Approved [signature]
March 14, 1990 Date

MINUTES OF THE HOUSE COMMITTEE ON FEDERAL AND STATE AFFAIRS.

The meeting was called to order by Representative Ginger Barr at
Chairperson

1:30 ~~a.m.~~/p.m. on February 20, 1990 in room 519-S of the Capitol.

All members were present except:
Representative Cates - Excused
Representative Gjerstad
Representative Peterson

Committee staff present:
Mary Galligan, Kansas Department of Legislative Research
Lynne Holt, Kansas Department of Legislative Research
Mary Torrence, Revisor of Statutes Office
Juel Bennewitz, Secretary to the Committee

Conferees appearing before the committee:

Bill Bell, Indianapolis, Indiana
Ann Wigglesworth, M.D., Manhattan, Kansas
Dorothy Reister, M.D., Kansas City
Elsie Shore, Ph.D., Wichita State University
Joseph Hughey, Ph.D., University of Missouri - Kansas City
Lu Ann Nauman, Kansas Association of School Health
Wanda Shoffner, Clinic Manager, Midtown Clinic, Greater Kansas City
Arriane Gump, Student, Kansas State University
Gayle Bennett, Religious Coalition for Abortion Rights
Reverend George Gardner, College Hill United Methodist Church, Wichita
Myrna Stringer, League of Women Voters
Karen Sexton, Student, University of Kansas
Marilyn Harp, Board President, Planned Parenthood of Kansas
Charlotte Elder, R.N., Topeka, Kansas

Chairman Barr restated the hearing procedure outlined at the February 19, 1990, meeting.

Staff was recognized for its efforts in preparation for these hearings.

The Chairman acknowledged two boxes of petitions from pro-choice advocates containing over 16,000 signatures. It was requested the petitions be presented on the House floor for enrollment.

Chairman Barr recognized conferees who yielded their time to other conferees but would be available for questions from the committee.

Bill Bell commented on a press release from Cynthia Patton, Attachment No. 1, made in response to Mr. Bell's press statement earlier in the day. Attachment No. 1A is a transcription of Mr. Bell's comments. Mr. Bell opposed parental notification based on his family's experience, Attachment No. 1B.

Dr. Ann Wigglesworth testified in opposition to parental notification asking the state not to further interfere with the practice of medicine and make felons of doctors, Attachment No. 2.

Dr. Dorothy Reister seconded the position of Dr. Wigglesworth regarding malpractice and confidentiality. She described a recent situation concerning a 14 year old, five months pregnant, whose mother did not know and the father was non-custodial. She questioned the options for the girl and asked the committee to not risk girls' confidentiality or their lives.

Dr. Elsie Shore presented findings of the American Psychological Association (APA) regarding four categories of psychological factors relative to adolescent abortion, Attachment No. 3. Attachment No. 3A is "Adolescent Abortion, Psychological Legal Issues", *American Psychologist*, January, 1981.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Dr. Hughey discussed results of a recent study from the Johns Hopkins School of Hygiene and Public Health concerning the psychological effects of abortion, Attachment No. 4. Attachment No. 4A is the study as printed in Family Planning Perspectives, Vol. 21, No. 6; November/December, 1989. Attachment No. 4B is a brief for amici curiae APA, et al., Supreme Court, October, 1989 term.

Lu Ann Nauman opposed HB 2663 and asserted that forcing a minor to complete a pregnancy and assume responsiblity for a child has more overall negative effect than an abortion, Attachment No. 5.

Wanda Shoffner stated that 51% of teens are communicating with their families concerning reproductive choice. She stated that teens affected most will be those from dysfunctional families and gave examples of recent attempts in Missouri to abort pregnancies through the use of clothes hangers.

Arriane Gump testified against parental notification because of the impact on girls from small towns, dysfunctional families as well as normal families, saying girls from the latter would rather risk their lives than tell their parents, Attachment No. 6.

Gayle Bennett discussed anti-choice clinics operations and asserted young women know best how news of a pregnancy would be received by their families, Attachment No. 7.

Reverend George Gardner opposed parental notification based on his experience in counseling, Attachment No. 8.

Myrna Stringer spoke in opposition to parental notification and advocated the proper role for the state was in sex education, Attachment No. 9.

Karen Sexton testified in opposition to parental notification based on her experience as a counselor, Attachment No. 10.

Marilyn Harp opposed parental notification and discussed specific legal points in both HB 2663 and HB 2779, Attachment No. 11.

Additional statements in opposition to parental notification were received from the following, most of whom had yielded their time to other conferees:
- Marian Shapiro, Director, Planned Parenthood of Kansas, Hays Clinic
- Margo Smith, Director of Counseling, Comprehensive Health Care Services, Overland Park
- Belva Ott, Director of Governmental Affairs, Planned Parenthood of Kansas
- Peggy Jarman, Public Relations, Women's Health Care Services, Wichita
- Beth Powers, Kansas Choice Alliance
- Margot Skinner, Board of Directors, Planned Parenthood of Kansas
- Jodie Van Meter, Kansas National Organization for Women
- Adele Hughey, Executive Director, Comprehensive Health Care Services, Overland Park
- Brenda Leerskov, Public Affairs Director, ProChoice Action League
- Sharilyn Young, Executive Director, Planned Parenthood of Kansas
- Gordon Risk, M.D., President American Civil Liberties Union
- R. S. Delamater, Wichita, Kansas

Committee discussion:

Q. To Ms. Harp - re: Both bills - HB 2663 has a preamble stating legislative intent. Is it your opinion this is to address constitutionality?

A. The Supreme Court found the preamble in the Webster case to be verbiage and therefore unnecessary.

Q. To staff - Yesterday it was stated there are 38 states with parental notification laws. How many of those are in effect?

A. Research indicates 11 such laws in effect, one being very new, not yet having been tested in court. Thirty-six states have some type of law on the books, the difference being those specifically found unconstitutional because they were tested individually or not being enforced due to court decisions. Thus there are 11 such laws actually in effect.

Q. To Dr. Wigglesworth - What is the actual cost of an abortion? How do teens raise the money? Do doctors ask for the money "up front"?

A. The doctor responded, to her knowledge, the money is required "up front". The costs range from $200-$600 and vary as the lenth of gestation and complication of the procedure. The money is borrowed from friends, sometimes given as "hush money from the impregnator" or sometimes teens "pass the hat".

Q. To Dr. Wigglesworth -If judicial bypass could take up to four weeks, what would happen to a teen seeking an abortion if it were delayed an unreasonable amount of time?
A. It could make the difference between a first and mid-trimester procedure. The latter are attended by greater risk of hemorrhage and to the mother. There would also be increased cost.

Q. To Dr. Wigglesworth - Does your experience indicate primarily younger women wait longer to take action because they seem to go through a period of denial.
A. "There's no question." The doctor expressed the opinion that many teens who carry to term only do so because they "didn't have the courage to tell anyone" or they were too advanced in the pregnancy.

Q. To Dr. Wigglesworth - What is the typical approach of your office with a pregnant teen?
A. The response indicated the effort to accommodate her being seen, primarily if she sounded young, as they are often desperate to receive help. In the doctor's area there are two other places where help may be received in the form of a free pregnancy test and counseling. The majority of teens in Riley County seem to approach public agencies first rather than private practitioners. In the doctor's practice, many of the girls' mothers are also patients creating a difficult situation but if the doctor does not maintain confidentiality, the girl may never return. The doctor's approach is to counsel regarding the results of the test, ask if the parents know, encouraging the girl to tell her parents, and enumeration of her options. Dr. Wiggelsworth advocated some latitude in dealing with the patient and asked the state to not dictate how patients are counseled.

Q. To Peggy Jarman - What is the charge for an abortion?
A. The current charge for a first trimester abortion is $275.00.

