Letter from the President

I am pleased to be able to invite you to the Third Annual Professional Paper Session to be held in Washington, D.C. at the Crystal City Hyatt, Room Potomac I, on Wednesday, July 20, 1988. The topic this year will be: The After-Effects of Abortion. The program will run from 8 p.m. to 10:30 p.m., followed by refreshments.

The primary purpose of the paper session is to bring professionals together to share data, findings and ideas for research on the effects of abortion on our society. A second purpose is to provide information to those concerned with pro-life issues. Everyone is welcome to attend the paper session; there is no charge. In addition, everyone is welcome to stay for the Convention of the National Right to Life Committee, at the same hotel from July 21-23. Information regarding the costs and programs of the Convention can be addressed to the National Right to Life Committee, 419 - 7th Street N.W., Suite 500, Washington, D.C. 20004.

The program for the Association’s paper session consists of four presentations. Wanda Franz, Ph.D., will discuss: “A Profile of 160 Women Seeking Services at a Crisis Pregnancy Center.” This paper will present a statistical profile of women seeking help for problem pregnancies, including the outcome of the woman’s decision-making process. In addition, the issue of research questionnaires will be discussed.

The second paper is “Post-Abortion Problems and Personal Counseling” by Monte Harris Liebman, M.D. Dr. Liebman will discuss the types of problems presented to counselors on a telephone hotline. In addition, he will examine counseling methods to facilitate the effectiveness of counselor responses to traumatized clients.

The third paper presents “The Abortion Experience for Victims of Rape and Incest. Findings from a National Sample.” David Reardon will review literature on victims of rape and incest, and discuss the impact that abortion had on their traumatized lives. He will compare this literature with the cases of women in his national sample of WEBA women.

The fourth speaker will be Thomas Strahan, who will present “Increased Smoking Among Women Following Induced Abortion. A Literature Review.” The paper will review the data on smoking and discuss this in terms of the health implications for America’s women. Recommendations will be made for future research.

THIRD PROFESSIONAL PAPER SESSION
The After-Effects of Abortion on Women
Hyatt Regency Crystal City, Potomac I Room
8:00 – 10:30 p.m., Wednesday, July 20, 1988
Refreshments following the Presentations
EVERYONE IS WELCOME TO ATTEND. THERE IS NO CHARGE.
Abortion in Relationship Context: How Abortion Affects Males

There is broad consensus among most researchers, therapists, and authors as to the basic components of the male sex role. The following focal concerns typically translate into expected and encouraged male roles: aggression/activity; dominance/power; self-reliance/autonomy; achievement/success; and responsibility/protectiveness.

The abortion experience interfaces with each of these concerns and frequently nets considerable confusion and anxiety about role performance. The abortion experience is a gnawing paradox. At a time when more men than ever are involved in changing roles and being more involved with their children and their caretaking, men are systematically excluded from the right to be involved in life-or-death decisions affecting their children’s lives. In the abortion decision and resolution, all too frequently the male’s role is marginal and passive. He may be bypassed by his sexual partner, ignored at the abortion clinic, and helpless in the act and aftermath of the abortion itself. By law he is systematically excluded from being otherwise.

The male experience with abortion is an exercise of impotency, no matter what his religious beliefs, personal convictions, feelings, or desire for parental responsibility.

A recent national poll found that 87% thought that the male ideal should “stand up for his ideas.” And yet, in abortion, his input is predetermined to be negative and insignificant because of the absolute autonomy provided his sexual partner under the law. One seventeen-year-old expressed it in this way:

I though I was a much more liberated man. I’d be able to walk in here and say, “Here’s an abortion” and that would be it. But now that I’m here, I’m a wreck... I don’t think that anyone could depend on me in this situation... I’m shaken... I really want to know what they will do for her... How about me? Do they have something for me to lay on while I die?

Men must be independent, strong and brave; conversely, they must not be weak or dependent.

Men fear self-disclosure, physical weakness, and dependency needs. Abortion compounds the problem. And for the insecure male who is frequently unable to control his own life and make decisions, the abortion experience may be just another situation which reinforces his impotency and lack of autonomy.

