Character does count, respect for the truth, respect for hard work, respect for each other. He demonstrated that as a role model. So I thank him. I thank the members of the Committee on Government Reform and the Subcommittee on Postal Service for bringing this bill out on the floor of the House. So I ask people to vote for it.

Mr. Speaker, I yield back the balance of my time.

Mr. CUMMINGS. Mr. Speaker, may I inquire as to how much time we have remaining?

The SPEAKER pro tempore (Mr. GIBBONS). The gentleman Maryland (Mr. CUMMINGS) has 8 minutes remaining.

Mr. CUMMINGS. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, as I listened to the distinguished gentleman from Illinois (Mr. GUTIERREZ), I could not help, Mr. Speaker, but think about my own life in South Baltimore and watching Roberto Clemente on television.

I just want the gentleman from Illinois to know, Mr. Speaker, that he is absolutely right. Roberto Clemente was more than a hero to just the Puerto Rican community or Hispanic community, but he was a hero to all of us. When we look at what he accomplished in his life, he not only touched the Hispanic and Puerto Rican community, but he touched the world. He touched the world in a way that we could probably never do right by in these proceedings.

1515

Last but not least, I was also very moved, Mr. Speaker, by the comments of the gentleman from Illinois (Mr. GUTIERREZ), when he talked about the naming of a post office so that the children could have an opportunity to see that name on that post office. Many, many years from now, when that post office stands and that name is up there, it may be so long from now that somebody may say, well, who was that. The fact is that somebody will know who he was and will know that he came upon this Earth, he saw it, he looked and said, I can make a difference by simply being the best that I can be, working hard, and giving to mankind.

Mr. Speaker, I applaud the gentleman for this bill. I want to thank the gentlewoman from Maryland (Mrs. MORELLA) and the entire committee for making sure this bill got to the floor, and I urge all my colleagues to vote in favor of it.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. GIBBONS). The question is on the motion offered by the gentlewoman from Maryland (Mrs. MORELLA) that the House suspend the rules and pass the bill, H.R. 4831, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The title of the bill was amended so as to read: ''A bill to redesignate the facility of the United States Postal Service located at 2339 North California Avenue in Chicago, Illinois, as the 'Roberto Clemente Post Office'.''.

A motion to reconsider was laid on the table.

MESSAGE FROM THE PRESIDENT

A message in writing from the President of the United States was communicated to the House by Mr. Sherman Williams, one of his secretaries.

SENSE OF CONGRESS WITH RESPECT TO POSTPARTUM DEPRESSION

Mr. BILIRAKIS. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 163) expressing the sense of the House of Representatives with respect to postpartum depression.

The Clerk read as follows:

H. RES. 163

Whereas postpartum depression is the name given to a wide range of emotional, psychological, and physiological reactions to childbirth including loneliness, sadness, fatigue, low self-esteem, loss of identity, increased vulnerability, irritability, confusion, disorientation, memory impairment, agitation, and anxiety, which challenge the stamina of the new mother suffering from postpartum depression and can intensify and impair her ability to function and nurture her newborn(s);

Whereas as many as 400,000 American women will suffer from postpartum depression this year and will require treatment. This constitutes up to 20 percent of women who give birth. Incidence of mild, ''transitory blues'' ranges from 500 to 800 cases per 1,000 births (50 to 80 percent);

Whereas postpartum depression is the result of a chemical imbalance triggered by a sudden dramatic drop in hormonal production after the birth of a baby, especially in women who have an increased risk. Those women at highest risk are those with a previous psychiatric difficulty, such as depression, anxiety, or panic disorder. Levels of risk are greater for those with a family member suffering from the same, including alcoholism;

Whereas women are more likely to suffer from mood and anxiety disorders during pregnancy and following childbirth than at any other time in their lives. 70 to 80 percent of all new mothers suffer some degree of postpartum mood disorder lasting anywhere from a week to as much as a year or more. Approximately 10 to 20 percent of new mothers experience a paralyzing, diagnosable clinical depression;

Whereas many new mothers suffering from postpartum depression require counseling and treatment, yet many do not realize that they require help. It is imperative that the health care provider who treats her has a thorough understanding of this disorder. Those whose illness is severe may require medication to correct the underlying brain chemistry that is disturbed. This often debilitating condition has typically been a silent condition suffered privately by women because of the feelings of shame or guilt;

Whereas postpartum depression frequently strikes without warning in women without any past emotional problems, without any history of depression and without any complications in pregnancy. Postpartum depression strikes mothers who are in very satisfying marriages as well as those who are single. It strikes women who had easy pregnancies and deliveries, as well as women who suffered prolonged, complicated labors and caesarean section deliveries. Symptoms may appear at any time after delivery, often after the woman has returned home from the hospital. It may strike after the first, third, or even fourth birth;

Whereas postpartum depression is not a new phenomenon. Hippocrates observed the connection between childbirth and mental illness over 2,000 years ago. Louis V. Marce, a French physician, detailed the identifiable signs and symptoms of postpartum depression in 1858;

Whereas the most extreme and rare form of this condition, called postpartum psychosis, hosts a quick and severe onset, usually within 3 months. 80 percent of all cases of this more extreme form present within 3 to 14 days after delivery with intensifying symptoms; once suffered recurrence rate with subsequent pregnancies is high;

Whereas postpartum mood disorders occur after the mother has had frequent contact prenatally with health care professionals who might identify symptoms and those at risk. In the United States, where medical surveillance of new mothers often lapses between discharge from the hospital and the physical checkup 6 weeks later, the recognition of postpartum illness is left mainly to chance. The focus of the 6-week checkup is on the medical aspects of her reproductive system and not her mental health;

Whereas having a baby often marks one of the happiest times in a woman's life. For 9 months, she awaits her child's birth with a whole range of emotions ranging from nervous anticipation to complete joy. Society is quite clear about what her emotions are expected to be once the baby is born. Joy and other positive feelings are emphasized, while sadness and other negative emotions are minimized. It is culturally acceptable to be depressed after a death or divorce but not by the arrival of an infant. Because of the social stigma surrounding depression after delivery, women are afraid to say that something is wrong if they are experiencing something different than what they are expected to feel. Mothers are ashamed, fearful, and embarrassed to share their negative feelings and can also be fearful of losing their babies;

Whereas treatment can significantly reduce the duration and severity of postpartum psychiatric illness;

Whereas postpartum depression dramatically distorts the image of perfect new motherhood and is often dismissed by those suffering and those around her. It is thought to be a weakness on the part of the sufferer—self-induced an self-controllable;

Whereas education can help take away the ''stigma'' of postpartum depression and can make it easier to detect and diagnose this disorder in its earliest stages, preventing the most severe cases;

Whereas at present, the United States lacks any organized treatment protocol for postpartum depression. Sufferers have few treatment resources. The United States lags behind most other developed countries in providing such information, support, and treatment;

Whereas the United States Government and its agencies collect very little data on postpartum illness;

Whereas if early recognition and treatment are to occur, postpartum depression must be discussed in childbirth classes and obstetrical office visits, as are conditions, such as hemorrhage and sepsis;

Whereas early detection, diagnosis, and treatment of postpartum illness will become easier if public education is enhanced to lift the social stigma, thereby increasing the chance that women will inform others of her

symptoms as she would for physical complications;

Whereas research shows that in the first few weeks after delivery, a woman's chance of requiring a psychiatric admission is 7 times higher than at any other time in her life. It is estimated that as many as 90 percent realize something is wrong, but less than 2 percent report symptoms to their health care provider. The remaining individuals are either undiagnosed, misdiagnosed, or seek no medical assistance;

Whereas it is estimated that as many as 90 percent of women realize something is wrong; however less than 2 percent report symptoms to their health care provider. Only about 20 percent of women with the disorder receive treatment. The remaining individuals are either undiagnosed, misdiagnosed, or seek no medical assistance;

Whereas in addition to the mother, the effects of postpartum depression can also impact the child and the father significantly. Infants of mothers with postpartum depression are at risk for socioemotional difficulties in life. Maternal depression can affect the mother's ability to respond sensitively to her infant's needs. A depressed mother is less likely to provide her children with appropriate levels of stimulation and to express positive affect. Research generally shows that children who receive warm and responsive caregiving from the moment of birth and are securely attached to their caregivers cope with difficult times more easily when they are older. They are more curious, get along better with other children, and perform better in school than those who are less securely attached;

