -- it hurts women who bear the shame and guilt silently -- it touches every aspect of her life exactly

like it would to give birth and to kill it then." See Exhibit B-2, Bates 1673. This is an example of a woman who has been remembering her aborted child for more than 25 years, who also reports experiencing shame, guilt and emotional distress during this entire period of time. She said, "I'll never get over it as long as I live."

66. Statements such as these, the statements from women in the study and the statements made by MKK, CL, and by Ms. Otto, are very similar to the statements I have heard frequently in my clinical experience with women who have had abortions. Numerous women have come to me with unresolved abortion issues, from abortions that took place, 10, 20, or 30 years ago, and sometimes longer.

67. Rose (pseudonym) had an abortion at age 17, in 1975 (Shuping & Gacek, 2010; Shuping, 2011). She said, “I really wanted this child, but I didn’t know what to do.” She paid for the abortion herself through savings from a job, and through selling some treasured possessions. She reported that after the abortion, "I thought about him every day," wondering about the color of his eyes, the color of his hair, whether he would like sports. She had learned her child was a boy, so she read books about infant care to learn about baby boys. In this case, bonding not only persisted beyond the death of the unborn child, but actually grew stronger over time, through her continued thoughts and activities (such as reading infant care books). This has occurred with some of my patients, and has been noted in the published literature.

68. Rose discussed how as the years went by, she married and had children, but the memory of the aborted child intruded into her family life and impacted her relationships

with her husband and children for many years, an example of the long duration of attachment to the aborted unborn child that many women experience.

69. Mary (pseudonym) went to nursing school after her abortion (Shuping & Gacek, 2010; Shuping, 2011). She reported that during her training, "I was working the ER, and a young woman came in pregnant, cramping. I was helping to examine her as she miscarried, and in my hand, I could see the baby. It made me think of my baby, and I wanted him back." The miscarried baby was about the same gestational age and size as the baby she lost to abortion. This experience caused her to have distressing thoughts about her past abortion, and it was this experience that led her to seek treatment for issues related to the past abortion.

70. Mary's experience as a nursing student is a type of experience that for some women increases the bonding to their own fetal child. Some women who may have had limited attachment or no apparent attachment to their aborted unborn child at the time of the abortion may see something later that causes them to recognize their fetal child as a baby, and as "my baby," increasing feelings of regret, guilt, grief, or other negative emotions associated with the abortion. For some women, this occurs during a later, intended pregnancy when the women sees the ultrasound image and realizes her own aborted child would have looked like the image she is now seeing, or during a later, intended pregnancy when she hears a fetal heartbeat and realizes that the aborted child would also have had a heartbeat . Or a nurse or other healthcare professional who had an abortion in the past may later encounter fetal images or a miscarried baby as Mary did,

which may then lead to increased attachment to the aborted child, and increased distress over the death of the aborted child.

71. I have heard testimonials of this type of occurrence from a number of my patients, who have sought treatment for psychological problems and disorders which they have associated with a past abortion, and which I have diagnosed as being associated with a past abortion. Events such as this sometimes contribute to a much greater degree of attachment to the aborted child and contribute to greater distress later, even years after the abortion, when the woman becomes aware of the aborted baby as her child and then experiences distress at the child's death through abortion. Speckhard has also observed that, 'in the case of a woman who learns more about fetal development later a delayed post-traumatic reaction may result" (1999). For some women, in my clinical experience, it is these later experiences that lead them to seek counseling or abortion recovery programs.

72. Some women report an experience of attachment to their baby occurring at the moment of the abortion or immediately afterward, and women have reported that they experienced the abortion as the death of their child.

73. For example, Joy (MN) was only 7 weeks pregnant at the time of her 1995 abortion, but in her 2008 declaration she stated, "During my abortion I physically felt the life of my baby being literally sucked out of me, and if I could have stopped it right then, I would have, but I knew it was too late for her." See Exhibit B-2, Bates 1632 to 33. Thus, in that moment, she recognized the unborn child as "my baby," recognized that the abortion was taking the life of her baby, and would have stopped it at that moment had it

been possible, but the procedure was already in progress. For Joy, the attachment to the aborted child persisted over many years, associated with distress at the loss of her aborted child. She stated, "For many years I suffered deep mental anguish over the loss of my baby. I relived the abortion procedure over and over and was traumatized by it. I hated myself for killing my baby and worried constantly…..I had flashbacks to the procedure for years afterward."

74. Jody Clemens (ND) in her declaration (Exhibit B-1, Bates 1119-20), states, "My name was called and I was ushered back to the procedure room where I underwent an excruciating and painful procedure. I cried. What I had worked to successfully deny and dehumanize now became a reality. I knew my baby was dead and what I had done I could never undo." Ms. Clemens did not report any prior experience of attachment to her baby; but at some moment during or immediately after the procedure, she did experience attachment to her baby, an attachment that has persisted over many years, also associated with distress over the loss of her baby. "The years that followed my 'free choice' were lost years in many ways. I engaged in self-destructive behavior and was emotionally exhausted as I worked to keep my secret…..I suffered in silence for ten years living with shame, guilt, and grief…..My child died that day and I will forever be hurt by that loss every day."

75. Terry Melby of North Dakota, who has submitted testimony concerning her abortion (Bates 1123-24), states, "After the abortion, I realized that I had taken the life of my child. No one told me that; I instinctively just knew it." See B-1, Bates 1123-24. She asks, "How could a good mother kill her own child?" and states that after the abortion, "I

began to drink very heavily and daily. I engaged in reckless, self-destructive behavior, drinking and driving with my kids in the car. I desired to become pregnant again, to replace the baby I had just lost. I was suicidal, and nearly completed a suicide plan less than a month after the abortion. I suffered with physical complications caused by the abortion. Everything in my life changed after the abortion, and it took years to recover from it." From Ms. Melby's statement, she understood the unborn child as "my child," she believed that she had "taken the life of my child," experiencing this as the death of her child. She blamed herself harshly for causing her child's death, and clearly suffered mental health consequences following the abortion. She experienced ongoing attachment to her child over many years, stating, "My child would be 32 years old now," and she states it took "years to recover" from the effects of the abortion.

76. These statements made by Joy (MN) (¶ 73 above), by Jody Clemens (ND) (¶ 74 above), and by Terry Melby (ND) (¶ 75 above) are similar to reports given to me by patients within their medical and psychiatric history which I have considered in the course of psychiatric evaluations, in which I have diagnosed psychiatric symptoms, problems and disorders associated with past abortion(s).

77. Based on the foregoing, it is my opinion that even when pregnancy is unplanned, and occurs under challenging circumstances and results in an abortion, significant maternal bonding frequently occurs, and this bond can persist well beyond the unborn child's death, for many years, even decades, for many women. Some women who do not report prior bonding to the unborn child do experience awareness of attachment to their baby while they are undergoing an abortion procedure or immediately afterward, and

attachment arising at that time frequently persists for many years. Even when bonding may be weak or ambivalent at the time of the abortion, the attachment can persist and grow stronger over time. However, although this attachment persists after abortion, it persists within a situation of disruption and loss. The bonding is a natural process that serves to prepare the mother to care for her child after birth. When bonding is present, but abortion has occurred, the abortion is often a source of enduring psychological distress, experienced by many women. I will discuss below the effects of abortion when bonding has occurred, though some of the statements of women who have been quoted above have touched on some of the distress they have experienced.

78. Not all mental health problems or relationship problems following abortion are necessarily related to maternal-fetal attachment. It is important to recall that there are other risk factors besides "attachment to the pregnancy," and mental health problems that can occur whether or not bonding has taken place. Nevertheless, the experience of abortion in a context of maternal-fetal attachment is a very important and unique risk factor which requires further consideration as below.

(3) Psychological, Emotional and Mental Health effects of abortion when maternal - fetal bonding has occurred

79. A 2004 study by Rue et al. revealed that for both American and Russian women, bonding to the unborn child was predictive of a negative psychological outcome. Earlier published literature has reported that the degree of bonding is predicative of the degree of trauma symptoms that are experienced after abortion. (Speckhard, 1985; Speckhard, 1987; Speckhard, 1997; also Speckhard & Rue, 1992).

80. Speckhard (1999) has stated that "When maternal attachment occurs in pregnancy, even very early pregnancy, the traumatic disruption of this attachment bond is capable of causing enduring psychological damage. The consequences of disrupting maternal attachment via abortion can include psychological trauma and bereavement resulting in complicated mourning."

81. Kersting et al. (2007) stated, "The traumatic loss of an unborn child by induced termination of pregnancy because of fetal malformation is a major life event that causes intense maternal grief." Here, Kersting is only considering terminations associated with fetal malformation and not due to other reasons. The purpose of this study was to identify, through measurements of brain activity, which parts of the brain were affected by grief associated with fetal loss. The study compared post-termination women with women who delivered a healthy child. The brain activity was different in the women who terminated, who demonstrated "an involvement of the neural maternal attachment network in grief after the loss of an unborn child." Thus, there is an actual biological basis for the grief after loss of an unborn child.

82. Returning to the study by Dykes et al. (2011), which involved women who had chosen to terminate for non-medical reasons (elective abortions), "participants described the long-term emotional impact of their termination of pregnancies as predominantly negative…..” From some of the interviews, it appears that time has not diminished these negatives which the women reported (see quotations from the women of this study, below), and for some women, the impact is the same or greater now than at the time of

the abortion. Negative emotions included shame, guilt, and regret, with some women reporting nightmares, flashbacks and additional symptoms.

a. Ann said, “It’s haunted me to be honest, I’m ashamed, I think it’s just something else I have to hate myself about” (Dykes et al., 2011).

b. Claire said, “I’ll probably have nightmares the rest of my life, I hate myself so much” (Dykes et al., 2011).

c. Elaine stated that the abortion was "wrong," stating, "I feel worse than a prostitute." She also made it clear that her feelings about the abortion related to her action in ending the life of her fetal child: "I was just so depressed, I didn’t want to live anymore, I was suicidal and I started drinking, because all I could think about is that I’ve murdered this baby…” She stated she had originally "thought it would be okay," when she chose abortion, but it affected her "a lot more than I ever thought it would" (Dykes et al., 2011).

83. In considering whether they think about the abortion more or less now that they are menopausal (Dykes et al., 2011), Mary said, “As I’ve got older I feel guilty and more aware of what I did … I think about it more now.” Elaine said, “I’ve never not thought about it, but it never hurt me as much as it has now, I feel as hurt as I did when I first had it done.” Barbara also reported she thought about it more as she got older. Clearly, the emotional impact can remain as intense, or can worsen as the years go by. This study was small and not designed to be generalizable, but it does show that for some women, the intensity of the distress can persist or worsen over time, which has been shown in other

studies. Acknowledging that the methodology was not intended to lead to generalizations, the authors (Dykes et al., 2011) did recommend, based on this study, that women should have access to "post-termination" counseling "throughout life," apparently due to the long lasting negative reactions that these women reported.

84. In the case of Rose (see ¶ 67 above) who had experienced bonding to her child before the abortion, she stated, "I didn't anticipate how strong the feeling of loss and regret would be. Even before the abortion, I already felt shame and guilt, but I didn't think I would have all the regret which I did almost immediately." Her negative feelings were very severe: "I hated myself after the abortion and tried to commit suicide." Soon after the abortion, she attempted to shoot herself but the gun misfired, then took a massive overdose of pills as a suicide attempt but after sleeping for two days, awakened unharmed. (Shuping & Gacek, 2010; Shuping, 2011) She continued to experience abortion related mental health problems and problems with family relationships for many years until receiving help through an abortion recovery program.

85. MKK (SD, see Exhibit B-2, Bates 1711) who reported bonding prior to her abortion, and lifelong persistent attachment to her aborted child, reported lifelong distress. "Year after year I kept my secret, and year after year I suffered not only the pain of losing my child but the guilt and shame of what I had done. I cannot tell you the mental anguish that that abortion has had on my life."

86. Erin Hill is a North Dakota woman who had an abortion at age 16 and who has submitted written testimony for this case (See Exhibit B-1, Bates 1125-26). She was a young woman who unknowingly went into an abortion with multiple risk factors present.

Ms. Hill stated that she "really wanted to keep my baby," but "decided that I had to have an abortion," indicating that she was experiencing ambivalence which is a risk factor for negative reactions after the abortion (Baker et al., 1999; Baker & Beresford, 2009; Coleman Report, Exhibit D). Adolescence has also been determined to be a risk factor (Coleman report, Exhibit D; Curley & Johnston, 2013; Mulfel, 2003; Shuping, 2011; Speckhard & Rue, 1992).

87. Ms. Hill was also experiencing attachment to her baby. When she attended a counseling session, she says she "cried the entire time….. I remember the counselor asking me why I was crying. I was upset that she had to ask. 'I'm here to have an abortion. To kill my baby.'" Prior to the abortion she was already thinking of the pregnancy as "my baby," and she considered the abortion as the killing of her baby. She reported that during the abortion procedure, "I cried the entire time, saying 'I'm sorry, I'm so sorry' over & over. The nurse held my hand and asked why I was sorry. I told her I was telling my baby I was sorry because I didn't know what else to do."

88. Not surprisingly, Ms. Hill reports a negative reaction to the abortion, stating, "It poisoned my life." She reported that she became promiscuous and began to drink, also suffering from depression. These are some of the negative reactions that were listed in *Clinician's Guide* (Baker et al., 1999) as being associated with abortion for some women, and many of my own patients have reported these symptoms as being associated with their abortions, and I have diagnosed these symptoms as being associated with my patients' past abortions.

89. Speckhard (1999) states, "For the woman whose individual meanings define pregnancy as involving the conception of a human being, abortion is a human death event. This death event is further complicated for the women who has formed an image of her fetal child and who has begun an attachment to this child; abortion then becomes defined for her as the death within her body of "my own child."

90. We see an example of what Speckhard was describing in Erin Hill, who said, "I'm here to have an abortion. To kill my baby." MKK (SD) (see B-2, Bates 1712) also expresses the concept of killing her child: "We who have had abortions have chosen to kill our children. We understand, too late, what we have done. I must live with the fact that I chose my reputation and my social appearance over the life of my child. It was my choice and I regret it to this day."

91. Speckhard (1999) states that "trauma researchers generally agree that abortion is capable of causing enduring psychological harm for some women. Abortion for the woman who defines her unborn child as her own child, involves a death experience which is volitional, intended, and horrific, even more so for the woman who becomes aware of details of her abortion experience." She states that even though a "crisis pregnancy" can be stressful, abortion is a unique "stressor by virtue of containing a traumatic death event capable of engendering deep and enduring psychological trauma." Speckhard (1999) states, that "traumatic stress from an abortion event can function as the basis of the etiology of a number of …psychopathologies," including posttraumatic stress disorder and other disorders. "For the woman who perceives the fetus as human and who may have formed an attachment, the abortion stressor event is defined by her as the actual

death of her offspring." Speckhard testified that "for these women, abortion is experienced as…a human death experience from which PTSD can follow" (testifying according to the diagnostic criteria in place at that time).

92. In the examples of Joy (Exhibit B-2, Bates 1632-33), Jody Clemens (Exhibit B-1, Bates 1119-20), and Terry Melby (Exhibit B-1, Bates 1123-24), above, each has reported experiencing the unborn child as her own "baby," and each experienced the abortion as the death of her baby. Each of these women experienced this as intended and volitional, as each was at the clinic for the purpose of having an abortion and each was at the clinic by her own choice, and not by force. Each experienced the abortion as a source of enduring emotional distress over many years. The testimonials of these women are very similar to testimonials of many women who have come to me seeking professional help for mental health symptoms, problems and disorders that they attribute to a past abortion and that I have diagnosed as attributable to a past abortion.

93. In reviewing the published literature concerning the impact of maternal-fetal attachment in the context of abortion, there is some clarification needed, concerning attachment that persists beyond death, and "disruption" of that bonding when abortion takes place. "Disruption" could perhaps be understood as meaning the cessation or termination of the relationship, but this is not what occurs, based on women's statements, and based on the published literature. From careful review, I would clarify as follows: It is very frequent, even in the first trimester, for maternal – fetal bonding to take place. Even when an abortion takes place, the woman still has attachment to the unborn child, with whom she has identified as "my baby," but the baby is gone and the relationship is

forever altered in a way that is experienced as a loss and as a death experience for the woman which is a source of enduring emotional distress for the woman.

94. To make a comparison, if a woman's mother died, even though the mother is no longer physically present, the relationship persists in some fashion, in the thoughts and memories. The woman still refers to the mother as "my mother" and she may do certain things to respect or honor her mother, for example, giving to a charity that was important to her mother, or even making a career decision based on her mother's previously expressed desires. Alternatively, if the relationship were conflicted, the daughter might make decisions of which her mother would not approve, and the daughter might even take satisfaction in the decisions. But there is a sense in which there is still a relationship after death; there is still "my mother" in thoughts and memories, but at death, that relationship is forever altered, and a loss is experienced since the person is no longer physically present, and the opportunities for future companionship or interaction are no longer present.

95. For the many women who bond to their baby prior to or during the abortion (or who experience delayed bonding which occurs at a later time), the bonding very often persists for years, even decades, but it becomes a source of emotional pain, since the child is no longer available for the relationship which the mother may later desire—or which she may have desired even at the time of the abortion. The bonding does not end with the death of the child, nor does the perceived relationship end with the death of the child, since the mother who has already bonded to her baby may still consider the baby as "my baby." But the opportunities for enjoyment of that relationship and for interaction

are gone, and opportunities for continued development of that relationship are extremely limited. A mother may choose to read baby care books, as Rose did, with the desire to maintain some connectedness to her child, and the attachment may actually increase through such behaviors. The relationship is now characterized by loss. The actual opportunities for a living relationship with the child no longer exist. The mother cannot physically breast feed the aborted child or kiss her child goodnight, cannot watch the child play baseball or see him graduate from college. As Lisa (MN), stated in her 2009 declaration, "Abortion takes a life away, one that I can only dream of having gotten to know and raise." See Exhibit B-2, Bates 1652-53. The bonding or attachment does not end, and the relationship does not end, but the relationship is characterized by disruption and loss and it becomes a source of pain, particularly for those women who experience the abortion as described by MKK (SD) in her 2005 affidavit, "We who have had abortions have chosen to kill our children." See Exhibit B-2, Bates 1711. For many women, a relationship they now desire with their aborted child is no longer accessible to them, and they live with the knowledge that the lost opportunities, and the physical death of their child, came about by their own decision.

96. Thus, in my opinion, maternal-fetal bonding or attachment (mother-child bonding to the unborn child) is a source of significant, enduring psychological, emotional and mental health distress for many women who have abortions. In my opinion, many women experience abortion as a death experience, in many cases experiencing this as the death of "my baby." For those women who experience abortion as a death experience, and especially as the death of "my baby," this death experience is a trauma sufficient to give

rise to Posttraumatic Stress Disorder as will be discussed below. In my opinion, the death experience of this maternal-fetal bonding from an abortion also increases the risk for other psychological, emotional and mental health disorders in addition, but here we will specifically discuss Posttraumatic Stress Disorder.

(E) Posttraumatic stress disorder after abortion (PTSD)

97. It should be noted first of all that the American Psychiatric Association (2013) has recently published a new diagnostic manual in which diagnostic criteria for many disorder have been modified, which is the case for the diagnosis of Posttraumatic Stress Disorder (PTSD). Thus, studies and reports which were published prior to 2013 were based on slightly different diagnostic criteria. Particular points within the diagnostic criteria have changed, but the main symptoms are in essence the same as before despite some changes. There are a number of specific criteria that must be met in order for this diagnosis to be made.

98. According to the American Psychiatric Association (2013), the diagnosis of Posttraumatic Stress Disorder (PTSD) starts with "exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways," which can include "directly experiencing the traumatic event(s)," "witnessing, in person the event(s) as it occurred to others," or "learning that the traumatic event(s) occurred to a close family member. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental."

99. Speckhard (1999) has testified, "For the woman who perceives the fetus as human and who may have formed an attachment, the abortion stressor event is defined by her as

the actual death of her offspring…..for these women, abortion is experienced as…a human death experience from which PTSD can follow," testifying according to the diagnostic criteria in place at that time that abortion presented a type of death experience that could serve as a trauma that could lead to PTSD.

100. Using current diagnostic criteria for PTSD, we will consider examples from the affidavits and declarations and also examples from published research to demonstrate how these PTSD criteria are frequently met by women who have had abortions. I discuss the criteria at Paragraphs 101-103 (directly experiencing the traumatic event), 104-105 (witnessing, in person the event(s) as it occurred to others), 106-107 (learning that the traumatic event(s) occurred to a close family member) and 108-117 (abortion as violent death).

101. **Directly experiencing the traumatic event:** For women having an abortion, who have experienced the abortion as the death of "my baby," there has been a death experience which they have directly experienced—the death of their baby in their own body. In considering the statements of Joy, (Exhibit B-2, Bates 1632-33) Jody Clemens (Exhibit B-1, Bates 1119-20), and Terry Melby (Exhibit B-1, Bates 1123-24) in describing their abortions, it could be said that they directly experienced the traumatic event, in that they were aware of the death of their baby in their own body at the time of the abortion. Karen Choma (MN) stated, "When the baby was aborted, I instantly and instinct[ively] knew I had ended a life," directly experiencing the ending of a life. Exhibit B-2, Bates 1639. I have heard similar reports from my own patients, and similar

examples have been included in published literature, for example, Speckhard & Rue (1992).

102. Although above we considered the woman directly experiencing the trauma of her baby's death, a woman having an abortion also or instead directly experiences "threatened death or serious injury" involving her own life. Mary A. Hill-Griffith (FL) (one of the *Gonzales* affidavits) stated that "immediately after abortion" she experienced severe hemorrhaging that required an "emergency D & C" procedure. By her report, she apparently believed herself to be at risk of death. See Parker Affidavit, Bates 1143-44, 1427.

103. Linda Huffstetler (TX), in her 2013 declaration, tells about experiencing severe life threatening complications when she had a first trimester abortion at 7 weeks during 1977. She says, "During the abortion the nurses told me I almost didn't make it and there was complications…..I was in recovery for the next 10 hours." Exhibit C, Bates 1753-54. She survived an experience in which she was told she almost died, and she also talks about the death of her baby through the abortion, so for her both types of traumatic experiences were present. Ms. Huffstetler states that she was later able to find reports that 14 young women had died during abortion procedures with the doctor who performed her abortion, and she has reflected on the possibility that she could have been one of those young women. She reports that she had PTSD for more than 30 years, and she lists a number of PTSD symptoms that we will review below including guilt, shame, anxiety, fear, anger, and nightmares.

104. **Witnessing, in person the event(s) as it occurred to others:** In cases in which women may have been exposed to fetal parts in the process of the abortion, it may be said that they witnessed "in person the event as it occurred" to their baby. I have had patients who have reported to me that they have seen fetal parts during the course of a surgical abortion, and this has been reported in the published literature (Speckhard, 1987; Selby, 1990). Additionally, in medical abortion by use of RU-486, it is common for women to see the expelled unborn child during the abortion procedure which is typically completed at home. I have had patients who have had medical abortions and have seen the expelled unborn child, and this has been reported by Hallden et al. (2009).

105. In later abortions, some women have experienced the baby's increased movements during the procedure and then the cessation of movement, which has been reported to me, and which is another way in which the woman may be a "witness" to the death of the unborn child.

106. **Learning that the traumatic event(s) occurred to a close family member:** In some cases, the precipitating event may have involved the situation of learning that the traumatic death occurred to a family member, their baby. An example of this is the case of Mary (Shuping & Gacek, 2010; Shuping, 2011) who as a nursing student held in her hand a miscarried baby and then realized that her own previously aborted unborn child would have been at that age and stage of development. A woman who experiences attachment to her baby at a later time and at that time comes to appreciate the meaning of the abortion as the death of her own child would be in a situation analogous to someone learning about the death of a family member at a later time.

107. The 2008 declaration of Patty Miller (SD) gives another example of this type of experience. Exhibit B-2, Bates 1740-41. She had a first trimester abortion at 8 weeks, and states, "The day I had my first child and held him in my arms was the day I realized I had truly killed two other babies with my poor 'choice.' The pain of realizing what I had done nearly killed the joy of receiving this new baby in my arms."

108. **Abortion as violent death:** Regarding the concept of abortion as a "violent" death, many of the women who have had abortions have given statements that indicate their understanding of the abortion as an act of violence.

109. Joni Lineberry (MT) in her 2010 declaration concerning her first trimester (10 weeks) abortion in 1975 stated, "I was not informed of the horror and pain that my baby would feel." Exhibit B-2, Bates 1688-89. Without commenting on research data as to what her unborn child may have experienced, clearly it is Ms. Lineberry's belief that her baby suffered because of the abortion, and it is her belief about the nature of the death experience that is relevant to her experience of the abortion as the traumatic death of her baby.

110. Linda Prok (MN) in her 2008 declaration concerning her first trimester abortion in 1981 stated, "No one told me that I would have to wait on the table while the doctor made sure that all the baby's parts had been removed. Now it was no longer 'tissue' as they had said, the baby had a body." Exhibit B-2, Bates 1650-51. It is usual that the physician or other personnel would check to make sure that all fetal parts were accounted for, because if fetal tissue were left inside the woman, complications such as infection or bleeding could follow. However, for Ms. Prok, her awareness that her baby "had a body" that was

in "parts" seems to have given her an understanding of her baby having experienced a violent death. She reports for more than 20 years she "suffered with the thought that I had taken my child's life," and carrying "the guilt for what I had done throughout my life." She also reported experiencing long lasting shame even at the time of the declaration, 27 years after the abortion.

111. Loretta Bingham (FL), in her affidavit (one of the *Gonzales* affidavits) stated, "I was called back into the clinic because they thought they hadn't gotten all the baby out of me." (See Parker Affidavit, Bates 1161, 1279.) "In my mind, I kept seeing an infant with its arms and legs pulled off. Twenty years later – it still hurts."

112. Darlene Crumbo (CA) in her affidavit (one of the *Gonzales* affidavits) stated, "It hurts so bad to think of the child I could have had. To think of the baby that was sucked out of me like a vacuum cleaner." See Parker Affidavit, Bates 1172, 1299.