Q. To Dr. Shore - In discussion with teens, 30-50% indicated their parents had talked with them about alcohol, drugs or sex. It seems that parents are not taking responsibility for talking with their teens. These bills would still put tremendous pressure on teens. In view of the increase in teen suicide, could we push someone into suicide or to seek an illegal abortion? Do we have reason to be concerned?
A. The response was, "Yes, absolutely." Dr. Shore explained parental communication is not as free or open as it should be and parents do not take the initiative to speak to their children. She called 30-50% surprisingly high and projected if the topics (drugs, alcohol, sex) were separated, the percentage for sex would be much lower than the other two topics.

Q. To Ms. Harp - Is the current status of either consent or notification laws that some kind of bypass be easily accessible?
A. The answer was affirmative. The first parental consent law to go before the Supreme Court was in 1979 (known as Bellotti II) which still stands. The Supreme Court has agreed to hear Minnesota and Ohio's state laws, both of which have bypass provisions, though the attorney general of Ohio has asked to have its bypass provision removed.

Q. To Ms. Harp - re: The waiting period. Is it correct that 48 hours has been struck down as too long while 24 hours has been upheld?
A. Ms. Harp's repsonse was that she would check and submit the answer to the questioner. At the court of appeals in Ohio, the three week provision was ruled too long. Kansas law is that every case going to the appellate court level has a four week limit, one week more than ruled too long by the court of appeals.

Q. To Ms. Harp - Would you comment on Section 4, the penalty section, of HB 2663?
A. Ms. Harp responded she had not seen a like provision but that she had not read every such law. She speculated the reason it made it into law was: a.) criminal laws are generally enforceable only by law enforcement officers where civil law can be brought by anyone claiming an interest in the case; b.) the burden of proof is different with criminal cases being "beyond reasonable doubt" where with civil law, it is "clear and convincing evidence". Someone could be held liable in a civil situation where a criminal conviction wouldn't be a possibility. She called it incredibly onerous on the medical community.

Q. To Ms. Harp - In yesterday's discussion, waiving of notification in case of incest was discussed. A conferee stated verification of incest was a medical determination. How would a doctor verify incest?
A. In proof of criminal incest charges, there is the possibility of DNA or other blood chemical analyses, costing $300-$500 to obtain the proof. The supposition was that if the law were passed, the physician would note incest in the medical records and then report to the proper authorities - SRS who would begin child in need of care action against the pregnant woman and refer the case for criminal action against the father.

Q. To Ms. Harp - re: Section 3, what is "diligent effort"?
A. The only source of reference Ms. Harp could provide was the requirement provided by law for other sorts of notice. An example would be, notice of a lawsuit where if the person cannot be found, there is allowance for publication kinds of notice. By not addressing that point, HB 2663 makes vague the actual requirements in the medical practitioner's judgment. She added that the other legal issue is that abortion, as defined in HB 2663, covers vast amounts of birth control.

Q. To Dr. Hughey - In your opinion, do notification bills help promote communication?
A. As a basic premise for understanding familial communication, most psychological textbooks indicate that open and honest communication does not occur in a contentious environment. It is the position of the American Psychological Association that parental notification laws create a negative environment for communication - a coercive environment.

Q. To Dr. Hughey - re: Medical care. Many seem to be saying they want to be involved but as a bottom line, they want the best medical care. What would the majority desire?
A. Data will show the best estimate at 75% for at least one parent becoming involved in the abortion decision - after the fact. Data on dysfunctional families indicates alcohol, drug, physical or sexual abuse shows approximately 25% of families, there is an individual having a vested interest in hiding a pregnant teen. Discussion with teens shows a lower percentage of involvement prior to the pregnancy so the emphasis should be on education. The best emphasis is on prevention. If the state is involved, it sets up "de facto" coercive environments.

Q. To Dr. Hughey - Following childbirth, is there a shift in the ability of teen reasoning that would allow informed consent for the medical care of a child but not for the teen herself prior to birth?
A. No, but in most states a young woman who delivers a child can consent to treatment of that child. There is no psychological shift in their reasoning capability that indicates they are more capable of making an informed decision. There is increased good data to indicate young women, as early as 14 years old, think like adults regarding abortion decisions.

Charlotte Elder was recognized and she explained that families in crisis handle a teen pregnancy situation the same as any other crisis. When any outside agency interferes and requires non-verbal families to talk, verbal families to stay quiet or dysfunctional families to function, the fragile family mechanism is disrupted. When there is an outside requirement that all parenting is the same, parenting "falls apart", Attachment No. 12.

Q. To Ms. Smith - Could you describe the procedure at your clinic and what happens in the event of a problem abortion?

A. Prior to the procedure, there is a counseling session of approximately one hour which includes an explanation of the risks; review of the consent form which is read aloud; questions are answered in lay language; and explanation of after care including what constitutes an emergency situation and how to make contact for help.

Q. To Ms. Smith - With the new ruling in Missouri, have you seen an increase at your clinic?

A. "Yes, somewhat."

Q. To Ms. Smith - Do you have any special provision for those who cannot afford an abortion?

A. Generally, people are encouraged to provide their own resources.

Q. To Mrs. Bell - Having attended yesterday as well as today's hearing, is there anything you'd like to say to us, as legislators, who will have to resolve this problem?

A. Mrs. Bell recounted her daughter's experience and its effect on her family, Attachment No. 13.

Q. To Ms. Smith - Could you comment on Kansas' reputation as being less restrictive?

A. Ms. Smith gave her opinion that Kansas has a good reputation. She explained there has been an increase in the number of clients with fetal deformities as they are unable to receive assistance in other places. She called it sad that Kansas is becoming the alternative for such assistance.

Attachment No. 14 - Marian Shapiro
Attachment No. 15 - Margo Smith
Attachment No. 16 - Belva Ott
Attachment No. 17 - Peggy Jarman
Attachment No. 18 - Beth Powers
Attachment No. 19 - Margo Skinner
Attachment No. 20 - Jodie Van Meter
Attachment No. 21 - Adele Hughey
Attachment No. 22 - Brenda Leerskov
Attachment No. 23 - Sharilyn Young
Attachment No. 24 - Gordon Risk, M.D.
Attachment No. 25 - R. S. Delamater

Also submitted were:

Born Unwanted: Developmental Consequences for Children of Unwanted Pregnancies, Attachment No. 26.
Teen Pregnancy: The Facts, Attachment No. 27.
The Emotional Effects of Induced Abortion, Attachment No. 28.
Abortion: Facts at a Glance, Attachment No. 29.
"Notification Means More Teen Moms" (article by Denny Clements), Attachment No. 30.
Article from Indiana NOW opposing parental notification, Attachment No. 31.
Article from U.S.A. Today, "Parents: Abortion law kills", Attachment No. 32.
"The Impact of Mandatory Parental or Judicial Involvement", Attachment No. 33.

Attachment No. 34 is a cover letter from Senator Lana Oleen and Attachment No. 34A is Kristi Armstrong's statement in support of parental notification.

The meeting was adjourned at 3:08 p.m. The next meeting of the committee is scheduled for February 21, 1990, 1:30 p.m. in Room 526-S.