Whereas a mother's marriage can also become severely strained when dealing with a postpartum illness. Husbands/fathers feel anxious and helpless, not understanding what is going wrong or what is the source of the depression. They can express exasperation and even resentment as a result of the problems created by the illness. They are also more likely to become depressed themselves, further compromising the functioning of the family. Lack of support from the partner can contribute to the development or continuation of postpartum depression. Husbands, partners, family members, and friends need access to information on these issues in order to support their wives, relatives, or friends;

Whereas severe postpartum illness can obstruct the important pattern of friendship and support that most couples with newborns tend to form. Family units as a whole can experience isolation;

Whereas education is helpful to new parents coping with these emotional and hormonal changes and also helps them to decide if and when they need to seek outside help; and

Whereas postpartum depression is one of the most treatable and curable of all forms of mental illness. Learning about postpartum depression helps prevent it and relieve it: Now, therefore, be it

Resolved, That the House of Representatives—

(1) recommends that all hospitals and clinics which deliver babies provide departing new mothers and fathers or family members with complete information about postpartum depression, its symptoms, methods of coping with it, and treatment resources;

(2) encourages all obstetricians to inquire prenatally about any psychiatric problems the mother may have experienced, including substance abuse, existence of the above in any family members, and, ideally screen for ongoing depression;

(3) encourages all obstetricians to screen new mothers for postpartum depression symptoms prior to discharge from the hospital and again when they bring in their babies for early checkups;

(4) recommends that appropriate health care professionals be trained specifically in screening women for signs of postpartum depression in order to improve chances of early detection;

(5) recognizes that a coordinated system of registry should be developed to collect data on mental disorders in the new mother and that the National Institutes of Health should undertake additional research on postpartum psychiatric illnesses;

(6) recognizes the impact of a mother's postpartum depression on fathers and other family members as well and strongly encourages that they be included in both the education and treatment processes to help them better understand the nature and causes of postpartum depression so they too can overcome the spillover effects of the condition and improve their ability to be supportive; and

(7) calls on the citizens of the United States, particularly the medical community, to learn more about postpartum depression, how to educate women and families about it, and thus ultimately lower the likelihood that women around the country will continue to suffer in silence.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Florida (Mr. BILIRAKIS).

GENERAL LEAVE

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H. Res. 163, the legislation now under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume, and I rise today in support of H. Res. 163, a resolution expressing the sense of the House of Representatives regarding postpartum depression, legislation introduced by our colleague, the gentleman from Georgia (Mr. KINGSTON).

This year, as many as 20 percent of American mothers will suffer from postpartum depression. The resolution before us recognizes that this condition is the result of a chemical imbalance triggered by a sudden dramatic drop in hormonal production after the birth of a baby. H. Res. 163 is designed to increase public awareness and understanding so that thousands of women will no longer be forced to suffer in silence.

Among its provisions, the resolution encourages all obstetricians to screen new mothers for postpartum depression symptoms prior to discharge from the hospital and again when they bring in their babies for early checkups. It also recommends that appropriate health care professionals be trained specifically in screening women for signs of postpartum depression in order to improve chances of early detection.

Mr. Speaker, H. Res. 163 emphasizes our commitment to increased access to information about postpartum depression, its symptoms and treatment resources. I ask every Member to join me in supporting passage of this important resolution by the House today.

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in strong support of H. Res. 163, which focuses on a condition that has not received the attention that it deserves. I want to commend my colleagues, the gentleman from Georgia (Mr. KINGSTON) and especially the gentlewoman from California (Mrs. CAPPS), for introducing this resolution.

The gentlewoman from California (Mrs. CAPPS), a nurse, is one of the most knowledgeable and active members of the Subcommittee on Health and Environment of the Committee on Commerce. I feel privileged to work with her in the subcommittee, and I am proud to join her as a cosponsor of this resolution.

The gentlewoman from California's district is home to Postpartum Support International, an advocacy and support group founded by Jane Honikman. Jane is a pioneer in this field, and I know the gentlewoman from California would want to acknowledge her important contribution, as we do here today.

Each year, 400,000 American women, 20 percent of those who give birth, experience some postpartum depression caused by chemical imbalance. Hundreds of thousands more experience some of the symptoms, which can include such impairments as disorientation, memory impairment, profound anxiety, and heightened fatigue. This is not an exhaustive list.

It is tragic that so many new mothers are robbed of the joy at such a miraculous time in their lives, and it is tragic that postpartum depression is so often ignored or stigmatized when it should be aggressively treated.

The first months of life are critical for a newborn and profoundly challenging for new mothers. This resolution recommends several important steps the Nation can take to help new mothers and to help their families cope with postpartum depression.

It recommends providing women with information on postpartum depression before they take their babies home from the hospital so that women affected by this condition recognize the symptoms and seek help as soon as possible.

It recommends providing training so health professionals know what signs to look for in new mothers. Doctors should be encouraged to screen new mothers for symptoms prior to discharging them from the hospital and when they bring their babies for early checkups.

And it also recommends we begin to collect data on postpartum depression in the United States.

To effectively target public awareness and treatment, it is important to track the incidence and the prevalence of this condition in different subpopulations. Again, I applaud the gentleman from Georgia (Mr. KINGSTON) and the gentlewoman from California (Mrs. CAPPS) for offering this resolution, and I urge its passage.

Mr. DINGELL. Mr. Speaker, I support H. Res. 163, which recognizes the debilitating effects of post-partum depression on new mothers, their babies and their families. I want to pay particular tribute to my friend and colleague, Representative CAPPS, as well as Representative KINGSTON, for their work on this matter.

H. Res. 163 encourages health care providers to become more attuned to the signs of this common, treatable aftermath of pregnancy in order to detect the problem in its earliest days and offer appropriate interventions.

This weeks' announcement that the Nobel prize in medicine is being awarded to three scientists whose discoveries have unlocked keys to the central nervous system, including the understanding the biochemical underpinnings of depression, underscores the importance of the mind-body connection. Depression is indeed a physiologic response, and there is no time in a woman's life when her physiology changes as markedly and as abruptly as it does with the delivery of a baby. Set against the excitement of a new birth, the emergence of an unexpected mood disorder, such as post-partum depression, can be frightening and confusing. Ironically, detecting this problem takes us back to the heart of the patient-provider relationship by employing our lowest-tech, most-highly valued tools, talking and listening to the patient.

The American College of Obstetricians and Gynecologists suggests that thorough medical history-taking as early as the first prenatal visit can assist providers in identifying those women at highest risk for post-partum depression. Post-partum depression can be diagnoses by simply asking a new mother about a number of aspects of here new life. Her answers and mood are keys to an early and correct diagnosis. This approach also provides an opening for a woman to discuss feelings she may finding shameful and frightening. With an accurate diagnosis, treatment can begin, benefitting mother, baby and family.

As Congress today recognizes the research and treatment needs of women experiencing post-partum depression, we must also recognize that many of the women at highest risk for this condition live outside of the health care safety net, and therefore will not benefit from early detection and intervention. The Congress must work to solve these inequities. We must also work to assure that whatever reforms occur in the healthcare delivery system, providers must never stop talking with their patients. As the lines between medical and mental health problems blur, all health care providers need access to the most up-to-date information, so that opportunities to diagnose and treat problems such as post-partum depression are not missed. This resolution is one step in that direction.

Mrs. CAPPS. Mr. Speaker, I rise today in strong support of H. Res. 163, which calls attention to a condition that affects thousands of women across this country, post partum depression.

This resolution was introduced in May of 1999 by my colleague JACK KINGSTON and I. I want to thank him for his hard work and leadership in this area.

Approximately 400,000 women will experience post partum depression this year, and many do not even know that they need help. This condition can put a strain on family relationships, at a time when most families are often experiencing the joy of the birth of a child.

As a nurse for many years, I have seen firsthand how much women, their families and partners struggle with this difficult condition.

There is great stigma associated with post partum depression, as many women feel ashamed of the feelings that they are experiencing.

There are some steps that can be taken to alleviate this suffering. Our resolution makes some important recommendations.

This legislation recommends that women be provided with information on post partum depression before they leave the hospitals with their babies. This way they can know what signs to look for in those early post-natal days.

It also calls for more training of medical providers, so that they know what signs to look for in new mothers. Doctors should be encouraged to screen new mothers for symptoms prior to discharge from the hospital and when they bring their babies for early check-ups. The earlier we identify the symptoms, the better.

Finally it recommends that we begin to collect data on post partum depression in the U.S., so that we can measure its extent. The National Institute of Mental Health is currently researching the topic, but more must be done. Federal funding is sorely needed in this area.