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The achievement drive for success in males is well documented in the literature. The cult of success and the compulsiveness of achieving are heavy burdens for men. The abortion experience can hardly be described as one typifying success.

For the male, the abortion experience, whether he knows about it or not, frequently yields the demise of the unmarried relationship with his partner. Numerous studies confirm that the costs of status loss or failure in relationships are great: alcoholism, suicide, depression, mental illness, physical illness, and premature death. Hence the greater the demand to assert himself, be hard, aggressive, and not show feelings, the greater the problems of adjustment that emerge. This is particularly true in the abortion experience.

On the other hand, abortion well serves the erotically compulsive male, or one with such tendencies, who strives to maintain his self-esteem and to gratify narcissistic needs through sexual achievement. Typically this Don Juan male is minimally involved in the personality of his partner since his ability to love is sharply limited. His sexual activity is invested in countering feelings of inferiority by proving his

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erotic successes. After such a conquest he loses interest in the chosen woman and reacts with hostility towards her, since he devalues her after the successful seduction. He is then off for his next compulsive conquest. Abortion is a handy passport for such an adventure.

When young, such a man may not care for a woman he has gotten pregnant. But when he matures, his value system changes and he may begin to see the aborted child as “mine” rather than “a thing.” When this stage arrives, So does guilt or grief.

Nowhere is the abortion experience more painfully felt than in the area of the man’s role expectation to be responsible and to protect his loved ones. Like an isolated beacon light, fatherhood seems to pulsate with this singular purpose: to provide for and protect the family. The essence of the role drifts out beyond economics to embrace the behavior of children, the resolution of emotional conflict, guidance in the unpredictability of decision-making, assuming command in a crisis, and spiritual or moral development. Regardless of domain, the uniqueness of this role remains the same.

The results of a national poll indicated that three out of four respondents still believe that the ideal man is one who will fight to protect his family. This notion of protectiveness is well ingrained in the American tradition of masculinity. How can one protect, when one is not allowed by law to be involved in a life-or-death decision? How can one be responsible when knowledge can be purposefully withheld and patterned role exclusion is socially sanctioned?

The powerlessness of men is evident in the comments of a thirty-seven-year-old husband and father of three who came for marital therapy because his wife was distant and hostile. From separate interviews with his wife and unknown to him, the following facts emerged: She had an affair three years ago which lasted for four months and ended in her becoming pregnant by her lover and having an abortion. She expressed panic at the thought of telling her husband, yet admitted to being aloof and punitive toward him ever since the incident. He felt helpless and frustrated over the past three years because his wife continually rejected him and he could not understand why. He claimed that he cared very much for her, but that she would not let him love her.

Linda Francke, in part drawing on her own abortion experience, which nearly ended her marriage, warned of considerable role conflict for males in that they are so eager to protect the female’s well-being that they tended to discount or suppress their own needs, a realization that added to a man’s unexpressed guilt and anger which can fester for months or years afterward. Francke found men devastated—that is, the ones who cared. In addition, Francke found men to be “silent sufferers, bewildered and frustrated by their emotional responses” to abortion. Furthermore, she concluded that abortion is a far greater dilemma for men than researchers, counselors, and women have even begun to realize.

Sociologist Arthur Shostak, himself affected by abortion, in his study of the impact of abortion on males noted that three out of four male partners stated they had a difficult time with the abortion experience, that most relationships did not survive the abortion stresses and that a sizeable minority reported persistent day and night dreams about the child-that-never-was, and considerable guilt, remorse and sadness.

Abortion, then, has major implications for married life. Because of the basic inequality between the partners in the abortion decision, the capacity to develop trust, enhance communication and problem-solving skills, and build intimacy, honesty, and companionship is severely handicapped and restricted. This same unequal-

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Pelvic Inflammatory Disease and the Role of Induced Abortion

Pelvic inflammatory disease (PID) is an inflammation of the female genital tract. It starts in the cervix and may spread to any of the female organs and even into the pelvic cavity. It is a major direct cause of permanent sterility, chronic abdominal pain, and increased risk of extra-uterine pregnancy. Dysmenorrhea, other menstrual disorders, chronic ill health, and being "depressed and embittered with life" are also possible additional sequelae. Clinically, PID can vary from an almost symptom-free disease to a life-threatening condition.