GUEST LIST

FEDERAL & STATE AFFAIRS COMMITTEE

DATE February 20, 1990

(PLEASE PRINT) NAME	ADDRESS	WHO YOU REPRESENT
Mary Garberg	8210 W. 101 St O.P.	KFL
Lisa Gill	12031 Hemlock O.P.	KFL
Tori Foy	5407 S.W. 12th Terr.	Rep. Artie Lucas
SHERYL FOY	5407 SW 12TH TERR TOPEKA	KANSANS FOR LIFE
Sarah Wood-Clark	1196 SW Garfield, Topeka	Capital City N.O.W.
Sheila Putman	3435 SE Golden Ave	KANSANS FOR LIFE
[illegible]	1191 [illegible] Topeka KS	Kansans for Life
[illegible]	Rt 1 Wetmore KS	Right to LIFE
Brenda Conert	RR 1 Box Hallowell, Ks.	PSU Nursing Student - Right to Life
Jan Galitzer	1504 Humboldt Manhattan	Manhattan area dept Religious Coalition for Abortion Rights
[illegible]	4230 N.W. Union Dr. Topeka	R.C.A.R.
Darlene Stearns	1248 Buchanan 66604	RCAR
Joe Gilman	2908 Stratford Rd. Lawrence, KS. 66049	- concerned citizen -
John Watkins	3606 Yale, Lawrence KS 66049	- irritated citizen -
Martina Arnoldy	RR#1 Tipton Ks. 67485	Kansans For Life, concerned citizen
Priscilla Arnoldy	710 W Vermont Osborne KS 67473	Kansans for life
Julie Ramshaw	510 W. Jefferson Pittsburg KS.	Right to Life
Delma Potter	4821 W 75 St PV KS	Federal - Civil Servant H 4 S
Steven Neuberger	1147 Tenn #3 Lawrence	KU Pro-Choice Coalition
Pat Goodson		Right To Life of Kansas
Beverlyn Brown	920 SW 17th St. Topeka	
Janet Franklin	924 N Western	
W.G. Slusher	9935 Goddard, O.P. Ks	CITIZEN
Cleta Renyer	R 2, Box 98 Sabetha	Right to Life of Ks.
Beth O'Malley	127 Pinecone Dr. Lawrence, KS	Lawrence, Kansans for Life - citizen & parent of two
MJ Van Buren	Topeka, Ks	~~Topeka~~ Capital City NOW

GUEST LIST

FEDERAL & STATE AFFAIRS COMMITTEE

DATE February 20, 1990

(PLEASE PRINT) NAME	ADDRESS	WHO YOU REPRESENT
Dorothy N. Hager	5118 W. 77th St	Volunteer Prairie Village 66208
Reta Ensminger	Moran, KS	Rep. Ensminger's Mother
Margot Skinner	Wichita, Ks	Planned Parenthood - Ks
Teresa Ott	Lenexa KS	Pro Choice
William T. Smith Jr.	Topeka, Kan.	Pro Choice
Trish M. Diedrich	1501 N. 2nd Atchison, KS	[illegible]
Rebecca A. Hand	Lawrence	Rep Charlton's Office
Jim McBride	Topeka	Observer
Barb Haberkorn	9630 S.W. K-4 Hwy	Pro-Life citizens
Jodie Van Meter	Topeka	KNOW
Donna Blount	St Francis Ks	

PRESS RELEASE

RESPONSE TO WILLIAM BELL'S STATEMENT:

From Kansans for Life, Cynthia Patton

"If Planned Parenthood had complied with the law and notified her father, Becky Bell would have received the adult support she needed and she would have been alive today. Planned Parenthood counseling was totally inadequate and amounted to a little more than a conspiracy to avoid adult involvement" according to Cindy Patton, KFL spokesperson. This girl had an opportunity for an abortion two days hence what she needed was love and support.

The Becky Bell situation demonstrates:

1. That even 17 year olds are too immature to cope with an unplanned pregnancy indicating the need for more adult involvement and support, not less.

2. The NOW organization and others who are pushing home abortion kits are putting women at risk.

Background Information:

According to Newsweek January 8, 1990, Becky Bell was 17 an an Indianapolis, Indiana high school junior. She had gone to planned parenthood. She was counseled how to avoid the parent consent law. She was scheduled to have an abortion the day before she died. According to Newsweek she tried a home remedy.

For more information contact:

Cynthia J. Patton
913-267-0116

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 1
February 20, 1990

TRANSCRIPTION
BILL BELL'S RESPONSE TO CYNTHIA PATTON'S PRESS RELEASE
Before the HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE
February 20, 1990

Madame Chair and Members of the Committee:

Before I begin my testimony I would like to publicly set the record straight. Yesterday, Ms. Cynthia Patton released to the press a response to my statements made earlier in the day at a press conference. I think you should have copy of that press release.

It was clearly an attempt to discredit my daughter, her mother and I, and to discredit Planned Parenthood. In her response she stated that Planned Parenthood had not complied with the law and had not notified the father. Well, there is no law.

She further stated that Planned Parenthood had conspired to avoid adult involvement. Did my daughter not deserve her rights of confidentiality? Further she stated my daughter had an appointment for an abortion two days before she died. This is simply not true, she was in bed at home at the time.

Her concluding remarks were quoting Newsweek magazine, obviously the source of truth for all of us, that she had been counseled by Planned Parenthood to avoid the parental consent law. Another untruth. I talked with the counseling person. My daughter was advised of the laws and what her options were.

She then contradicted her earlier untruth in saying my daughter was scheduled to have an abortion the day before she died. Another untruth.

And lastly, she stated my daughter tried a home remedy, yet another untruth.

In conclusion, it is obvious Ms. Patton's failure to contact Becky's mother and I for the real facts that her cause would be better served by filling the newspapers with untruths.

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 1A
February 20, 1990

KANSAS CHOICE ALLIANCE

My name is Bill Bell and I reside in Indpls, In with my wife Karen and my 20 yr old son Bill.

I appear before this committee today with mixed emotions, dreading to relive my daughters death but also realizing a responsibility to others: I do not want her death to be the first of many.

Had she lived in the state of Kansas she would be alive today.

My daughter Becky made a mistake and became pregnant.

Parental consent laws, very similar to the bills being considered before this

Committee, dictated that in order
to terminate her pregnancy she must
obtain the approval of her parents,
petition the courts, travel to another
state that would allow her a safe
clinical abortion, OR seek back alley
assistance. She died of an illegal abortion.
In confiding with her best friend she
said "I don't want to disappoint my
Mother and Dad, I love them so much."
Knowing ~~our~~ my daughter, I believe that
the judicial option would have been
too intimidating, given her desperate
emotional state. She would also have
been faced with the prospect of appearing before

FSA
1B-2
2-20-90

a pro-life judge. Hardly a
reasonable option considering
~~that~~ the fact she had decided
to terminate her pregnancy. She chose
the last option available to her, an illegal abortion.
Unfortunately, we have been unable to
piece together all the circumstances
and today we struggle with the question,
why did our daughter have to endure the
mental torture in making what turned
out to be her final decision?
She was intelligent enough to pursue
her options, yet we live the pain of
knowing our daughter was desperate and
alone, and because of these punitive and

FSA
1B-3
2-20-90

restrictive laws, she further compounded

her initial mistake with another,
and paid for it with her life.
My daughter was a quality child.
She was raised in a functional family
environment and encouraged to develop
her own thinking and reasoning
skills. Yet, in in time of crisis,
others had dictated how she must
react, thus denying her a legitimate
option that all women should enjoy,
the right of self-determination.
Had our daughter come to us, her mother
and I would have counseled her, made
her aware of all her options, the circumstances
and the consequences, to the best of our ability

FSR
IB-4
2-20-90

But, I can state emphatically that the final decision would have been hers.

In ~~the~~ testimony given yesterday before this committee "parental rights" ~~were~~ was the main focus. Not once, were the rights of the young women mentioned. As it stands today legislators, judges and parents are making the decisions for these young women, allowing little or no input from them. Decisions that are clearly along the lines of their own political or moral beliefs.

FSA
IB-5
2-20-90

How can we legislate or dictate that

families must communicate? How can we dictate ~~how~~ to people how they must act or react in a time of crisis.