My district is home to Post Partum Support International, an advocacy and support group founded by my constituent Jane Honikman. Jane is a pioneer in this field, and I applaud the work that she continues to do on this topic every day.

Mr. Speaker, here in Congress we must work to raise awareness of post-partum depression, in order to ultimately lower the likelihood that women around the country will continue to experience it. Women and families around this country have suffered for too long in silence.

Mr. BLILEY. Mr. Speaker, I rise in support of H. Res. 163, which expresses the sense of the House of Representatives with respect to postpartum depression.

The birth of a child is a most joyous occasion for a family. Unfortunately, postpartum depression after childbirth is a common condition for some new moms. In fact, up to 80 percent of new moms experience ''baby blues,'' a mild depression that begins in the first days after childbirth and lasts 2 weeks or less. Postpartum depression lasts longer than the ''baby blues'' however and its symptoms are far more intense and constant.

This condition also affects women who for whatever reason do not carry their pregnancy to term. The sudden and dramatic drop in hormonal production after the termination of pregnancy often results in feelings of guilt, insomnia, and postpartum depression. The same sudden drop in hormonal production found in women with postpartum depression also contributes to the feelings of guilt, insomnia, and depression immediately following an abortion. In fact, a national poll found that at least 56 percent of women experience a sense of guilt over their decision to have an abortion, and a 5-year study shows that 25 percent of women who have had abortions sought out psychiatric care, versus just 3 percent of women who have not had abortions. Further, numerous studies reveal that women who have had an abortion experience a high incidence of depression, stress, low self-esteem, suicidal feelings, and substance abuse. Some abortion reactions may even fit into the model of complicated bereavement or pathological grief.

I ask unanimous consent to enter into the RECORD two studies on the link between clinical depression and abortion (Angelo, E.J., ''Psychiatric Sequelae of Abortion: The Many Faces of Post-Abortion Grief,'' Linacre Quarterly, 59(2): 69–80, 1992; Brown, D., Elkins, T.E., Lardson, D.B., ''Prolonged Grieving After Abortion,'' J Clinical Ethics, 4(2): 118–123 (1993)).

In light of these widespread and related afflictions, Congress should be more attentive to post-abortion depression as a related condition that calls out for more research from the National Institutes of Health. I urge Members to join me in supporting passage of H. Res. 163.

PSYCHIATRIC SEQUELAE OF ABORTION: THE MANY FACES OF POST-ABORTION GRIEF

(By E. Joanne Angelo, M.D.)

This paper was presented at the N.F.C.P.G. annual meeting in October of 1991.

Induced abortion is the surgical or medical intervention in a pregnancy for the purpose of causing the death of the embryo or fetus. (If the procedure results in a live birth, the outcome is a preterm delivery, not an abortion.) Every abortion, then, is an iatrogenic death. Every post-abortion woman has undergone a real death experience—the death of her child.

Grief is a natural consequence of death. Current obstetrical and psychiatric literature abounds with articles about grief following perinatal death—death due to spontaneous abortion, premature birth, stillbirth, and Sudden Infant Death Syndrome. However, it is only in recent years that the medical profession has begun to understand that perinatal losses can be followed by a grief reaction similar to the loss of an older child or an adult as illustrated by the following statement in Clinics of OB/GYN in 1986. ''I can state most assuredly that couples with recurrent, unexplained or explained early pregnancy losses grieve as intensely as those with later losses or losses of live-born children. Their grief is not visible, however, since society, family, friends, press, or clergy do not support or are not trained to support them. The grief is very real and if unattended can eventually be felt by them to be aberrant, unnatural, or even unhealthy.''

Hospital obstetrical units have developed teams of physicians, nurses, and social workers to help parents deal with perinatal death and the issues of grief, anger, and guilt which it raises. The September 1990 issue of the British Journal of Obstetrics and Gynecology states: ''Ways of helping parents cope with their losses have been recommended and have reduced the frequency of prolonged emotional disturbance and of abnormal grief reactions. . . . Ways of facilitating the grieving process have been identified. These include seeing and holding the dead baby, giving it a name and taking photographs; all help make the situation a reality and to create memories. It is difficult to grieve when no memory of the individual exists.''

In addition to the 20 to 30 percent of pregnancies thought to end in spontaneous abortion in this country, there is now one elective abortion for every three live births. Evidence is mounting that the reaction to the loss of a child from induced abortion is part of the same continuum of grief. In an editorial in the Lancet (March 2, 1991) entitled, ''When is a fetus a dead baby?,'' the author acknowledges that grief follows early pregnancy loss regardless of its cause, ''There is no doubt that the profession, led by society, more readily accepts that miscarriage, termination, stillbirth, and neonatal death lie in a spectrum of the same grief. . . . Why should the death of a baby be a unique zone of grief? Perhaps it is because to the parents, and to the mother in particular, an unknown potential has been lost.'' With half of all pregnancies resulting in fetal death, our society is facing a potential epidemic of invisible mourning and pathological grief.

Grief after induced abortion is often more profound and delayed than grief after other perinatal losses. Grief after elective abortion is uniquely poignant because it is largely hidden. The post-abortion woman's grief is not acknowledged by society because the reality of her child's death is not acknowledged. In order to gain her consent for the abortion she has been told that the procedure will remove a ''blob of tissue'' a ''product of conception'', or a ''pre-embryo.'' She has been assured that her ''problem will be solved'' and that she will be able to ''get on with her life'' as though nothing significant had happened.

Yet the pregnant woman knows by the changes in her body that something very significant is happening to her: her menses have stopped, her breasts are enlarging, she is sick in the morning (or all day long), and she knows that the process which has begun in her will most likely result in the birth of a baby in nine months time if allowed to run its course. She is aware of the expected date of delivery and she has often thought of a name for her baby as she has begun to picture the child as he or she would be at birth (Bonding begins very early in pregnancy.). All of these feelings and fantasies about her pregnancy must be denied in order to undergo an elective abortion. The pregnant woman is asked to deny the fact that she is carrying a child at all!

Society offers her no support in grieving. Her decision to undergo an abortion is made very quickly without time for calm reflection or seeking advice. The whole process is usually kept secret from her family and friends and professional colleagues, and often even from the father of her child. Abortion clinics offer no ''Perinatal Loss Team'' to help her deal with her confusing and perhaps overwhelming feelings. She is typically alone, without her partner during the procedure. There is no dead child to hold, no photographs, no funeral, burial, or grave to visit, no consolation from friends, relatives or clergy. Her only memories are of a rushed, painful procedure and of her own efforts to convince herself that what her ''abortion counselor'' had told her was true. The psychological defense mechanisms of denial and repression are massively in effect by the time she leaves the clinic. It is not surprising then, that ''exit poll'' research and studies of the immediate post-abortion days, weeks and months find that women feel relieved and claim to have no adverse psychological aftereffects of elective abortion. When pain and bleeding remind her of the physical assault on her body and when the sudden and unnatural endocrine changes cause her to become emotionally labile, society continues to expect her to act as if nothing had happened. Her attempts to comply with those expectations are at great personal expense. She may begin to dose herself with alcohol or sleeping pills to deal with the nightmares and her feelings of grief and guilt; she may throw herself into intense activity—work or study or attempts to repair her intimate relationships or to develop new ones. When waves of sadness, anger, emptiness, and loneliness overwhelm her she berates herself for not ''feeling fine'' as is expected of her.

Women who have chosen abortion are often haunted by the obsessive thought, ''I killed my baby!'' They find themselves alone to cope not only with the loss of the child they will never know, but also with their personal responsibility in the child's death. their guilt is not merely subjective or neurotic; it is objective and real. Reminders are all around them—the expected date of delivery, children the same age that their children would have been, a visit to the gynecologist, the sound of the suction machine in the dentist's office, a baby in a television ad, a new birth, another death experience. Each of these may trigger a breakthrough of guilt, grief, anger, and even despair. This cycle typically continues for many months or years before appropriate help is found because until recently mental health professionals have failed to recognize the many faces of post-abortion grief.

UNCOMPLICATED BEREAVEMENT (NORMAL GRIEF)

Grief is the subjective experience which follows the death of a loved one. Psychiatrists agree that the period of mourning after a significant loss normally continues for at least a year after the death, and that if ''grief work'' is not accomplished appropriately, unresolved grief can produce a variety of psychological and psychosomatic symptoms over time.

Horowitz divides normal grief into four stages:

1. OUTCRY which occurs immediately after the death when there may be an intense expression of emotion and an immediate turning to others for help and consolation.

2. DENIAL PHASE during which the bereaved person may avoid reminders of the deceased and focus attention on other things and during which an emotional numbness of blunting may occur.