113. Kristen Frank (MN) signed a declaration in 2008 concerning her 2007 abortion at 9 weeks. Exhibit B-2, Bates 1641-43. She stated, "I didn't realize that the 'scraping' and vacuum actually break up the being into pieces before it is sucked out. It's just extremely mutilating….." She also speaks of abortion as "killing your own child" by allowing another to use "instruments" to "mutilate your baby and then suck it out with a vacuum."

114. Rashel Brown (MT) signed a declaration in 2010 concerning her 1998 first trimester abortion. Exhibit B-2, Bates 1701-02. She gave a graphic description of what she believed occurred to the body of her unborn child during the abortion, and expressed her belief that the unborn child feels pain, a belief echoed in a number of the affidavits and declarations. She also stated her belief that killing the unborn child is "murder."

115. Many of the women who submitted affidavits and declarations used the term "murder" to describe their abortion, for example, Lisa (MN) who signed a declaration in 2009, stated, "Abortion is murder," and a number the women speak of their abortion in that way, or of the baby as having been murdered. Exhibit B-2, Bates 1652-53. Deanna Hall (CA) in her affidavit (one of the Gonzales affidavits) stated, "When I woke up in recovery, I immediately knew the horror of what I had done…..I am a murderer….." defining herself as a murderer. Parker Affidavit, Bates 1166, 1287.

116. I should add that none of the abortion recovery programs that I have served as a consultant have defined abortion as "murder," nor do the workbooks or participant manuals of any of the major abortion recovery programs in the U.S. use this term. The forms on which some of the affidavits and declarations are written include some questions in many cases, but none of the forms use the word "murder," and some of the women's statements were typed or written on blank paper without any specific questions to direct their answers in any way. Nevertheless, a number of women, in the affidavits and declarations, have spontaneously used the word "murder" as their expression of how they view the death of their aborted child. The women themselves often use the term "murder" in the affidavits and declarations both to describe the experience of their baby, and in judging their own action. Many of my own patients have also used the term "murder" in discussing the abortion when seeking treatment for abortion related mental health problems.

117. Speckhard and Rue (1992) refer to national polling data from *The Los Angeles Times* from 1989 (Skelton, 1989) indicating a majority of Americans (57%) viewed

abortion as murder. A more recent *Los Angeles Times* poll (Rubin, 2000) revealed that 57% of Americans still viewed abortion as murder. Elaine (in the study by Dykes et al., 2011), stated, "all I could think about is that I've murdered this baby…" Since Elaine is English, this would indicate that this viewpoint is not uniquely part of American culture, though it is a widespread belief in the U.S. In any case, many of the women themselves within the declarations and affidavits have reported viewing abortion as murder, which indicates that these women are viewing the abortion as a violent death, and this is similar to what my own patients have reported to me in discussing their psychiatric problems which they attribute to the abortion, and which I have diagnosed as being associated with their past abortions. Clearly, many women who have had abortions view the abortion as a violent death.

118. Prior to 2013, the previous criteria specified that "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," and also specified that the person's response involved "intense fear, helplessness or horror." (American Psychiatric Association, 1994). In either case, whether using old or new criteria, the death or threatened death was the initiating experience, but a number of specific types of symptoms must follow for the diagnosis of PTSD to be made.

119. There is abundant evidence that a substantial number of women do in fact experience PTSD after abortion. In order to make this diagnosis, after the death experience, there are currently four types of symptoms that must be experienced. To illustrate the types of symptoms in each category, I will use examples from my clinical

experience, from the published literature, and from the affidavits and declarations of post-abortive women. However, it is not my intent to state or imply that any of the women quoted actually have PTSD, since that diagnosis could only be determined by an individual psychiatric or psychological evaluation. But a number of women have reported specific symptoms that are characteristic of PTSD, and their statements are used below as examples.

120. **PTSD intrusion symptoms:** These include:

a. "recurrent, involuntary, and intrusive distressing memories of the traumatic event(s),"

b. "recurrent, distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s),"

c. flashbacks "in which the individual feels or acts as if the traumatic event(s) were recurring."

d. "intense or prolonged psychological distress at exposure to …cues that symbolize or resemble an aspect of the traumatic event(s)."

121. Intrusive, distressing memories were reported by Ruth Ruch (ND) in her statement (Exhibit B-1 Bates 1121-22). She says that after the abortion, "I tried so hard to erase the memory of my abortion." Her statement that she "tried" to eliminate the memory would seem to indicate that she the memory was involuntary. Her statement that she tried "hard" to erase the memory indicates some effort was required, and in the next sentence states she "struggled with alcohol addiction and thought of suicide often," which seems to reflect on the degree of distress she experienced from these memories. Much

later, "When I became pregnant with my last child, 14 years later, I studied furiously all the baby development books I could. I realized what my aborted baby looked like at 8 weeks and the memories came flashing back in tidal waves." These memories were sufficiently distressing to Ms. Ruch that, although pregnant at the time, "Once again, I began drinking heavily."

122. Nancy Hook (SD) states in her affidavit, referring to her abortion, "There is barely a day that goes by that I don't think about it," even after thirty years. Exhibit B-2, Bates 1739. Similar statements can be found throughout the affidavits and declarations, and I have frequently heard similar statements from numerous patients who I have evaluated for abortion-related psychiatric problems and disorders, similar in that the memories connected with the abortion are often present on a daily basis, persisting for many years. The memories can be so consuming, taking up so much of the woman's thoughts, that it interferes with normal life, as expressed by Ruth Ruch (ND, above) who stated, "It robbed me of nearly 20 years of my life."

123. Nightmares were reported by Claire in Dykes' study (2011), and by Debbie Otto (MT, Exhibit B-2, Bates 1673). Dianne Heynen (SD) in her 2008 declaration said, "I had no idea it would still be haunting me now after twenty-nine years…..Just last night I had an abortion related nightmare" (Exhibit B-2, Bates 1725-26). Pamela Berry (TX) said in her affidavit (one of the *Gonzales* affidavits), "I had nightmares of babies crying" (Parker Affidavit, Bates 1161, 1280). Teresa Renee Zell (NC) (one of the *Gonzales* affidavits) is another one of many who reported nightmares (Parker Affidavit, Bates 1153, 1264). As

noted above, *Clinician's Guide* (Baker et al., 1999) had listed nightmares about babies as a possible symptom of guilt, but it is also a symptom of PTSD.

124. Flashbacks were reported in the study by Dykes et al. (2011). Joy (MN, Exhibit B-2, Bates 1632-33), reported flashbacks in her affidavit, stating, "I had flashbacks to the procedure years afterward." Darla Weaver (TX) in her 2002 affidavit (one of the *Gonzales* affidavits) stated, "I can drive down the street and flashback to the abortion table" (Parker Affidavit, Bates 1156, 1269).

125. Intense distress at a cue that resembled the past trauma was reported in the affidavit of S.T. (TN) (one of the *Gonzales* affidavits): "Having the D & C after miscarriage brought back horrible memories of the abortion" (Parker Affidavit, Bates 1152, 1263). Kay Kiefer (ND) (Exhibit B-1 Bates 1128-29) also describes this symptom of distress at reminders of the abortion: "Every time… I heard something about abortion, I felt like a hot spear went right through me."

126. Unfortunately for many women, babies are a reminder of the abortion, and thus it can be emotionally painful for them to be around other people's children, or even their own children. Sandi Taylor (MT), for example, says in her affidavit, "Now I want to burst into tears every time I see a mother and child" (Exhibit B-2, Bates 1703-1706).

127. Carrie Sanchez (SD), in her affidavit, said that soon after her abortion she went to visit "one of my best friends who had just had a baby boy. I am sure she has never figured out why when I held him I began to cry" (Exhibit B-2, Bates 1719-23). She stated, "Every time I see my friend's son who is now 10 years old I am sadly reminded of [the abortion]. It never goes away." She stated that after she was married and was again

pregnant, "At my first ultrasound, I was exactly 8 weeks pregnant. I heard the baby's heartbeat and began to cry. These were not tears of joy. I instantly thought that I had killed a heartbeat just like that 9 years ago."

128. Megan Petty (MT) in her declaration states, "Seeing babies hurts my heart," even thirty-five years after the abortion (Exhibit B-2, Bates 1709-10).

129. When women experience distress associated with reminders of the abortion, this can lead to avoidance symptoms as discussed below at paragraphs 130-134. Since babies and children remind some women of the abortion, this can lead to avoidance of babies and children.

130. **PTSD avoidance symptoms:** Avoidance symptoms include efforts to avoid distressing memories, or avoidance of people, places, or activities that serve as reminders of the abortion (a type of symptom that was also listed in *Clinician's Guide*, as above). Some women I know have reported driving miles out of their way to avoid driving past the abortion clinic. Some women avoid going for routine gynecological care because the examination reminds them of the abortion. Some women avoid family gatherings when babies would be present at holidays, or avoid baby showers for family members, because they do not want to be around babies or anything that would cause them to think about babies, because babies are a distressing reminder of the abortion.

131. Mary Ellen York (MI) stated in her affidavit (one of the *Gonzales* affidavits), "For years, I couldn’t even look at a baby and when I heard the word “abortion” I would just cringe" (Parker Affidavit, Bates 1153, 1265).

132. Becky Abell (OK) in her affidavit (also one of the *Gonzales* affidavits) states, "I avoided anything to do with babies." Ms. Abell married and gave birth to a son, five years after the abortion (Parker Affidavit, Bates 1150, 1259). She says, "It was during that pregnancy I realized I had destroyed a life through abortion. My downward spiral began."

133. Many women stated in the affidavits and declarations that they had trouble bonding with subsequent children born after the abortion, and I have heard these reports from many of my own patients. In cases in which the baby is a distressing reminder of the abortion, in which the woman then develops an avoidance pattern of behavior to avoid the painful emotions, it is understandable that bonding problems could arise with subsequent children, which has been reported.

134. The declaration of Tammy Litchfield (NC; one of the 4200) states that "the trauma of the abortion did not present itself instantly. I eventually was unable to even look at babies, be involved with baby showers or anything that pertained to a birth of any kind…..Years later, when I did become a mother, I was very…unloving. I held myself back from my children…..I could not even enjoy the birth of my children. I went through the motions numb" (Exhibit C, Bates 1750-52).

135. **"Negative alterations in cognitions and mood associated with the traumatic event":** Symptoms of PTSD in this category can include a "persistent negative emotional state, which could be, for example, "fear, horror, anger, guilt or shame." The statements submitted by MKK (SD, Exhibit B-2, Bates 1711), Debbie Otto (MT, Exhibit B-2, Bates 1673), and CL (SD (Exhibit B-2, Bates 1715-16) (already quoted in part,

above) each specifically mentioned both shame and guilt. Considering the 96 statements, declarations and affidavits, from women of North Dakota, South Dakota, Minnesota and Montana, more than half specifically state they experienced either shame or guilt, or both. Fifty three women out of the 96, more than 50%, specifically used the word "shame," or the word "guilt," or both words in their statement. Many of the women additionally mentioned feelings of "self-loathing," "disgust" for themselves, "worthlessness," "disgrace," or similar words that may have represented shame, though I only counted "shame" when that specific word was stated by the woman. Likewise, one woman made the statement that it took her "years" to forgive herself, and others made similar statements that may have represented "guilt," but I tallied only the number of women who specifically used the exact word "guilt." So, at least 53% of the 96 women reported guilt or shame, and many more expressed what was very likely the same emotion using other words. See Exhibits B-1 and B-2.

136. The report of guilt and shame by so many women is particularly important since many studies have focused these two emotions after abortion. One study showed that "shame-proneness was positively correlated with PTSD symptom severity," that those experiencing shame have more severe PTSD symptoms (Leskela et al., 2002). Also, the effects of shame and guilt can be very disabling, can prevent women from seeking help, and may "impede emotional processing of the event" (Lee et al., 2001). One study found that guilt and shame 10 days after abortion predicted high PTSD avoidance scores two years later (Broen, et al. 2004).

137. However, although guilt and shame are uniquely associated with PTSD in some studies, nevertheless, the diagnostic criteria do not require guilt or shame. There are seven different types of symptoms listed under the heading of "negative alterations in cognitions and mood," one symptom being "persistent negative emotional state," which could include guilt or shame as above, but could include any negative emotional state. In the group of 96 affidavits and declarations, almost every woman expressed at least one or more negative emotion, with many listing several, including fear, anger, guilt, shame, grief, regret, sadness or sorrow, self-hatred, or feeling depressed and/or anxious. For almost all the women the negative emotions appeared to be very persistent over the years, and many women wrote that it was "life-long," that it "never went away," or in some cases they stated the number of years since the abortion and indicated that it had been ongoing for that number of years--for many of the women, for decades. See Exhibits B-1 and B-2.

138. Only two women (of the 96) did not name a clearly recognizable negative emotion, but one used the term "downward spiral" that persisted for six years after the abortion during which time she was engaged in "heavy drinking and promiscuous sex," while the other stated she had not known "that my baby would be ripped limb from limb" and she had not known that the consequences of abortion would be so long lasting--but she did not specify a particular emotion. Other than these two, each woman of the 96 did name one or more specific negative emotions.

139. Tammy Litchfield's declaration (NC; one of the 4200, also referenced above) described her emotional state as "continual emotional pain," "torment" and "self-

loathing" after her abortion from age 17 until age 31, until she "began my healing process" (Exhibit C, Bates 1750-52). She says she had angry outbursts that were "horrifying and cruel to those closest to me."

140. Some of the other symptoms of this category ("negative alterations in cognitions and mood") can include "persistent inability to experience positive emotions (e.g. inability to experience happiness… or loving feelings)" and "feelings of detachment or estrangement from others." Recall Tammy Litchfield (NC, above), describing herself as an unloving mother, and stating, "I could not even enjoy the birth of my children. I went through the motions numb" (Exhibit C, Bates 1750-52).

141. This sense of detachment and inability to experience loving feelings, which is a symptom of PTSD, contributes to the bonding problems with subsequent children that many women reported in the affidavits and declarations, and that many of my patients have reported to me during evaluation for psychiatric symptoms, problems and disorders that I have diagnosed as associated with their past abortion. There are also studies in the published literature showing increased bonding problems, increased child neglect, and increased child abuse after abortion.

142. Those women who experience distress in the presence of their children, as above, and at the same time, find themselves unable to enjoy their children and unable to have loving feelings, are experiencing bonding problems, and this is completely consistent with the reports of many women in the affidavits and declarations, the statements of many of my own patients who have had abortions and have subsequently had bonding problems with their living children, and the published research on bonding problems after

abortion (Coleman et al., 2002; Coleman, 2009). In addition, among those women who experience decreased bonding or attachment to their own children, and who find it distressing to have to care for their children, it is follows that there is increased child abuse and neglect, which is shown in the published literature-- abortion is associated with increased child abuse and neglect (Ney et al., 1993; Coleman et al., 2005; Coleman et al., 2007). Child abuse and child neglect are not specifically symptoms of PTSD, but a sense of detachment and inability to experience loving feelings is a symptom of PTSD from which problems in the parent-child relationship and also problems in the husband-wife or couple relationship may arise, and according to published literature, problems in these relationships are increased in families in which an abortion has occurred in the past.

143. Also within this category of PTSD symptoms, "negative alterations of cognitions and mood," another of the possible symptoms listed is: "inability to remember an important aspect of the traumatic event(s)," which was expressed in *Clinician's Guide* (Baker et al., 1999) as "blocking out the experience." Even though as above, many women are bothered by intrusive memories about the abortion, when the experience is very severely traumatic and overwhelming to the person, there can be portions of the memories which are not accessible to the person—there can be gaps in the memory where certain portions of the experience are actually not able to be remembered.

144. **"Marked alterations in arousal and reactivity associated with the traumatic event(s)":** Symptoms of PTSD in this category include "reckless or self-destructive behavior," "irritable behavior or angry outbursts," "problems with concentration," or "sleep disturbance." As above, Terry Melby (ND – Exhibit B-1, Bates 1123-24) reported

engaging in "reckless, self-destructive behavior, drinking and driving with my kids in the car." Nine of the 96 women described their behavior as "self-destructive" or "reckless," using those exact words. (See Exhibit B-1 and B-2.) In addition, 18 of the 96 reported suicidal thoughts and behaviors, but only two reported actually making suicide attempts, so only these two were counted as "self-destructive" due to their reported self-destructive behavior, thus giving a total of 11 out of the 96 (11%) who could be counted as "self-destructive." **(**Others listed alcohol or substance abuse, promiscuity, eating disorders and behaviors that may have been self-destructive, but I have counted them as "self-destructive" only if they described themselves with the exact words "self-destructive" or "reckless" or reported an actual suicide attempt). However, it is not a requirement that a person have reckless or self-destructive behavior to be diagnosed with PTSD, as other arousal symptoms may be present instead, such as sleep disturbance or angry outbursts.

145. A study of medical records of 56,284 women with no known history of sleep problems revealed that women were more likely to be treated for sleep disorders after an abortion compared to childbirth (Coleman & Rue, 2006). The increased risk of sleep problems for the post-abortive women was highest during the first 6 months after the abortion, but persisted for four years. Women whose medical records showed prior history of sleep disorders were excluded from the study.

146. Problems with anger were reported by 15% of the 96 women. Exhibit B-1 and B-2.

147. In addition to the above symptoms of the various types, the disorder must persist for at least one month, and must cause clinically significant distress or impairment for the

diagnosis to be made. To meet criteria for the diagnosis the patient must have one or more symptom of intrusion and one or more symptom of avoidance, and two symptoms involving negative cognitions or mood, and two arousal symptoms. Thus, not every symptom must be experienced by every patient, but a specified number from each type of symptom (and for brevity, I have omitted listing some symptoms from the various categories).

148. From this review of the various symptoms of PTSD along with examples from the affidavits and declarations, and from the published research, one can see that a significant number of women do report these symptoms after abortion, and I have treated many women who report these symptoms to me after abortion. I have evaluated and treated many patients who met the diagnostic criteria for PTSD, patients who reported symptoms and problems that they attributed to a past abortion, whom I diagnosed as having PTSD arising from their past abortion, using the criteria in use at the time. However, on review of some of the cases I have treated, they would also have met criteria for PTSD under the recently revised criteria for PTSD. The patients in my own practice who met criteria for PTSD arising from their past abortion(s) reported symptoms and problems similar to the symptoms and problems reported in the affidavits and declarations from which I have quoted only a few representative examples.

149. Based on the foregoing, I conclude and it is my opinion, to a reasonable degree of medical and scientific certainty, that it is very common for women to have symptoms of PTSD arising from an abortion , and that a significant number of women do meet full criteria for PTSD after abortion. In addition, many other women have some symptoms of

PTSD after abortion, even though in some cases not meeting all the criteria. As we will see below, even "subthreshhold PTSD," also called "partial PTSD," is a significant clinical problem and a source of distress and disability for many who have these symptoms. My opinion is further supported by the published research discussed below.

(F) High risk of PTSD after abortion in published literature

150. Sharain Suliman, a psychologist, and co-authors who included psychiatrists, a psychologist, and an anesthesiologist, conducted an important analysis of PTSD after abortion (2007). The concept for this study originated with an anesthesiologist, Dr. Labuschgne, who provided anesthesia for abortions (Sharain Suliman, personal communication, November 18, 2013). The study took place at a private abortion clinic and at a hospital that provides abortions, with the cooperation of these facilities. This was not a study by researchers known for a pro-life perspective. The research team was aware of published literature on PTSD after abortion, and wanted to find out if one type of anesthesia or another could lead to better outcomes in regard to reducing occurrence of PTSD following abortion.

151. This was a prospective study in which actual abortion patients were given seven psychological tests at the abortion facility immediately before and after the abortion on the day of the abortion. In addition, blood was taken to check for cortisol levels. (Cortisol levels are affected in a unique way when PTSD is present -- Auxier & Runyan, 2012). Some studies of PTSD have used interviews or old records to look back at a past abortion, but there are few if any comparable studies of PTSD after abortion in which immediate data was collected at the abortion facility, with administration of multiple

psychological tests (not just questionnaires) before and after the abortion, on the day of the abortion and at one month and three months follow up.

152. In the introductory section of the published article, Suliman et al. (2007) discussed published literature showing that some women develop PTSD or PTSD symptoms after abortion, for example, a study of first trimester abortion patients in which some women reported nightmares, flashbacks, and unwanted thoughts related to the abortion (Slade, et al., 1998). Suliman et al. (2007) also cited research showing that simply "being conscious during surgery is a traumatic event that may result in developing chronic PTSD" (Osterman, et al., 1998).

153. In this discussion, Suliman et al. (2007) considered possible causes of PTSD after abortion. "Seeing the foetus may be traumatic," (Suliman et al., citing Urquart & Templeton, 1991), "while awareness or consciousness during experiences of blood, pain and death (of the foetus) have also been associated with PTSD-type symptoms (Suliman et al., citing Slade et al., 1998).

154. Suliman et al. (2007) conducted a study comparing two types of anesthesia to determine whether one type of anesthesia or another could reduce the risk of PTSD. But the type of anesthesia made no difference in terms of long-term outcome. At three months after abortion, 18.2% of the women were diagnosed as having PTSD. Suliman et al. concluded: "High rates of PTSD characterize women who have undergone surgical abortions (almost one fifth of the sample meet criteria for PTSD)….."

155. Suliman's results were similar to the results of other previous studies. For example, a study by Barnard (1990) found 18.8% of post-abortive women met criteria for

PTSD 3 to 5 years after abortion with an additional higher percentage of those women having some symptoms of PTSD (without meeting criteria for full PTSD), such as 39% reporting sleep disturbance and 45% having flashbacks).

156. Suliman et al. noted that rate of PTSD in their study was intermediate between the rate of 14.3% reported by Rue et al. (2004) after abortion, and 25% (at one month after pregnancy loss) reported by Englehard et al. (2001). The study by Englehard et al. was of women who had miscarriages, not abortion, but "the results indicate that pregnancy loss is potentially traumatic, putting women at risk of developing PTSD."

157. Broen et al. (2005) compared women after elective abortion (within first 12 weeks of pregnancy) and women after miscarriage, administering tests 10 days after abortion or miscarriage, and again at 6 months, 2 years, and 5 years. A clinical interview and several tests were used, including the Impact of Event Scale (IES) which is well-established as reliable to distinguish between traumatized vs. non-traumatized groups, and which measures symptoms of PTSD. The study design did not include assigning any diagnosis to any study participant, but simply compared the scores on the various measurements. The results were statistically significant. Both the abortion group and the miscarriage group had symptoms of PTSD, but both groups differed from each other in several ways.

158. In this study (Broen et al., 2005), women who had abortions had high scores for avoidance on the IES, and the scores stayed "almost unchanged throughout the five years." At each time of measurement, the abortion group had higher avoidance scores and also higher anxiety scores than the miscarriage group. At each measurement, the

abortion group also showed significantly lower quality of life, from 10 days through 5 years, compared to the miscarriage group.

159. Regarding PTSD "intrusion" symptoms, the miscarriage group started out with higher scores compared to the abortion group (though both groups had elevated intrusion symptoms). But the miscarriage group completely recovered by two years, while the abortion group also had some intrusion symptoms that persisted even at 5 years (Broen et al., 2005).

160. One other difference between groups was that the abortion group had higher scores for shame and guilt, and also for relief, compared to the miscarriage group (Broen, et al., 2005). This is of particular interest since various studies over the years have shown "relief" after abortion, particularly studies conducted soon after the abortion. In this study, even though "relief" was measured in the abortion group, the abortion group also had many PTSD symptoms as above, as well as guilt and shame, demonstrating that "relief" can coexist with negative emotions and even with symptoms of PTSD.

161. It has been widely reported and communicated to patients that many women experience relief after abortion, in a way that gives many women hope that the abortion will be a positive experience. MMP (MN) in her affidavit, in response to the question, "Were you adequately informed of the consequences of abortion?" stated, "I thought the only consequence would be tremendous relief and freedom from worry" (Exhibit B-2, Bates 1588). Other women made similar statements within the affidavits and declarations, that they had expected to feel relief, but did not. MMP states, in answer to the question, "How has your abortion affected you?" stated that she experienced "extreme

isolation, depression, anxiety, grief for someone who should be alive but is not because of my 'choice.'" She didn't mention relief at all, though she had expected to feel relief, and I don't recall seeing "relief" reported in any of the affidavits or declarations, but a number of studies have shown that relief can coexist with other very negative emotions or symptoms (Broen et al., 2005).

162. A study comparing Russian and American women who had previously had abortions (Rue et al., 2004) showed that both groups had high scores on a test that reliably measures trauma symptoms, the TSI Beliefs Scale. The average score for the Russian women was 276 and for the American women the score was 260, with both scores indicating significant trauma. As a point of reference, in a previous study of battered women in the U.S., the average score on this test was 242.

163. Further, 77.9% of American women reported "guilt" associated with the abortion (Rue et al., 2004).

164. Very few women reported benefits of the abortion, with only 0.3% of the Russian women and 0.9% of the American women saying they "felt better" after the abortion, only 2.2% of Russian women and 0.9% of American women saying their relationship with their partner improved after abortion (Rue et al., 2004).

165. Using the American Psychiatric Association diagnostic criteria for PTSD, Rue et al. (2004) found 14.3% of post-abortive American women met full criteria for PTSD, but 65% reported some symptoms of PTSD, for example, 47% reported unwanted memories of the abortion, 50% avoided thinking or talking about abortion, and 25% had difficulty

being near babies (with many other symptoms being reported, too many to list here), even though only 14.3% fully met the criteria to be diagnosed with PTSD.

166. The condition of having some symptoms of PTSD without meeting all criteria has been termed "subthreshhold PTSD," also referred to in the literature as "partial PTSD" or as "PTSS" (posttraumatic stress symptoms) (Lundell, et al., 2013). Even though only "partial," this condition is associated with "substantial disability and suicidal risk." In a study by Marshall (2001), higher numbers of subthreshold PTSD symptoms were associated with greater impairment, comorbidity, and suicidal ideation.