I realize a great number of young women are going to their parents for counsel and for this I am grateful. Since the death of my daughter, my wife and I have counseled ~~[illegible]~~ several young women, and have been fortunate to get the parents involved – But what about the young women who won't, for whatever reason go to their parent, what about the those who don't want to disappoint

FSA 10-6 2-20-90

their families, who are frightened?
In the bills ~~before~~ being considered
by this committee, neither ~~none~~ of them
has any accomodation or consideration
for a situation ~~such as I have~~
like a Becky Bell -
In testimony before you yesterday,
it was stated ~~that~~ and I quote
Pat Goodson
"Theirs is an isolated case" end quote.
Well, I submit to you these restrictive and
punishing laws being considered and
if enacted will further isolate the
young women of Kansas - are you
going to punish them because they
have made a mistake - because they

FSA
1B-7
2-20-90

love their parents and don't want to disappoint them.

~~Self-appointed moralist have come before you~~

Having some experience as a father tells me that there are those young people, no matter how stable the family structure, who are not going to seek the counsel of their parents in times of trouble concern or crisis.

In the interest of political gain and in the name of God, ~~our~~ my daughter was punished, ~~are you going to punish the young women of Kansas, because they make a mistake~~?

FSA
13-8
2-20-90

~~Once~~
My daughters fate was decided
by others, thus denying her a safe
option, a choice she was ~~clearly~~ not
~~denied~~ allowed to make. The
parental consent laws clearly denied
her a safe option, and because
she had decide to terminate her
pregnancy, forced her into making
a fatal mistake.
My daughters death has to count
for something, she was somebody,
somebody beautiful.
I will not sit idly by and not
speak out to others that could face

FSA
1B-9
2-20-90

the same torment that the Bell family now lives with. Not as long as there are those who will go to any length to take away basic human rights.

I am not promoting abortion. I am speaking out against those who want to punish, who suggest that we can reduce teen age pregnancy through legislation. I am speaking out against those who will simply not address the needs of birth control, and further sex education.

Sex among teenagers will never be regulated by legislation, but

FSA
1B-10
2-20-90

through education.

~~It hurts so bad to stand before~~

~~your~~ MURDER!! -

I stand before you, a man with a broken heart, it is my desire that in speaking out, it will in some way prevent others from sharing this same fate.

~~I urge this committee to defeat~~

~~the two Bills being considered~~

~~The two bills being considered~~ before

~~this~~ committee are punitive and

It hurts -

FSA
IB-11
2-20-90

TRANSCRIPTION
TESTIMONY OF ANN WIGGLESWORTH, MD.
BEFORE THE HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE
February 20, 1990

I was invited here today not to talk about parents or children so much as to talk about doctors. I am actually in Manhattan now. I am an obstetrician-gynecologist and practice in Manhattan. I work 80 hours a week trying to do the best I can for women and their reproductive health needs of all kinds. As an obstetrician, I'm the advisor for the Pottawatomi County Health Department where we assist women to make reproductive choices all the time. We want them only to make good choices, however if we are prevented from ever seeing them, we can't help them.

Now I hear that we have a proposal to make a felon out of any doctor who does not report to both parents of any young girl who wants to have an abortion, 48 hours prior to performing that procedure, does not seek out those parents actively, do everything they can to find them and inform them, not with a phone call but with some way that I don't quite yet understand. Perhaps I'm to go to their houses myself even if one is a non-custodial father and lives in California. They are going to make a felon out of any doctor who does this and I want to ask you, "What next?" The state already has its hands in medical practice in a number of ways. The state tells me I can't have a license to practice medicine unless I carry $1 million worth of malpractice insurance coverage but the state turns its back when I have to pay $70,000 a year to an out of state insurance company to get that coverage. The state meddles in my relationship with women who want to have sterilization procedures, too. If a mother of four, anticipating her fifth baby, wants to have her tubes tied, and doesn't think about it until three weeks before the baby is born, she can't do that at the time the baby is born because she hasn't signed a Medicaid consent if she is so unfortunate to be with a Medicaid card. She can't unless she signs a consent 30 days ahead of time at which time she says I have explained every other possible method of birth control to her, to have her tubes tied. Oh, she can do it. I can do it without any penalty accruing to me except I won't get paid and that doesn't go very far toward making a $65,000 malpractice payment. The hospital doesn't get paid either and that doesn't go very far toward keeping the hospitals open. Now they want to make me a felon. Now they don't only want to make me not have a license and not get paid, they want to make me a criminal.

As the mother of three teenaged children I don't quibble for a minute about the need of parents to know what their children are doing. We need to know what our children are doing particularly if they are out having sex when they are 14. We need to know what is being done to and for them. We need to talk to them and we need to make it possible for them to talk to us. As a mother, I know that no matter how we try to facilitate that time at home, sometimes it doesn't always happen that way. My experiences in trying to communicate with my children hasn't always been glorious with hymn singing, full of roses and sunshine.

As a mother I can't quibble with the need of the parents to know but as a doctor, I have to say I've seen the other side of it. I see it all too often.

I see young teens, some of them very young, caught in disastrous pregnancies that they are absolutely unable to share with any one or both parents. Perhaps that is because one parent is far away, not interested or absolutely hostile. I'm not talking about the girl who "goes too far" or the boyfriend who forgets to use protection. I'm talking about, for example, the 13 year old who is molested and impregnated by that ubiquitous 20th century lecher, the mother's live-in boyfriend. (I'm talking about the girl) who faces threats, denials, scorn, villification and intimidation when she goes home with the story that she has had a positive pregnancy test. I'm also talking about those girls with supposedly stable homes who have a positive pregnancy test and for whom it is a real danger to carry that news home. I'm talking about the girls in homes where they will be beaten or locked in a closet or burned with cigarettes or even turned out on the street when they go home with that news. And believe me, I've seen them and they exist. I'm not talking about parents who are interested in being supportive. For those women there is danger not only in the pregnancy because everybody knows that teenage pregnancies are attended by incredible medical dangers which the pregnancies of older people don't necessarily have. I'm talking about the danger in just making it known. If we tell these girls we are going to tell both of their parents, we are going to lose them and I appeal to you, in the name of common sense, for the sake of maintaining the doctor-patient relationship, and allowing us to be present to help these girls, one of the few confidential relationships left in our society, don't pass a law that makes me a crook.

Testimony to Kansas State Legislature

Summary

The testimony summarizes psychological research on adolescent abortion, especially the findings of an interdivisional committee of the American Psychological Association. The psychological literature indicates:

1. There is no research evidence to support the assumption that adolescents are vulnerable to serious psychological harm as a result of abortion.
2. There is some evidence that children born as a result of denied abortion are at greater risk for mental, physical, and psychological impairment, even years after birth.
3. There is no evidence to support the assumption that adolescents are less competent to make reasoned health decisions than are adults.
4. Inclusion of a mature minor rule in legislation is problematic as the courts have not defined the term "mature," thus inviting arbitrary judgments and possible lawsuits.
5. Establishment of a judicial bypass procedure has not increased reasoned decision making or increased protection of adolescents.
6. The tendency of adolescents to delay seeking medical attention poses a risk to their physical and emotional health. To the extent that parental notification and other legislated restrictions cause anxiety in adolescents and cause them to delay seeking help, these restrictions will place adolescents at increased risk.

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 3
February 20, 1990

Testimony to Kansas State Legislature
Re: Adolescent Abortion Legislation

Elsie R. Shore, Ph.D.
Wichita, Kansas

I am a community-clinical psychologist and associate professor of psychology at the Wichita State University. I received the doctorate in community-clinical psychology, with a minor in psychology and law, from the University of Nebraska, Lincoln, Nebraska, in 1981. I am a member a number of professional organizations including the American Psychological Association.

I am testifying regarding a number of psychological issues involved in consideration of legislation to limit access to abortion by minors. The American Psychological Association (APA), which is the major organization representing psychologists in the United States, often provides testimony, amicus briefs, and other forms of information regarding psychological factors in legal proceedings. In an effort to provide the courts and legislators with information on the psychological factors involved in adolescent abortion, the APA sponsored a committee charged with reviewing the state of knowledge in this area. I primarily will be reporting the findings of this committee. I will focus on four areas that the courts and legislators have raised regarding access to abortion for adolescents. These areas are (1) the vulnerability of adolescents to harmful consequences of abortion, (2) the competence of adolescent decision making, (3) the determination of adolescent maturity, and (4) the effect of judicial bypass procedures.