3. INTRUSION PHASE during which negative recollections of the deceased become frequent, including bad dreams and daytime preoccupations which may interfere with concentration on other tasks.

4. WORKING THROUGH during which the bereaved person begins to experience both positive and negative memories of the deceased, but without the intrusive, disturbing quality which they had had previously and when emotional numbness lessens. The process of working through has reached completion when the bereaved person once again has the emotional energy to invest in new relationships, to work, to create, and to experience positive states of mind.

PATHOLOGICAL GRIEF

Pathological grief occurs when the normal stages of grief are intensified, prolonged or delayed and when the bereaved person is not able to resume normal functioning due to the development of other psychiatric of psychophysiologic symptoms. Horowitz gives the following examples of pathological grief.

Immediately following the death the OUTCRY may be intensified into a panic state where behavior is erratic, and self-coherence is lost in a flood of uncontrolled fear and grief. Alternatively, the bereaved person's withdrawal may be exaggerated into a dissociative state or a reactive psychotic state.

When the DENIAL PHASE is pathological the following may occur; ''overuse of alcohol or drugs to anesthetize the person to pain. Some persons may seek to jam all channels of consciousness with stimuli, avoiding thinking and feeling about the death. To escape feeling dead and unreal, one may engage in frenzied sexual, athletic, work, thrill-seeking, or risktaking activities.''

Risk factors for the development of pathological grief are listed in Michels' 1990 textbook Psychiatry:

''Some circumstances are likely to increase the severity or duration of grief reactions. These include pre-existing high dependency on the deceased, pre-existing frustration or anxiety in relating to the deceased, unexpected or tortuous deaths, a sense of alienation from or antagonism to others, a history of multiple, unintegrated earlier losses or simultaneous losses, and real or fantasied responsibility for the suffering or death itself. When several of these factors are present, a complicated bereavement reaction may result that warrants diagnosis as one of the anxiety or depressive disorders (including Post-traumatic Stress Disorder), an adjustment disorder, reactive psychosis, or a flare up of a pre-existing personality disorder.''

DEPRESSION

Pathological or unresolved grief has long been recognized as a precursor to serious depressive illness. Shakespeare's Macbeth says, ''Give sorrow words; the grief that does not speak knits up the o'erwrought heart and bids it break . . .'' The current Diagnostic and Statistical Manual of Mental Disorders states, ''morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment, or psychomotor retardation, or prolonged duration suggests that bereavement is complicated by a Major Depressive Episode.''

In a review article, ''Mental Health and Abortion'' in the Psychiatric Journal of the University of Ottowa (1989), Phillip Nay concludes that although depression was once a frequent indicator for induced abortion, ''depression is likely to be worsened by abortion because if increases guilt and causes another loss.''

Depressive disorders are the most common reason for psychiatric referral of post-abortion women in my experience. Suicidal ideation, impairment of the ability to carry out daily functions at work, school, or home, somatic symptoms such as weight loss and insomnia make psychiatric care imperative. Psychiatric intervention often includes antidepressant medication and/or hospitalization, as well as intensive psychotherapy. Although the diagnosis of Major Depressive Episode is made and appropriate initial treatment instituted, the significance of the early pregnancy loss through abortion as a causative factor is often overlooked. This may occur for a number of reasons.

1. The patient may not volunteer her abortion history, and may be reluctant to answer routine questions about her reproductive history because of intense shame and guilt and because of a lack of a trusting relationship with her therapist, which takes time to develop.

2. A long time may have passed since her abortion, and the psychiatrist may not be aware of the very common delay of eight to ten years from the induced abortion until the woman seeks help for her depression, which has become so severe that she can no longer function and her life is in danger. An eight to ten year delay in seeking help has been a common finding in outreach programs to post-abortion women across the United States.

3. So many other negative factors in the history could account for the woman's depression: alcohol and drug abuse, failed marriages, job stress, intrusive obsessive

thoughts which may appear to be psychotic in nature. An example of the latter is the case of a 75 year old woman in a nursing home who was heard muttering over and over again ''I killed my baby!'', and who, in fact, had an abortion sixty years before.

4. Society's ''blind spot'' regarding the significance of perinatal loss and the grief following induced abortion is shared by many psychiatrists and other mental health professionals. If her tentative attempts to share her profound grief and guilt with her therapist are not heard or are belittled, the post-abortion women's sense of worthlessness and despair may increase and she may be confirmed in her conviction that no one will ever understand or be able to help. She may discontinue her medication, cancel appointments, and sink even more deeply into depression.

Peterson, who is studying post-abortion women in Germany, believes that when deep feelings of guilt which have been suppressed for a long time are followed by ''a breakthrough of destructive deep awareness, with chaos and panic, revulsion and hate'' these feelings must be acknowledged and the woman helped to come to ''acceptance of existing reality, responsibility and feeling of guilt toward the dead child.'' It is my experience that only when the therapist can endure the flood of primitive emotions which the patient needs to pour out over a number of sessions without rejecting her or asking her to diminish their intensity, can he or she begin to help the post-abortion woman in her work of mourning.

Although there are no visual memories of her child, no pictures, no shared experiences to help her work through the grief process, she has frequently formed a mental image of her child. It is in fact that mental image which has been haunting her, intruding itself into her thoughts day and night. Often the image is of an infant being torn to pieces sucked down into a tube, crying out in pain, or reaching out to her for help. She has often named her child and may have regularly occurring conversations with him or her in her mind. The work of therapy involves allowing her to share these images and to accept her guilt while at the same time the therapist is kind and supportive to her. Gradually she will learn to accept the reality of what has happened and her own responsibility in the death of her child. In time she can begin to develop a mental image of her child no longer suffering and crying out to her but at peace and at rest.

The treatment of depression in a post-abortion woman involves more than providing for her safety and physical well-being (emergency psychiatric care) or offering her appropriate anti-depressant medication if indicated. One must also allow her to share the overwhelming guilt, sorrow, anger and self-hate which she has harbored perhaps for years and which she has attempted to deal with by dosing herself with alcohol, drugs, and frenzied activity. Her fantasies about her dead child must also be acknowledged for these are her only memories of her baby. Gradually these fantasies can be shaped in a more positive and consoling manner so that she can finally put them to rest. Clergy can be helpful in this process both in helping the woman seek forgiveness and in offering prayers and/or a memorial service for her baby.

SUICIDE

''Women in the first year after childbirth and during pregnancy have a low risk of suicide'' is the conclusion reached by Appleby after studying all women aged 15 to 44 who committed suicide in England and Wales from 1973 to 1984.'' The actual number of suicides in this group was only one-sixth of that expected relative to other women of the same age leading him to conclude, ''Motherhood seems to protect against suicide. Concern for dependents may be an important focus for suicide prevention in clinical practice.''

The same study found, however, that the suicide rate after stillbirth was six times that for all mothers after childbirth. While the birth of a living child seems to ''protect against suicide'', it would appear that the birth of a dead child greatly increases the risk of suicide. What then of the risk of suicide after elective abortion when the mother is not only dealing with the death of her child but with her responsibility in causing that death? In my search of the literature I have not found any such demographic studies.

It is well known that youthful suicides are increasing at an alarming rate, and that the majority of these occur between the ages of 15 and 24 years which is the same age group where most induced abortions occur. Most adolescent suicides occur in the middle and upper socioeconomic class as do most abortions. ''Suicidal behavior in 'normal' adolescents'' is the topic of a 1989 study published in the American Journal of Orthopsychiatry, Sexuality and loss were two of four risk factors which causes a nearly five fold increase in the risk of suicidality in a sample of 300 public high school students in grade 9–12 in a small Northeastern community. Although the report of the study does not include data about abortions, the correlation between teen sexual activity, pregnancy and loss through abortion is apparent in this population.

The newsletter of the American Suicide Foundation observes that, ''Specific crises and environmental stressors may precipitate suicidal behavior, although it can be hard to appreciate the stressfulness of a seemingly minor event that falls on the shoulders of an adolescent who is already burdened with depression.''

Some case vignettes from my own practice may illustrate why elective abortion is anything but a minor event in the lives of young women and their partners.

''Lorna'', a 22 year-old woman in the military was referred to me because of an eating disorder. In our first visit she told me that for the past year since her elective abortion she had wanted to die. In fact she had made a suicide attempt two days before he scheduled abortion when she felt that she could neither go through with it nor face the rest of her tour of duty in the military as a single parent. When she was unsuccessful in causing a fatal automobile accident after she had overdosed on drugs and alcohol, she had been admitted to a psychiatric inpatient unit.