The cost of PID

Unfortunately, PID is not required to be reported to public health officials in the United States and it has not received the public attention that is badly needed. One study by the Center for Disease Control calculated that nearly one million women in the United States suffered from PID and its sequelae in 1978. PID accounted for more than 2.5 million physical visits, 250,000 hospital admissions and nearly 150,000 surgical procedures. It was estimated that the direct annual cost is greater than $600 million and the total cost for this disease is upwards of $3 billion in the United States.

A more recent study of PID concluded that the total cost of PID and PID-associated ectopic pregnancy and infertility in the U.S. exceeded $2.6 billion in 1984. By 1990, the estimated cost of PID and its sequelae will total $3.5 billion per year, if the annual medical care inflation is 5% and the incidence of PID remains constant during this six-year period. It concludes that these estimated costs of PID and its associated sequelae emphasize the urgent need for effective programs to prevent PID.

PID and sexually transmitted diseases (STDs)

Since the first reports of PID in the literature, a strong correlation has been observed between sexually transmitted diseases and PID. In recent studies up to 75% of cases of PID in women less than 25 years of age have been associated with cultural and/or serologic evidence of infection with n. gonorrhææ, c. trachomatis, or m. hominis. Adolescents, unmarried women and unmarried women under 20 years of age with multiple sex partners are all at high risk for c. trachomatis infection. For example, the prevalence of chlamydial infection in 280 sexually active urban Baltimore adolescents studied was 26%: 35% in male adolescents, 27% in pregnant female adolescents, and 23% in non-pregnant female adolescents. Chlamydia was almost three times as prevalent as gonorrhea in the same population.

In another survey, about 20% of 4,000 patients at an adolescent health clinic in Richmond, Virginia were screened for STDs. Thirty percent had at least one infection. Most common were gonorrhea and chlamydia. About 12% were pregnant and one quarter of them also had a STD.

A recent study estimated that approximately 30-50% of PID episodes are caused by c. trachomatis infection. It estimated that each year 402,000 episodes of chlamydial PID occur leading to 1,005,400 outpatient visits, 106,900 hospitalizations, 8,050 infertility consultations, 13,900 ectopic pregnancies, and 280 deaths. Another concluded that PID caused by sexually transmitted pathogens results in infertility in more than 20% of the cases and the risk of ectopic pregnancy increases six to ten fold after PID.

PID and Induced Abortion

PID is a common complication of induced abortion. One researcher concluded it occurs in 2-20% of the cases. One reason for the wide reported incidence can be traced to: (1) differences in definitions of post-abortion infection, (2) use of prophylactic antibiotic treatment, (3) time of observation, and (4) differences in methods of detecting PID. Prior reproductive history and level of sexual activity may also account for differences. Scandinavian studies generally conclude that the rate of PID following induced abortion ranges from 6 to 13%. There are no

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known published U.S. studies on the incidence of PID after induced abortion.

However, if chlamydia trachomatis is present at the time of induced abortion the incidence of PID greatly increases. For example, in a Danish study the presence of chlamydia in the cervical canal at the time of induced abortion increased post-abortal PID by a factor of 2.8 ($P = 0.25$) from an initial 10 to 28% one month after the abortion. There were no symptoms at the time of the abortion to indicate chlamydia was present. In a Swedish study women with endocervical chlamydial infections were over five times more likely to develop PID within 4 weeks after first trimester induced abortion than uninfected women. In yet another Scandinavian study the rate of PID following induced abortion in women with chlamydial infection in the cervix at the time of the abortion was 21.7%; in those without chlamydial infection of the cervix the figure was only 2.4%. Considering that substantial numbers of women have chlamydial infection at the time of abortion, these higher rates of PID will occur in many instances.

**The role of antibiotics**

Antibiotics are not routinely used in the U.S. in connection with curettage abortion. Nausea and vomiting caused by tetracyclines make it difficult to use prior to abortion. Use of antibiotics after abortion may reduce PID, but the degree of effectiveness is not clear and studies are few in number. One study concluded that total incidence of pelvic infection could be cut in half by prophylactic treatment in women who have had an earlier pelvic infection.