Vulnerability

Briefly, the issue here is whether adolescents are at greater risk for serious psychological harm as a result of having an abortion. There is no research evidence to support an hypothesis of this sort (Adler & Dolcini, 1986; Melton & Russo, 1987).

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Abortion is stressful for many women, but "it generally does not po substantial threat to emotional well-being" (Adler & Dolcini, 1986, p. 91). When negative reactions occur, they are almost always brief and mild. When adolescent reactions are negative it is felt that the response may be related to the fact that adolescents tend to delay having an abortion. Delay may result in the utilization of medical procedures that are more stressful for the woman.

> "If increased governmental regulation of adolescent abortion in fact results in even greater delay, legal procedures ostensibility designed to protect pregnant adolescents may in fact increase the probability of undue distress" (Interdivisional Committee, 1987)

It might be noted here that the medical morbidity and mortality rates from adolescent full-term pregnancy are much greater, possibly eleven to fifteen times greater, than those from abortion. Although there are not much data, it appears that the same is true for psychological risks of abortion as compared with completion of pregnancy, whether the mother keeps her child or relinquishes the child for adoption.

Consequences of Refused Abortion - There is evidence of negative effects of denied abortion on mother/child relationships and of serious impairments in children's mental, emotional, and physical development (Marecek, 1986). Most directly to this point are two European studies in which children were followed up from sixteen to twenty-one years after birth (David & Matejcek, 1981, as cited in Melton & Pliner, 1986; Forssman & Thuwe, as cited in Marecek, 1986). In both studies the children were deficient in a number of areas as compared with wanted children. Referrals for mental health services were higher and educational attainment was lower. The fact that the differences were still present a long time after birth led David and Matejcek to conclude that unwantedness constitutes a risk factor for the subsequent life of the child.

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Competence of Adolescent Decision Making

The concern here is that adolescents are less competent than adult women to make decisions about abortion. Melton and Pliner (1986) indicate that there is a substantial body of research showing that teenagers do not differ from adults in their ability to understand and reason about treatment alternatives. Lewis (1987) reviewed more direct evidence regarding decision making about abortion, including research on persons adolescents consult about pregnancy decisions, type of advice they receive and their skill in evaluating it, their likelihood to conform to parental and peer advice, their reasoning skills, and whether the developmental tasks of adolescence influence this decision making. Lewis concluded that parents are, in fact, the source of advice for most teenage girls, that they are not highly influenced by peers, that developmental needs do not impair their decision making, and that they may equal adults in the competence of their decision making. Based on these and other studies the American Psychological Association has urged that states presume that minors fourteen years of age and older are competent to make their own abortion decisions, instead of assuming diminished competence (Interdivisional Committee, 1987).

With regard to parental notification, Melton (1987) points out that minors who do not involve their parents in abortion decisions tend to be older and relatively unconflicted about their decision. Parental notification in these cases is likely to interfere with, rather than enhance, the decision making process. He also points out that adolescents who do not notify their parents may have good reasons for doing so, including fear of negative results such as retaliation and physical abuse. Teenagers whose pregnancy is the result of incest also may be harmed by parental notification statutes. Finally, the perception that parents will be unsupportive or hostile may increase minors' delay in seeking medical attention and, thus, increase their health risks.

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The Mature Minor Rule

There has been discussion in some venues of imposing a mature minor standard, whereby the minor would need to be determined to be mature in order for her wishes regarding abortion to be upheld without parental notification or consent. One problem with this concept is that there is no legal definition of "mature." Following from this lack of definition, there are no studies to indicate "whether maturity can be reliably and validly assessed within a reasonable period of time" (Melton, 1987). Using an ambiguous standard could lead to arbitrary judgments. A physician who believes a minor to be mature and does not notify parents could be liable to criminal penalties if the minor is subsequently determined to be immature. Similarly, a physician who assumes a minor is immature and informs her parents could be liable for violating her constitutional rights and medical professional ethics (Melton & Pliner, 1987).

Judicial Bypass

The requirement that adolescents seek the approval of a third party, usually a judge, is contained within legislation in a number of states. As a result, it is possible to evaluate the effect of judicial bypass on adolescent abortion decisions. Melton (1987) states that "there is no evidence that they promote more reasoned decision making or screen out adolescents who may be particularly immature or vulnerable" (p. 80). The hearings that are held appear to be cursory and pro forma, accomplishing little other than delaying action and, thereby, increasing the medical and psychological risks associated with abortion.

In addition, the statutes do not appear to have stimulated greater parental consultation. Anecdotal data from judges and lawyers indicate that the procedure is an "ordeal" for the pregnant minors, creating embarrassment and anxiety. The procedure invades privacy about personal information, something very important to adolescents (Melton, 1987).

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Conclusion

The APA Interdivisional Committee on Adolescent Abortion concluded that

> "there is little evidence to support age-graded policies about abortion; research supports neither the contention that adolescents are especially unlikely to make reasoned decisions about abortion nor the assumption that adolescents are vulnerable to serious psychological harm as a result of abortion" (Interdivisional Committee, 1987, p. 75)

The imposition of mature minor standards or judicial bypass requirements also appear not to significantly increase the protection of pregnant minors or serve the interests of the state. From this evidence I conclude that considerations regarding access to abortion should not be different for teenagers than they are for adults.

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Adolescent Abortion

Psychological and Legal Issues

Interdivisional Committee on Adolescent Abortion

ABSTRACT: Findings from empirical research differ greatly from the Supreme Court's assumptions about psychosocial factors in adolescent abortion. Psychological research does not support age-graded policies about abortion. Psychologists should be careful to preserve adolescent clients' privacy in counseling about pregnancy-related decisions. Government should encourage counseling services for pregnant adolescents and research on psychological aspects of their decisions.

Few issues in our society are as emotion laden as the question of the circumstances under which abortion should be legally available. The issue is especially charged in regard to adolescents, because it raises the profound dilemmas of the proper ordering of the interests of the adolescent, her family, and the state. The question is no less basic than whether adolescents are to be considered true persons entitled to respect for privacy in personal decisions.

Beyond the general public interest in issues related to adolescent abortion, psychologists have special interest in the problem for several reasons. First, although the Supreme Court has recognized the application of the right to privacy for minors in abortion decisions, the Court has also made clear that states may regulate minors' access to abortions in ways that would be unconstitutional if applied to adult women (see Melton & Pliner, 1986, for a review). It has based the latter conclusion on assumptions that minors are especially vulnerable to deleterious psychological effects of abortions and that pregnant minors are substantially less able than adult pregnant women to make a reasonable decision about whether to terminate a pregnancy. Psychologists can assist courts and legislatures in evaluating the validity of these and related assumptions so as to determine whether there is any compelling basis for age-based regulation of women's access to abortion. Similarly, psychologists can evaluate legal procedures to ensure that they enhance support for pregnant adolescents and that they do not themselves add undue stress or create other unintended negative effects.

Second, as clinicians or counselors in schools, mental health centers, and health care settings, psychologists are often involved in assisting adolescent clients or other health professionals in decisions about abortion. Few situations raise as many complex ethical and legal issues for psychologists (see Scott, 1986, for a review). Analogously, there are special ethical and legal problems for psychologists who seek to provide the scientific basis for practice through study of pregnant adolescents' decisions or the effects of their decisions.

Third, and most generally, as scientists and professionals committed to the promotion of human welfare (American Psychological Association [APA], 1981, Preamble), psychologists are dedicated to ensuring that adolescents and families faced with difficult decisions have access to services that will assist them in understanding the alternatives and dealing with their consequences. Psychologists are ethically bound to respect individual privacy and to protect the civil rights of their clients (APA, 1981, Principle 3c).