Her psychiatrist advised her to go through with the abortion which has been scheduled for her the next day. Since that time her cocaine and alcohol use had escalated and her weight had continually dropped. She was haunted by a strong desire to be united with her baby, and by the urge to kill herself. In the year in which I worked intensely with her she made several suicide attempts and was re-hospitalized once. Before she moved out of the area she thanked me for having helped her, saying: ''I'm not going to kill myself now, but when I die I know that's how it will happen.'' A year later it did happen.

A 23 year old single woman whom I have called ''Joyce'' was referred to me after a suicide attempt which also involved a planned drunk driving accident. Her obsessive through was, ''I want my babies!'' She had had two abortions, one at the age of 17, and once at the age of 18 while in high school. She was the youngest in a large family and still living at home. Her fear was that if she told her parents (who were older and in precarious health) that she has become pregnant and had the abortions they would ''drop deaf of heart attacks.'' She suffered alone for six years with her guilt and her longing for her lost children. When an uncle who was a priest returned from overseas she planned to tell him her tragic story. Before she could talk with him he suddenly died of a heart attack. Mourning his death and now convinced that she would never be able to share her guilt and grief without risking further losses, she planned her own death both to end her pain and to achieve a reunion with her children and her uncle.

An 18 year old gas station attendant, ''Peter'', shot himself and died three months after his father's unexpected death. Only his closest friend knew that at the time of his suicide he was despondent over his girlfriend's abortion. Their child had been conceived on the day of his father's death. In Peter's mind a mental image of the child had formed: he had told his friend that he would have a son and that he planned to name the boy after his father. The loss of that child and all that he represented to Peter was more than he could bear.

POST-TRAUMATIC STRESS DISORDER

Post-traumatic Stress Disorder is one of the Anxiety Disorders listed in the Diagnostic and Statistical Manual of Mental Disorders. ''The characteristic symptoms involve re-experiencing the traumatic event, avoidance of stimuli associated with the event or numbing of general responsiveness, and increased arousal . . . The most common traumata involve either a serious threat to one's life or to physical integrity; a serious threat or harm to one's children, spouse, or other close relatives and friends. . . . The disorder is apparently more severe and longer lasting when the stressor is of human design.'' A list of life events which may cause sufficient stress to produce Post-Traumatic Stress Disorder includes abortion. The most familiar type of Post Traumatic stress disorder or P.T.S.D., is ''Post Vietnam Syndrome.'' Following induced abortion, many women experience similar symptoms. In fact the similarities are so striking that some clinicians have coined the term ''Post Abortion Syndrome.''

Characteristic symptoms of Post Traumatic Stress Disorder include: recurrent and intrusive distressing recollections and/or dreams of the event, sudden acting or feeling as if the traumatic event were recurring (flashbacks), and intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma; persistent avoidance of stimuli associated with the trauma, emotional numbness and an inability to feel emotions of any type, especially those associated with intimacy, tenderness and sexuality; and increased symptoms of arousal i.e. startle responses; recurrent nightmares and sleep disturbances. A case vignette follows:

''Alice'', an attractive professional woman in her early thirties, was referred because of marital problems, sleeplessness, anxiety and a sense of being hyperalert and over-reactive to loud noises. These latter symptoms interfered with her work which placed her constantly in the public eye. She had had a traumatic abortion a year before arranged for her by her husband in a clandestine manner. She had been experiencing frightening dreams, daytime flashbacks, intense anger and loathing for her husband and suicidal preoccupations for the past year. ''I killed my baby! I don't deserve to live!'' were the intrusive thoughts which haunted her waking hours. She had been seriously contemplating suicide.

ANNIVERSARY REACTIONS

Suicide attempts on the expected date of delivery of the aborted child or subsequent

anniversaries of that date or the date of the abortion are common. Tishler describes two adolescent girls who attempted suicide on the approximate date the fetus would have been born had it come to term although one of them was not consciously aware of the significance of the date prior to her medication overdose.

Thirty out of 83 women surveyed regarding post-abortion coping reported anniversary reactions associated with the abortion or the due date in a 1989 study from the Department of Psychiatry of the Medical College of Ohio. In addition to intense and persistent emotional pain after abortion, these anniversary reactions were characterized by physical symptoms most commonly involving the reproductive system—abdominal pain and dyspareunia, also headaches, chest pain, eating irregularities and increased drug and alcohol abuse. The authors state, ''The time-specific relationship of the symptoms to the original experience is often not recognized by the subject and appears to be an attempt to master through reliving rather than remembering. Unresolved grief and pre-existing dysphoria have been suggested as increasing the likelihood of anniversary reactions.''

If the conflicted issues could be sequestered on a subconscious level throughout most of the year and arise only under camouflage to some extent, then a protective role is certainly possible. The woman might be able to receive concern and attention from others without necessarily having the conflict identified. The authors advise physicians and therapists to ask about particular events which may have occurred around the time of year when the patient presents poorly explained physical or psychiatric symptoms. It is easy to see how excessive medical work-ups could lead to unnecessary tests and procedures and even unnecessary surgery.

The authors also report that women in the non-anniversary group in their study mentioned self-punishment as their reason for having a hysterectomy or tubal ligation or for suicidal behavior.

The following case illustrates an unusual anniversary reaction:

''Akiko'', a Japanese college student, was referred for presumed Premenstrual Syndrome (PMS) which was in fact an acute anniversary reaction to her abortion which recurred monthly. One or two days each month her dormitory staff reported that she would not come out of her room for meals or for classes and spent the time crying inconsolably—a most unusual occurrence among Asian students in their experience.

Akiko had had an abortion the day before she left Japan to come to the U.S. to study early childhood education. Her first college classes focused on pre-natal development. During a film showing intra-uterine life she suddenly became aware of the actual developmental stage of the fetus she had aborted a few weeks before. From then on, each month on the anniversary of her abortion she had become overwhelmed and inconsolable by sadness and guilt which she could not share with anyone.

In the context of helping her to work through her grief, I asked Akiko about how women in Japan deal with post-abortion grief. I learned that it is common for mothers in Japan to request memorial services for their children whom they believe they have ''sent from dark to dark.'' At Buddhist temples parents rent stone statues of children for a year during which time prayers are offered for the babies to the god Jizu. More recently, the goddess Mizuko Kanon is believed to be better able to care for these water babies who arrive with smashed heads and shredded bodies because she has large hands with webbed fingers. Parents regularly visit these statues and leave toys, flowers and written messages for their babies.

PSYCHOSOMATIC SYMPTOMS

In addition to the psychophysiological anniversary reactions described above, the chronic stress of unresolved post-abortion grief can also provide classical psychophysiologic reactions as the following case illustrates.

''Jerry'' was doubled over in pain before a scheduled media presentation. He had not had time for breakfast and forgotten the antacid medication he regularly took to control the peptic ulcer which he had recently developed. Jerry's wife had aborted their first child without his knowledge, and had aborted their second child without his consent. After the birth of their third child, Jerry had become over-protective of the boy, spending every waking moment with him, even changing his work schedule so as to be alone with him while his wife worked. A divorce ensued and sole custody of the child was awarded to his ex-wife. Jerry's grief became profound and his psychosomatic symptoms increased.

FAMILY ISSUES

As has been described above, post-abortion grief may be responsible for marital conflicts, problems with sexual intimacy, and parent-child relationship difficulties. Two additional case vignettes will further illustrate these issues.

''John'' was a 28 year old office worker who entered psychotherapy because of a depressed mood, difficulty sleeping, lack of concentration at work, and conflicts with his wife and children. After several apparently unproductive sessions with his therapist, he reported a dream during which a former girlfriend brought him into a room and introduced him to a ten year old boy, stating, ''This is your son!'' Only then did he recall her pregnancy with their child and his active participation in her abortion. Subsequent work with him revealed that it was his unresolved grief and guilt over that child's loss which was responsible for his current symptoms.

''Jeannie'' was a six year old girl who was referred for evaluation of school phobic symptoms. Her separation anxiety began at kindergarten and had not abated in first grade. She often stayed home complaining of stomach aches and headaches. She would only go to school accompanied by her mother, and terrible scenes occurred each time her mother was encouraged to leave with crying, screaming and kicking. Jeannie's mother was afraid to leave her at school in that state even though the teachers assured her that within a few minutes after her mother's departure Jeannie was able to enter the classroom and participate with the other children.

Jeannie's mother had aborted her previous pregnancy—a decision which she deeply regretted. This next child was burdened with her mother's pathologically intense attachment to her which did not allow for age-appropriate separation and growth for her child.