167. A large U.S. government study, The National Vietnam Veterans' Readjustment Study, was conducted in the 1980's due to a Congressional mandate to investigate PTSD in Vietnam veterans. (Price, 2007; Kulka et al, 1988; Kulka et al., 1990a; Kulka et al., 1990b;). The study results indicated that 15.2% of male and 8.5% of female Vietnam theater veterans met full diagnostic criteria for PTSD at the time of original study (Price, 2007; Schlenger, et al., 1992). Considering female Vietnam veterans who had "high levels of war-zone exposure," 17.5% met full criteria for PTSD at the time of the original study (Kulka et al., 1988; Price; Schlenger). However, an additional percentage of men and women had "partial PTSD," which was also considered a serious clinical problem (Kulka et al., 1988; Price; Weiss, et al., 1992). Kulka et al. (1988) stated that those with partial PTSD suffered from "impairments in function" and were "seriously affected by PTSD" and in need of treatment, even though not meeting full criteria for PTSD. This is analogous to the findings of Barnard (1990) and Rue et al. (2004) that some women who experience trauma associated with abortion develop full PTSD while an additional

percentage experience some symptoms of PTSD, "partial PTSD," which is an important clinical problem requiring attention. In regard to partial PTSD after pregnancy loss, Englehard et al. (2001) concluded that even when PTSD symptoms do not meet full criteria for PTSD, symptoms may still impair quality of life.

168. In addition, a follow-up study on the veterans discovered that a high percentage of those with PTSD or partial PTSD had failed to improve after many years, with 78% of those with PTSD continuing to experience PTSD symptoms 20-25 years after Vietnam (Price, 2007; Schnurr, et al., 2003). Kulka et al., the original authors of the study in 1988, stated at that time that PTSD is a "chronic, rather than acute, disorder," meaning, it is a long-term disorder, but the follow up study showed it was much longer term than anyone had realized in the 1980's (Price, 2007).

169. This is consistent with other research showing that PTSD can be very long lasting over a lifetime. A major U.S. study of PTSD, the National Comorbidity Study, demonstrated that "more than one third of people with posttraumatic stress disorder fail to recover even after many years." (Kessler, 1995). Other studies have shown that the duration of PTSD can span an entire lifetime (Yehuda et al., 1995; Port et al., 2001; Schnurr et al. 2002).

170. A 2005 study by Kersting et al. is pertinent in regard to the long-lasting nature of PTSD and also grief in women having abortions. Kersting et al. administered psychological tests to 83 women after abortion, including the Perinatal Grief Scale which "is a tried-and-tested" measurement for grief associated with perinatal losses including abortion, and the Impact of Event Scale, Revised, which is well established as a reliable

test for PTSD symptoms. Kersting et al. administered these tests at 14 days after the abortion, and again 2 to 7 years after the abortion. It was expected that grief and trauma symptoms would have decreased over the 2 to 7 year period, but that was not the case. Comparing trauma symptoms in each of the three categories (avoidance, intrusion and hyperarousal symptoms), there was no significant difference between the trauma symptoms at 14 days compared the trauma symptoms at 2 to 7 years. The trauma scores were significantly higher in the abortion group compared to a group of women who delivered healthy babies. Similar results were obtained for grief, with four out five of the subscales showing no significant difference, with only one subscale having decreased significantly. Kersting et al. concluded: "The results indicate that termination of pregnancy is to be seen as an emotionally traumatic major life event which leads to severe posttraumatic stress response and intense grief reactions that are still detectable some years later."

171. An important finding of the follow-up study of Vietnam veterans is that many veterans had "delayed onset" of PTSD, which is defined as onset of PTSD occurring 6 months or more after a traumatic event (Schnurr et al., 2003). Of veterans with PTSD, almost 40% reported that their PTSD symptoms started 2 or more years after Vietnam. Almost one third of veterans with PTSD experienced their symptoms starting between 2 to 5 years after Vietnam, and a "late onset cluster" experienced the start of PTSD symptoms on average 6 years after Vietnam, and up to 22 years after Vietnam. Delayed onset is "common" with PTSD, and various studies of PTSD have shown from 22% to 70% of PTSD patients having had delayed onset (Schnurr et al., 2002).

172. In my clinical experience, I have evaluated and treated many individual women who had delayed onset of PTSD symptoms which originated several years after the abortion, and this is clearly consistent with the published literature on PTSD. As with the case of Mary (Shuping, 2011; Shuping & Gacek 2010) who held a miscarried unborn child in her hand, some women who do not have PTSD symptoms immediately may at a later time hear a baby's heartbeat or see an ultrasound image during a subsequent intended pregnancy and at that time come to understand the abortion as the death of their child, and then develop PTSD symptoms arising from that experience.

173. It is well-established in the trauma literature that all trauma is cumulative—each new traumatic stress continues to add to the burden of trauma carried by a person (Neuner et al., 2004; Mollica et al., 1998). 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. This may explain why women who have already experienced past abuse or unresolved trauma are known to be at increased risk for problems after abortion (Baker et al., 1999; Baker & Beresford, 2009; Speckhard & Rue, 1992), since the trauma of the abortion is additive to the effects of the earlier trauma.

174. PTSD is a serious condition that is frequently is a cause of disability and is also associated with many other health problems. A 2007 study by Sareen et al. showed PTSD is associated with chronic pain conditions, cardiovascular diseases, respiratory disease, gastrointestinal illnesses, also suicide attempts, poor quality of life, and both short- and long-term disability. PTSD is predictive of poor general health (Lauterbach, 2005).

(G) PTSD Rates after Abortion are Likely Higher than Studies Reflect

175. There are several reasons that the true rate of PTSD for women who have had an abortion is higher than reflected in the literature. One reason is that many studies are considering only the "current" prevalence of PTSD at one point in time, whether that may be one week after abortion, or three months after abortion, not considering the number of cases that may arise at a later time which would indicate the "lifetime prevalence" of PTSD, which would be a larger number than "current" prevalence. Additionally, because of distress associated with recalling the abortion which is a symptom of PTSD and because of avoidance symptoms of PTSD, many women choose not to participate in research studies related to abortion, or may drop out later due to the distress they experience. Thus, many studies greatly underestimate the true prevalence of mental health disorders after abortion, including PTSD. It is also important to realize that these same factors also cause underestimation of other mental illnesses and disorders that occur after abortion.

176. In studying the prevalence of any disorder, one can examine "current prevalence," or lifetime prevalence. With the Vietnam veterans, in the original study (Kulka et al., 1988) it was stated that the "current" percentage of men with full PTSD at the time of the study was 15.2%, meaning that 15.2% of Vietnam veterans had PTSD at that time. But the total "lifetime prevalence" for men, referring to how many male veterans had ever had PTSD in their entire life after entering Vietnam was 30.9%. As an example, suppose a veteran developed PTSD in 1970 and still had PTSD currently at the time of the study. He would be counted as a "current case." But suppose another man developed PTSD and

had completely recovered by 1980. He would be counted in the "lifetime prevalence" category because he had PTSD in his life even though not currently, and the man who currently had symptoms would also be counted in the lifetime prevalence rate. "Lifetime prevalence" in this study included any veteran who ever had PTSD after entering Vietnam including past cases and current cases. The lifetime prevalence is higher than the current prevalence.

177. Looking at data for women veterans, although the "current" prevalence was 8.5% for full PTSD, the lifetime prevalence for full PTSD was much higher, 26.9%, which was comparable to lifetime prevalence for male veterans (Kulka et al., 1988).

178. Similarly for partial PTSD, the original current prevalence for men was 11.1% and lifetime prevalence was 22.5%. For partial PTSD the original current prevalence for women was 7.8% but lifetime prevalence was 26.9%. Any time one determines the lifetime prevalence for PTSD, it would be expected to be higher than the "current" prevalence (Kulka et al., 1988).

179. Considering the study by Suliman et al., wherein psychological tests were given after the abortion and at one and three months, 18.2% was the "current" prevalence for PTSD within the first three months after abortion. But we have already discussed that many cases may not develop until later, for example, when the woman has her first intended pregnancy or her first miscarriage, or when there is some other trigger. Some women do have symptoms immediately or soon after the abortion, as Suliman et al. reported, but some women can be expected to develop PTSD at different points in time

and the lifetime prevalence for PTSD would be higher than what can be determined at any one point in time.

180. Considering that the majority of the veterans with full PTSD had delayed onset after more than 6 months, with 40% first meeting criteria for the diagnosis 2 to 5 years after Vietnam, also considering the "late onset" cluster with PTSD being diagnosed at 6 years to 22 years after Vietnam (Schnurr et al., 2003), studies looking for PTSD in the first three months after abortion would be expected to find a lesser number of cases compared to the number of cases that would emerge over a longer follow up period. It is possible that at three months, the current cases in Suliman's study may represent a minority of those who would eventually develop PTSD, or at any rate, it is very likely that a significant number of additional cases of PTSD would be discovered later if the study could have continued for a much longer duration.

181. However, it is often extremely difficult to conduct studies with longer follow -up periods, because there are usually more dropouts over increased length of time. Study participants may move to new addresses or drop out for various reasons, and dropouts are one of the other reasons it is difficult to get a complete picture of the number of women being impacted by PTSD (or by any of the other mental health problems associated with abortion). The fact that many studies of women's mental health after abortion are short term or do not consider lifetime prevalence is a deficiency that is difficult to avoid. These studies are very likely to identify a lower percentage of women affected by abortion if the study is not designed to consider lifetime prevalence of PTSD.

182. The next problem is the problem of non-participation by women in studies, whether by initially refusing to participate, or by dropping out. As we have already discussed, avoidance is a symptom of PTSD, and many women with PTSD do not want to talk about their abortions. Many women in the affidavits and declarations stated that they did not want to talk about the abortion, and some said they had difficulty even saying the word "abortion."

183. A number of authors over a period of decades have concluded that the more severely distressed women have a greater likelihood of dropping out of a study or not participating in the first place. Adler (1976) reviewed 17 studies of women after abortion, and found attrition rates ranging from 13% to 86%." Adler concluded: "Results support the suggestion that women for whom the abortion was more stressful are less likely to be represented in the final sample."

184. Wilmoth et al. in 1992 stated, "The available evidence strongly indicates that these women who refused to participate or who did not provide follow up data were different from those who did in ways that most likely would increase the prevalence rate of negative psychological responses."

185. Ruth Ruch (ND – Exhibit B-1, Bates 1121-22) stated that after her abortion, "For the next 3 weeks of my life, I drank alcohol until I passed out…I hated myself for what I had done." Her distress persisted for many years and she eventually did obtain counseling, about 14 years later, but for many years, "it was a secret I swore I would keep until I died." Ms. Ruch does not report having been invited to participate in a study, but this gives an example of what some women are doing and how they are feeling after their

abortion. Women in this much distress are very unlikely to participate in an abortion follow up study. In my clinical experience, many women have reported severe distress such as this following their abortion, and many women have also reported to me having used alcohol abuse and substance abuse as a way to cope with their distress (and increased substance abuse after abortion is also demonstrated in published research such as Coleman, 2005; Coleman et al., 2005b; Morrissey & Schuckit, 1978; Reardon & Ney, 2000; Reardon, Coleman, Cougle, 2004).

186. Weisaeth (1989) did a very useful study that demonstrates how non-participation can be due to trauma, and which shows how a high percentage of non-participation can hugely distort a study's findings. In this study, 246 employees were exposed to an industrial disaster. In this study, "resistance" was measured by counting the number of contacts required in order to get the person to come in to participate in an evaluation. Employees were repeatedly contacted until they agreed and came for the evaluation, so that ultimately, there was 100% participation. But it was found that the employees who had been exposed to the highest degree of trauma in the disaster were the ones who had the highest resistance to participating (24.2% resistance in the high trauma group), those with intermediate exposure to trauma had an intermediate resistance to participating (6.8%), and those who had the least exposure to the trauma had the least resistance (4.2%). After gaining 100% participation and conducting the assessments, it was found that if the initial refusals had been accepted, the researchers would have lost 42% of the PTSD cases, and would have lost 64% of the most severe PTSD cases. (The persistent contacting that was done with employees after the disaster is obviously not an acceptable

method to use with abortion patients, who prefer not to participate in a study, or who change their mind and drop out, but it is likely that the non-participants in abortion studies are likewise the most traumatized, and this suggests the magnitude of the effect of this disproportionate resistance or refusal by those who are most traumatized.)

187. Returning to the study by Suliman et al. (2007), the dropout rate was high, with only 37% of the original sample continuing through the entire study. It is extremely likely that a disproportionate percentage of women with PTSD dropped out, and also extremely likely that those who dropped out were experiencing a higher degree of trauma symptoms compared to those who continued in the study. Therefore, although Suliman et al. found 18.2% of women in the study experiencing PTSD at three months, and considered that "high," in reality had it been possible to retain the dropouts, it's quite likely the percentage may have been much higher than the original number, and higher still if it were possible to continue the study for a much longer time to include women who experience delayed onset. The exact prevalence cannot be known with certainty, but it is extremely likely to have been higher than what was found.

188. A study by Coleman et al. (2010) did overcome some of the limitations in a study that appears to more effectively capture the lifetime prevalence data and that appears to allow a greater comfort level for highly traumatized individuals to participate. This study used online surveys to gather data on 374 women who had experienced either a first trimester abortion (up to 12 weeks) or a 2nd or 3rd trimester (13 weeks or later). The results showed that "52.5% and 67.4% in the early and late abortion groups, respectively, met the DSM-IV symptom criteria, a considerably higher percentage than in earlier

published reports." Coleman suggested a number of reasons for these results being so much higher.

189. "First, for this particular sample of women, a great deal of time had elapsed since the abortion (an average of 15 years) and the symptoms could conceivably have developed later in this extended time frame" (Coleman et al., 2010). Some women may have initially experienced the abortion as a trauma but did not develop PTSD until additional trauma was experienced at a later time (for example, a later miscarriage), due to the cumulative effects of trauma. As has been seen with the veterans study (Schnurr, 2003), some people do develop PTSD symptoms years after the initial trauma, and for some women, the PTSD symptoms do not arise until later, when the woman hears a heartbeat or sees an ultrasound image in a later intended pregnancy, or when she in some other way experiences the aborted child as her own child who died in the abortion.

190. In the study by Coleman et al. (2010) the wording of the survey asked women to identify symptoms that occurred at any time after the abortion that were attributed to the abortion. This allowed women to endorse symptoms they may have experienced in the past even though they may not currently be experiencing that symptom.

This study was essentially collecting data on the lifetime prevalence of PTSD after abortion, rather than merely a current prevalence rate. It potentially provides a clearer picture of how many women were impacted in total over a longer period of time, though identifying a higher percentage of women affected by PTSD compared to studies only considering current prevalence.

191. Additionally, this sample (Coleman et al. 2010) "was characterized by high rates of exposure to potentially traumatizing physical and sexual abuse in childhood and adulthood," which are predisposing factors that are known to increase the risk of mental health problems after abortion (Baker et al., 1999; Baker & Beresford, 2009).

It should be noted that childhood sexual abuse has been experienced by 25% of U.S. women, (Pereda, 2009; Centers for Disease Control and Prevention, 2013). This is a common problem that would have an effect on many women who have abortions. In Coleman's study, 32% had a history of childhood sexual abuse, 7% higher than the national prevalence, thus while this may have had some impact, it would not explain the large difference in PTSD found in this study compared to other previous studies.

Similarly, a history of childhood physical abuse was seen in 36% of Coleman's sample, while the national prevalence for history of childhood physical abuse in adult women is 27% (Centers for Disease Control and Prevention, 2013). Coleman's sample is 9% higher than the national average. Thus, Coleman's sample appears to have been more highly traumatized prior to the abortion though it does not appear that this would fully account for the very high rate of PTSD in Coleman's study (Coleman et al., 2010).

192. Coleman et al. (2010) discuss that in this sample, "more than a quarter of the current sample had experienced more than one abortion and the effects may have been cumulative. ″ It is very likely some women who had multiple abortions experienced cumulative effects from past abortions, since it is well established that the effects of trauma are cumulative, and there is abundant literature that women having multiple abortions are at increased risk for mental health problems. However, in this sample only

26.6% of the women had more than one abortion; Guttmacher Institute reports that nationally in U.S., 48% of abortion patients are having repeat abortions (only 28% for North Dakota women). Thus, in this study, the higher rate PTSD would not be due to the percentage of women having repeat abortions.

193. An important factor with this study was that the data were collected anonymously, online, so that women who had been more negatively affected may have felt more willing to participate in this study compared to the usual response rate for the more severely affected women. In my opinion, it is possible that this study is simply identifying a true lifetime prevalence rate by using a format that is more comfortable for the participation of the more traumatized women who would otherwise not participate, but it's also possible that the study included a disproportionate number of women with PTSD due to the method used. While in many studies there is legitimate reason for concern that cases of PTSD are being missed due to dropouts, in this study there is the concern that highly traumatized individuals may have been disproportionately represented, and the results could be higher than would have been seen in a representative sample. This is not a randomized sample, and it is possible that this study over-estimates the lifetime prevalence of PTSD after abortion.

194. A 2013 PTSD study by Curley and Johnston is also worth considering. These researchers recruited students with a past history of abortion and students who had never been pregnant for a comparison group. Of the 151 female students, 89 had a history of past abortion an average of 3 years previously (range, one month to 10 years). Surprisingly, *all* the students in the abortion group reported symptoms of PTSD and grief

lasting on average three years. For some, the effects were still very severe. For example, one woman enrolled in the study, but then became so distressed while completing the form that she felt it necessary to drop out of the study. Five students were referred to university psychiatric services either due to expressing suicidal thoughts, or due to their responses on a psychological test indicating depression or suicidal thoughts. "Twelve students requested and were referred for psychological follow up services to address the abortion at the time of the interview." (Curley & Johnston, 2013).

195. Part of the study involved determining how many of the post-abortive women desired to receive "psychological follow up services, which are not typically offered within healthcare, to address distress after their abortion." More than 50% of the students with a past abortion desired psychological follow-up services. The authors note that "a 50% incidence of persistent distress after abortion is significantly higher than 30 to 40 % that was previously thought." In their introduction, they had stated that "young women under age 25 years are at highest risk for developing mental health problems after abortions," citing literature that reported up to 40% of women in this age group have mental health problems after abortion.

196. Results of several tests including the Impact of Events Scale showed that the group that preferred treatment had moderate to severe PTSD symptoms indicative of partial or full PTSD, while the group that did not prefer treatment also had lingering symptoms of PTSD though less severe. The authors concluded: "It is evident that, among university women, the psychological impact of having an abortion may be more severe and of longer duration than was previously estimated."

197. It is not possible to design the perfect study that will provide the exact prevalence of PTSD after abortion because of the nature of PTSD. It is an intrinsic feature of PTSD to experience distress when confronted with reminders of the trauma, such as occurred with the woman who could not complete the questionnaire (Curley & Johnston, 2013), and it is intrinsically part of the disorder to avoid those painful reminders that would cause distress, as has so often occurred when women drop out of studies intended to measure the psychological effects of abortion. Considering that it can be distressing for some even to complete a questionnaire (Curley & Johnston, 2013), one can appreciate the problem of obtaining the needed data. It's also quite possible that other women on the campuses where Curley and Johnston recruited had even more severe PTSD symptoms and chose not to volunteer for the study due to greater severity of symptoms and greater avoidance symptoms in particular, but there is no way to obtain that information.

198. It is not possible for any researcher to state with certainty the prevalence for PTSD associated with abortion. The true prevalence of PTSD associated with abortion is underestimated in the literature due to the various factors discussed, including the fact that many patients have delayed onset, and many of the most traumatized women decline to participate in studies or drop out later. Additionally, many avoid treatment out of shame (which will be discussed further below) and thus do not show up in analyses of medical records. No one can produce an accurate figure as to exactly how many women are impacted by PTSD after abortion (which is not the only adverse psychological reaction to abortion, though it is a very important one because it is very long lasting and has so many affects in every aspect of a woman's life). However, published studies are

increasingly utilizing better methods and are recognizing the long-term, chronic course that is typical of PTSD including PTSD after abortion, and with each study, we obtain additional information. It is essential to understand, as discussed above, that studies will unavoidably underestimate the number of women impacted, but certainly, good studies are identifying significant numbers of women with severe symptoms, and there is no question that many women are affected. The lifetime prevalence for full PTSD in American women, from all causes, is 10.4% (Kessler et al., 1995). Even though it is not possible to state with certainty the exact lifetime prevalence of PTSD or PTSD symptoms after abortion, it is definitively known that women who abort are at a significantly increased risk for PTSD compared to women who do not abort.

(H) Conclusions Regarding PTSD

199. Based on the foregoing, and based on my clinical experience, and from my review of the literature on PTSD, which is not limited to the studies cited here, it is my opinion to a reasonable degree of medical and scientific certainty, that many women experience enduring, severe, psychological distress from PTSD (whether full PTSD or partial PTSD) caused by and associated with past abortion(s). Whether full PTSD or partial PTSD, the PTSD symptoms have a very long-term, adverse effect on the health and the quality of life of the women, and frequently have an adverse effect on their ability to bond to their living children, and often prevent them from enjoying their living children, as well as adversely impacting their relationship with their spouse or partner. Considering women who have had abortions, it is my opinion that many women develop symptoms of PTSD after abortion and many women, who do not originally experience symptoms of PTSD,

experience delayed onset of PTSD, sometimes several years after the abortion, often during a subsequent intended pregnancy, which prevents them from enjoying the happiness that they expected from the intended pregnancy and childbirth subsequent to the abortion. PTSD is typically a serious, chronic, long-term condition, and these symptoms frequently persist for decades, very often for a lifetime. Many women experience severe distress at the loss of companionship and loss of enjoyment of the relationship with the unborn child, and experience severe distress in recalling the death of their unborn child, and their role in that death. Severe shame often prevents women from talking about the abortion to anyone, and prevents the most traumatized from seeking counseling, making it much less likely that they will recover from the effects of the abortion(s). Full PTSD and partial PTSD are both clinically important problems occurring after abortion and having an adverse effect on the women affected and also having an adverse effect on society, since either can be a cause of disability. In the practice of psychiatry, I have treated many patients who are disabled by PTSD, and it is a condition that is disabling for many patients. Many women meet full criteria for PTSD at some time during their lifetime after abortion, and many other women will also experience distress from subthreshhold PTSD. Therefore, in my opinion HB 1456 protects women from these adverse effects of an abortion and in turn promotes the health, safety and well-being of women, along with protecting the life of unborn children and the health and well-being of their families, and is medically and scientifically sound and reasonable.

200. Limiting abortion to the period of time before the heartbeat is detectable, as set forth in HB 1456 will decrease the risks that result from abortion – indeed the statements and declarations of women that have had abortion demonstrate this.

201. Recall the statement of Carrie Sanchez (SD) who said, concerning an intended pregnancy after her abortion: "I heard the baby's heartbeat and began to cry. These were not tears of joy. Exhibit B-2, Bates 1719-23. I instantly thought that I had killed a heartbeat just like that 9 years ago."

202. Jody Clemens (ND) (Exhibit B-1 Bates 1119-1120), who reported experiencing isolation, shame and despair after her abortion, states that after she married, "I became pregnant again, and only then learned that 21 days after conception, that my baby's heart was beating. That meant there was new blood circulating through new veins in a new little human being…Why wasn't I provided with this information when I had my abortion?...Had I known the truth that my baby's heart was beating at the time of the abortion I would never have gone through with the procedure. A beating heart means there is life. My baby was alive—he may have been small but he was very much alive. If this law had been in effect for me, I would not have suffered the irreparable injury I have."

203. Ms. Clemen's statement is one of many women who express that they wish they had not had the abortion, and that they emphatically would not have desired the abortion had they known of the presence of the heartbeat.

204. Rhonda Nygaard (ND) (Exhibit B-1, Bates 1127) stated, "If I had been told the truth about the development of my baby--that he…had a heartbeat at 6 weeks--I would never have gone through my abortion."

205. Terry Melby (Exhibit B-1 ND, Bates 1123-24) was previously quoted concerning her reaction to her abortion, which included drinking and driving with her children in the car, and a suicide attempt within one month of the abortion. She states "if I had just been told the truth, that the baby was formed and had a heartbeat, I would not have gone through with the abortion. The child would be 32 years old now."

(I) PTSD Not Comparable to Post-Partum Depression

206. Sometimes questions are raised as to whether PTSD after abortion might in some way be comparable or analogous to post-partum depression. But these are very different conditions. Post-partum depression typically arises soon after birth primarily due to hormonal changes. This is most frequently treated with antidepressant medication, and in the cases I have treated, there has been improvement within about two weeks. The time course for post-partum depression is typically weeks, not decades as I have often seen with PTSD after abortion, and as reported in some of the affidavits and declarations, and as demonstrated in the research (above). Many of the women who have come to me for help with PTSD symptoms have not sought treatment earlier or have failed to respond to previous treatment and in either case, are coming to me for help after experiencing many years of PTSD symptoms, but I have never seen any patient in their 50's or 60's coming in for treatment of postpartum depression. The patients I have treated for post-partum depression have started treatment soon after childbirth and have responded to treatment

quickly, within weeks, and do not have lingering symptoms decades later. As we have seen, PTSD can continue for many years, even for a lifetime.

207. Di Scalea and Wisner (2009) reviewed 7 studies of prevention and 13 studies of treatment for postpartum depression. Treatment with antidepressant medication is effective for both prevention and treatment, and additionally, studies have also shown "robust and rapid response" with use of hormone treatment. Hilgers (2004) reports very rapid response with use of injectable progesterone treatment, with 95% effectiveness, and with symptoms beginning to improve within hours. This is in contrast to PTSD which often "fails to improve after many years" (Kessler, 1995) and which can persist for one's entire life (Port et al., 2001; Schnurr et al. 2002; Yehuda et al., 1995);).

208. Postpartum psychosis is a more serious disorder than postpartum depression, occurring in only 1 or 2 pregnancies per 1,000. Of women suffering from postpartum psychosis a small percentage, up to 4% may attempt infanticide, and up to 5% suicide (Hilgers, 2006). This disorder is believed to be a form of bipolar disorder, and fortunately, there are a number of effective medications from which the physician can choose that can give a "quick, full recovery," and "prevention of future episodes" (Sit et al., 2006).

209. My opinion regarding postpartum depression is, to reasonable degree of medical and scientific certainty, that it is very unlike PTSD, in that postpartum depression is of much shorter duration and much more easily treatable than PTSD. They are not comparable or analogous conditions.