What Do We Know?

In both absolute and relative terms, abortion is common among adolescents (see Russo, 1986, for a review). About 40% of the 1.1 million pregnancies in females under age 20 annually are terminated by induced abortions. Nearly one third of all abortions are performed on females under age 20. Among younger adolescents (under age 15), almost half of the abortions occur among minority youth. Thus, beyond the moral and social issues involved in abortion generally, the sheer frequency of adolescent abortion, especially among disadvantaged groups, marks it as a social phenomenon worthy of careful policy analysis.

Quality of Decision Making

The Supreme Court has assumed that adolescents are less likely than adults to make sound decisions when they are faced with an unintended pregnancy. There are few studies directly focused on abortion decision making by adolescents. However, the available evidence on health care decision making generally suggests that adolescents are as able to conceptualize and reason about treatment alternatives as adults are (see, for reviews, Grisso & Vierling, 1978; Melton, 1981; Melton, 1984, pp. 463–466; Melton, Koocher, & Saks, 1983; Weithorn, 1982; see also Weithorn & Campbell, 1982). The developmental differences that occur in decisions about abortion appear to be related largely to differences in adolescents' and adults' social situations, not their psychological maturity. Thus, adolescents are more likely to perceive their decision as externally determined (Lewis, 1980), and parents frequently *are* involved in helping to make the decision (Clary, 1982; Rosen, 1980). Adolescents are also more likely to delay their decision (Bracken & Kasl, 1975; Russo, 1986), probably because of a variety of social factors: fear of familial consequences; lack of experience in

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contacting professionals; lack of money to pay professional fees; concern about confidentiality.

Several states have enacted statutory requirements for notification of parents before a minor obtains an abortion, and the Supreme Court has upheld the constitutionality of such requirements, at least when applied to immature, unemancipated minors. Parental notice requirements would serve a compelling state interest, however, only if they resulted in a more reasoned decision by the minor. Although the effects of the notice statutes have yet to be evaluated directly, there is reason to believe that they will frequently not have such a positive effect. First, studies of family planning clinics have shown that confidentiality is an important factor for adolescents considering whether to use their services (Torres, Forrest, & Eisman, 1980; Zabin & Clark, 1983). Lack of confidentiality may increase the tendency already observed among pregnant teenagers, particularly younger teenagers, to delay in seeking professional help. Second, there is considerable evidence that parent–daughter communication about sexuality often leaves much to be desired (Fox & Inazu, 1980; Furstenberg, 1971; Rothenberg, 1980). There is little reason to believe that the quality of communication would be greatly improved with a daughter's announcement that she believes that she may be pregnant, even when the law requires parental consultation. Third, although parental involvement if often desirable—perhaps more frequently than adolescents estimate (cf. Furstenberg, 1976)—it is also clear that there are circumstances in which parental consultation is likely to result in neither more reasoned decision making nor diminished risk of psychological harm. That is, when parents support their daughter's decision—whether to abort or to carry to term—and permit their daughter to make her own decision with their assistance, the probability of a positive outcome is increased (Adler & Dolcini, 1986). However, when these conditions are absent, parental involvement may exacerbate stress.

Psychological Effects

The Supreme Court has assumed that adolescents are especially vulnerable to serious psychological harm as a result of having an abortion and that these risks are substantially greater than the psychological risks that arise in the decisions required when a minor carries a fetus to full term. There is no research evidence to support these assumptions (see Adler & Dolcini, 1986, for a review). Although adolescents' reactions to abortions may be somewhat more negative on the average than adults', the magnitude of the age differences is small (see, e.g., Bracken, Hachamovitch, & Grossman, 1974). Moreover, when negative reactions occur, they are almost always mild and transitory. Indeed, the most common reaction to abortion among both minors and adults is one of relief (Olson, 1980; Osofsky, Osofsky, & Rajan, 1973). The slightly more negative average response of adolescents is probably related largely to their tendency to delay; the medical procedures involved in abortion late in gestation tend to be more stressful. If increased governmental regulation of adolescent abortion in fact results in even greater delay, legal procedures ostensibly designed to protect pregnant adolescents may in fact increase the probability of undue distress.

It is noteworthy that the medical morbidity and mortality rates arising from full-term adolescent pregnancy are much greater than those arising from adolescent abortion, especially in the first trimester (Cates, 1981). Although the data on psychological effects of adoption are limited, the available research indicates that the psychological risks entailed in adolescents' completion of their pregnancies—whether they keep their babies or relinquish them for adoption—are substantially greater than the psychological risks of adolescent abortion (Adler & Dolcini, 1986).

Social Effects

That abortion is typically a relatively benign alternative for pregnant adolescents is unsurprising when one considers the social consequences of becoming a teenage parent (see, for reviews, Marecek, 1986; Scott, 1984). Adolescent mothers frequently find their education interrupted, their occupational aspirations stunted, their income diminished, and their marriage (when it occurs) strained. There is often financial and emotional strain for the mother's family of origin, and adolescent fathers often also experience emotional strain and disruptions of education and occupation. Moreover, the children of adolescent mothers are at risk for developmental problems, and they may be more likely to have problems of psychosocial adjustment. In cross-national research, particularly deleterious developmental effects have been observed in children resulting from pregnancies in which an abortion was sought and denied (David & Matejcek, 1981). However, care must be taken in generalizing from these studies involving European populations to the American experience.

What Should Psychologists Do?

As the preceding review of the state of knowledge about adolescent abortion indicates, legal policy has often been grounded on assumptions that do not withstand empirical scrutiny or for which no empirical evidence exists. What-

This statement is a summary of the report of the Interdivisional Committee on Adolescent Abortion sponsored by Division 37 (Child, Youth, and Family Services) of the American Psychological Association, in collaboration with Divisions 34 (Population and Environment), 35 (Psychology of Women), and 41 (American Psychology-Law Society). The statement was endorsed by the executive committees of the sponsoring divisions in spring 1985, subject to the addition of references when published. The statement was also noted favorably by the APA Committee on Women in Psychology and the APA Committee for the Protection of Human Participants in Research.

Members of the committee included Nancy E. Adler, Henry P. David, Jeanne Marecek, Gary B. Melton (chair), Roberta A. Morris, Nancy Felipe Russo, Elizabeth S. Scott, Lois A. Weithorn, and Kathleen Wells.

The committee's full report is available in Melton (1986).

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ever the wisdom of existing law, however, psychologists must, of course, assist their adolescent clients within that legal context. This context is often ambiguous and complex, and the underlying moral issues are themselves difficult. Counseling adolescents about abortion decisions (or conducting related research) thus requires extraordinary attention to ethical concerns (see Scott, 1986, for a review).

Respect for personal autonomy and privacy demands support for freedom of choice in decisions of great personal significance, such as abortion. This general principle is consonant not only with psychologists' Ethical Principles (APA, 1981); it is also consistent with existing legal doctrine, which has been based on concern about the limits of adolescents' rational decision making. Within such an ethical and legal framework, psychologists who counsel adolescents about abortion decisions have the following two principal tasks: (a) to assist adolescents in weighing the alternatives (e.g., abortion; completing the pregnancy and relinquishing the baby for adoption; completing the pregnancy and keeping the baby), and (b) to provide emotional support for adolescents so that they can make sound personal decision under relatively unstressful conditions and that they will not suffer untoward psychological sequelae of the decision itself.

In order to assist adolescents in decision making, psychologists must, of course, be willing to explore the alternatives. Psychologists whose moral scruples prevent such open discussion should so inform their clients and provide referrals to other counselors, as needed. In order to be of assistance, psychologists must know the alternatives; accordingly, they should be able to explain the legal procedures in their jurisdiction for minors' obtaining abortions with or without parental consent and for placing a child for adoption.