CONCLUSION

In 1973, an article in the Journal of the National Medical Association stated, ''Early information would tend to alert the physician to the need for systematic follow-up of all abortion patients . . . The epidemologic consequences of abortion may (therefore) become statistically relevant in the not-too-distant future with far-reaching public health significance.''

With 26 million abortions in this country in the 18 years since Roe v. Wade, and the continuing rate of 1.6 million abortions per year, we can no longer deny the public health significance of their psychological and psychophysiological sequelae. Epidemological studies are urgently needed which are statistically sound and which follow women and men for at least ten years post-abortion.

In the meantime, case reports remain valid psychiatric documentation of the many faces of post-abortion grief. The traditional teaching of our profession has not been by means of controlled studies with a sample of several hundred and statistically significant standard deviations. Sigmund Freud, Eric Erikson, Viktor Frankl, Jean Piaget, and Robert Coles have told us about individuals who they have studied in depth. Their detailed case studies have led to lasting insights into human development and the origins and treatment of psychopathology.

The best treatment for any illness, of course, is primary prevention. Primary prevention of the negative psychiatric sequellae of abortion involves the prevention of abortion itself by means of offering compassionate alternatives such as support in child bearing, child rearing and adoption, but more importantly the prevention of untimely pregnancy by teaching the true meaning of an reverence for human sexuality.

___

[From the Journal of Clinical Ethics, Summer 1993]

PROLONGED GRIEVING AFTER ABORTION: A DESCRIPTIVE STUDY

(By Douglas Brown, Thomas E. Elkins, and David B. Larson)

INTRODUCTION

''Legal abortion of an unwanted pregnancy in the first trimester does not post a psychological hazard for women.'' As exceptions to this widely held generalization, most gynecologists have an anecdotal story or two about a patient's prolonged grieving after undergoing an abortion.

Clinicians searching for perspective on a patient's prolonged grieving may be surprised by the number of publications about potentially negative psychological sequel following induced abortion. Reviews of this vast literature have located at least 30 attempts to design either randomized longitudinal studies or retrospective studies of prolonged grieving after abortion. Based on questionnaires, psychological tests, and interviews, these studies have reported prevalences of negative psychological sequel ranging from 2 percent to 41 percent. Most of the studies did not follow participants past one year after their abortions. The six studies that attempted to identify and interpret prolonged negative experiences after induced abortion all reported the phenomenon, but they questioned whether the abortion itself or circumstances precipitating the choice of abortion brought on the symptoms.

Together, these studies have tended to encourage the generalization that abortion, when a conflict-free decision, brings relief to the patient. A corollary to this generalization is that abortion can have a disturbing or stabilizing impact, depending upon the past mental health history, emotional dynamics, and life circumstances peculiar to each woman who aborts. Most of the researchers who conducted these studies have been careful to admit that their conclusions are somewhat tenuous, given the possibly inherent incompatibility between the objectivity sought in a randomized study and the deeply personal subject matter. Recent literature reviews have drawn specific attention to such methodological limitations.

A clinician's search for perspective may be further complicated when the literature-review articles are themselves compared. For instance, American Family Physician and Psychiatric Journal of the University of Ottawa published review articles that had less

than one-third of their research citations in common. Of those few citations in common, one-third were presented with nearly opposite interpretations by the two reviews.

Both the research and the reviews of research that favor the generalization that in most instances abortion does not precipitate debilitating psychological sequelae appear to be significantly limited. Nonetheless, we do not in this article take issue with this generalization about abortion. We do contend that attention to each patient's well-being and to the containment of healthcare costs keeps the issue of potentially negative and prolonged psychological sequelae clinically relevant. For instance, given the annual average of 1.5 million abortions in this country alone, a 1 percent prevalence of a single psychiatric disorder—major depression—tranlates into 15,000 patients.

In response to a presidential assignment, Surgeon General Koop reported in 1989 that the research to date was so ambiguous or flawed that no conclusion about psychological consequences from abortion could be drawn. He believed the subject was important enough to recommend a definitive, multimillion dollar, randomized, longitudial study. However, when the initiation of such a study remains doubtful and when retrospective studies have proven inconclusive, some perspective on this concern can still be sought through a presentation of cases.

Accordingly, this article examines the experience of negative emotional sequelae after abortion expressed by one previously undescribed group of patients, with particular focus on the prolonged nature of their experience. What is lacking in objectivity from these unstructured responses is partially offset by the open-ended admission of feeling and still-active painful memories. Current attention in medical ethics literature to patients' life stories, which a case-series design complements, provides a conceptual framework within which to hear these women share a portion of their stories.

METHODOLOGY

This study documents the selfreported suffering experienced by 45 women after undergoing induced abortions. In 1987, the surgeon general invited several religious leaders from across the United States to Washington, D.C., to relate and comment upon the possible adverse consequences of abortion in the experience of women in their congregations. Among the invitees was the pastor of a large Protestant congregation in Florida. The congregation was predominantly of white, urban, and middle-to-upper-class.

After informing a Sunday morning gathering—which included from 1,600 to 2,000 women on any given Sunday—of the upcoming meeting, this pastor asked for descriptive letters from women who had negative experiences that they perceived to be linked with a past abortion. One week later, 61 replies, most anonymously forwarded through the mail, had arrived. No follow-up requests were made. Of the original 61 replies, five came from significant others (two husbands, two sisters, and one parent) who recounted the negative impact of an abortion on a family member. Another 11 letters were too brief to be useful. This report is an attempt to describe and analyze the remaining 45 letters.

We categorized the content of the letters for descriptive and comparative purposes. The categories we used were those found in the literature on negative psychological responses and on the comparison between the expressions of grief following abortion to expressions of grief associated with perinatal death, spontaneous abortion, and birth of a severely handicapped newborn. The symptomatic categories we included were masking, anger, loss, depression, regret, shame, fantasizing, suicidal ideation, and guilt. One of these classifications needs clarification. We used ''masking'' to categorize the disclosure that a patient hid inner feelings beneath an apparently stable and peaceful outward manner.

RESULTS

The letters revealed what these 45 women perceived to be the most acute consequences from their abortions. Since the women were not asked to provide specific clinical information or to comment on their perceived rationale for specific symptoms, we have avoided speculation about what the women did not mention. Categorization of reported experiences was based on explicit comments in the letters.

The ages of these women ranged from 25 to over 60 years; 87 percent of those who mentioned their age were less than 40 years old. Their ages at the time of abortion (a few had experienced multiple abortions) ranged from 16 to early 40s; 80 percent of those who mentioned age were under 30 years old. Of these women, 81 percent indicated they had undergone first-trimester abortions. Of those who indicated the reasons they sought abortions, 19 percent attributed their having abortions to overt family pressure; a few spoke of medical (4 percent) or financial (9 percent) reasons. Of the respondents, 64 percent spoke of more than incidental and transient grief immediately after the procedure. Half of the respondents mentioned having children subsequent to their abortions. Of the women who mentioned marital status, 75 percent were single at the time of the procedure, and 71 percent placed the time of their abortions after Roe v. Wade.

Table 1 gives a summary of the negative sequelae experienced by these women following their abortions. Analysis of the letters is reported both for the total group and for various subgroups.

TABLE 1.—NEGATIVE FEELINGS FOLLOWING ABORTION

	Feelings (percentage of respondents)								
	Masking	Anger	Loss	Depression	Regret	Shame	Fantasizing	Suicidal	Guilt
All respondents (*N*=45)	35.5	20.0	31.1	44.4	44.4	26.7	57.8	15.5	73.3
Age at time of abortion:									
Pre-21 (*N*=19)	47.4	21.0	36.8	47.4	42.1	31.6	52.6	10.5	73.7
21–30 (*N*=17)	17.6	29.4	17.6	47.0	47.0	35.3	58.8	17.6	82.3
Age at time of contact (1987):									
21–30 (*N*=18)	16.7	27.8	27.8	50.0	50.0	22.2	44.4	11.1	72.2
31–40 (*N*=14)	42.8	28.6	35.7	35.7	42.8	42.8	71.4	7.1	78.6
Reason for abortion:									
Elective (*N*=33)	32.2	17.6	29.4	44.1	47.0	26.5	52.9	17.6	73.5
Pressured (*N*=12)	41.7	33.3	50.0	66.7	41.7	33.3	75.0	16.7	100.0
Subsequent children (*N*=26)	38.5	11.5	46.1	50.0	50.0	19.2	73.1	19.2	73.1
Marital status at time of abortion:									
Single (*N*=30)	36.7	26.7	23.3	53.3	36.7	30.0	56.7	16.7	76.7
Married (*N*=10)	30.0	10.0	40.0	40.0	70.0	30.0	70.0	10.0	90.0
Practicing Christian at time of abortion:									
No (*N*=19)	42.1	15.8	10.5	47.4	42.1	31.6	52.6	15.8	73.7
Yes (*N*=11)	18.1	27.2	18.1	54.5	36.4	36.4	54.5	27.2	72.7
Time of abortion:									
Before Roe (*N*=10)	60.0	10.0	10.0	50.0	20.0	30.0	50.0	30.0	60.0
After Roe (*N*=32)	31.3	25.0	34.4	40.6	46.9	31.3	56.3	12.5	84.1

The responses of the women who described their abortions as uncoerced were not noticeably different from the total responses. However, the presence of coercion in the decision-making process did distinguish these womens' responses from the total responses more than any other variable. The mention of negative sequelae was consistently more frequent for women who felt coerced. The responses of women who had borne children subsequent to an abortion varied little from the total responses, except in the mention of loss and of fantasizing about the infant they might have had.