(J) Women with history of abortion are at increased risk for postpartum depression

210. A 2013 study by Giannandrea et al. (2013) revealed that women with a history of pregnancy loss (abortion, miscarriage, or stillbirth) are at increased risk for postpartum depression and for PTSD after the birth of a child, and those with multiple losses are at even higher risk (Giannandrea et al., 2013). For those women who may have already had partial PTSD due to prior trauma associated with the earlier pregnancy loss, aspects of the delivery process or baby itself may function as a reminder of the previous trauma and cause symptoms to worsen, becoming full PTSD, or these same "reminders" may serve as a stress that precipitates the onset of postpartum depression. Giannandrea concludes: "Although the clinician, and even the patient, may not see a pregnancy loss as significant, this study indicates it could add to her traumatic burden, making her more vulnerable to clinically significant distress at the time of another pregnancy and birth." Giannandrea states that even though "a woman may not have sought mental health treatment at the time of her loss or termination, or believes herself fully recovered," nevertheless she is still at increased risk for mental health complications during a future pregnancy if she has the history of prior loss.

211. In addition, a new study was published during November, 2013, showed that "fear of childbirth predicts postpartum depression (Räisänen et al., 2013). Fear of childbirth can be a symptom of PTSD associated with abortion. In this study, data show that women who had previous abortion have 41% higher risk of postpartum depression. However in this study, there is no increased risk of postpartum depression after miscarriage.

212. Based on the foregoing, considering the results of these two excellent new studies, also based on the body of trauma literature, and my clinical experience, it is my opinion to a reasonable degree of medical and scientific certainty that abortion places a woman at risk of developing postpartum depression or PTSD in subsequent pregnancies. In the previous discussion of the PTSD symptoms with examples, we have considered examples in which women saw an unborn child, heard a heartbeat or held their baby from an intended pregnancy and through that experience became more aware of the unborn child they had lost to abortion. Some women, at that point in time, come to think of the abortion as the death of their baby, and may then develop PTSD symptoms. Alternatively, they may develop severe grief at that time which can include symptoms of depression. The specific degree of risk cannot be known precisely with certainty, and I would not give an opinion only on the basis of two studies, but in this case, the two studies are completely consistent with my clinical experience and with the manner in which PTSD develops. The provisions of HB 1456 will serve to reduce this risk by limiting abortions to the period before the heartbeat is present, which will decrease PTSD symptoms and adverse psychological reactions that may arise from the abortion during subsequent pregnancies.

(K) Additional Risk Factors for Increased Risk of Mental Health Problems after an Abortion

213. I have previously considered a list of risk factors from *Comprehensive Abortion Care*, a textbook of the National Abortion Federation, and have discussed at length one of these risk factors, "commitment and attachment to the pregnancy." See Paragraphs 46 to 96 above. As identified earlier in this report at Paragraph 44 a – o, there are many

different risk factors which can place a woman at increased risk for mental health, emotional and psychological problems after abortion. As noted, a woman that has one of these risk factors, in turn has an increased risk of having mental health problems after abortion. I would like to review a few of these now and then draw some conclusions about risk factors.

214. **Pressured, Coerced and Forced Abortion (Abortion of Wanted Babies)** This topic concerns the risk factor of "perceived coercion to have the abortion," another risk factor that in my opinion is equally important. (Baker & Beresford, 2009; Baker et al., 1999). The 2008 A.P.A. Report (American Psychological Association, 2008) identified "pressure to abort" as a risk factor for mental health problems after abortion. The Council on Scientific Affairs of the American Medical Association (1992) has also identified pressure or coercion as a risk factor. Researchers and experts on both sides agree that pressure, coercion, and even "perceived coercion" (the woman's perception that she is being coerced, whether or not observers agree with the woman's assessment of her situation) place the woman at increased risk for mental health problems after abortion. (Reardon, 2003-2004; Rue et al., 2008; Rue & Speckhard, 1992; Speckhard & Rue, 1992). See also Exhibit D of the Coleman Report which lists 13 studies showing that "Coercion or Pressure from Others to Abort" is a risk factor for increased mental health problems after abortion.

215. According to one definition, coercion involves "intimidation" to "compel the individual to do some act against his or her will" which may be "by the use of psychological pressure, physical force, or threats." (The Free Dictionary). Thus, coercion

may involve "psychological pressure" though in some cases physical force or threats are used to compel the woman to obtain an abortion against her will.

216. For an adolescent or a young adult, if the parents or other adults “insisted” on the abortion, this could serve as psychological pressure that would make it very difficult or even impossible for the young woman to refuse the abortion. The following gives an example of a woman from South Dakota, who had an abortion due to pressure from her boyfriend's mother, and perceived pressure from her own parents. In the end, at the clinic, she changed her mind about going forward with the abortion and said so to the nurse, but her expressed wishes were not honored.

217. Carrie Sanchez (SD) had an abortion in 1995 and signed an affidavit in South Dakota in 2005, 20 years later (Exhibit B-2, Bates 1719-23). Ms. Sanchez was a college student and very much wanted to carry the pregnancy to term. But her boyfriend's mother "insisted" that she should have an abortion, while the boyfriend and his father said nothing. Later, her own parents said they would support her decision, but "it was clear… what they wanted," which was for her to have the abortion. She stated, "My mother took me to a clinic…to have the procedure. I was not doing this for myself. I did not want to have an abortion. As I sat in a waiting room with other women who were having an abortion, the feeling grew stronger in me that I did not want to do this. I made up my mind. Forget the papers I had signed, not even sure what they were. When they came for me (I was next) I would just tell them I did not want to do it, they would show me to my clothes and I would leave. Wrong!! ….. I told the nurse I had changed my mind. She said let's go in and talk to the 'Doctor.'" But Ms. Sanchez says that as soon as she sat down to

talk with the doctor, she was being stuck with a needle (either by the doctor or the nurse), and apparently received a strong sedative or anesthetic. She woke up in the Recovery Room with the abortion already completed. A nurse asked if she could get her anything. Carrie reported, "I first asked if it was done and she simply said, 'yes.' I told her yes you can get a gun for me."

218. Ms. Sanchez has continued to experience attachment to her aborted child and to experience distress associated with the abortion. She stated, "Every time I see my friend's son who is now 10 years old I am sadly reminded. It never goes away. I would rather look at my child and smile."

219. Ms. Sanchez said that after she was married and was again pregnant, "At my first ultrasound, I was exactly 8 weeks pregnant. I heard the baby's heartbeat and began to cry. These were not tears of joy. I instantly thought that I had killed a heartbeat just like that 9 years ago."

220. Another example comes from the affidavit of Deborah Schleif (MN) concerning her abortion in 1972 in California, where it was legal at that time (Exhibit B-2, Bates 1620-22). Her abortion was three days before her 16th birthday. She states, "When I first found out I was pregnant I was really scared. I was only 15 years old. It was a while before I told anyone. I told my mother first. She was upset, but I thought she would there for me. Next I told my father. He slammed his fist on the table and looked at me with such anger and disgust that I thought he could have killed me at that moment…Later that day my mother told me, 'Your father said that you either have to get an abortion or leave

this house.'" Then I told Michael the father of the baby. He wasn't happy about the baby. He wanted me to have an abortion, too. I wanted to have and keep the baby."

221. This is an important point about pressured, coerced and forced abortions: They are abortions of wanted babies. The mother wants the baby (unborn child) and others in her life do not support her desire but instead use psychological pressure and sometimes threats or physical force to secure the abortion. I have already discussed at great length the risk factor of aborting when the woman is "committed or attached to the pregnancy," and the evidence of how the woman is affected when prenatal bonding followed by abortion can give rise to PTSD. (See Paragraphs 46 to 212.) With a coerced or pressured abortion, the baby is typically wanted by the mother, as was reported by both Ms. Sanchez and Ms. Schleif, but the abortion of the wanted baby (though unplanned pregnancy) takes place due to the coercion or pressure from others. Because they are abortions of wanted babies, everything that has already been stated in regard to prenatal bonding and PTSD applies.

222. In the case of Ms. Schleif, she took the step of going to Social Services to apply for child welfare benefits, however, the father of the baby threatened to lie in court to say he was not the father, and he threatened that he would have some of his friends testify that she had slept with them, so that paternity could not be known (which apparently was before DNA testing was available). Because of the boyfriend's statements, she says that she did proceed with the abortion, against her wishes. "I know I did not want to do this and just before I went into the operating room the doctor asked me if I was sure I wanted to 'to do this.' I said, 'no, but I have to.' I cried."

223. She reports that following the abortion, she had fertility problems and was never able to have another child, despite fertility treatments. That was not necessarily a consequence of the abortion, but nonetheless, she has sadness that she aborted one child and was never able to have another. She experienced alcohol and drug abuse and a suicide attempt. She reports continued emotional pain that she thinks is hard for her current husband to understand. She still thinks about her aborted child and hopes that "one day in heaven, I will see my child." Thus, she has had difficult consequences from an abortion that she did not want and tried to avoid (by initially attempting to obtain child welfare benefits for her unborn child, but later feeling unable to withstand the pressure to abort).

224. If Ms. Schleif's situation occurred today in 2013, the baby's father would not be able to use that threat of perjury, since DNA testing to establish paternity is now widely available and most people are well aware of this. So that particular tactic is not likely to work today, but at the time, she was young and was receiving what was for her strong pressure. However, today, there are cases where the pressure can escalate to physical violence and even murder of women who refuse to abort; homicide is now the leading cause of death of pregnant women. (Curtis, 2003; Gazmararian et al., 1995; Hilberman & Hilgers et al.,1981; Horon & Cheng, 2001; McFarlane et al., 2002; Munson, 1977-78;).

225. There is a continuum of pressure that can range from the more subtle, such as Ms. Sanchez saying she knew what her parents wanted her to do, or the baby's father saying, "I will never love that baby," to parents threatening to cut off college funds, to the extreme of being sedated and restrained for a forced abortion. (Shuping, 2011).

226. Although some clinics now screen for coercion, many women tell me that they have felt pressured and they felt they had to say whatever was needed in order to obtain the abortion, though they didn't want the abortion at all. One woman told me her father had told her and the doctor that she was not to leave the clinic with a baby still on board (that he didn't want her to leave the clinic without having an abortion). Another woman told me recently, "I would have said whatever I had to." Screening may perhaps help to prevent some of this, but if the pressure is strong enough, due to threats of physical violence or threats of homelessness or threats withholding of financial support, women may not speak truthfully about their situation at the clinic. The reality is that wanted babies are being aborted, and women suffer when this happens.

227. No one knows the precise prevalence of this problem, but I know of many such cases from my own psychiatry practice. From the group of 96 affidavits and declarations, 45 women stated they were pressured when had their abortion, and many were pressured by more than one person, often several, including parents, the father of the baby, the father's parents, friends, and even clinic staff (counselor or nurse). Exhibit B-1 and B-2. The fact that 46% of this group report "pressure" is a partial explanation of why this group is experiencing very severe distress over so many years—they didn't want the abortion in the first place. This is also some indication that this is not a rare circumstance.

228. The 2004 study of Russian and American women revealed that 64% of the American women and 37.7% of the Russian women felt "pressured by others." It is important to note that this was not a pool of psychiatric patients, but women in a general gynecology practice who had a history of past abortion who had agreed to participate in

the study. Of these women, 64% of the American post-abortive women reported feeling "pressured by others."

229. The following article was written by me and I submit this as part of my expert opinion, marked as Exhibit E:

Shuping, M. (2011). Wantedness & coercion: Key factors in understanding women's mental health after abortion. *Association for Interdisciplinary Research in Values and Social Change Research Bulletin* 23(2), 1 - 8. Retrieved from: http://www.abortionresearch.us/images/Vol23No2.pdf

This article gives additional background and explanation regarding the problem of wanted babies being aborted due to coercion and pressure, including some case examples and further analysis of this problem.

230. At Exhibit D of the Coleman Report, in addition to the bibliography of studies related to coerced abortions, there is a list of 18 studies related to the risk factor of "Commitment to the Pregnancy." These studies give additional evidence of the harmful effects of pressured, coerced, or forced abortions, since pressured, coerced, or forced abortions are in most cases a situation in which the women was committed or attached to the unborn child or preferred to give birth, but due to pressure, she has the abortion instead. There is no question that researchers and professional organizations on both sides consider this a risk factor for increased mental health problems after abortion, but it often is not recognized what a large problem this truly is.

231. **Significant ambivalence about the abortion decision.** Another identified risk factor is "Significant ambivalence about the abortion decision." Many women in the

affidavits and declarations report ambivalence—wanting conflicting things at the same time, or having difficulty and distress at making the decision. Terry Melby of North Dakota (Exhibit B-1, Bates 1123-1124) stated that she "didn't want to have an abortion," but "started to think of abortion as my only option." There are many variations on this that be seen in the different women's statements, but this is one example.

232. **Putting great effort into keeping the abortion a secret for fear of stigma.** Another risk factor is "Putting great effort into keeping the abortion a secret for fear of stigma." One of the women stated in her affidavit or declaration that prior to the abortion she discussed with clinic personnel her concern that she did not want to have to tell her own personal physician, and clinic personnel told her she would not have to disclose this. Therefore, this woman did not tell even her own personal physician about the abortion. The woman did not disclose the abortion on medical forms, felt badly about the dishonesty, but felt too much shame even to disclose the abortion within her medical history when seeking treatment. It is a common theme among the affidavits and declarations that the women tell no one, or only a very "select few." Some women in their statements indicate they have withheld the information even from their spouse, and I have had patients whose husbands never were told. The results of one study (Layer et al., 2004) showed that the average person in an abortion recovery treatment program had told either two or fewer people, but some had told no one. Many women continue the secrecy for years, even decades or a lifetime, and this is partly why they fail to recover. But in examining pre-existing risk factors occurring prior to the abortion and predicting adverse consequences after the abortion, we are considering secrecy prior to or at the

time of the abortion as predictive of later problems. In this example, the woman had a concern about secrecy while talking to clinic staff before her abortion. They assured her she would not have to tell anyone, even her doctor(s). Many women spoke of the need for secrecy within the affidavits and declarations, and this is certainly true of a large percentage of my own patients, although I do not have specific data from my practice for this well-documented risk factor that is also acknowledged in the 2008 APA Report (American Psychological Association Task Force on Mental Health and Abortion, 2008).

233. **Advanced stage of pregnancy.** Another risk factor is the "Advanced stage of pregnancy." Not only the *Clinician's Guide* (Baker & Beresford, 2009), but also The 2008 APA Report (American Psychological Association, 2008) and other sources recognize that abortions beyond the first trimester carry a higher risk of mental health problems. Based on data from the Guttmacher Institute, this represents about 144,000 abortions in the U.S. annually. Possibly there is higher risk of problems due to longer time period in which bonding can occur, and greater opportunity for feeling fetal movements prior to the abortion, which would enhance awareness of the unborn child as a unique individual and thus contribute to a greater possibility of trauma if abortion occurs. Similarly, there is higher risk of a coerced abortion in these later abortions, since the woman may have tried to conceal the pregnancy or avoid an abortion, but when parents or partner discovered the pregnancy, there was pressure that eventually led to abortion. Likewise, ambivalence may have been present and delayed a decision; ambivalence would represent an additional risk factor, but with late abortions there can be several inter-related risk factors. While the majority of women submitting affidavits

and declarations did have first trimester abortions, some reported having had an abortion beyond the first trimester.

234. **"Preexisting experience of trauma" and "Past or present sexual, physical or emotional abuse."** Other identified risk factors are "Preexisting experience of trauma," and also "Past or present sexual, physical, or emotional abuse." These are similar risk factors, in that any past trauma can predispose toward a higher risk of PTSD when additional trauma occurs. Thus, women who have had prior sexual abuse, rape, or other experience of trauma are more vulnerable to experiencing adverse mental health consequences of abortion, including but not limited to PTSD. Further below is a separate section regarding this particular type of risk. (Paragraphs 244-275)

235. "**Intense guilt and shame before the abortion**." Within the affidavits and declarations, there is so much shame and guilt expressed, but now sometimes decades later, it would be difficult to say how much was present originally and how much came later. These are common experiences and some women identify a specific recollection of shame or guilt prior to the abortion. For example, Ruth Ruch of North Dakota (Exhibit B-1, Bates 1121-22), stated that immediately before her abortion, when the doctor came in, she was sobbing uncontrollably. The doctor asked what was wrong and, "I told him I couldn't go through with it--that I was Catholic." This may indicate that she was feeling some guilt, or some moral conflict about the abortion, and in fact, she said she "couldn't go through with it." But she states the doctor responded, "It's okay--I'm Catholic, too." She said nothing further and the abortion was completed. (This example reminds me of an example from the abortion provider textbook, further below, in which it is suggested

that a response to crying is to hand the woman a Kleenex and move on, which is similar to what Ruth Ruch experienced). Certainly many women in the affidavits and declarations report guilt and shame after the abortion, but some express clearly that there was guilt at the beginning, such as having a memory of praying at the abortion that God would forgive them for what they were about to do, or a sense of guilt at knowing they were violating their own conscience. Some studies rather than looking at "guilt and shame" prior to the abortion, have also identified "acting against one's own conscience" or against one's own beliefs or values as being a risk factor for increased mental health problems later, and that is seen in some of the affidavits and declarations.

236. **Existing emotional disorder or mental illness prior to the abortion.** Another risk factor is "An existing emotional disorder or mental illness prior to the abortion." This is a risk factor which is thought by many to be the strongest predictor for later problems, and certainly those who already have mental health problems do have an increased risk of mental health problems after the abortion, which may be an exacerbation of the original problem or additional new problems. Certainly, MKK (SD – Exhibit B-2, Bates 1711) reported having been receiving treatment with a psychologist prior to her abortion, and then had years of severe mental suffering later, though she was too ashamed to seek further counseling. Others reported pre-existing eating disorders or pre-existing addiction problems or other mental health problems that worsened after the abortion, though the majority of women who submitted affidavits and declarations did not report prior problems. Baker et al. (1999) is clear that even though it is a risk factor,

that women with pre-existing mental health problems are certainly at increased risk, some women have problems who have no prior mental health history.

237. **Belief that abortion is the same act as killing a newborn infant.** Another risk factor is "Belief that abortion is the same act as killing a newborn infant." It is hard to tell after the fact how many women believed this at the time of the abortion, versus how many believe this now. Many women who submitted affidavits and declarations clearly believe this now, but less so originally. But this is worth mentioning since there is an example related to this in the section further below on counseling. The abortion provider textbook gives a suggestion as to how to handle a situation in which a woman expresses this belief prior to the abortion. Unfortunately, even though this belief is a known risk factor listed in the textbook, the suggested response to learning that a patient has this belief did not include a discussion with the patient concerning this belief as being a known risk factor.

238. **Risk Factors in the APA 2008 Report**. (American Psychological Association Task Force on Mental Health and Abortion, 2008). This report actually identified 17 risk factors that identify subgroups of women at increased risk for mental health problems after abortion. Many of them are the same risk factors or very similar to those already considered, such as: terminating a pregnancy that is wanted or meaningful, feelings of commitment to the pregnancy, perceived pressure from others to terminate a pregnancy, history of mental health problems prior to the pregnancy, ambivalence about the abortion decision; perceived need for secrecy; late term abortion (abortions beyond the first trimester are associated with greater risk of mental health problems), history of prior

abortion, being an adolescent (not an adult), having a non-elective "therapeutic" abortion, history of prior abortion, lack of perceived social support from others, feelings of stigma, and a few others. As can be seen, most of these have already been considered, and the APA 2008 Report (American Psychological Association Task Force on Mental Health and Abortion) lends additional support, while also reporting on some other well established risk factors, such as the risks associated with later abortions beyond 12 weeks, which Baker & Beresford (2009) had not listed, and repeat abortions also constituting a risk factor.

239. On reviewing the group of 96 affidavits and declarations, I observed that a majority of women who submitted statements included reference to one or more risk factors. Exhibit B-1 and B-2. The questionnaire did not specifically ask them about the various possible risk factors, other than one question asking whether or not the woman was pressured by anyone to have an abortion, and if so, who pressured her. As noted already, 46 women of the 96 reported being pressured, so these women were clearly at increased risk for problems after abortion. But 11 had experienced multiple abortions which is a risk factor, and a number of women reported ambivalence, high need for secrecy, young age under 21, and others at age 21-22 which is still at increased risk, several late abortions beyond the first trimester, though the majority were first trimester, a number expressing lack of emotional and support, and being very isolated, and several reported acting against their own beliefs. The forms were not designed to elicit risk factors that pre-dated the abortion, but on reading women's stories it was possible to identify that a woman was very conflicted about her decision, that another had a very

high need for secrecy and so on, so that appears that the majority had one or sometimes multiple risk factors operating and it is not surprising that so many of them report such severe lifelong symptoms. The reality is that their stories are similar to many women who choose abortion, and some of the same risk factors can be identified in some of the Red River Women's Clinic patients ' statements also. Many of these are commonly experienced among women seeking abortions.

240. Looking also into some of the other risk categories such as secrecy, ambivalence, acting against one's own beliefs, shame or guilt—these are common among women. It is well established they are risk factors, but it is not known with certainty how many women fall into each category. But from the frequency of these risk factors, it is clear that many women are at risk for increased problems after abortion.

(L) Understanding Risk Factors and Mental Health after Abortion

241. Many parents tell their children, "Don't smoke cigarettes, you'll get cancer." That is not strictly true, because my father smoked for 30 years and he did not die of lung cancer. Not everyone develops lung cancer from smoking cigarettes. In fact, smoking cigarettes increases the chances of getting lung cancer and a whole host of other illnesses, from emphysema, to chronic obstructive pulmonary disease, to heart disease, and a number of other very serious illnesses in addition to lung cancer. Some people smoke for years and perhaps do not develop any of these illnesses, but very clearly, research shows that smokers are much more at risk, not just lung cancer, but for a host of illnesses. Similarly, abortion does not automatically cause all women to have PTSD, or to commit

suicide, to develop addiction problems or sleep disorder, but it does increase their risk for all these problems, according to the best research.

242. I am speaking of risk in two different ways here, because first we considered that women in one category or another have pre-existing "risk factors" through which they experience increased risk if they have the abortion—if they have bonded to their baby, they are at increased risk, if they are pressured they are at increased risk etc. But what they are at risk of getting as a result would be a range of mental health, emotional and psychological problems. Being in a risk category does not guarantee that the woman will have mental health, emotional or psychological problems after abortion, but having one or more risk factors means that a woman is at "increased risk" to develop a problem after the abortion.

(M) <u>Conclusions Regarding Risk Factors and Mental Health after Abortion</u>.

243. To a reasonable degree of medical and scientific certainty, it is my opinion that abortion is a substantial contributing factor and cause in increasing the risk of mental health, emotional, and psychological problems for women that have had an abortion. The overwhelming preponderance of medical and scientific evidence demonstrates abortion is a substantial contributing factor in women's mental health, emotional and psychological problems. Risk factor research identifies subgroups of women at increased risk, but the presence of risk factors is ubiquitous, that most women would fall into one or more categories and thus experience some increased risk. Overall, the overwhelming preponderance of medical and scientific evidence demonstrates that abortion is a

substantial contributing factor and associated with and causes an increased risk of women's mental health, emotional and psychological problems.

(N) Rape and Incest.

244. As we have seen in the list of risk factors from the abortion provider textbook (Baker & Beresford, 2009), if a woman has had past or present sexual, physical or emotional abuse, or a prior experience of trauma, she is at risk for increased mental health problems after abortion. Contrary to popular belief, there is no basis to assume that most women would desire or benefit from an abortion in this situation.

245. The book *Victims and Victors* reports on a comprehensive analysis of reports from 192 women who had become pregnant through sexual assault, 164 by rape and 28 by incest (Reardon et al., 2000).

246. "Of the 164 women who became pregnant as a result of rape, 73 percent carried the pregnancy to term, 26 percent carried the pregnancy to term, and 2 percent had miscarriages" (Reardon et al., 2000).

247. Of those pregnant rape victims who aborted, 93% "said that abortion had not been a good solution to their problems, and stated they would not recommend it to others in their situation" (Reardon et al., 2000).

248. The authors note that "19 of the 44 rape victims who aborted (43 percent) indicated that they felt pressured or strongly directed by family or health care workers to choose an abortion (Reardon et al., 2000). For these women the desire to abort did not originate from within themselves, but was instead a concession to the suggestions or demands of others." The authors quote a number of women (in some cases using real

names, and when anonymity was requested, using pseudonyms), but the four below are representative examples:

249. "I was 22 weeks pregnant and had decided I really wanted to keep my baby. But I felt a tremendous pressure from all sides—especially to please my parents—and I finally gave in" (Reardon et al. 2000).

250. "I went to Rape Crisis and they offered to pay for the abortion. There was no alternative from them, the clinic, or even the few friends who knew [about the rape]. I chose abortion thinking it was really the only solution" (Reardon et al. 2000).

251. "Basically my friend took me by the hand and led me to the clinic where there was no discussion about alternatives, just an appointment made for me…" (Reardon et al. 2000).

252. "My parents were embarrassed about the pregnancy and insisted I have an abortion…" (Reardon et al. 2000).

253. These statements from four of the women in this study who became pregnant from the rape and then aborted do not indicate that they desired abortion. Rather, these statements indicate pressure from others, particularly parents, and also lack of exploration of options and a lack of information. Following the abortion, many women reported severe distress associated with the abortion which persisted for years, and which many reported to be more "far-reaching" than the effects of the rape.

254. Debbie Enstad (her real name), who was raped while a college student, experienced drug and alcohol abuse, suicide attempts, a failed marriage, and another abortion. She said, "I tried for years to drown the guilt and pain I felt in drugs and alcohol

But it got to the point where there weren't enough drugs…to dull the pain" (Reardon et al., 2000).

255. Helene Evans (her real name) was date raped while in college, became pregnant and aborted. She said, "Abortion does not help or solve a problem—it only compounds and creates another trauma for the already grieving victim by taking away the one thing that can bring joy." Discussing the period immediately after the abortion, Helene stated, "After the abortion, I wanted to die. How could I live when I had just ended the life of my child? The negative feelings resulting from the rape were not eliminated by the abortion…..the grief was now doubled. I became severely depressed and suicidal." With the passage of time, Helene reported, "I no longer have negative feelings about the rape…..It is the abortion that I still struggle with on a daily basis. It is difficult for me, when I see a child, not to wonder what mine would have looked like" (Reardon et al., 2000).