In some jurisdictions, psychologists may be unable to guarantee confidentiality to minors who seek counseling about abortion. These constraints should be made clear to clients when they initiate counseling. When legal strictures are unclear (e.g., whether counseling by school psychologists is confidential; whether state-imposed parental notice requirements may be applied to mature minors and, if not, how "maturity" is to be assessed), legal advice should be sought (e.g., an attorney general's opinion). Psychologists should advocate laws that will safeguard their clients' privacy.

In jurisdictions in which judicial permission is required for an adolescent to receive an abortion without parental consent, psychologists may be asked to determine whether the client is "mature" and whether an abortion would be in her best interest. These are legal and moral determinations about which psychologists and other health professionals have no special expertise (cf. Bonnie & Slobogin, 1980; Morse, 1978). Thus, although psychologists may be able to provide information that will be helpful to the court in making its decision, they should resist offering ultimate-issue opinions (i.e., opinions about whether the legal standards for "maturity" and "best interest" have been met).

There are still sizable gaps in what is known about alternatives for policy on adolescent abortion. For example, there have been few evaluations of the effects of the various limitations that states have imposed on minors' access to abortion (but see Cartoof & Klerman, 1986; Donovan, 1983; Mnookin, 1985; Pliner & Yates, 1986). The literature on the psychology of pregnant adolescents' decisions is also still quite limited. Psychologists can and should conduct the research needed to answer these questions, because they are crucial both to policy formulation and the development of counseling techniques. However, it must be acknowledged that there are special ethical and practical problems in conducting such research. Can a minor who is able to consent to an abortion independently also consent to research about abortion? Federal regulations permit minors to consent to research independently and privately in such a circumstance, but state laws may provide no specific imprimatur for an exception to the usual rule that minors are per se incompetent to consent to research. In view both of the private nature of the decision involved and the societal interest in increasing knowledge about adolescent abortion, states clearly should permit minors to consent independently to research about abortion if they are able to demonstrate an understanding of the risks and benefits of the research. However, in view of the emotional loading of the topic and the usual legal presumption that adolescents are incompetent to consent, psychologists conducting research on adolescent abortion should pay special attention to the ethical issues in their research. In addition to the usual review by institutional review boards, researchers might consider establishment of an independent advisory group to safeguard the welfare of participants.

What Should Policymakers Do?

Although the policy chosen is likely to have significant psychological consequences, the questions of whether family privacy is superior to individual privacy and when abortion is to be permitted are issues of morality and law, and are not subject to empirical psychological study. However, insofar as the legal calculus is based on psychological assumptions, policymakers should stimulate and attend to relevant psychological research. In that regard, there is little evidence to support age-graded policies about abortion; research supports neither the contention that adolescents are especially unlikely to make reasoned decisions about abortion nor the assumption that adolescents are vulnerable to serious psychological harm as a result of abortion.

Consideration should be given to abolishing mature minor standards in determination of whether minors are able to obtain an abortion without parental notification or consent. It is hard to imagine a minor too immature to make the decision but mature enough to rear a child. In any case, no research has been conducted to determine whether "maturity" can be reliably and validly assessed. In the absence of clear legal standards, it is very probable that such assessments are often erroneous. In view of the

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time consumed in performing such assessments and their questionable validity, it is unclear whether a mature minor standard can be effectively implemented even if it makes sense in the abstract.

Finally, government should encourage the development of counseling services for pregnant adolescents and their families. As the Supreme Court has recognized, these services should be provided by professionals with special training in counseling. Competent counseling is likely to enhance the quality of adolescents' decision making and to minimize emotional strain. Support for research is also essential if counselors are to be able to respond optimally to pregnant adolescents' needs for information and emotional support. The policy of the current Administration to provide few, if any grants, for abortion-related research and counseling services is apt ironically to hamper efforts to facilitate careful and relatively unstressful decisions by pregnant adolescents.

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Appendix A

APA Brief in Thornburgh v. American College of Obstetricians and Gynecologists

The Requirement That Minors Fourteen Years Of Age And Over Seek Parental Or Judicial Consent For Abortions Does Not Satisfy The *Danforth* Significant State Interest Test.

[A great] burden on [minors' abortion] rights is posed by the implicit presumption in § 8206 [of the Pennsylvania Abortion Control Act] that, unless otherwise demonstrated, women under the age of eighteen are less capable than adults of making decisions regarding abortion in a reasoned manner. This presumption is not supported by the relevant empirical studies. To the contrary, there is a substantial and growing body of psychological literature which supports the view that by the age of fourteen, most minors do not differ from adults in their ability to understand and reason about treatment alternatives or to comprehend and consider risks and benefits regarding those alternatives. Nor do minors fourteen and older differ in the quality of decisions actually made. *See generally* Melton & Pliner, *Adolescent Abortion: A Psycholegal Analysis* in ADOLESCENT ABORTION: PSYCHOLOGICAL AND LEGAL ISSUES (G. Melton ed. in press); Lewis, *A Comparison of Minors' and Adults' Pregnancy Decisions,* 50 AM. J. ORTHOPSYCHIATRY 446 (1980).[20]

Indeed, the fact that a minor has chosen to abort may show the deliberation, foresight as to consequences, and sense of responsibility that mark mature decision-making:

> Minors who seek abortions express reasons similar to those of adults, and demonstrate a comparable appreciation of their dilemmas. Like adults, they are attempting to escape from a potentially shattering, life-long handicap. These minors recognize that childbirth is age-inappropriate. They often wish to continue in regular junior or senior high schools without stigma rather than attend schools for pregnant girls, and some may have longer range ambitions as well. If they are members of fatherless families supported by public assistance, an unwanted pregnancy to term and childbirth may dash their hopes of rising above their mothers' education and socio-economic status. They may be disillusioned by the inconstancy and unconcern of the biological father, often also a minor, or they may find their pregnancies repulsive as the result of incest or rape.

Dembitz, *The Supreme Court and a Minor's Abortion Decision,* 80 COLUM. L. REV. 1251, 1256 (1980) (footnote omitted).

Thus, in view of the Court's reliance on minors' presumed "lesser capability for making important decisions" as the primary justification for requiring women under the age of eighteen to secure parental consent or to initiate judicial proceedings by which they may demonstrate sufficient "maturity" to make an independent choice, these studies call for a re-evaluation of that presumption in order to ensure that the fundamental privacy rights recognized in *Roe v. Wade* are not being applied to minors in an impermissibly restrictive manner, unsupported by "any significant state interest . . . not present in the case of an adult." *Danforth,* 428 U.S. at 75.

As noted above, the "significant interest" recognized by this Court as sufficient justification of statutory parental/judicial consent procedures such as those at issue in *Thornburgh* is the State's interest in ensuring that a minor's decision to abort is the product of a mature and rational decisionmaking process. However, the studies cited above and at n.20, *supra,* show that there is no empirical basis for concluding that minors fourteen and older are less capable of making informed decisions than adults. Thus, the Commonwealth's interest in ensuring the informed consent of minors fourteen and older is no different from its interest in ensuring the informed decisionmaking of adults.

For example, in a recent study by two noted developmental psychologists, minors aged nine and fourteen and adults aged eighteen and twenty-one were presented with four hypothetical vignettes about individuals suffering from particular medical or psychological disorders, and were asked to choose among several treatment options. The subjects were presented with detailed information about the nature, purpose, risks, and benefits of the alternative treatments, and were asked to choose among them. The subjects were then asked a series of standardized questions about their decisions, and about the vignettes. In most instances, the responses showed no difference between the adults and the fourteen year olds in any of the scales of competency used in the study: inferential understanding (*i.e.,* appreciation), factual understanding, reasoning, reasonable outcome, and evidence of choice. *See* Weithorn & Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions,* 53 CHILD DEVELOPMENT 1589 (1982).[22]

These and similar findings by other researchers support the conclusion that there is no factual justification for treating fourteen year old women differently, in this respect, from eighteen year old women. And, "without [the] assumption [of a minor's inability to make reasoned and informed decisions,] there seems to be an inadequate constitutional justification for imposing upon her the burden of proving her entitlement to exercise a consti-

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Note This excerpt is reprinted verbatim from APA's brief in *Thornburgh v American College of Obstetricians and Gynecologists* (pp. 25–29). Some of the footnotes have been omitted. The brief was prepared by Donald N. Bersoff, Laurel Pyle Malson, and Bruce J. Ennis of Ennis Friedman & Bersoff. It was submitted to the United States Supreme Court on August 21, 1985. A copy of the complete brief can be obtained from Clarence Augustus Martin, Office of Legal Affairs, APA, 1200 17th St., N.W., Washington, DC 20036.