The most frequently mentioned long-term experience was the continued feeling of guilt. Every woman who recalled being coerced to have an abortion spoke of guilt. Those who had terminated pregnancies after *Roe* v. *Wade* spoke more frequently of guilt than those who had aborted before *Roe* v. *Wade.* Fantasizing about the aborted fetus was the second most frequently mentioned experience, with more attention given to this experience by the older respondents and by those who felt coerced to have an abortion.

Many of the respondents noted, with varying wording, that they were writing ''the most difficult letter'' they had ever written. Half of the participants referred to their abortions as murder. Others used such phrases as ''a horrid mistake,'' my worst experience,'' ''a living hell.'' Several mentioned that hearing the word ''abortion'' would awake painful emotions. A number of the women spoke of suicidal ideation (15.5 percent), recurrent nightmares (13.3 percent), marital discord (15.5 percent), phobic responses to infants (13.3 percent), fear of men (8.9 percent), and disinterest in sex (6.7 percent).

Half of the women who admitted fantasizing about the infant they might have had referred to that aborted fetus as ''my baby.'' One woman, subsequent to the abortion, had named ''her baby'' Jeremy. Several commemorated the anniversaries of the abortion and of the aborted child's projected birthday. These women described drifting into thoughts about the aborted child's sex, talents, appearance, and interests. Some found relief in vividly anticipating a reunion with their aborted infants in an afterlife. Unavoidable reminders—such as celebrating Mother's Day, receiving the news of a friend's pregnancy, being invited to a baby shower, seeing children on a playground, and even planning a birthday party for their own children—kept many of these women moving from one painful emotional fantasy to the next. One woman explained:

''One cannot escape children—their birth, the joy of a baby whether it be next door or around every corner you turn. After all, who would want to? Unless the reminder is unbearable. It takes years and you always remember. Your own children remind you. As I face the rest of my life I will be reminded daily, sometimes hourly. One day I will be a grandmother—I hope—and then the pain will once again become unbearable. I will always be there. An abortion is forever.''

Another woman commented: ''It (an abortion) may seem the fastest way and easiest way to put a bad experience behind them, but it does not stay there. It will surface when they fall in love, when they consider marriage, at the birth of their child(ren), each time they have a physical, each time the word ''abortion'' is mentioned, when your child shows an interest in the opposite sex, when you look into the face of a baby, etc., etc. You see, it never goes away. Never.''

Of these women, 20 percent related negative responses to the abortion procedure itself. Some recalled crying continuously, while others remembered trying to stop the procedure once it had started. Every woman who mentioned the procedure expressed dissatisfaction with the lack of or superficial counseling they received and with the physicians involved in the procedure.

In some cases, the onset of negative sequelae was immediate; Table 2 illustrates the length of time these symptoms had been experienced. Of the respondents, 64 percent described their suffering as beginning immediately after (or during) the procedure, and 42 percent reported negative emotional sequelae endured over 10 years. One woman experienced such symptoms for 60 years. After years of turmoil, few at the time of writing expressed confidence that their symptoms might be eradicated.

TABLE 2.—DURATION OF NEGATIVE FEELINGS FOLLOWING ABORTION

Characteristics of respondents	Duration (percent of respondents)			
	Immediate onset	0 to 5 years	6 to 10 years	10+ years
All respondents (*N*=45)	64.4	6.7	40.0	42.2
Age at time of abortion:				
Pre-21 (*N*=19)	68.4	5.3	36.8	57.9
21–30 (*N*=17)	70.6	11.8	28.6	42.8
Age at time of contact (1987)				
21–30 (*N*=18)	61.1	16.7	55.5	16.7
31–40 (*N*=14)	57.1	.....	7.1	64.3
Reason for abortion				
Elective (*N*=33)	51.5	3.0	33.3	42.4
Pressured (*N*=12)	100.0	.....	37.5	25.0
Subsequent children (N=26)	65.4	3.8	34.6	53.8
Marital status at time of abortion				
Single (*N*=30)	73.3	10.0	46.7	36.7
Married (*N*=10)	70.0	.....	30.0	60.0
Practicing Christian at time of abortion				
No (*N*=19)	68.4	5.7	47.4	31.6
Yes (*N*=11)	63.6	18.1	27.2	36.3
Time of abortion				
Before Roe (*N*=10)	50.0	.....	.....	90.0
After Roe (*N*=32)	68.7	9.4	46.9	34.4

Note.—Because 11 respondents did not specify length of time, percentages do not add up to 100 percent.

DISCUSSION

Due to the manner in which the data became available, this study's design falls far short of the gold standard—a randomized, double-blind longitudinal study. The data are retrospective and self-reported. The person responsible for gathering the data made no provision to control for population variables. No uniform instrument was used. The participants came from a self-selected population group (the Protestant congregation) with a known bias against induced abortion. The possibility of embellishment by the sample population, given the stated purpose for the requested letters, existed. Only negative responses to the experience of abortion were solicited. No psychological testing could be done, nor was the frequency or perceived effectiveness of mental health treatment noted. Incomplete demographic information permitted limited aggregate evaluation and conclusions.

Still, we believe that the testimony of these women permits four observations that suggest some perspective on prolonged negative sequelae possibly associated with abortion. First, this series of cases reinforces a clinician's anecdotal awareness that such sequelae occur. If ethics has to do with what ought to be done all things considered, then clinicians should be careful not to be inattentive to indications that an abortion may create for the woman terminating her pregnancy a period of crisis, requiring effective counseling and reliable support.

Such attention has not been encouraged by the social and political turmoil that has surrounded abortion since Roe v. Wade. Opinion about whether abortion inevitably causes psychological harm for women terminating their pregnancies had begun to shift when the U.S. Supreme Court decided Roe v. Wade. The American Psychiatric Association membership, for instance, did an about-face between 1967 and 1969 on the issue of legalizing abortion on request—with those in favor increasing from 24 to 72 percent. In the aftermath of Roe v. Wade, elective abortion came widely to be seen, in most instances, as a conflict-free decision. Consistent with this perception, interpreters of data that suggested the occurrence of negative psychologic sequelae tended to minimize the incidence. For instance, Smith reported that ''only'' 6 percent of the 80 women studied had necessitated psychiatric treatment within two years of their abortions. Lazarus found that ''only'' 15 percent of the 292 women followed for two weeks after abortion acknowledged feelings of guilt and depression. American medical literature turned to other facets of potential perinatal grief responses. The cultural climate permitted preabortion counseling to become optional, rather than a prerequisite to the procedure.

Second, it has been estimated that nearly half of all women who received abortions deny having had abortions. The letters in this article suggest that such denial is a refusal to publicize an experience, but not a refusal privately to face painful consequences. Of these women, 35 percent spoke of masking their experience with the appearance of well-being. Women who received abortions before they were 21 mentioned masking their psychological pain far more frequently than the women who had abortions when they were older. Women who had abortions before Roe v. Wade mentioned this hidden pain twice as often as women who had abortions after Roe. This difference may illustrate that since Roe, the social stigma associated with having an abortion has lessened.

Third, a clinician has reason to be concerned when a women perceives the termination of her pregnancy as a coerced decision. The responses of the women who described their decisions to abort as freely chosen did not differ significantly from the total responses, suggesting doubt about the perception that only coerced decisions put a woman at risk. However, the responses of the women who spoke of being coerced (by peers, family, medical complications, economic fears) to have an abortion showed a higher incidence of negative sequelae in all but one emotional category (Table 1). They unanimously admitted guilt feelings. Their problems were, without exception, manifest immediately after the procedure, whereas only half of the women who did not feel coerced but later experienced problems mentioned such immediate sequelae. This difference draws attention to the need for professionals as well as significant others to probe signals of ambiguity from women considering abortion in a manner that is sensitive yet accurate.