256. Patricia Ryan (pseudonym) became pregnant after being drugged and raped, then obtained an abortion at the urging of Planned Parenthood. She said, "The effects of the abortion are much more far-reaching than the effects of the rape in my life" (Reardon et al., 2000).

257. Rebecca Morris (pseudonym) was raped at age 15 and became pregnant, having an abortion at her mother's urging. Rebecca said, "They say abortion is the easy way out, the best thing for everyone. But they are wrong. It has been over 15 years and I still suffer" (Reardon et al., 2000).

258. The women I have known who have had abortions following rape have experienced lengthy, severe, adverse mental health, emotional and psychological consequences, which is consistent with research and consistent with these statements and similar statements quoted in *Victims and Victors* (Reardon et al., 2000).

259. In contrast to the women who aborted, the majority of pregnant rape victims who carried to term "explicitly expressed happiness that they had chosen to give birth to their child. *None* of the women stated they did not want their child or wish that they had chosen abortion instead" (Reardon et al., 2000). This is what I have observed with patients who have been sexual assault victims who have become pregnant and carried to term.

260. Mary Murray (real name) said, "I thank God for the strength He gave me to go through the bad times and for all of the joy in the good times. I will never regret that I chose to give life to my daughter" (Reardon et al., 2000).

261. Kathleen DeZeeuw (real name) had originally considered aborting her child conceived from rape, but decided to carry to term. She reports on the bonding that she experienced with her son as the pregnancy progressed: "Once the baby continued to kick and move, I began to have different feelings toward the child. I began to realize that this little life inside me was struggling too. Somehow, my heart changed." She reports maternal feelings after her son was born: "I can't begin to explain the very strong maternal feelings I had for my son. This little one had come from my womb. He's fought hard to get this far…..We were *both* victims of this assault" (Reardon et al., 2000).

262. In this same study, of the 28 women who became pregnant through incest, 50 percent carried the pregnancy to term (with some children placed for adoption and others raised by family members or the birth mother) and 50 percent had abortions (Reardon et al., 2000).

263. The decision to abort was not the choice of the young women. "None of these women reported having any input into the decision. Each was simply expected to comply with the choice of others." (In most cases, the girl's parents or the perpetrator made the decision and made the arrangements for the abortion.) In some cases, "the abortion was carried out over the objections of the girl who clearly told others that she wanted to give birth to her child" (Reardon et al., 2000).

264. "Of the 14 incest victims who had abortions, eleven explicitly stated that the abortion was not a good solution and they would not recommend it to others" (Reardon et al., 2000).

265. Edith Young (real name) was 12 years old when she became pregnant as a result of rape by her stepfather. At age 37, she stated, "The abortion which was to 'be in my best interest' just has not been. As far as I can tell, it only 'saved their reputations,' … and allowed their lives to go merrily on.....My daughter, how I miss her so. I miss her regardless of the reason for her conception." She reported years of severe emotional distress that she attributed to the abortion, and many painful physical problems such as chronic infections of tubes, ovaries and bladder." She said "Twenty-five years have gone by but the consequences of the abortion are still going on" (Reardon et al., 2000).

266. Carla Harris (pseudonym) became pregnant at age 15 as a result of sexual abuse, and the stepfather told her abortion was her only option. As an adult, married with one child, she stated, "The memories of the abortion itself are horrible, but even more painful is the fact that I killed a child…I have often wondered what my child would be like today if I hadn't had an abortion" (Reardon et al., 2000).

267. In contrast, of the 14 incest victims who carried to term, all were happy that they had been able to carry to term" (Reardon et al., 2000).

268. Considering both rape and incest victims together, of the 133 sexual assault victims who carried to term, *not one* expressed regret concerning their choice to give birth, and *not one* expressed "a wish that they had chosen abortion instead" (Reardon et al., 2000). More than 80 percent of this combined group "explicitly expressed happiness that they had chosen to give birth to their child."

269. Dr. Sandra Makhorn is a rape counselor whose earlier research results were similar to Reardon's. In a study of 37 pregnant rape victims, she found that 28 women chose to carry the pregnancy, five chose abortion, and four had unknown outcomes. Thus, at least 75% or possibly up to 85% chose to carry to term—evidence against the widely held assumption that most rape victims desire abortion. (Mahkorn, 1979).

270. Dr. Makhorn's work also showed that the majority of women who carried to term had improved self-image and a positive view of the child by the time of delivery. She concluded that "pregnancy need not impede the victim's resolution of the trauma," rather, with adequate support "healthy emotional and psychological responses are possible." She recommended that it was important to focus on ways of supporting women through their

pregnancies rather than taking the approach that "abortion is the best solution" (Makhorn & Dolan, 1981).

271. There is no published literature giving evidence that abortion improves psychological outcomes for women who become pregnant as a result of sexual assault.

272. We have already considered that women who are victims of sexual assault are at risk for having increased mental health problems after abortion, as stated in the textbook *Comprehensive Abortion Care* (Baker & Beresford, 2009). But other risk factors may additionally be present. For example, as we have seen, some of the women reported they felt "pressured" to abort, and "perceived coercion" is a known risk factor for increased mental health problems after abortion (Baker et al. 1999; Baker & Beresford, 2009; American Psychological Association Task Force on Mental Health and Abortion, 2008; Priscilla Coleman expert report, Exhibit D).

273. For a woman still an adolescent or a young adult, as was the case with many of the women in Reardon's study at the time of the sexual assault, if the parents "insisted" on the abortion, or if the perpetrator made the abortion decision, it would likely be very difficult or in many cases impossible for the young woman to refuse the abortion. Thus, a number of women from the study appear to have been experiencing coercion or pressure which is an additional, separate established risk factor for mental health problems after abortion, as reported in *Comprehensive Abortion Care* (Baker & Beresford, 2009), the APA 2008 report, and in other sources. In addition, adolescence is itself a risk factor, so multiple risk factors may be present in young women who have been sexually abused or raped, placing them at much higher risk of mental health problems after abortion.

274. Among women I know who have had abortion after rape or after sexual abuse, some have said that the abortion was more difficult for them than the rape or sexual abuse, and they have experienced distress associated with their abortion. There are few studies of women who have been raped or who have experience sexual abuse in which there has been a comparison of women who aborted vs. women who carried a pregnancy to term. However, it has been seen that there are no proven mental health benefits associated with abortion at Paragraphs 18-23 above, and there are no proven mental health benefits established for the subgroup of women who have been sexually abused or raped. The reports by Reardon et al (2000) and by Mahkorn (1979) and by Mahkorn & Dolan (1981) are consistent with what I have observed with my own patients. Due to the fact that prior sexual abuse or prior trauma have been shown to be risk factors for increased mental health problems, I would have to conclude that abortion is more harmful than helpful to women who have been sexually abused, raped or otherwise traumatized. In addition, aside from abortion risk factor research, it is known that the effects of trauma are cumulative, and when trauma occurs after previous trauma, there is greater risk of PTSD. Thus, those who have had previous trauma are generally at increased risk for mental health problems after abortion, but they are particularly at risk for developing PTSD. Thus, prevention of abortion for this group of women would be protective for their mental health.

275. Based on the foregoing, to a reasonable degree of medical and scientific certainty, my opinion is that when women have been raped, or have been victims of sexual abuse or sexual assault, or when women have been victims of trauma, they are at increased risk of

mental health problems after abortion, and they are at increased risk of developing PTSD after abortion. Thus, any reduction of abortion for this group of women will serve to reduce their risk of mental health problems by preventing the risk of abortion being added to the trauma they have already experienced. The limitation of abortion to that early period of development before heartbeat occurs will be protective of women's mental health due to abortion taking place at an earlier time period before heartbeat occurs and/or by reducing the occurrence of abortions.

(O) Failure of Counseling before and after Abortion.

276. I have already quoted portions from the affidavit of MKK (SD). Exhibit B-2, Bates 1711. She reported 27 years of "mental anguish" including the "pain of losing my child," and "the guilt and shame of what I had done." However, she states "to this day, I have only told a select few. I have had no formal counseling because I am too ashamed." She points out there is danger in women not obtaining help while inside they "still carry the wounds and scars of killing their child."

277. MKK goes on to say she avoided formal counseling because of her shame, and there is published research that indicates that shame, which is especially associated with PTSD, often keeps people from seeking help they need (Lee et al., 2001). It was also observed with the Vietnam veterans (Price, 2007) that many who needed treatment avoided it and did not seek treatment.

278. Patty Miller (SD) says, "I was so ashamed that I never talked about it with anyone, even the father, whom I later married….." Exhibit B-2, Bates 1740-41. She reports that finally, 30 years later, she did go through a counseling program which was

helpful. However, she says the negative thoughts and behaviors have absorbed half her lifetime, and that the price has been too high.

279. Shame is a very important factor in keeping women from seeking help. In my private practice, for some years, I advertised that I offered treatment for various "women's issues" including abortion issues as well as several other types of problems of special concern to women. One woman came to me seeking psychiatric help for anxiety and depression, and I treated her for two years before she finally told me that she really came because she wanted to talk to me about her past abortion. She said she had seen that ad in the phone book which is why she had chosen me, but she was too ashamed to tell me about the abortion. This gives an idea of how powerful the shame can be. I had been unsuccessfully treating her anxiety and depression with various medications for all that time, not knowing that she was struggling with memories and emotions associated with her past abortion.

280. As I have already discussed, "avoidance" is a symptom of PTSD, and of partial PTSD, and women who experienced trauma associated with abortion would be unlikely to seek counseling because of avoidance that is an intrinsic part of PTSD. They are in distress, but they fear that seeking treatment will cause even more distress, because of the necessity of revisiting the abortion experience. Many of the women who submitted affidavits and declarations stated they avoided talking about the abortion, and some said they could not even bring themselves to say the word abortion. Recall that one of the university students in the study by Curley and Johnston (2013) became so distressed when she tried to complete a questionnaire that she had to drop out of the study. For all

these women, it would be very difficult for them to go to a counselor for help, not only because of the shame, which is powerful, but because of the symptoms of avoidance, and because of the distress they experience when they do encounter reminders of the abortion. Thus many keep their secret and try to forget. There is great hesitation to talk about the abortion, but the fact that many cannot even speak of it, which is part of the illness, prevents or limits the possibility of recovery.

281. However, in addition to the shame and avoidance, there are some factors related to women's experiences with counseling at the abortion clinic that create barriers to seeking mental health treatment after abortion. Indeed, these factors in many cases prevent women who have had an abortion from obtaining the necessary and important mental health treatment they need after they have had an abortion.

282. The webpage of the National Board of Certified Counselors (NBCC) states the following: "All states in the US license professional counselors. The state counselor licensure boards administer the application processes and procedures that have been established by law in each state." In every state in the U.S. there is a licensing process for counselors.

283. In the state of North Dakota, the North Dakota Board of Counselor Examiners is responsible for the licensure of counselors who are required to have a Master's degree, which is usual for counselors in every state. See N.D.C.C. Chapter 43-47.

284. However, Dr. Warren Hern, M.D., a founding member of the National Abortion Federation, and author of an abortion textbook that is still in use, states that "there are no formal qualifications for being an abortion counselor. We have found it helpful for

prospective counselors to have a college or graduate background in the social sciences, but we have specifically avoided requirements for professional qualifications *per se.* Personal qualities are much more important."

285. It is interesting to consider that in every state in the United States there is a requirement that counselors be licensed, and the usual requirement for licensure is a Master's Degree and completion of the NBCC exam with a high enough score to meet state requirements. See N.D.C.C. § 43-47-06. But Dr. Hern views the personal qualifications as being more important for abortion counseling, with no specific academic preparation necessary for abortion counseling.

286. The personal characteristics that Hern thinks are important are that the counselor "convey warmth," and "it is important that she be a generally happy person," with "a sense of humor," who is able to "get along with others," and who has "an ability to cope with stress." As far as knowledge and skills he notes, "it is important that a prospective counselor either be well-informed about abortion in its medical, social, and political aspects or be interested in learning about it." The political aspects of abortion are apparently more important than graduate study in the actual skills of counseling.

287. Considering that abortion clinic employees provide "counseling" for which no graduate education in counseling is required, there exists a deficiency because the abortion industry has its own set of rules, while the patient’s expectations and the licensing statutes, like North Dakota, have a different set of expectations, needs and requirements.

288. In my clinical experience, patients have reported that when they arrived at the abortion clinic, they desired help with decision-making regarding their pregnancy and were still looking for options. However, because abortion clinics do not provide counseling by licensed counselors, these expectations were not met. For example, Ruth Ruch of North Dakota (Exhibit B-1, Bates 1121-22) stated, "Once I was at the abortion facility, when asked why I wanted the abortion, I told them simply, I had no other choice. I wished someone would have said—yes, you do have options, and here they are. Instead, I was told I was doing the right thing. But in my mind, I was still screaming for other options."

289. The experiences reported by my patients, and the experience of Ms. Ruch are consistent with published research. For example, in one study, (Rue et al. 2004) 79% of post-abortive women reported they were not counseled on alternatives, and 84% believed they had not received adequate counseling, with only 10.8% reporting that they considered that the counseling they received was "adequate."

290. This mismatch in expectations between the abortion patients and the clinic staff appears to originate with the National Abortion Federation. The *2013 Clinical Policy Guidelines* of the National Abortion Federation list several standards for "counseling" but no standards regarding skills, training, education or licensure for those providing the counseling (National Abortion Federation, 2013), thus providing for what is called "counseling" without use of personnel who are defined as counselors under North Dakota state law (See N.D.C.C. § 43-47-06).

291. These guidelines (National Abortion Federation, 2013) list four references regarding counseling at the abortion clinic. One is the chapter by Baker et al. (1999) in the abortion provider textbook *Clinician's Guide*, that has the National Abortion Federation logo on the cover. In the first paragraph of the chapter on counseling in the second sentence, the authors state: "The preabortion counseling session allows the patient to review her decision before taking action, identify emotions, manage those that provoke anxiety, and receive information necessary to give informed consent for the procedure."

292. Notice, the first thing that is said in that sentence is "review her decision," which would seem to indicate that the decision is already made, and she is just going to run through it one more time before taking action. There is nothing there about weighing options, getting additional information and sorting things through to make sure she makes the decision that is best for her.

293. The textbook also points out that the primary, immediate benefits of effective abortion counseling are a more pleasant and positive patient-provider relationship and a less painful abortion procedure, though secondarily, the authors point out that "unresolved conflicts may surface later, sometimes months or even years after the abortion," while, "patients who address their emotional conflicts in a timely fashion experience fewer emotional difficulties later." But as one reads through the chapter, it does appear that the primary focus is on helping the woman to have a good abortion experience that day, and to get the abortion taken care of expeditiously, not to help the woman with her decision making process. In fact, that is one of the standards listed in the

National Abortion Federation's 2013 Clinical Policy Guidelines: "A patient must undergo the abortion as expeditiously as possible in accordance with good medical practice."

294. Many women desire help in thinking things through, but the clinic is programmed to move things along expeditiously, with counseling to a large extent a formality to get the informed consent forms signed, and to make sure the woman is prepared so that she can get through the abortion process with a minimum of difficulty.

295. In the textbook (Baker et al., 1999), there is some discussion of the counselor trying to identify those patients who have significant ambivalence or emotional distress, but most clinics, like Red River Women's Clinic, do not have professional counseling staff, only personnel who are called counselors, but who are not counselors, and who may not have the skills to assess ambivalence or other risk factors. Indeed, the deposition testimony of Dr. Eggleston and Tammi Kromenaker illustrate the failure to provide adequate counseling.

296. For example, Dr. Eggleston testified at her November 26, 2013 deposition that with respect to surgical abortions, she is in the room with the patient for approximately 15 minutes and in that brief period of time, she asks whether the patient wants to have an abortion to assess whether there is coercion and performs the procedure itself. See Eggleston Deposition, pp. 50-52, pp. 70-72. This time in the examination room is the first time Dr. Eggleston will have even met the woman. Eggleston Deposition, p. 60. Once Dr. Eggleston completes the abortion, she leaves the examination room where this procedure occurred and unless there is some problem, she does not see the patient again. See Eggleston Deposition, pp. 72-73. In fact, Dr. Eggleston explained that 1-2% of the

surgical abortion patients ever return and it is not for any counseling. Eggleston Deposition, p. 62. Dr. Eggleston stated that unless the women encounters a problem, the only follow-up for medication abortions is only to perform a vaginal ultrasound to make sure the unborn child has actually "passed" but if anything "unusual" happens that the patient is given a phone number to call the Clinic. Eggleston Deposition, pp. 68-69. Dr. Eggleston confirmed the Red River Clinic has no counselors to assist women, but instead it has what she described as a patient educator. Eggleston Deposition, pp. 62-63. In a candid description of the Red River Clinic, Dr. Eggleston, in responding to what follow-up care is provided or even offered to the women who have abortions through the Red River Clinic, testified "our clinic is mainly an abortion clinic and so those appointments are few and far between." Eggleston Deposition, p. 60. In summary, Dr. Eggleston, by her own admission spends no more than 15 minutes of time with a woman and provides little, if any, counseling before the procedure and nothing afterward.

297. Likewise, the testimony of Tammi Kromenaker at her November 26, 2013 deposition illustrates the failure to provide adequate counseling, and failure to recognize the need for counseling that may include "options counseling" and exploration of the woman's unique circumstances and needs. First, Tammi Kromenaker in her November 26, 2013 deposition stated the women's decision to abort had already been made when a simple phone call is made to their clinic: "I would assume that somebody calling and saying I would like to make an appointment for an abortion has made that decision that that is her intention." Kromenaker Deposition, pp. 46-47. This is simply not the case because as explained, women do wish to explore options other than abortion, even when

present at the clinic that may perform the abortion. In addition, there are no licensed counselors on staff at the Red River Women's Clinic and no other licensed mental health professional on staff--no psychiatrist, no psychologist, though at some unspecified time in the past decade Red River Women's Clinic did have a licensed counselor on staff. Kromenaker Deposition, pp. 28- 29. Ms. Kromenaker testified that she herself has a bachelor's degree in social work but that she is no longer licensed as a social worker (page 9-10).

298. From my own experience in earning a B.S. in Psychology from the Honors College at Michigan State University, as well as from my experience in working with and supervising Masters level counselors in my career as a psychiatrist, a B.A. or B.S. is not preparation for counseling, and the knowledge and skill level is vastly different, which is why the North Dakota Board of Counselor Examiners requires an M.A. degree, as do other states. See N.D.C.C. § 43-47-06. Although I worked as a volunteer abortion counselor while an undergraduate, I did not at the time think that my training was adequate to prepare me to do what is now called "options counseling," and after helping several women obtain their abortions, I chose to move on to other aspects of clinic work due to recognition of my own lack of preparedness for the counseling work at my stage of education at the time.

299. At the website for the National Abortion Federation, I copied one paragraph of a description of a counseling education module that at some time in the past apparently was available for purchase, but is not now. I have included this paragraph below, and the section that is most pertinent in my opinion I have put in bold.

300. "Module 2 - Counseling and Informed Consent. This section provides an overview of approaches used for counseling patients seeking abortions and for obtaining informed consent. It is written with the understanding that counseling is a developed skill that requires a certain level of training and experience. The techniques for and content of **pregnancy-options counseling and pre-abortion counseling are somewhat different** subjects that require unique skills. **In many cases, the trainee may not routinely provide counseling on pregnancy options to the patient and thus may not be required to develop special skills in this area. However, the trainee should be familiar with the content of pregnancy options counseling and must be familiar with pre-abortion counseling** as well as the special considerations that apply in obtaining informed consent for abortion."

301. This "Module-2" also explains that "pregnancy-options" counseling is different from "pre-abortion counseling." Here is that mismatch again. Many women come in with the expectation that a counselor is a real counselor, and the counselor will help them to sort things through and make a good decision. Yet the "pre-abortion counseling" and "options counseling" are clearly different and those who are counseling at the abortion clinic generally do not have expertise in options counseling, and routinely do not provide this type of counseling. Therefore, any counseling that is conducted is nothing more than the requisite informed consent process and is for the purpose of trying to get the women through the procedure. They do not routinely provide counseling on pregnancy options to the patient and thus may not be required to develop special skills in this area. In fact, Ms. Kromenaker testified at her deposition that when reviewing the risks of abortion with a

woman, "we read the required statements" that are "part of that informed consent process." Kromenaker Deposition, pp. 42-44.

302. It appears that the Red River Women's Clinic is following the standards of the National Abortion Federation, but the National Abortion Federation has not kept up with mainstream health care standards. In 1973 when abortion became legal and widely available throughout all 50 states, few if any states had licensure laws for counselors, and there was no national examination for counselors in existence. Today, every state has a licensure law for counselors, with this transition to licensure of professional counselors taking place especially through the 1990's. In addition, many interdisciplinary medical teams include licensed professional counselors or licensed clinical social workers as part of a team approach to health care. For example, in cancer treatment, in rehab units treating victims of serious physical injuries, or in a dialysis center, or anywhere else within medicine that a "counselor" is used, this is normally, in 2014, a licensed counselor with a master's degree. The academic degree and the skill and expertise that go along with that degree and licensure are assumed and expected by members of the public. However, the understanding of counseling and the standards for counseling within the abortion clinic have not moved forward since the 1970's as they have within mainstream medicine.

303. Returning to the textbook *Clinician's Guide* (Baker et al., 1999), there are two items that are extremely pertinent as to the reasons women do not seek professional counseling, in my opinion, but I first want to return to the statement of MKK (Exhibit B-2, Bates 1711). She stated, "In 1978, I became pregnant and I went to my psychologist to

seek advice. He told me to go to Rapid City to get an abortion. I was never told that my baby was really a baby, I was never told there would be pain, nor was I ever told I would go through years of regret and mental anguish as a result of the abortion." Since MKK already had a relationship with a psychologist ("I went to my psychologist"), she apparently had a pre-existing mental illness, which is a very clear, undisputed risk factor for increased problems after abortion; however, she was not warned, perhaps because it was not known at the time. Even more importantly, since the psychologist had given her the advice to have the abortion, but it turned out very badly for her, it would be natural that she would no longer have confidence in that counselor and that she would not return to him. This may have been what happened because she said, "I have had no formal counseling, because I am too ashamed," for 27 years. She was not too ashamed to seek counseling for her original mental illness, but she was too ashamed to talk to anyone about the abortion—and she very likely did not have confidence in that psychologist having the ability to help her, when his original advice was so wrong for her.

304. In my opinion, a similar process as that outlined by MKK happens for women experiencing what is said to be counseling at the abortion clinics. If a woman has a counselor at the clinic, who is not skilled and not helpful, she will feel discouraged from seeking further help when needed after the abortion. Two examples from the textbook, *Clinician's Guide* (Baker et al.,1999) are illustrative. These examples demonstrate that what is considered "counseling" at the abortion clinic deviates from professional counseling in mainstream medical settings.

305. Here is the first excerpt: "When a patient cries, the clinician need not do more than pause, let her cry, and hand her a tissue. The patient's distress may diminish when the clinician attempts to understand the source of her tears. For example, 'A number of women cry at times like this and for many different reasons. I am wondering what your tears are about.' ….. If the patient says that she does not know why she is crying, she may feel relieved to realize that many other women have said the same thing. The patient and clinician can then move on" (Baker et al., 1999). The authors may be considering this recommendation in light of the abortion industry standard that "a patient must undergo the abortion as expeditiously as possible" (National Abortion Federation, 2013) but seemingly without considering the other half of the standard, "in accordance with good medical practice."

306. First of all, it is not normal for patients to cry before surgery. During my medical school training, I obtained supervised clinical experience in general surgery and in gynecological surgery through required and additional elective courses. I performed pre-op examinations on many adults and adolescents over a period of months, and never saw an adult or adolescent patient cry or exhibit tears before surgery, even before cancer surgery. It is not normal for adults or adolescents to cry before surgery. Thus, it seems highly unusual that women are crying during the pre-op preparation at the abortion clinic in this textbook example. The fact that the authors (Baker et al., 1999) chose to discuss tears occurring prior to an abortion suggests that this is a relatively frequent occurrence prior to abortion. This excerpt indicates it is indeed a frequent occurrence, stating that "a number of women cry" and that "many other women" have had this experience of crying

before an abortion. Thus it appears from the textbook that this is a frequent occurrence--frequent at an abortion clinic, but very different from what is usually seen in hospitals prior to general surgery or gynecological surgery.

307. In 1973, when I received one evening of training to become an "abortion counselor," I was taught that abortion is comparable to a tonsillectomy in that both were, at that time, considered to be very simple, safe procedures. Since that time, there has been a significant decrease in the number of tonsillectomies being performed (American Academy of Otolaryngology--Head and Neck Surgery, 2014), partly because newer information has changed the risk vs. benefit analysis today, but the belief at the time was that these were very easy surgical procedures that were not expected to elicit worry or distress or medical complications for the patient. However, if abortion is just another surgical procedure, and a very easy one at that, why the tears?

308. While it is reasonable to hand a tissue to a crying woman, responsible medical or counseling practice would require some discussion of the meaning of the tears to that woman in that circumstance. The tears indicate distress associated in some way with the abortion, and are very likely to be related to one or more of the known risk factors including ambivalence about the abortion, commitment or attachment to the pregnancy, perceived coercion to have an abortion that the woman does not desire, appraisal of abortion as extremely stressful before it occurs, or other known risk factors that should be explored (Baker & Beresford, 2009; Coleman Report, Exhibit D). Failure to fully explore the meaning of the tears with that patient prior to elective, non-emergency surgery, is unacceptable and does not meet the standard of care.

309. The second example from . *The Clinician's Guide* says, "If she is feeling guilty about 'killing a baby'" it is recommended that the counselor respond, "Your believing that you are killing a baby must make this very hard for you. Tell me more about how you are feeling." It is also suggested that the counselor ask, "Do you believe that having an abortion is the same act as killing a 4-year-old child?" If the patient says, yes, she does believe that, then the counselor may ask, "How do you think you will feel about your decision to have an abortion after it is over?" Also, "How do you think you will feel about yourself?" And, "What will you do to cope?"