Lower genital tract infections from chlamydia may be treated with one week of tetracycline or doxycycline. Finding and treating women while they still have lower genital infection can help prevent upper genital tract complications and sequelae such as infertility and ectopic pregnancy.

Unfortunately, antibiotics do not effect a permanent cure for PID. Reinfecion in women after PID has been found to be the single factor having the most effect on fertility. In one study out of five, previously healthy women having acute PID had a second infection. The relatively low frequency of sterility (12.8%) after one infection was nearly threefold (35.5%), after two infections and sixfold (75%) after three or more infections. It strongly appears that more could be done to prevent infection and PID in women following induced abortion. Lack of concern for the unborn child appears to carry over to indifference for the subsequent health of the woman in this area.

**Conclusion**

It is estimated that induced abortion is responsible for between 150,000-250,000 cases of PID annually in the United States. Use of antibiotics in women undergoing induced abortion and treatment of infected partners could reduce significantly the incidence of PID. PID is very costly both in terms of economic loss and also loss of reproductive ability and other adverse physical and psychological effects. One important way to prevent PID is to limit the availability of induced abortion.

**Footnotes**

6. Favors Barrier Methods over OCs for Sexually Active Teenagers, Brookman, Family Practice News 17 (November 1-14, 1987).
10. Significance of Cervical Chlamydia Trachomatis Infection in Post-Abortal Pelvic Inflammatory Disease, Westergaard et al., Obstetrics and Gynecology 60(3) 322-325 (September 1982).
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ity has the potential to breed displaced male aggression via child abuse, spousal abuse, or self-abuse. The latter could be accomplished through depression, acting out, substance abuse, or aggressive self-deprecating behavior.

“In the abortion decision, the capacity to develop trust, enhance communication and problem-solving skills and build intimacy, honesty, and companionship is severely handicapped and restricted.”

Like the Trojan horse, abortion is only beginning to be seen for what it truly is and does. There is evidence to suggest that induced abortion promotes “mystification and masking” within the family which is dysfunctional for the individual in every context. In relationships, abortion provides “pseudo-homeostasis,” that is, a stability through non-adjustment rather than through readjustment, which promotes even more serious disequilibrium. For men it increases masculine insecurity and provides alienation, role conflict and, for some, limited relief. For women it provides relief, but it also induces a heavy burden of guilt, secrecy, and intrapsychic conflict. Clinically, if an unwanted pregnancy is a mistake or a problem, then abortion becomes a denial of the problem. Psychologically then, abortion reinforces defective problem-solving behavior.

For any male, regardless of religious belief, abortion is the destruction of the man’s seed. It is a death event. The pain of promoting the death of that seed, and of the child of that seed, can be enormous.

Abortion exists for women, yet it is against women, men, and children. Like an anesthesia, abortion comfortably numbs all from experiencing the burden of pregnancy. Abortion has become a social eraser of choice, individually, quickly, and secretly eliminating all traces of the problem that is pregnancy. And yet, traces always remain. Within the depths of male/female relations, the indelible marks of violation reappear.


Vincent M. Rue, Ph.D., is executive director, a psychotherapist and family and marriage therapist at the St. Thomas More Clinic of Southern California. He has served as a consultant and expert witness throughout the United States on family relationships and development. Dr. Rue has written and spoken extensively on the adverse effects of abortion and has conducted an extended professional literature search on the topic. He is co-author of Parenting and Family Education (1979).

Additional reading
Forgotten Fathers, Vincent M. Rue, Life Cycle Books, P.O. Box 792, Lewiston, NY 14092-0792. Pamphlet.
Abortion and Men, Linda Francke, Esquire, 58-60 (September 1978).

EXTENSIVE BIBLIOGRAPHY AVAILABLE

A bibliography of over 450 key articles and books in support of the detrimental effects of abortion is available from the Rutherford Institute, P.O. Box 510, Manassas, Virginia 22110. Cost $15.

The bibliography covers key public policy issues and private rights including social, psychological, physical and relational aspects. Important findings and conclusions are included.