Fourth, these letters raise questions about the hypothesis that religious fervor causes and/or magnifies psychological complications after abortion. Two out of three respondents mentioned that they were not practicing Christians or active members of this particular church when they had their abortions. Although there is the possibility that religious beliefs encouraged the prolonged grieving, the responses of those women who were not practicing Christians when they had their abortions did not differ significantly from the responses of all the respondents. Those who were practicing Christians when they had their abortions did indicate a slightly higher incidence of depression and shame. The letters suggest that religious convictions and religious involvement appear to have deepened the psychological pain for some of the women, while for others the same convictions and involvement served as an important resource to reduce the feelings of guilt and despair that had already developed.

CONCLUSION

These letters have provided a window into the ramifications that can surround abortion. We are not taking issue with the generalization, ''legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard for women.'' However, generalizations are, by definition, subject to exception. The more frequent the exceptions, the more tenuous becomes the generalization. Here, 81 percent of the women who experienced painful and prolonged emotional sequelae indicated that their abortions were first-trimester abortions.

Our interpretation of these letters does not reinforce either of the categorical positions—for or against abortion—that are presently polarized in public debate. This study does reinforce the need, if possible, for clinically valid studies of the syndrome of delayed grief among what appears to be a small but significant number of women who have abortions. The causal relationship (or lack thereof) between such women's abortions and their enduring, psychologic pain needs research documentation. The frequency needs to be determined. Factors that predict such problems need to be identified so that psychologic intervention can be made more readily available and even encouraged in some settings.

Clinical implications, not political ramifications, have prompted their descriptive study. The quality of medical care and the assurance of truly informed consent in the termination of pregnancy depend ultimately upon prospective research of negative psychological sequelae. Until such research is achieved, case services of such experiences should not be discounted on methodological grounds or exploited in public debate. Instead, they should be documented as reminders that abortion is, for some women, a moment of crisis of immediate and/or enduring proportion. What is at stake is not the validity of either side in the ongoing public debate over abortion, but the issue of patient care.

Mr. BROWN of Ohio. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida (Mr. BILIRAKIS) that the House suspend the rules

and agree to the resolution, House Resolution 163.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the resolution was agreed to.

A motion to reconsider was laid on the table.

LUPUS RESEARCH AND CARE AMENDMENTS OF 2000

Mr. BILIRAKIS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 762) to amend the Public Health Service Act to provide for research and services with respect to lupus, as amended.

The Clerk read as follows:

H.R. 762

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Lupus Research and Care Amendments of 2000''.

SEC. 2. FINDINGS.

The Congress finds that—

(1) lupus is a serious, complex, inflammatory, autoimmune disease of particular concern to women;

(2) lupus affects women 9 times more often than men;

(3) there are 3 main types of lupus: systemic lupus, a serious form of the disease that affects many parts of the body; discoid lupus, a form of the disease that affects mainly the skin; and drug-induced lupus caused by certain medications;

(4) lupus can be fatal if not detected and treated early;

(5) the disease can simultaneously affect various areas of the body, such as the skin, joints, kidneys, and brain, and can be difficult to diagnose because the symptoms of lupus are similar to those of many other diseases;

(6) lupus disproportionately affects African-American women, as the prevalence of the disease among such women is 3 times the prevalence among white women, and an estimated 1 in 250 African-American women between the ages of 15 and 65 develops the disease;

(7) it has been estimated that between 1,400,000 and 2,000,000 Americans have been diagnosed with the disease, and that many more have undiagnosed cases;

(8) current treatments for the disease can be effective, but may lead to damaging side effects;

(9) many victims of the disease suffer debilitating pain and fatigue, making it difficult to maintain employment and lead normal lives; and

(10) in fiscal year 1996, the amount allocated by the National Institutes of Health for research on lupus was $33,000,000, which is less than ½ of 1 percent of the budget for such Institutes.

TITLE I—RESEARCH ON LUPUS

SEC. 101. EXPANSION AND INTENSIFICATION OF ACTIVITIES.

Subpart 4 of part C of title IV of the Public Health Service Act (42 U.S.C. 285d et seq.) is amended by inserting after section 441 the following section:

''LUPUS

''SEC. 441A. (a) IN GENERAL.—The Director of the Institute shall expand and intensify research and related activities of the Institute with respect to lupus.

''(b) COORDINATION WITH OTHER INSTITUTES.—The Director of the Institute shall coordinate the activities of the Director under subsection (a) with similar activities conducted by the other national research institutes and agencies of the National Institutes of Health to the extent that such Institutes and agencies have responsibilities that are related to lupus.

''(c) PROGRAMS FOR LUPUS.—In carrying out subsection (a), the Director of the Institute shall conduct or support research to expand the understanding of the causes of, and to find a cure for, lupus. Activities under such subsection shall include conducting and supporting the following:

''(1) Research to determine the reasons underlying the elevated prevalence of lupus in women, including African-American women.

''(2) Basic research concerning the etiology and causes of the disease.

''(3) Epidemiological studies to address the frequency and natural history of the disease and the differences among the sexes and among racial and ethnic groups with respect to the disease.

''(4) The development of improved diagnostic techniques.

''(5) Clinical research for the development and evaluation of new treatments, including new biological agents.

''(6) Information and education programs for health care professionals and the public.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2003.''.

TITLE II—DELIVERY OF SERVICES REGARDING LUPUS

SEC. 201. ESTABLISHMENT OF PROGRAM OF GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall in accordance with this title make grants to provide for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with lupus and their families.

(b) RECIPIENTS OF GRANTS.—A grant under subsection (a) may be made to an entity only if the entity is a public or nonprofit private entity, which may include a State or local government; a public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, or homeless health center; or other appropriate public or nonprofit private entity.

(c) CERTAIN ACTIVITIES.—To the extent practicable and appropriate, the Secretary shall ensure that projects under subsection (a) provide services for the diagnosis and disease management of lupus. Activities that the Secretary may authorize for such projects may also include the following:

(1) Delivering or enhancing outpatient, ambulatory, and home-based health and support services, including case management and comprehensive treatment services, for individuals with lupus; and delivering or enhancing support services for their families.

(2) Delivering or enhancing inpatient care management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities of individuals with lupus.

(3) Improving the quality, availability, and organization of health care and support services (including transportation services, attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance) for individuals with lupus and support services for their families.

(d) INTEGRATION WITH OTHER PROGRAMS.—To the extent practicable and appropriate, the Secretary shall integrate the program under this title with other grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

SEC. 202. CERTAIN REQUIREMENTS.

A grant may be made under section 201 only if the applicant involved makes the following agreements:

(1) Not more than 5 percent of the grant will be used for administration, accounting, reporting, and program oversight functions.

(2) The grant will be used to supplement and not supplant funds from other sources related to the treatment of lupus.

(3) The applicant will abide by any limitations deemed appropriate by the Secretary on any charges to individuals receiving services pursuant to the grant. As deemed appropriate by the Secretary, such limitations on charges may vary based on the financial circumstances of the individual receiving services.

(4) The grant will not be expended to make payment for services authorized under section 201(a) to the extent that payment has been made, or can reasonably be expected to be made, with respect to such services—

(A) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

(B) by an entity that provides health services on a prepaid basis.

(5) The applicant will, at each site at which the applicant provides services under section 201(a), post a conspicuous notice informing individuals who receive the services of any Federal policies that apply to the applicant with respect to the imposition of charges on such individuals.

SEC. 203. TECHNICAL ASSISTANCE.

The Secretary may provide technical assistance to assist entities in complying with the requirements of this title in order to make such entities eligible to receive grants under section 201.

SEC. 204. DEFINITIONS.

For purposes of this title:

(1) The term ''official poverty line'' means the poverty line established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(2) The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 205. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out this title, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2003.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Florida (Mr. BILIRAKIS).

GENERAL LEAVE

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 762, the bill now under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, it is with great pleasure that I rise today in support of H.R. 762, the Lupus Research and Care Amendments. This important measure addresses the devastating, devastating, I underline devastating, disease of lupus. It was introduced by my colleague, the gentlewoman from Florida (Mrs. MEEK), who lost her sister to complications from the illness.

Lupus is a disease which causes the body's immune system to attack its