310. This illustrates yet another failure of the counseling process. Women who believe they are killing a child are at increased risk for mental health, emotional and psychological problems later. This is a well-established risk factor that is listed in both *Clinician's Guide* and in *Comprehensive Abortion Care* as a risk factor (Baker et al., 1999; Baker and Beresford, 2009). Although this patient is clearly demonstrating the presence of an established risk factor, the suggested response does not indicate any recognition of that fact. The patient with these thoughts is not being appropriately warned that she is at increased risk of mental health, emotional and psychological problems in the future, if she proceeds with the abortion while holding these beliefs. A thorough discussion of risk factors is certainly indicated, but that is not suggested in this example in which a woman feels guilty about "killing a baby." (Baker et. al, 1999). Rather, the counseling is first directed toward helping the patient to consider coping strategies apparently so that the woman may be able to expeditiously proceed with the abortion. However, in my opinion, proceeding with the abortion without warning of the increased

risk of mental health problems is not "in accordance with good medical practice" which is part of the National Abortion Federation's counseling standard--the abortion must be provided expeditiously but at the same time "in accordance with good medical practice." It is not accordance with good medical practice to proceed with a surgical procedure in the presence of a known, observed risk factor without warning the patient. In this example, a belief that abortion is "killing a baby" is objectively known as a risk factor that if present places the woman at increased risk for subsequent mental health problems, and it is a risk factor that is clearly in evidence within the statements made by the patient. It does not meet the standard of care for a counselor to attempt to direct the patient to think of possible coping strategies, with a goal of proceeding with the abortion expeditiously, while failing to disclose a known risk and failing to have a full discussion of the woman's unique situation and future mental health problems for which she would be at increased risk.

311. Secondarily, the authors suggest asking this patient "What about adoption?" (Baker et al., 1999). Asking this question in this way is a very weak suggestion for possible "options counseling" at this time. "Options counseling" is certainly appropriate before proceeding with an abortion in the case of a woman who believes that abortion is "killing a baby" and who is thus at increased risk for future mental health problems. The woman deserves a full consideration of the various options that may be possible for her. Yet the National Abortion Federation viewpoint, with which I disagree, is that it is not necessary for all abortion "counselors" to be skilled at options counseling, and that some abortions "counselors" do not need to provide "options counseling." Many women in my

clinical experience have expressed that they desired "options counseling" prior to their abortion, but they were not provided with "options counseling, and many have reported receiving no counseling at all, or to the contrary, many report having experienced pressure from clinic personnel to proceed with the abortion in what they later view as undue haste.

312. In regard to the suggested question, "What about adoption?" (Baker et al., 1999), I find this a very weak and ineffective attempt at "options counseling," because in my experience the abortion patient does not know much about adoption, and it would be more appropriate for the abortion counselor to know something about adoption and to be prepared to present it in a useful way. The counselor should be able to say, "With you having this belief that you are killing a baby, I am concerned because research shows that you are at increased risk for mental health problems later. I really think we need to spend some time talking through your options. If you do feel you can't parent this baby yourself, but the abortion is already troubling you in this way, it would be good to just review some information about the many different types of adoption that are available today, and you may even want to talk to an adoption counselor before you consider proceeding with your abortion plan." The textbook response of "what about adoption" is useless, in my opinion, because adoption has changed a lot in the last twenty years and I know social workers and counselors who are not well-educated on modern adoption practices. To ask the patient "what about adoption" is asking her to consider an option the woman knows little to nothing about, rather than offering information and counsel that would help the woman evaluate that option.

313. I find that the textbook responses (Baker et al., 1999) illustrate that abortion clinic personnel are not prepared to meet the expectations of women who are clearly experiencing risk factors and who are clearly experiencing distress and conflict about the abortion prior to the procedure. Likewise, the textbook examples illustrate that clinic personnel are not prepared to help those women who are not firm in their decision, who are still looking for options, and who want help with their decision. It should be noted that in this chapter, more space is allocated to the discussion of tears than to the discussion of options counseling. Similarly, the section on guilt is also more extensive than the discussion of options counseling which is limited to one paragraph, plus the one additional sentence, "What about adoption?" These examples demonstrate the failure of the abortion counseling process to assist the woman to identify and consider risk factors clearly pertinent to her own unique situation, and the failure to provide "options counseling" to women clearly experiencing distress prior to the abortion.

314. Some additional evidence about the counseling process comes from a report of a survey of members of the National Abortion Federation (Landy & Lewit, 1982), which states: "Counseling provided by specially trained abortion counselors is a unique contribution of abortion facilities to health-care delivery. Virtually all facilities employ counselors who are neither doctors nor nurses. Most NAF facilities have more counselors than nurses and more nurses than doctors. Counseling in virtually all facilities includes providing written as well as verbal information about the nature of the procedure and its medical risks; such information is given to the patient so that she can give informed consent for the abortion. Almost all facilities include information about contraception and

about the options available to a woman with a problem pregnancy." Here it says that "specially trained abortion counselors" (non-licensed counselors who in some cases are non-degreed, since no specific degree is required) are making a unique contribution. Then it lists all the many things these counselors do, first informed consent, and second, contraceptive information, third information about "options" (although remembering not all abortion counselors do that or have the skills to do it, as per National Abortion Federation website). The National Abortion Federation touts the fact all the non-licensed "counselors" who outnumber the actual nurses and doctors, are "specially trained" for informed consent counseling, and birth control counseling and can provide options counseling. Yet without any graduate education, licensing and an internship in counseling, these untrained "counselors" at abortion clinics are unlikely to have the skill level or knowledge to do this effectively.

315. Indeed, as Ms. Kromenaker testified at her November 26, 2013 deposition (page 29), the Red River Women's Clinic does not have even one licensed counselor on staff, so that any non-licensed counselors who provide abortion counseling are not being trained and supervised by a licensed counselor. Dr. Eggleston confirmed there are no licensed counselors who can offer care and services to women that come to their Clinic.

316. Considering all of the above, it is my opinion that there is ineffective and improper counseling by abortion clinics, because these "counselors" do not have sufficient education, training or counseling internship experience to prepare them to facilitate the woman's exploration of her own unique situation and her mental health risk factors, beyond a "check the box" form. This failure of providing effective and proper

counseling leads to women being dissatisfied with the counseling they receive at abortion clinics, and this in fact is what most of my patients have reported to me concerning their level of satisfaction with counseling at abortion clinics. Therefore, in my experience women view the counselor at the abortion clinic as having failed to provide assistance because the counselor permitted and even encouraged them to make a decision that they subsequently regretted, and the counselor permitted or encouraged them to make a decision to abort an unborn child without warning them about the long-term consequences and adverse effects to their mental health.

317. A different situation occurs after the abortion when women do seek help. Many years I ago, I had a patient who had an abortion she did not want, which she had at the urging of her husband who did not want more children, although she desired the pregnancy and they were financially secure. She had the abortion to please her husband but afterwards she experienced severe depression that caused her to be admitted to a hospital where I treated her. Although her perception was that she had been well until her abortion, which is when all the symptoms started, my supervisor at the time believed that the abortion was not the problem, that the woman was only obsessing about the abortion because she had a chemical imbalance that required medication.

318. I do know that when a woman is raped, if she starts having nightmares about the rape, or if she has increased anxiety or crying spells, or bad memories of the rape, no one would tell that woman, "It's not the rape, you just have a chemical imbalance." The woman who has been raped may indeed need medication, but she needs counseling to help her process the effects of the rape and move forward, and there are support groups

and treatment protocols for helping a woman in that circumstance. But when it comes to abortion, in the past, mental health professionals have often dismissed the symptoms and have failed to recognize that the abortion is also causing serious trauma for some women.

319. At one time this lack of recognition occurred in regard to incest, when Freud long ago thought that his female patients must have been imagining the sexual abuse they reported to him, although now the mental health profession recognizes that this has been a hidden problem for too long and today there are many therapy groups and treatment protocols for adults who experienced childhood sexual abuse. This recognition process took a long time for the problem of sexual abuse, and is still in process in regard to abortion.

320. When women do come for treatment for mental health problems, it is not standard to ask routine questions about any past abortions, and if a problem is identified, few counselors have had specific training in how to help. When a woman does seek mental health treatment, she may not be believed that her problems relate to an abortion. Further, the counselor may not know how to help if he or she did recognize that a problem was associated with an abortion. Due to the shame the woman may not reveal the abortion or symptoms such as nightmares about dead babies, further hindering treatment. Finally, the counselor has not been trained to ask about past abortions. Many women will avoid going to a professional counselor due to avoidance symptoms or shame, and if she does go to a professional counselor or psychiatrist, it is not highly likely she will be helped, due to these factors.

321. However, increasingly, women are receiving help through peer support programs and faith-based programs. With peer support programs, often founded and administered by women who have had themselves had an abortion, the women do not have as much fear of being judged and shame is less of a barrier to participation in these programs (though shame is still a barrier that can prevent or delay some women's participation). Often the leaders of such programs may disclose their own past abortion as they promote the support programs through churches and in the community, so that women recognize "here is someone who understands," and it removes a barrier to seeking treatment. The faith based peer support programs have been actively promoting themselves and have been rapidly growing and multiplying over the past fifteen years especially.

322. Because there are many different peer support and faith-based programs operating with some overlap between programs, it is hard to be certain how many people are being helped in this way, but the numbers are not trivial.

323. In the Catholic Church, there are 195 church districts called dioceses. Each diocese is supposed to have a post-abortion ministry (also referred to as abortion recovery ministry). The Catholic Church in the United States has an official outreach to post-abortive women called Project Rachel, and about 160 dioceses operate a local affiliate of the national Project Rachel Ministry. Other dioceses have abortion recovery ministries that may be unaffiliated and operated independently. The Project Rachel office provides national and local training conference for clergy, lay ministers, professional counselors and peer counselors. Project Rachel recommends that each church district identify and provide special training for licensed counselors and for clergy to whom women can

receive confidential referrals for individual help if desired regarding their past abortions, and in addition, many diocesan programs offer support groups, prayer services and weekend retreats for abortion recovery. Conservatively, at least 50 women per year on average in each diocese are being helped through Catholic programs, and some programs serve 150 women or more annually. Thus over the entire U.S., 10,000 women or more are being served annually by Project Rachel. In private communication, the founder of Project Rachel, Vicki Thorn, said she thought the estimate of 10,000 per year was reasonable though probably low, and she pointed out that Project Rachel refers to priests when a clergy referral is desired, but the priests do not keep any records or numbers, due to their own standards for confidentiality, so any woman receiving help through a priest may not be counted (V. Thorn, personal communication, Dec. 9, 2013). Thorn also named a number of different additional programs including some pro-choice programs that are now offering abortion recovery, and stated there really is no way to capture the total number of those being helped through the many and varied abortion recovery programs now available.

324. CareNet, a national affiliate organization for many pro-life pregnancy resource centers, offers faith-based peer support abortion recovery groups. Data collected from CareNet affiliates indicates they serve 16,000 clients annually (personal communication, Cindy Hopkins of CareNet, November 20, 2013).

325. Heartbeat, International is a similar network of pregnancy resource centers of which 737 of their U.S. affiliates offer peer support groups for abortion recovery (personal communication, Susan Dammon, R.N., of Heartbeat, International, Nov. 21,

2013). Heartbeat does not collect data on how many people are served at each center, but if each group served 20 people per year, which is a realistic estimate, Heartbeat Centers would be serving close to 15,000 per year.

326. Abortion Recovery InterNational (ARIN) has a "Care Directory" listing thousands of abortion recovery programs in the U.S. and counselors who are prepared to help with abortion issues. The Care Directory can be accessed online, or through phoning a toll free phone number. During 2012, more than 40,000 people contacted ARIN to seek help for abortion related mental health problems. Of these, some were from other countries, but more than 30,000 were from within the U.S. and more than 80% were first time contacts seeking referrals. Some of the CareNet and Heartbeat programs are additionally listed with ARIN, which is one reason I mentioned "overlap." Some of the women counted in the 16,000 for CareNet centers may have originally contacted ARIN which may be how they learned about the CareNet program, but there are also many smaller abortion recovery ministries and unaffiliated centers, and other national programs that list with ARIN, so certainly not everyone calling ARIN would have been referred to a CareNet program, and CareNet generates many of their own local referrals through local advertising. ARIN is intended to serve as a comprehensive directory and referral source for "all" the abortion recovery programs in the U.S., to the extent possible. Not every abortion recovery program is represented but they have thousands of abortion recovery programs in their directory. (I am on the Advisory Board for ARIN).

327. There is also a National Helpline for Abortion Recovery program that receives up to 300 phone calls per month seeking referrals. They have more than one thousand

abortion recovery programs in their data base so that callers are given referrals to programs in their local area, which could be to a CareNet abortion recovery program, or to a Heartbeat program, or to Rachel's Vineyard, or to an independent counselor or program. The National Helpline may be providing around 3,000 referrals per year. A unique feature of their program is that it is staffed entirely by post-abortive individuals so that callers know they are talking to someone who understands their experience. Everyone who calls is offered a packet of resources that can be mailed to them, in addition to being given a referral. The director of the National Helpline, Millie Lace, is a licensed counselor who has written an abortion recovery treatment protocol and workbook; she uses this protocol with her own clients and is training other therapists in its use, but the Helpline refers callers to recovery programs of various types depending on the caller's preferences and what is available in the caller's local area.

328. Rachel's Vineyard Ministries, Inc. has 250 ministry teams all over the United States (and others on six continents, though only the U.S. teams are being considered here). If each team is serving only 40 people per year, that would be 10,000 people per year served by Rachel's Vineyard. This program is conducted by a team that includes at least one minister or priest, at least one mental health professional, at least one peer counselor who has had an abortion, and other volunteers to the extent needed considering the number of people served. The Rachel's Vineyard weekend program usually serves groups of approximately 10 to 20 people at one weekend, and most teams offer at least two weekends annually, sometimes three or four weekends per year. Additionally, each local Rachel's Vineyard program may offer a range of services other than just the

weekend retreat. Rachel's Vineyard does not keep data at the national office on numbers of people served throughout the U.S., but 10,000 would be a reasonable estimate of people receiving direct services through affiliates of this organization. A few Rachel's Vineyard teams receive referrals through ARIN or through the National Helpline for Abortion Recovery, but Rachel's Vineyard has their own "hotline" to help refer people to their teams throughout the U.S., and local teams also promote their programs by speaking in churches and in the community, by various means of advertising, and receive many referrals by word of mouth.

329. The Rachel's Vineyard team in Atlanta (P.A.T.H.) on whose board I serve, provides both weekend retreats and faith based support groups, and some individual or small group counseling and peer support, serving about 60 people per year. The Atlanta organization has a counselor with a Master's degree as director, and has had several other mental health professionals involved in assessing new clients and in provision of programs which also include peer counselors.

330. Having served on the advisory board for Rachel's Vineyard and having served as a consultant and trainer for many Rachel's Vineyard teams, I know that many teams are serving 60 to 70 clients per year, and in larger cities, some teams serve 150 clients annually. I think the estimate of 40 clients annually per team is low, and may be an underestimate, but there is no way to know with certainty how many are being served by Rachel's Vineyard teams, and the estimate of 10,000 (250 teams x 40 people served by each team per year) is reasonable.

331. In addition to these major national ministries listed above, there are actually many others. Save One is a peer support group program, whose founder and national director is a post-abortive women. They operate a peer support group program led by post-abortive women which runs for about 12 or 13 weeks, and can be done four times per year. Save One has more than one hundred chapters throughout the United States (as shown on their website). If each of these teams served only 10 people year, that is 1,000 people each year being helped by Save One.

332. Surrendering the Secret is a faith-based program that started three years ago that has sold 10,000 copies of their workbook since 2009 and which has trained 1,500 leaders in the past three years, though they do not know how many women have gone through their program. From the number of workbooks sold, it would appear they are averaging about 2,500 women annually (personal communication with Pat Layton, founder, Nov. 21, 2013).

333. If we add up 10,000 women served by Project Rachel, 10,000 by Rachel's Vineyard, 16,000 by CareNet, 15,000 by Heartbeat,1,000 through Save One, and 2,500 through Surrendering the Secret, at least 54,000 women are being served annually through faith-based programs, some which utilize mental health professionals and peer counselors, others relying on peer counselors. This does not account for all the people receiving help through this type of program, because there are many unaffiliated local programs which may use materials or methods from some of the larger programs or from other programs or publishers. The webpage for ARIN lists many additional programs that we have not considered here, and the total of 54,000 does not include the 40,000 people

who contacted ARIN, or those who contacted the National Helpline for Abortion Recovery, to avoid possible duplication.

334. Additionally, the American Association of Christian Counselors (AACC), a membership organization with 50,000 members, many of whom are professional, licensed mental health counselors, has recently created a new division for professional mental health counselors who have a special interest in providing counseling for problems related to pregnancy, abortion, or sexual trauma. This is a new division, and currently there are only 300 members, but this division is organizing annual continuing education workshops relevant to this topic, and increasingly, their membership will be professionally prepared to help women with mental health problems associated with and/or resulting from a previous abortion. Also, the AACC has adopted the abortion recovery program, "Into My Arms," created by a therapist who is in leadership within the new AACC division. AACC members are free to utilize any appropriate professional counseling methods to help people with abortion recovery issues, but this program is being promoted by the division, so this is another program that is and will be in the future increasingly serving many women.

335. The purpose of discussing these various abortion recovery programs is that these data show the magnitude of the mental health, emotional and psychological problems suffered by women who have had an abortion. As this discussion of these recovery programs illustrate, many women who are suffering from abortion-related trauma or other mental health effects of abortion are not entering the mental health system and receiving treatment there, due to shame and avoidance, and due to lack of expectation that they will

be helped. Some do, for example, one woman said in an affidavit or declaration that she had made a suicide attempt and had awakened in a hospital in restraints, so some do receive professional help at various times, but certainly many say they kept silent and did not seek help for a long time. When they do seek help, it is often because they have received hope through hearing a testimonial from another post-abortive individual who has spoken about her own abortion recovery through a faith based programs. Then some women, tired of suffering for so long, and discovering that nonjudgmental help is available, choose to seek help through faith based programs which have been growing exponentially over the past 15 years or so. In my opinion, the 54,000 that I suggest is an underestimate; the true number may be closer to 100,000 a year or more.

336. One benefit of the faith based programs for women who are experiencing the loss of their unborn child, is that faith based programs provide an opportunity to have a Memorial Service for the unborn child who is viewed by the woman as her own baby, and it gives her hope of seeing her child in heaven.

337. One other point is that most of these programs are entirely free of charge, since they are sponsored by nonprofit organizations and churches, though some would involve payment of a small fee for workbooks or a donation to cover lodging and meals when a weekend retreat facility is used. But the recovery programs are almost entirely operated by non-paid volunteers, and most of these programs, and even the individual mental health counseling provided, would not be billed to insurance. Thus, these programs are very low cost to the participants, which overcomes another possible barrier to treatment and there is no "record." There is a higher degree of confidentiality with these programs

since the information never gets entered to one's medical record, but when large data sets are examined for evidence of mental health treatment after abortion, participation in faith based programs will now show up, and the numbers of people receiving such treatment is not reflected in studies that utilize medical records or insurance claims. At the same time, the numbers of women participating in these faith-based programs, though the total number of participants is not fully known, demonstrates that some women do have significant distress following abortion for which help is sought.

338. It is my opinion to a reasonable degree of medical and scientific certainty that there is a failure to provide proper counseling and psychiatric care for women by abortion providers, like the Red River Clinic, and this in turn substantially increases the risk of mental health, emotional and psychological problems for women who have abortions. Again, in my opinion, this is a complete failure on the part of the Red River Clinic. Further, it is my opinion to a reasonable degree of medical and scientific certainty that many women who experience distress after abortion do not return to the abortion clinic to seek help and often do not seek help through the professional mental health system due to symptoms of avoidance and due to shame, and additionally due to disillusionment with the counseling profession based on ineffective counseling at the abortion clinics and in some cases unhelpful professional mental health counseling which has failed to recognize and address the abortion issues in a helpful way. Because of these factors, many women fail to seek treatment at all and thus do not come to professional attention, and this further conceals the problem from awareness by mental health professionals. Increasingly, many women are seeking help through faith based peer support programs and the growing

number of women seeking this help serves to illustrate that there are many women who have had distressing experiences with abortion from which they need recovery.

(P) Women unable to access abortions within time limits are protected from increased risk of mental health, emotional and psychological problems and disorders

339. To a reasonable degree of medical and scientific certainty, based on my clinical experience and the published literature, it is my opinion that to the extent that women may find themselves unable to obtain an abortion because of time limit, detection of a heartbeat or gestational age, this will provide a protection from pressure for those women who may have been experiencing pressure from others to undergo an abortion, and will protect their mental health in that they will not experience the increased risk associated with abortion. We have already considered at 18 through 23 that there are no established mental health benefits from abortion, so the women who would be turned away, if any, are not being deprived of any established mental health benefit. In my opinion, there is no peer reviewed evidence of any increased risk of any psychiatric diagnosis arising from being denied an abortion, but rather only a mental health benefit for women that could not have an abortion. Therefore, it is my opinion, to reasonable degree of medical and scientific certainty, that HB 1456 will benefit the women of North Dakota by preventing the mental health, emotional and psychological risks of abortion, and that there is no evidence of increased risk of any psychiatric diagnosis occurring from the event of women being unable to access abortion within a time limit; any short-term emotions that may, if at all, be associated with failing to obtain an abortion would be much less than the

increased risk of more severe negative reactions and mental health problems, as already discussed in this report, if the abortion were to take place after the heartbeat is present.

(Q) Statements of Red River Women's Clinic Patients

340. There is little that can be definitively concluded from the statements of the Red River Women's Clinic Patients. As mentioned previously, it is not clearly possible to tell in every case which statements were written before the abortion and which after the abortion. In addition, there are gaps of many months in between some of the statements. I note that some entries are dated, and the entries will jump from one date to another date several months later. It appears that either most patients do not write in the journals, or only certain pages have been submitted.

341. From the journal pages submitted, whatever the hopes are immediately prior to abortion or even at the time of the abortion while they are in recovery, the risk of mental health problems after abortion and of PTSD in particular would not necessarily be evident immediately, since as I have already stated, the literature shows that many people have delayed onset or late onset. So we do not know what the outcome will be for the individuals who made these statements.

342. It is true that a number of writers make hopeful statements, suggesting that abortion will make their life better, and sometimes expressing logical reasons for the abortion. But the centers in the brain that process trauma do not respond to logic. There is no research evidence that having a logical reason for an abortion prevents adverse mental health consequences of abortion. Many of these patients and those accompanying them

mention risk factors, such as being a teen, without knowing that their age places them at increased risk for mental health problems later.

343. One young man, a high school student, states of his girlfriend, "I can't imagine going through her pain." (This is located immediately following a page numbered PL 674; this may be intended as PL 675 since it is the next page following, but the copy is too dark for me to read any number that may be present.) This statement would seem to imply that he has observed her having some emotional pain concerning the abortion. If she is having emotional pain because of the abortion, why is she experiencing this pain? Is it because she has already bonded to her unborn child and it is painful to allow its life to be taken, even though because the young woman and boyfriend are still in high school, it is a logical decision. But if the young woman has bonded to her unborn child, she is at risk for future problems, whether in the short term or the long term, for example, when she carries her first intended child to term, and is reminded of this earlier child. She is at risk for future mental health problems by the fact of being in her teens, and perhaps because of having bonded to her unborn child, which is not known, or perhaps by having had distress in making this decision. We don't know the specific reason for the emotional pain, there is simply that observation, "I can't imagine going through her pain." There is no basis to expect that good, logical reasons for the abortion will override the effects of abortion in the presence of risk factors. We can't know what to except for any of these patients by their hopes or logical reasons either moments before or moments after their abortion.

344. I noticed one statement by a 15-year-old full of hope that the abortion would help her to have a better future, and it reminds me of some of the statements in the declarations and affidavits in which some women had thought that good would come from their abortion, but it brought them grief and anguish.

345. Some women mention having had a previous abortion, and they are back again; these women are at increased risk for mental health problems later, though they may have no idea, but studies show higher risk of problems for those who have repeat abortions.

346. Some of the notes are "thank you" notes to express appreciation for the funds received to obtain the abortion, but they don't reveal information about possible risk factors, nor can we know from these notes what the outcome will be for these patients three months or five years after the abortion.

347. My opinion is that nothing can be concluded from the notes of the Red River Women's Clinic patients except to recognize that some of them are in risk groups due to factors such as young age, ambivalence or repeat abortion, and some clearly are already experiencing emotional pain, which is suggestive that there may be problems later. However, it is impossible to draw any conclusions about this group.

V. SUMMARY

348. In summary, it is my opinion that an abortion is a substantial contributing factor and cause in increasing the risk of mental health, emotional and psychological problems and disorders for women who have had an abortion and in turn an abortion has a significant and profoundly adverse effect on the mental, emotional and psychological health, safety and overall well-being of women. Therefore, in my opinion HB 1456

protects women from these this increased risk and adverse effects of an abortion and in turn promotes the health, safety and well-being of women, along with protecting the life of unborn children and the health and well-being of their families, and is medically and scientifically sound and reasonable.

VI. FEES AND RECENT EXPERIENCE

349. Fees for expert services: $350 per hour for all in-office work, including record review, attorney consultation, client interviews, scientific literature searches, report-writing, affidavit construction, and testimony preparation; $350 per hour for depositions and courtroom testimony.

350. See my CV attached noting list of cases in which I was deposed or testified at trial as an expert witness.

I declare under penalty of perjury that the foregoing is true and correct.

Dated this 6th day of January, 2014

/s/ Martha W. Shuping, M.D.
Martha W. Shuping, M.D.

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EXHIBIT D

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF South Dakota)
)
COUNTY OF Minnehaha)

"My name is Dianne S. Heynen. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1) When and where was your abortion performed? 1979. Planned Parenthood in Minneapolis, MN.

2) Please describe how your abortion affected your life – has it been a positive or negative affect (please provide as much detail as possible, such as providing examples of your behaviors or events that you engaged in and your mental, emotional and physical condition that you can attribute to having your abortion)?

My abortion has had a very negative long-term affect on my life. I deeply regret it and will all the days of my life. The short-lived relief I felt after my abortion gave way to guilt and shame within weeks of the procedure. While I was glad I didn't need to tell my parents of my pregnancy, I greatly feared they would learn of the abortion. I knew that would devastate them far more greatly than my unplanned pregnancy at age 16. The guilt contributed to low self-worth, self-loathing, anxiety, anger, and great spiritual brokenness. I felt anger toward myself, our government, the abortion clinic and abortion industry. The clinic personnel never even asked about my abortion decision-making. If they had, they would have learned that two teenaged kids who found themselves "in trouble" simply didn't know how to resolve our differences. Both of us wanted to give birth to the child, with one of us wanting to place the child for adoption and the other wanting to raise the child. We were scared to ask our parents for help, so we decided on abortion -- a choice neither one of us truly wanted. Planned Parenthood claims to care

for the welfare of women, yet their abortion counseling consisted of having me watch a video rather than helping me with my obvious mental, emotional, and spiritual needs during my time of crisis. They offered no additional consideration of my needs given my young age of 16.

In subsequent years, I tried to cover my emotional distress with alcohol, promiscuity, and some drug use. When any mention of abortion occurred in discussions with family or friends, on TV, or written media, I became distressed and quickly found a reason to leave. I couldn't be around pregnant women or infants due to the emotional pain of my abortion. When my older sisters started having children, I could no longer avoid or suppress my emotional pain and my distress resulted in depression. My sisters' beautiful babies brought the reality home of what I had destroyed by my abortion. I kept most of my distress secret since only a couple of serious boyfriends and my eventual husband ever knew of my abortion. It was my well-hidden dirty, shameful secret. When I began having nightmares of giving birth to dead baby parts, I eventually, I sought help through counseling which helped the anxiety and depression. Spiritual healing brought mercy, forgiveness, and renewed hope for living purposefully.

Questions arise whether the fibromyalgia I developed in my twenties may be related to the trauma of my abortion experience or the subsequent depression and anxiety. In my forties, I had significant female problems leading to an eventual hysterectomy. It is unclear whether these female problems were related to my teenage abortion.

Prior to my abortion, I had faith in the United States government. I trusted they cared about and served to protect the welfare of their citizens. I believed they would never legalize anything that could cause such harm. My abortion experience shattered this trust. Not only was I emotionally wounded, an innocent life was terminated--limb by limb, body part by body part. Yet life, this precious life, is what our US Constitution professes to protect.

The only positive affect of my abortion on my life is the compassion I developed for hurting people through my own experience of deep emotional and spiritual suffering from my abortion. This compassion propelled me into the field of professional counseling psychology where I help bring healing to other people devastated by abortion and/or other psychological or spiritual needs.

3) Was there was a normal patient-doctor relationship between me and the abortionist?

No. I had never met the physician prior to the actual time of the abortion nor did I have any follow-up contact with him. Even at the time of the abortion, I had no consultation with the doctor. He just showed up to do the procedure. I don't think I ever saw his face other than his steely gray eyes. He stayed hidden behind his surgical mask. The only time I recall he spoke with me was to warn me of a cold scapula and when I could anticipate the most intense pain.

4) Why do I feel the abortion industry does or does not represent my interests?

I believe the psychological disequilibrium and vulnerability of women facing crisis pregnancy demands sensitivity and unbiased support. We need help to exploring our decision-making to ensure our decisions are made rationally and reflectively rather than in reaction to our fears: fear that we cannot afford to care for the child, that we are too immature, that we will be ridiculed, that we will be abandoned by our family or by the baby's father. We need help making reasoned responses to our situation based on accurate information, understanding of all options, and in accordance to our own values

and beliefs. We need accurate information about the fundamentals of each option, including various termination methods, the spectrum of adoption agreements, and resources available for pregnant women and single parents. We need to be referred to trusted associates of our faith community for our concerns of morality. We need to be screened and informed of risk factors that could lead to negative outcomes physically, psychologically, and spiritually.

Abortion is a medical right that comes from the health needs of a woman. It can only be exercised after adequate consultation with a responsible physician. The physician bears the ultimate responsibility for ensuring the recommendation to abort will benefit the us given our unique circumstances and our physical and emotional makeup. In addition, the physician is also responsible for helping the us fully understand the basis for his or her recommendation, attendant risks, and alternatives so that we can independently reevaluate the situation in light of the disclosures. Screening women for risk factors and giving them accurate information about the psychological risks they pose is highly relevant in our decision-making.

Many women, like myself, hope and expect to find this basic standard of professionalism and assistance at abortion clinics. However, from my professional work with post-abortive women, I believe the experience of many women is similar to my own: no options counseling, no fetal development information, no consultation with the physician, nor screening or inclusive information about the physical, psychological, or spiritual complications of abortion. Rather than giving accurate fetal development information, the abortion industry referred to the child in my womb as "a clump of cells", "tissue", or "the contents of the uterus". While under the pretense of protecting women from anxiety and guilt, abortion facilities' customary use of such terms robs us of our right to make a fully informed decision consistent with our beliefs and values. In effect, by depriving me of accurate fetal development information, the abortion industry made a moral decision on my behalf that caused me long-term psychological and spiritual suffering.

The abortion industry's general propaganda deceived me into believing the life of a fetus does not begin until the heart starts beating, which, at the time of my abortion in 1979 was believed to be in the second trimester. Medical science now knows the heart starts to beat on day 18. Furthermore, through advances in molecular biology, medical science knows that life begins at conception. At the moment of fertilization, the DNA of the child is formed. This DNA establishes that a totally unique human being has been created. At that moment, the sex of the baby is determined, his or her eye color, hair color, adult height, as well as many other hereditary factors. The human being is fully programmed for human growth and development for his or her entire life at the one cell stage. Each human life is a continuum that begins at conception and advances in stages until death: zygote, blastocyst, embryo, fetus, infant, child, adolescent, and adult. According to our Declaration of Independence, all humans are created equal no matter their stage of life -- from zygote to elderly adult. And, they are endowed with certain unalienable rights: life, liberty, and the pursuit of happiness. By ending the life of whole, separate, unique, innocent, living human beings, the abortion industry is in direct violation of these rights and values we Americans hold so dearly.

Abortion-on-demand is intended to eliminate the stress of crisis pregnancy. However, though the stress of the crisis pregnancy may end, the abortion itself may be experienced as a stressful and even traumatic event for many women as it was for myself. Psychological literature estimates 10 to 30% of women who experience abortion report pronounced and/or prolonged psychological difficulties attributable primarily to the

abortion. While this may be a minority of women who undergo abortion, it nevertheless translates into 5 - 15 million women harmed by abortion since its legalization in 1973.

I believe the abortion industry can prey upon vulnerable people in crisis. Rather than helping women and men work through the issue of unplanned pregnancy according to their own beliefs and values, the abortion industry portrays terminating the pregnancy as the panacea. If a couple is distressed and inconvenienced by their child's diagnosis of a major medical issue should they be given a gun and told it is their right to end the stress by killing their child? Of course not! The abortion industry contends that women have the right to choose to end their pregnancy. I disagree. No one has the right to end the life of an innocent human being.

In summary, I believe Ericka Bachiochi says it well in her book *The cost of "choice": Women evaluate the impact of abortion:*

> A culture that values the faculties of both intellect and will--that values the human person in the fullness of her dignity--would be one that comes to the assistance of the pregnant woman in crisis, helping her to see beyond her fears, to know of the help available to her, and to understand the nature of that which grows inside of her. Such a culture would expect all educated people to have some understanding of fetal development and to value the dignity of the most innocent and helpless beings in the human race. (Bachiochi 2004, 25)

5) How did my abortion or abortions impact me economically and socially: Did it help or hurt me to participate fully in the economic and social life of the nation?

As previously mention, the trauma of my abortion prevented me from sharing in our nation's social dialogue about abortion for over 20 years. For years, I also was unable to cope with the emotional pain triggered by being in relationship with pregnant women or families with infants. Additionally, I have suffered some social stigma for being a woman who killed her own child in-utero.

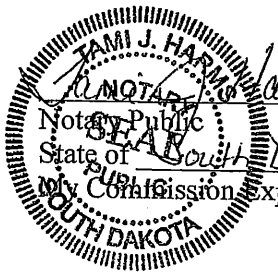
"I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct."

Executed this 22 day of Nov., 2013.

Please use my: ☐ Full name ☒ Initials only

Signature: DianneMNeyren

Subscribed and sworn before me by Dianne S. Heynen this 22nd day of November, 2013.



Tami J Harms

Notary Public
State of South Dakota
My Commission Expires: May 31, 2019

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp.,
d/b/a Red River Women's Clinic, et al.,

Plaintiffs,

vs.

Birch Burdick, in his official capacity as
State Attorney for Cass County, et al.;

Defendants.

Case No. 1:13-cv-071

DECLARATION

STATE OF New York)
COUNTY OF Westchester)

"My name is Theresa Bonopartis I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1) When and where was your abortion performed? 1971, United Hospital Port Chester New York by a Dr. Mallory

2) Please describe how your abortion affected your life – ~~was~~ has it been a positive or negative affect (please provide as much detail as possible, such as providing examples of your behaviors or events that you engaged in and your mental, emotional and physical condition that you can attribute to having your abortion)?
I suffered for years from depression, anxiety, panic attacks, low self esteem. I chose poorly because I felt I was not worth anything. I also had suicidal ideation and would close myself in my room isolating. Overwhelming feelings & fears of abandonment.

3) Was there was a normal patient-doctor relationship between me and the abortionist? Not at all- He never explained anything - the development, procedure - Nothing.

4) Why do I feel the abortion industry does or does not represent my interests? The abortion industry continues to decrease & disregard the experience of me and countless other women.

5) How did my abortion or abortions impact me economically and socially: Did it help or hurt me to participate fully in the economic and social life of the nation? Definitely a negative impact. Did not function to my potential because of the trauma and the way I viewed myself.

"I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct."

Executed this 26 day of November, 2013.

Please use my: ☐ Full name ☐ Initials only

Signature: Theresa Bonaparte

Subscribed and sworn before me by Theresa Bonapartes this 26 day of November, 2013.

Concetta Ficarra
Notary Public
State of New York
My Commission Expires: 8/22/

CONCETTA T. FICARRA
Notary Public, State of New York
No. 01FI6032155
Qualified in Westchester County
Commission Expires Aug. 22, 2014

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF TEXAS)
)
COUNTY OF ROCKWALL)

"My name is Linda Ann Huffstetler. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1) When and where was your abortion performed? 1) 1977 In Los Angeles CA. Avalon Memorial Hospital by Dr. Edward Allred. Under General Anesthesia. 2) 1980 West Covina CA Under Local Anesthesia

2) Please describe how your abortion affected your life – has it been a positive or negative affect (please provide as much detail as possible, such as providing examples of your behaviors or events that you engaged in and your mental, emotional and physical condition that you can attribute to having your abortion)? 1977 - At the very young age of 14, I made an appointment to have an abortion. The clinic told me that I would be there for about an hour and no more than two hours. I sat down with my boyfriend in the waiting room only for a few minutes, since I was the first appointment that morning. A nurse called me back. I walked into a room and they quickly had me undress, laid me on a gurney and put me completely out. A procedure that was suppose to take a few minutes ended up taking a lot longer. I was at this clinic for over 8 hours. I was never given any explanation of why I was there so long, except upon waking up, one of the nurses said that I was a lucky little girl because they thought they lost me on the table. Later, with

future surgeries, I found out that I have sensitivity to drugs used as anesthetics. This in itself was emotionally damaging, but nothing like the shame, guilt and depression I experience for many years later. I went into this clinic a scared little girl and left a different person. I numbed the pain with drugs and alcohol. I was faced with another crisis pregnancy at the age of 17. This experience was different from the first one because I was awake during the procedure. The pain was very intense and for years later I experienced post-abortion trauma and didn't even know it. I was sad all the time, had outbursts of anger for little or no reason, anxiety, nightmares, alcohol and drug abuse, and a deep depression. Eventually, I totally blocked out the memory of the second abortion completely from my mind for over 20 plus years. I became obsessed with my outward appearance. This led to bulimia. I tried to appear like I had it all together, but inside I was an emotional wreck. It nearly destroyed my marriage. I was an over-protective mother and struggled with co-dependency. Regrettably I didn't understand the reason behind these emotions until 30 years later.

3) Was there was a normal patient-doctor relationship between me and the abortionist? Absolutely not. I never even met the doctor for my first abortion in 1977. I never talked to him or saw him, before or after the procedure. I didn't even know his name until years later while I was desperately seeking the truth. 1980: I never met or talked to the doctor. The first time I saw him, he had a mask on and the only words he said to me was when I asked him to stop. He said "You should of thought about this before you got pregnant and besides it is too late." He finished the abortion and turned and walked out without saying another word. I never talked to the anesthetist. No medical history was taken and certainly no parental consent was needed.

4) Why do I feel the abortion industry does or does not represent my interests? Dealing with a crisis pregnancy, trying to make a life changing decision, I seeked out counsel to help me. I ended up calling a clinic, asking if I could talk with someone about my situation. As a teenage girl being too afraid to go to my parents or friends, I felt at the time I didn't have anyone else to talk to. I felt very scared and alone. I just need someone to tell me it was going to be alright and walk me through what to expect while being pregnant. I wanted advice on how to tell my parents. The counselor at the clinic quickly told me that "it" wasn't even a baby yet. She told me that it is just tissue until the 12th week of pregnancy. I was at nine weeks and she said that I better get in this week before the cells begin to change into a baby. She then began to lecture me, telling me that if I chose to keep this baby and make my boyfriend drop out of college, I would regret it. She then began to tell me how selfish I was to even to consider keeping the baby. She assured me that it was safe because I would be awake, not like my first abortion where I was

over-anesthetized and experience complications. She left the room while I was crying and came back with the appointment book and said that the only appointment available was the very next day. I felt pressure to agree because of fear and desperation. She then hugged me and told me that after tomorrow I can go on with my life with no one having to know as if it never happened. The next day before the procedure, I was told that it will only feel like mild menstrual cramping. The pain was so intense. I begged the doctor to stop because it was hurting really bad and I changed my mind. The doctor very meanly said I should of thought about this before I got pregnant and continued to rip my baby out of my body.

5) How did my abortion or abortions impact me economically and socially: Did it help or hurt me to participate fully in the economic and social life of the nation? My abortion experience isolated me from my friends and family. I was very insecure and never felt good enough, always feeling like I had to prove myself to others. Keeping a secret for years becomes emotionally draining. Economically - I stopped working after the birth of my first born son. Because of the abortion, I never trusted anyone with my baby even for a few hours. I was over-protective with my children because I felt like I deserved to lose my babies because of the choices I made. They never left my sight. So, I quit being a Register Dental Assistant and never went back. Moving to Texas in 2007 I went into the goat business. Before understanding post-abortive trauma I had an extremely hard time selling the kids. I couldn't handle the doe goat having her kid taking from her. It was heart breaking hearing the mom cry out for her kid and the kid crying for the mom. It got to the point that I ended up keeping every kid. I was not going to be the one to separate a mom from her kid. This was very unhealthy. Having to sell some because of tax reasons was very difficult. The behavior I had was very unhealthy. I had to interview each person who wanted to perchance from me. I had to make sure that they would love the livestock the way I did. After selling them I would go out of my way to drive by the ranch to make sure the goat was alright. This is not normal. It was like a light bulb going on once I understood post-abortive trauma. Not only did the abortion affect my human children but it spilled over to my livestock.

"I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct."

Executed this 26 day of November, 2013.

Please use my: ☑ Full name ☐ Initials only

Signature: _____

Subscribed and sworn before me by James Lamb this 26 day of NOVEMBER, 2013.

_____
Notary Public
State of TEXAS
My Commission Expires: Aug 16 2015

JAMES EDWARD LAMB
My Commission Expires
August 16, 2015

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF ___South Carolina_____)
)
COUNTY OF _____York_____)

"My name is__Golda Sharon Ross Dunn_____. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1) When and where was your abortion performed?

My abortion was performed in early February, 1975 at an abortion clinic in a low-income, predominately African-American neighborhood in Spokane, Washington. To my knowledge, no other services were provided at this facility, and no other services were offered to me.

2) Please describe how your abortion affected your life – has it been a positive or negative affect (please provide as much detail as possible, such as providing examples of your behaviors or events that you engaged in and your mental, emotional and physical condition that you can attribute to having your abortion)?

In almost every respect, my abortion affected me negatively. Physically, I had numerous female health issues, including an ectopic pregnancy, chronic bladder infections, debilitating menstrual cycles , cervical cancer and early hysterectomy. Emotionally, I struggled with depression, especially during "anniversary" dates of the abortion and what would have been the birthday of my child. I grieved a death that I couldn't share with others, and felt dead myself. Mentally, I struggled with self-hate, shame, and fear,

including fear of my "secret" being exposed and the rejection that I would receive from those around me. I was diagnosed with severe post traumatic stress disorder and treated with various anti-anxiety and anti-depression medications. I stayed in an abusive marriage with the birth father for an additional ten years, and subsequently had a failed second marriage. I tended to gravitate to abusive or non-participatory relational partners; I found it hard to bond and trust was a major issue. My work life suffered as I moved from job to job, didn't compete for promotion or recognition, and took positions below my ability and educational level. The only positive affect that my abortion had was to empower me to speak for the unborn and for the mothers of the unborn—to state clearly and loudly that there are lasting and long-term ramifications following abortion.

3) Was there was a normal patient-doctor relationship between me and the abortionist?

My abortion was arranged by phone. I did not have an initial consultation, or any after care. There was NO relationship between me and the abortionist, other than the procedure itself and the monetary relationship. I was given a couple of Valium when I entered the clinic the day of the procedure, and some pain medication to take home. I was told if I had any complications, excess bleeding or severe pain after the procedure, I should go to the nearest hospital emergency room—not return to the clinic.

4) Why do I feel the abortion industry does or does not represent my interests?

In my case, the abortion was strictly about the interests of the provider, not about my interests. I made a decision based on desperation, and this desperation fuels an industry that is highly financially profitable. The $300 fee was at least ten times more than what an office visit to my physician would have cost me. My interests were not represented on any level— not financially/economically, not emotionally, in the provision of maternal health care, or in availability of other resources, which would have encouraged me to carry my pregnancy to term and care for another child. My interests were never mentioned or discussed; by definition, therefore, they could not be represented. As my abortion was starting, I screamed and asked the provider to stop, clearly stating MY interests. I was told it was too late. Although there is talk about providing a "service," I was not counseled as to the possible long-term physical effects of having an abortion, the gestational development of my child, not told about the procedure before having the procedure, received no initial physical assessment or follow up care. The fee charged was a flat fee, and did not take into account my ability to pay. Given these facts, in my case I do not see that my interests were represented physically, mentally, financially, or emotionally.

5) How did my abortion or abortions impact me economically and socially: Did it help or hurt me to participate fully in the economic and social life of the nation?

My abortion impacted me negatively, both economically and socially. At the time of my abortion, I was not working. The fee for the procedure was borrowed. Subsequently, I moved from job to job—and from relationship to relationship. Socially, I withdrew and held my "secret" close. I did not like to see other pregnant women, and did not go to baby showers, even to those of friends. I did not form close relationships, and had a hard time trusting others. I did not like myself. I did not fight for my rights, on the job or in other relationships. I was in abusive relationships, and less than stellar jobs. I am now facing

the economic reality of being close to retirement age without the resources to move into retirement, and the possibility that I may become a drain on the economy of this nation instead of a contributor. Because I remained in a place of grief for many years, I did not participate fully in my life—and therefore, in the economic and social life of the nation.

"I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct."

Executed this 20th day of November, 2013.

Please use my: ☑ Full name ☐ Initials only

Signature: Golda S Dunn

Subscribed and sworn before me by Golda S. Dunn this 20 day of November, 2013.

Patricia S. Smith
Notary Public
State of South Carolina
My Commission Expires: 22 Feb. 2023

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF TEXAS)
)
COUNTY OF DENTON)

"My name is MYRA JEAN MYERS. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1) When and where was your abortion performed?

The last week of January 1973, I went to Planned Parenthood in Long Branch, N.J. and made an appointment for an abortion for that Saturday. As January 22 was a Monday in 1973, that Saturday was the 27th. The abortion was scheduled to be in N.Y., across the N.J. border, because the N.J. facility was not set-up yet to perform abortions. However, I would not have an abortion until February 3, 1973. Absolute Truth: The night of the 26th, I spontaneously spoke aloud, "God, is there anything wrong in what I am going to do? Man says it is not even life. What do You say?" The next morning, of my appointment, a clerk at the abortion facility in N.Y. called to tell me, "The doctor has to cancel his appointments for this morning. What do you want to do?" I did not remember my questioning of God the night before. I did not make the connection. I was not listening. When I told my husband about the cancelled appointment, he said, "What about next Saturday?" I made another abortion appointment, for February 3, 1973. My husband drove me to that appointment across the N.J. state line into N.Y. I have asked him to look at an area map. He says the abortion may well have been performed at the Planned Parenthood Newburgh Health Center, N.Y.

Please describe how your abortion affected your life – has it been a positive or negative affect (please provide as much detail as possible, such as providing examples of your behaviors or

events that you engaged in and your mental, emotional and physical condition that you can attribute to having your abortion)?

There has been nothing positive about the abortion's effect on my life. While waiting in a room for my appointment, I overheard the conversation of two other women. "It is our second, too soon." It is our third; we only want two." I felt nothing; I thought nothing. My denial was so strong, that as I lay on the abortionist's table I failed to remember being in this position five-times previously – as I birthed my children! I also failed to realize the abortion procedure would result in a hysterectomy two months later. When I recently asked my husband when did he first realize we should not have aborted our child, he replied, "When I saw your face," as I had returned to the car. The abortion destroyed our parent-child relationship and nearly destroyed our marriage through the grief, guilt, shame and the blaming! Few marriages survive. The hysterectomy following the abortion led to estrogen deprivation and depression, before and during menopause. I am still in need of hormonal therapy at the age of 69, as a result of an abortion and the following hysterectomy at 28 years of age! Believing the lie of the abortion industry that 'it is not a child ' led my husband and I to make the most devastating, tragic 'poor-choice' - resulting in our becoming responsible for the death of our child, guilty of murder.

Was there was a normal patient-doctor relationship between me and the abortionist?

I never knew his name nor had any contact with him before or after the abortion. No words were exchanged. I barely glanced in his direction as he entered the abortion room and would not be able to identify him today.

2) Why do I feel the abortion industry does or does not represent my interests?

Nothing wounds you like being responsible for your child's death! One word describes the abortion industry: Deception. Abortion took the life of our unborn child and wounded me, my husband, the siblings – our family, including the loss of our child's descendants.

How did my abortion or abortions impact me economically and socially: Did it help or hurt me to participate fully in the economic and social life of the nation?

Though my abortion took place nearly 41 years ago, there is still some medical expenses. Yet the greater negative impact is daily, individually and as a nation. With the loss of my child, the nation lost a citizen. With the collective loss of life to abortion our nation experiences the daily equivalent of 9/11! The loss of our citizens weakens the work force and military strength. Abortion's Deception that 'it' isn't life has resulted in the loss of the protection of life and the respect for life – of All 'human-beings! Abortion is destroying America, from within.

"I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct."

Executed this 13 day of December, 2013.

Please use my: ☒ Full name ☐ Initials only

Signature: Myra Jean Myers

Subscribed and sworn before me by MYRA JEAN MYERS this 3rd day of DECEMBER, 2013.

Cecile Jarman
Notary Public
State of TEXAS
My Commission Expires: 4/8/2017

CECILE JARMAN
Notary Public
State of Texas
Comm. Expires 4/8/2017

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF Texas)
)
COUNTY OF Dallas)

"My name is Paula M. Rambo. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1) When and where was your abortion performed?
Tyler, Texas
Summer (month unknown) 1990

2) Please describe how your abortion affected your life – has it been a positive or negative affect (please provide as much detail as possible, such as providing examples of your behaviors or events that you engaged in and your mental, emotional and physical condition that you can attribute to having your abortion)?
While the abortion was being done I began having an overwhelming sense of sadness and regret; I even asked the nurse if they knew whether I was carrying a boy or a girl. After leaving the clinic, I was physically sick to my stomach and overcome with grief and self-condemnation. That very day I no longer believed that I possessed any self-worth, and I labeled myself as a murderer who did not deserve respect, love or happiness in life.
For over 22 years after my abortion I engaged in unhealthy behaviors that were a direct result of the feelings about myself that my abortion caused. I detached myself emotionally from friends and family. My inability to connect to people emotionally caused me to go through two divorces and relinquish custody of my children because I did not feel that I deserved them. Because of this, my children suffered emotional trauma from being abandoned by their mother. My daughter had to undergo counseling for depression and suicidal thoughts that were a direct result from this experience. I used alcohol as a method to cope and cover up my emotional damage. The behaviors that I exhibited during this time in my life could and should have resulted in a number of life

altering permanent consequences, including but not limited to, being arrested or injuring/killing someone due to driving while impaired or contracting sexually transmitted diseases. I am fortunate that I was only left to deal with the emotional trauma that was caused by my abortion.

3) Was there was a normal patient-doctor relationship between me and the abortionist?
No. I never met the doctor who performed my abortion prior to having it done nor did I speak with him afterwards

4) Why do I feel the abortion industry does not represent my interests?
If they truly represented my interests, they would fully disclose all of the risks associated with abortion, including physical complications as well as emotional trauma that is known to occur.

5) How did my abortion or abortions impact me economically and socially: Did it help or hurt me to participate fully in the economic and social life of the nation?
My abortion had a much greater impact on me socially than economically. As I mentioned in question 2, I immediately became detached from all feelings and emotions to such an extreme that even through two divorces and being separated from my children I was unable to cry. I am very fortunate that my decisions did not have considerable impact outside of my immediate family

"I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct."

Executed this 11 day of December, 2013.

Please use my: ☒ Full name ☐ Initials only

Signature: Paula M Rambo

Subscribed and sworn before me by Paula M. Rambo this 11th day of December 2013.

KAREN BRADLEY
NOTARY PUBLIC
STATE OF TEXAS
MY COMM. EXP. 10/24/16

Karen Bradley
Notary Public
State of Texas
My Commission Expires: 10/24/2016

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF NORTH DAKOTA)
)
COUNTY OF CASS)

My name is Jody Clemens. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1) When and where was your abortion performed?

I underwent an abortion in 1972 in the State of Wisconsin.

2) Please describe how your abortion affected your life – has it been a positive or negative affect (please provide as much detail as possible, such as providing examples of your behaviors or events that you engaged in and your mental, emotional and physical condition that you can attribute to having your abortion)?

The negative effects of my abortion resulted in ten years of mental and emotional torment. I struggled with feelings of guilt, fear, shame, and regret because of the death of my child. I dealt with grief in unhealthy ways which only drove me into deeper despair. Part of me died the day my child's life was unjustly taken and I continue to live with regret and remorse.

3) Was there a normal patient-doctor relationship between me and the abortionist?

No!!! I never met or had one conversation with the physician prior to the procedure. I allowed some well-paid stranger to invade the sacred territory of my womb and end my child's life without just cause.

4) Why do I feel the abortion industry does or does not represent my interests?

The abortion industry is a money making industry that profits off women in vulnerable situations. They withhold valuable information that is essential for women to make well-informed decisions.

5) How did my abortion or abortions impact me economically and socially: Did it help or hurt me to participate fully in the economic and social life of the nation?

I was a school teacher prior to my abortion. After my abortion my life spiraled out of control resulting in me resigning from my teaching position. Because of my inability to continue teaching, I lost income and was not able to participate in the education of future generations.

6) I have previously made a statement concerning the effects of my abortion on my life which is attached as **Exhibit A,** and I incorporate all statements made therein into this Declaration.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 24 day of December, 2013.

Signature: Jody Clemens
Jody Clemens

Subscribed and sworn before me by Jody Clemens this 24 day of December, 2013

2013.

SHANNON S. LAVIN
Notary Public
State of North Dakota
My Commission Expires June 3, 2015

Shannon S Lavin
Notary Public
State of ND County OF Cass
My Commission Expires: _____

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION OF JODY CLEMENS

"My name is Jody Clemens. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

"As a woman who has been injured by the abortion industry in North Dakota, I speak from personal experience that the North Dakota ban on abortions after six weeks on a child with a heartbeat is necessary and beneficial. It will prevent devastating, irreparable damage to women like me."

"I was 23 years old, single, had successfully completed college and was teaching school when I took a pregnancy test that came back positive. I always knew getting pregnant was something that happened to others – but I never thought it would happen to me....but it did. I felt no joy or excitement but rather fear, shame and despair. My first response was that I had a problem that needed to be fixed."

"Feeling very vulnerable I spoke with several trusted individuals who advised me that abortion may be the best solution for 'this problem.' Alone and afraid and being driven by fear and insecurities an appointment was made for my abortion. The pregnancy test that once confirmed I was "having a baby" now became just another medical procedure that could be medically treated. This problem could be fixed."

"I remember vividly almost everything about the abortion. I was offered no information on the procedure, no information on fetal development, and no information on the affects and aftermath of abortion. But I was told that it wouldn't be painful, that it was a quick and easy procedure, that I would be in and out in no time at all, and that "it" was so small and nothing more than a blob of cells. They lied to me and they still are lying to women. They did not tell me about the devastating emotional consequences of abortion."

EXHIBIT A

1119

1776

"The money was collected for the abortion and then I sat and waited. My name was called and I was ushered back to a procedure room where I underwent an excruciating and painful procedure. I cried. What I had worked to successfully deny and dehumanize; now became a reality. I knew my baby was dead and what I had done I could never undo."

"I was taken to a recovery room and fear ripped my inmost being. I made a vow to myself that no one would ever know about this and I would never talk about it again. This was now my "secret" and I felt isolated and alone. My choice did not end my shame, despair, and fear ....it was only the beginning!"

"I left the abortion facility and guilt, fear, and remorse flooded every fiber of my being. The years that followed my "free choice" were lost years in many ways. I engaged in self destructive behavior and was emotionally exhausted as I worked to keep my secret. I was completely worn out and without hope. I kept thinking that if I could just do more or be better then maybe I could be okay. But I wasn't."

"I later married, never telling my husband about my abortion. I became pregnant again and only then learned that 21 days after conception that my baby's heart was beating. That meant there was new blood circulating through new veins in a new little human being. Questions flooded my mind. Why wasn't I provided with this information when I had my abortion? Why did the abortion industry hide this truth from me? Why had they lied?"

"Had I known the truth that my baby's heart was beating at the time of my abortion I would have never gone through with the procedure. A beating heart means there is life. My baby was alive – he may have been small; but he was very much alive."

"I had believed the lies of the abortion industry and in doing so allowed some well-paid stranger to invade the sacred territory of my womb to end the life of my child. Even though the Supreme Court of our beloved nation legalized this atrocity and crime against humanity they will never have the power to nullify the sense of justice that cries out to be satisfied once the truth about abortion is known. I suffered in silence for ten years living with shame, guilt and fear. I deserved the truth and did not yet it. I deserved better. All women deserve better."

"If this law had been in effect for me, I would not have suffered the irreparable injury I have. Part of me died that day and I will never fully be whole in this life. My child died that day and I will be forever hurt by that loss every day."

"I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct."

Executed this _____ day of _____, 20____.

_____

Jody Clemens

EXHIBIT A

1120

1777

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et. al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-CV-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF MINNESOTA)
)
COUNTY OF CLAY)

My name is Ruth Ruch. I am over the age of eighteen years and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1. No woman should be allowed to kill her child - no matter at what stage of life. I had my abortion in 1989 when I was 21 years old, a single mother of a 1-year-old child going to college. I was devastated by the positive result of my pregnancy test. I was raised in a loving home and never thought abortion would ever enter in my life so personally. At the time, I was young, naïve and profoundly desperate. I didn't know how I would ever manage to finish college, get a good enough job to raise two (2) children by myself, and quite frankly, was so scared of what my parents, friends and family would think of me for getting pregnant a second time out of wedlock. I thought abortion was my only option. It was the most selfish decision I ever made in my life.

2. Once I was at the abortion facility, when asked why I wanted the abortion, I told them I simply had no other choice. I wished that someone would have said - yes, you do have options and here they are. Instead I was told I was doing the right thing. But in my mind, I was screaming for someone to give me other options. I paid them money up front and no form of counseling was ever given to me. Looking back on it, they took advantage of my vulnerability in a desperate situation. I think it's important for people to know that I accept full responsibility for my actions but the abortion facility also had responsibilities and they failed miserably. Once I was led back to the room where the abortion was done, I was in extreme emotional turmoil. I had to have two

nurses hold me down as they administered 3 long needles into my cervix. When the doctor came in, I was sobbing uncontrollably. He asked me what was wrong - I told him I couldn't go through with it - that I was Catholic. He simply said, it's okay - I'm Catholic, too. I said nothing and the abortion was performed. My silence allowed the death of my child and I will no longer be silent on the issue of abortion.

3. When I was taken to the recovery room, I felt as though my heart was completely ripped out of my body. I felt dead inside. A nurse came up to me with a petri dish that was covered by a towel. She said to me, "I want you to take a look at your abortion so that you can empathize with other women in the future." What she showed me was tissue about the size of a pinky fingernail- not bloody, but simply a piece of tissue. She pointed to a small black dot in the tissue that was about the size of a pen dot. She told me that was the fetus and the entire tissue was my abortion. Now, I was 21 and knew that that was not my abortion but my frame of mind was such that I believed it was - I suppose as a way of preserving my sanity.

4. For the next 3 weeks of my life, I drank alcohol until I passed out. Slowly I began to realize that I had to somehow go on. I tried so hard to erase the memory of my abortion, but always felt like I was a terrible mother to the child I did have. I became a bulimic, struggled with alcohol addiction, thought of suicide often and lived in my own personal hell that I created for myself. I hated myself for what I had done. It was a secret that I swore I would keep until I died. When I became pregnant with my last child, 14 years later, I studied furiously all the baby development books I could. I realized what my aborted baby looked like at 8 weeks and the memories came flashing back in tidal waves. Once again, I began drinking heavily.

5. Looking back on the abortion, at the time I thought I couldn't afford to raise two young children on my own. Knowing what I know now, although I would have been poor, I would have been happy. I wouldn't be living with the guilt that I killed my child because "I couldn't afford her." It was a struggle being a single parent, but I made it and know I would have made it with two young children. I have worked hard my whole life and that wouldn't have changed. Instead, the abortion made me feel like a horrible mother.

6. I could no longer live in my private hell and sought counseling. Through a Rachel's Vineyard (www.rachelsvineyard.org) retreat, I was able to make peace with God, my child, and myself. I have since counseled many men and women through Rachel's Vineyard who have suffered the effects of their abortion - women who were raped, got pregnant through incest, and countless stories of pain and grief. Abortion hurts the unborn and their mother, their father, and entire families. If I could turn back time, I would not have had an abortion. It robbed me of nearly 20 years of my life. A person simply cannot take the life of someone else and have their conscience be free.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: December 3, 2013.

Ruth E. Ruch

Subscribed and sworn to before me this 3rd day of December, 2013.

Notary Public

REBECCA A. SWENSON
NOTARY PUBLIC—MINNESOTA
My Commission Expires JAN. 31, 2015

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp.,
d/b/a Red River Women's Clinic, et al.,

Plaintiffs,

vs.

Birch Burdick, in his official capacity as
State Attorney for Cass County, et al.;

Defendants.

Case No. 1:13-cv-071

DECLARATION

STATE OF NORTH DAKOTA)
)
COUNTY OF CASS)

"My name is Terry Melby. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

I was 27 when I had a first trimester abortion. I was a single mother of two children, and a full time nursing student. My educational goal at that time was to complete my master's degree in nursing and become a certified nurse midwife. Although I was prochoice, and had fought for abortion rights in the early 70's, I had said that I would never have an abortion. I had watched as several friends suffered after their abortions. I still thought abortion should be safe and legal, but that it should be rarely used, and only as a last resort.

There were two people I thought would help me through my pregnancy, both financially and with a place to live. I was shocked when they both said I needed to have an abortion. With their lack of support, I started to think abortion was my only option. I was managing as a single parent, and maintaining a 4.0 in college, but it was difficult. I couldn't envision staying in school and taking care of three children by myself. However, I still didn't want to have an abortion.

I went to medical professionals to ask questions about fetal development. I was told there was no human-like development; rather that it was just tissue, a POC (product of conception). Still reluctant, I asked specifically if "it" could feel pain, and was told no, that a mass of cells could not feel pain. They said the cells were about the size of dot made by a ballpoint pen. I tried to believe this. After all, they were nurses and doctors giving me the information.

The physician I went to was an infertility specialist. He did abortions in the evenings after his regular clinic hours. He offered the possibility of an adoptive home for my child with an infertile couple he was working with and said we could live with them during the pregnancy. However, I could not figure out how to explain to my other children that we would leave the baby with the adoptive couple after birth, so I declined his offer to meet with them. I told him that I did not want to have an abortion, but I did not know what else to do. The physician did not offer information on assistance with the pregnancy or single parenting with the three children. Reluctantly, I agreed to abortion, thinking it was my only option.

I was not given information about what would happen during the abortion, nor was I informed of possible complications or negative after-effects that might occur. I was told that the procedure was much safer than child birth. I was totally unprepared for the abortion procedure and its consequences.

During the abortion, I realized that I was taking the life of my child, but it was too late to stop the abortion. I did go to the post-abortion check-up, which is uncommon for women to do, mainly because I was hoping that by some miracle the baby had survived. I was told that the abortion was a success. I told him it was not a success; my child was dead. I realized I had taken the life of my child.

In the days following the abortion, I knew I was the worst mother in the world. My daily thought was: "How could a good mother kill her own child?" I began to drink very heavily and daily, which was a new behavior for me. I engaged in reckless, self-destructive behavior, like drinking and driving with my kids in the car. I desired to become pregnant again, to replace the baby I had just lost. I was suicidal, and nearly completed a suicide plan less than a month after the abortion. I suffered with physical complications caused by the abortion. Everything in my life changed after the abortion, and it took years to recover from it.

Looking back, I know I was lied to about the development of the fetus, both by the doctor and the nursing instructors who had encouraged me to have the abortion. If I had just been told the truth, that the baby was formed and had a heartbeat, I would not have gone through with the abortion. My child would be 33 years old now. My children would have had another sibling and my parents would have had another grandchild. Life would have been different for us all.

Over the past 30 years, I have worked with several post-abortive support groups, and heard the stories of many women. A common thread through their stories is the lack of accurate information they were given prior to the abortion, information that had it been received, would often have resulted in a different decision. Their children would have lived and they would have saved themselves a lifetime of regret.

I have also heard the horror stories of women who suffered with physical complications, both during and after the abortion. Most were not in a hospital setting where they could receive quality care for complications. Physical consequences included further surgery and infertility. Women said they were not warned of these possibilities. Some of the long-term consequences that women frequently talk about in a support group setting include relationship problems, self-hatred, alcohol and drug addiction, difficulty bonding with their children, eating disorders and other self-destructive behaviors.

Women deserve better. Prior to making this life-changing decision, they deserve nothing less than the truth about fetal development, the risks of the procedure, and the long-term aftereffects they may experience. If this information was readily available, many would choose to give birth to their children.

When we were fighting for abortion rights back in the 70's, we felt that we were helping to protect women's interests, to have children only when we wanted them. In the years following my abortion, I came to realize just how faulty this way of thinking was. One is never justified in killing another group of human beings, just because they are an inconvenience to ourselves or to society. As post-abortive women, we have lived with the knowledge that we took the lives of our children. It is a heavy burden, with lifelong consequences.

My abortion also had a major social and economic impact for me as a single mother. After the abortion, I changed my major, because I felt I could not work with the professors who had encouraged me to have the abortion. I completed school, but had very limited earning power with the degree I received, causing financial hardship for our family. For financial reasons, I eventually returned to school in a different state for a second bachelor's degree.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 13th day of December 2013.

Signature: Teresa A. Mahoney

Subscribed and sworn before me by Rachelle M Gerlach this 13 day of December, 2013.

RACHELLE M. GERLACH
Notary Public
STATE OF NORTH DAKOTA
My Commission Expires
August 9, 2019

Rachelle M Gerlach
Notary Public
State of North Dakota
My Commission Expires: 8/9/2019

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF North Dakota)
)
COUNTY OF Cass)

My name is Erin Hill. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

Though I didn't have my abortion in North Dakota, I know God is calling me to share my story in an effort to keep the new legislation that was passed in my dear state of North Dakota. Here is my abortion story:

1. I became pregnant at the age of 16. I got pregnant the same night I lost my virginity. It was the summer before my junior year in High School. I became very sick with classic morning sickness and knew that I was pregnant. My boyfriend was across the state, a junior in college. I was from Western North Dakota and there were no resources for a girl in a crisis pregnancy. Because we were so young & had big plans for our lives, I decided that I had to have an abortion. Though I really wanted to keep my baby, I knew that it wasn't feasible & I wouldn't get the support I hoped for from my parents. In a selfish, twisted version of love for my baby, I decided that if I couldn't have him, no one could. After I told him that I was pregnant, a few weeks after I *knew*, he began researching the abortion laws of North Dakota. We found out that because I was a minor, I wasn't able to have an abortion.

2. Eventually, my mom figured it out & confronted me. When I confirmed her suspicion of pregnancy, she quickly took action. When my boyfriend came back to visit for Thanksgiving, she told my dad. He was incredibly angry. I didn't say a word that night while my boyfriend explained *our* decision to have an abortion. The next day, I had a doctor's appointment with a Pro-choice doctor that my mom had found in Minot. That Dr. knew exactly why I was there. I was there to find out how far along I was in my pregnancy and where I needed to go to have an abortion. During that appointment, I found out that I was beyond 16 weeks pregnant, which meant that I had to leave the state to have my abortion. During that same appointment, the Dr. asked me if I wanted to hear the heartbeat of my baby. I was shocked. She *knew* why I was there. I refused because I knew that if I listened, I might change my mind & I couldn't do that.

3. After that appointment, my mom made an appointment for the abortion facility in Minneapolis. The morning of that appointment, we left early, picked up my boyfriend along the way & got to my appointment that afternoon. The first thing that happened, I paid for my abortion. $700 cash. After that, I had a supposed counseling session where I cried the entire time. I remember the counselor asking my why I was having an abortion & me explaining that I was only 16. No alternatives were offered. She also asked me why I was crying. I was upset that she had to ask. "I'm here to have an abortion. To kill my baby." I went back out into the waiting room. They move you around a lot, not allowing you a lot of time to think. The more time you are there, the more you feel invested into *their* time and more obligated to follow through with the decision.

4. After a little more waiting, we watched a movie about the procedure itself- it was an animated diagram-type movie-describing what was going to happen. I don't remember any of it because my boyfriend nearly fainted during it. Back to the waiting room. Then, to an exam room where an ultrasound was done to determine if they were legally able to do my abortion. I was 19 weeks pregnant. Near the same time when you get an ultrasound to find out the growth & development and, perhaps, the sex of your child during a "normal, healthy" pregnancy. The technician was very careful not to let me see the screen of my ultrasound. I know now that if I had seen that little head & the heart of my child beating, I would have fled and my son would be with me here today.

5. After more waiting, I was taken to change into a gown & then into an exam room where I was "implanted with 5 laminaria. They were similar in size to a wooden match stick. This was the most brutal thing that has ever happened to me. From that moment on, I HATED that "doctor". After this procedure, I was sent away to a hotel room for the night with antibiotics to prevent infection and the instructions to bring back anything

"that might fall out" wrapped in toilet paper back to the facility the next morning. I was too naïve to realize that what had just been done was putting me into labor & could have been reversed if I had been taken to an emergency room. While at the hotel I began cramping. I still had no idea what was happening. That I was going into labor, dilating & preparing to deliver & have my baby killed during the process. I hardly slept because of my discomfort.

6. The next morning, we arrived at the facility quite early. I was taken back to the same exam room I had been the day before. The same "doctor" came in & there was a nurse. She put in an I.V. for antibiotics. I remember a lot of pulling & tugging and a lot of discomfort during the procedure. I cried the entire time, saying "I'm sorry, I'm so sorry" over & over. The nurse held my hand and asked me why I was sorry. I told her I was telling my baby I was sorry because I didn't know what else to do.

7. After it was over, I got dressed & was taken to a recovery room for a little while. I then got in the car & drove back home. I went to school the next day.

8. From that day on, I was a completely different person. I became very controlling & angry. I second-guessed my every decision and have had difficulty trusting people. I became a perfectionist and an excellent student. I did everything I could to outwardly look like I was "fine".

9. I went to college to become a teacher. I know now that I did that to pay back for what I did. The father of my baby & I broke up. I became somewhat promiscuous & began to drink. I also suffered from depression.

10. My abortion was who I was, my identity. Everything I did was connected to the effects my abortion had on me. It poisoned my life. I was terrified that I would never be able to have children. And, if I did, they would be killed or hurt in some way because that is what I deserved.

11. Because of my abortion, I have had a hard time maintaining employment: I am an excellent employee, but after two or three years, I no longer have the desire to continue and tend to quite and move on to something new. This has caused a lack of security for our family.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 17 day of December, 2013.

Signature: _____
Erin Hill

Subscribed and sworn before me by Erin Hill this 17 day of December, 2013.

_____
Notary Public
State of North Dakota
My Commission Expires: Dec. 10, 2015

LEEANNE GIRODAT
Notary Public
State of North Dakota
My Commission Expires Dec.10, 2015

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF North Dakota)
)
COUNTY OF Cass)

My name is Rhonda Nygaard. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1. When I had my abortion, I was told that there were no harmful effects and my life would go back to normal. My life was anything but normal after I walked out of the abortion clinic. Immediately, I began living a lie. I kept it from family and friends as well as lying every time I went to a doctor appointment. I sabotaged relationships believing that no one could ever love someone who would have an abortion. My sense of self-worth was destroyed. I shut down emotionally and became an angry person. Being angry was safe because I could direct it at someone or something. No one told me about the emotional and physical trauma that comes with having an abortion. After years of living in pain and dealing with self-destructive behaviors, I came to a place where I wanted to reach out and help other women who were suffering from the aftermath of abortion.

2. I have been able to help several women deal with their abortions through Healing Hearts Ministries. They have experienced emotional trauma, turned to alcohol and/or drugs to bury the pain, and have had many struggles in their marriages, including affairs. They had had no idea of the devastation that awaited them after their abortions.

3. The only counseling I remember receiving was being told that no one would ever have to know. I was told that even during a medical exam, a doctor would not be able to tell I had an abortion so I wouldn't have to list it in my medical history.

4. If I had been told the truth about the development of my baby-that he was more than a mass of cells and had a heartbeat at 6 weeks-I would never have gone through my abortion.

5. After my abortion, I switched from a university to a trade school and changed my major. I believe that limited my opportunities and earning power. I realized years later that I was trying to run away from who I was and what I had done. My self esteem was destroyed and I felt so bad about myself and taking the life of my child that I didn't believe anyone could love me or want me for the mother of their children. As a result, I would sabotage relationships and never married or had other children. I believed for many years that being a wife and mother wasn't something I deserved.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 20 day of December, 2013.

Signature: Rhonda Nygaard
Rhonda Nygaard

Subscribed and sworn before me by Rhonda Nygaard this 20 day of December, 2013.

LYNETTE J. MASSETH
NOTARY PUBLIC—MINNESOTA
My Commission Expires JAN. 31, 2015

Lynette J. Masseth
Notary Public
State of Minnesota
My Commission Expires: Jan 31, 2015

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

MKB Management Corp., d/b/a Red River Women's Clinic, et al.,	)	
Plaintiffs,	)	
vs.	)	Case No. 1:13-cv-071
Birch Burdick, in his official capacity as State Attorney for Cass County, et al.;	)	
Defendants.	)	

DECLARATION

STATE OF NORTH DAKOTA)
)
COUNTY OF CASS)

My name is Kay Kiefer. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1) When and where was your abortion performed?

January 1984 in Grand Forks, ND.

2) Please describe how your abortion affected your life – has it been a positive or negative affect (please provide as much detail as possible, such as providing examples of your behaviors or events that you engaged in and your mental, emotional and physical condition that you can attribute to having your abortion)?

This was the single worst decision of my life. After my abortion, I felt intense guilt, shame, fear and self-hatred. For a time, I drank heavily to try to forget what I had done. I was terrified that others would find out and was certain that God would never forgive me. As the years went on, I became a perfectionist – trying to be the perfect wife and mother. I became depressed and developed an ongoing anxiety disorder.

3) Was there a normal patient-doctor relationship between me and the abortionist?

No. I never saw him before the abortion and never saw him after the abortion. No consult beforehand and no follow-up care.

4) Why do I feel the abortion industry does or does not represent my interests?

I do not feel that the abortion industry represents my interests – or the best interests of women in general. It is not good health care to fail to provide fully informed consent of all possible risks related to abortion, including physical and emotional consequences. That is the standard in medicine.

5) How did my abortion or abortions impact me economically and socially: Did it help or hurt me to participate fully in the economic and social life of the nation?

My abortion caused me to have very low self-worth, which led me to think I was not good enough/able/etc. to pursue further education or more profitable employment, until many years passed.

6) I have previously made a statement concerning the effects of my abortion on my life which is attached as **Exhibit A,** and I incorporate all statements made therein into this Declaration.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 16 day of December, 2013.

Signature: Kay Kiefer

Kay Kiefer

Subscribed and sworn before me by Kay Kiefer this 16 day of December, 2013.

Jolene Demarais
Notary Public
State of North Dakota
My Commission Expires: 11-06-19

JOLENE DEMARAIS
Notary Public
State of North Dakota
My Commission Expires Nov. 6, 2019

When I was 19 years old, I had a first trimester abortion. It was the single worst decision of my life. The emotional and spiritual fallout from that abortion nearly destroyed me.

Not one person talked to me about the baby – about what stage of development my baby was at and what developmental milestones may have already taken place. No one talked to me about the possibility of adoption and what that might look like. And, no one certainly talked to me about what could happen to me – physically, emotionally, spiritually - after my abortion.

No one told me that I could feel such intense hatred and disgust for myself and for what I had done. To deal with those feelings and to try to forget what I had done, I drank heavily for a number of years following my abortion. With the drinking came promiscuity and other self-destructive behaviors. I was terrified of God's judgment and knew that I deserved whatever I got. I was sure that if anyone knew this about me, that they could never accept me or love me. And, I was certain that I would never be able to have children.

I did go on to get married and have three children. I was extremely fearful during my pregnancies that something would happen to the baby or that something would be 'wrong' with them when they were born. I became a very strict, perfectionist mother – insisting that my children be perfectly clean, perfectly well behaved, etc... a most unrealistic expectation.

I threw myself into doing good things for other people and trying to be the best person that I could be, in an attempt to make up somehow for my abortion. I never spoke about the abortion...I couldn't even say the word 'abortion' out loud. Every time I drove by a pro-life billboard or heard something about abortion, I felt like a hot spear went right through me. After many years, I was exhausted by living this way and found myself in a pit of despair and depression. I was diagnosed with a major depressive disorder, combined with anxiety and was placed on medication. Several years ago, a counselor that I saw identified my abortion as the major source of my issues. I really didn't want to hear that and she made me kind of mad. But, she was right. Once I had turned to God and fully admitted to Him what I had done, I was finally free from fear and found peace. By that time, however, I had kept this secret for 20 years. It was a long time to be stuck in that place of isolation and fear and shame.

I am a nurse. In the medical profession, informed consent for procedures and surgeries is extremely thorough. Every possible risk or side effect, no matter how slight the risk, is disclosed to the patient BEFORE they proceed. Even when my own children had their wisdom teeth out, I remember clearly being told that a risk with anesthesia could be death. With abortion, things are much different. Risks are minimized, if discussed at all. There is another developing human being involved in this circumstance. As such, care should be taken so that the OTHER person in the circumstance (i.e. the mother) understands clearly all that she can about that little one. I remember when I discovered after my abortion that my baby's heart was already beating when he was aborted. I was devastated. A heartbeat is how we determine that someone is still alive. If I had known this before my abortion, I just do not believe that I could have gone through with it. It is simply not good health care

for women to avoid giving them the best information available about the risks and consequences of abortion, as well as explaining the stage of fetal development that their child is at.

Abortion hurts women. It hurts men, children and families. Abortion hurts society and it hurt me.

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EXHIBIT A
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