[20] These findings tend to show that the years between 11 and 14 are the transition period during which children develop the capacity to weigh risks and benefits in decision making.

[22] By contrast, the nine-year-olds were found to perform significantly less well on the understanding and reasoning scales.

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tutional right." Dembitz, *supra*, 80 Colum. L. Rev. at 1262 (footnote omitted).

The statutory consent procedures required by § 3206 impose a substantial burden on adolescent women seeking to exercise the constitutional right to choose abortion. Without regard to how simple, uncomplicated, and speedy the procedures may be, or how helpful and courteous the court personnel may be, the burden imposed on a pregnant minor by the requirement that she initiate and prosecute such proceedings, exposing the details of her pregnancy to numerous court personnel, nevertheless remains a substantial burden. Because that burden is not imposed on adult women—individuals whose informed decisionmaking capacity is not measurably different from that of fourteen year olds—who exercise their right to choose abortion, the imposition of such procedures on minors constitutes an impermissible burden on their constitutional right.

The imposition of such a burden is particularly inappropriate in light of the "unique nature and consequences of the [minor's] abortion decision," which this Court has recognized as a characteristic that distinguishes "the abortion decision . . . from other decisions that may be made during minority." *Bellotti II*, 443 U.S. at 642. In addition to the adverse and substantial consequences noted by the plurality in *Bellotti II*, there are a variety of other negative effects that result from requiring minors to submit to judicial proceedings to secure authorization for abortions. Those effects include self-imposed delays in initiating such proceedings because of embarrassment and the invasion of privacy inherent in petitioning a court; substantial increases in the psychological and medical risks of abortion which may result from such delays; anxiety, embarrassment, and feelings of degradation about discussing such intimate matters with a lawyer and a judge; and the damage to the minor's self-esteem and sense of individual personhood—the development of which are principal developmental tasks during adolescence—which necessarily results from the invasion of her privacy and the requirement that her abortion decision be reviewed and validated by a third party. *See generally* Melton & Pliner, *Adolescent Abortion: A Psycholegal Analysis, supra*.

In view of these considerations, the Commonwealth has failed to make the showing required by *Danforth* of a "significant state interest" in subjecting the abortion decisions of minors fourteen years of age and older to judicial review when similar decisions by adult women are not subject to judicial review. Accordingly, APA submits that the parental/judicial statutory consent provisions of § 3206 impermissibly burden the rights of women fourteen years of age and older to seek abortions, and respectfully urges the Court to hold § 3206 unconstitutional on that basis.[24]

[24] Consistent with these views, APA urges that States be required to *presume* that minors 14 years of age and older are competent to make their own abortion decisions. However, as with the presumption of an *adult's* competence to provide informed consent to health-care procedures, in circumstances in which the attending professionals have doubts as to the validity or reliability of the patient's consent, judicial or other third-party determination of the issue would be appropriate. Thus, any minor fourteen or older who is seeking an abortion and about whom health care professionals have serious doubt as to her competency to make an informed abortion decision would be required to petition the court for a *de novo* competency determination. As with existing procedures under § 3206, the judge would be permitted to consider whether an abortion would be in the minor's best interest only if he has made a prior determination of the minor's incompetency to make that decision for herself. Such a structure would protect fully the mature minor's constitutional right to an unburdened abortion decision, would serve the State's interest in protecting immature minors from "improvement" decisions, and would serve the additional salutary purpose of freeing judicial resources from difficult and unnecessary inquiries.

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Testimony before House Federal and State Affairs Committee
February 20,1990
Parental Notification Requirement for Minors' Access to Abortion
Joseph Hughey, Ph.D.

I am Joseph Hughey. I was awarded the doctorate in psychology from the University of Tennessee. I am a Social and Community Psychologist and associate professor of Psychology at the University of Missouri-Kansas City. I am a member of the American Psychological Association, the Academy of Management and other professional organizations.

I testify today as a psychologist in Kansas and as a citizen of Kansas.

I will briefly describe a recent study that sheds significant and meaningful light on the psychological effects of abortion.

Zabin, L. S., Hirsch, M. B., & Emerson, M. R. (1989). When urban adolescents choose abortion: Effects on education, psychological status and subsequent pregnancy. Family Planning Perspectives, 21, 248-255.

This study was conducted by researchers at The Johns Hopkins School of Hygiene and Public Health and funded by the National Institute of Child Health and Human Development of the National Institutes of Health and the Ford Foundation.

This well designed study concludes that unmarried, sexually active teenage women "were neither directly or indirectly any more likely than those in the control groups to suffer a change for the worse psychologically. In fact they experienced less negative change than the other teenagers."

This research is noteworthy for three reasons:

1. High quality design features:This was a prospective study meaning subjects were assessed before they knew results of pregnancy tests and of course before abortion for those who so chose.

2. Thoroughness of measurement: Three frequently used psychological tests were employed: State-Trait Anxiety, Self-esteem and Locus of Control. The study also assessed educational attainment, subsequent pregnancy and economic well-being .

3. Subjects were studied for two years : Measurements were taken before knowledge of pregnancy tests, at one year and again two years after the results of pregnancy tests.

334 teen women participated in the research. They were divided into three groups:
Abortion group. 141 who terminated pregnancy upon knowing results of pregnancy tests
Childbearing group. 93 who carried pregnancies to term
Negative test group. 100 who had negative pregnancy tests.

RESULTS

Anxiety. The data showed no differences over the two year period in underlying anxiety between the abortion group and those who carried to term and those who had a negative pregnancy test even when separating the transient psychological state associated with suspected pregnancy.

Self-esteem and Locus of Control. (Locus of Control measures the degree to which a young woman believes herself in control of her life.) All groups showed significant but small increases in self esteem. But only the abortion and negative test groups showed significant, positive gains in locus of control. Other differences in these variables consistently favored the abortion group, but all differences were small and of little substantive importance.

In light of these nonexistent and/or small differences the researchers compared the extent of negative change for all three measures combined. Importantly the researchers discovered that two years after abortion only 4.5 percent of those who chose to have an abortion experienced negative psychological change compared to an also small 5.5 percent for the childbearing group and 10 percent for the negative-test group.

Educational attainment. Educationally there were dramatic differences between the groups. 90 percent of those who had abortions had graduated from high school or were still in school after two years contrasted with 79 percent of the negative test group and 68 percent of the childbearing group. A twenty two percent positive difference for those who chose abortion versus those who bore children.

Subsequent pregnancy. There were also differences in subsequent pregnancy. Within 18 months, 58 percent of those who were not pregnant became pregnant, 47 percent of the childbearing group became pregnant again compared with 37 percent of those who had abortions. The researchers noted that the lower pregnancy rate for the abortion group could be attributed to the use of contraception.

Economic well-being. Significant differences in economic well-being were also noted consistently in favor of those who chose to have an abortion.

To conclude. . .The abortion group in this study fared well. To quote the researchers: "The young women who chose abortion did not differ from their peers in most respects at baseline and at followup were doing well (in both absolute and relative terms.)" p.254. Members of the committee, there are some who propose that abortion may have far reaching negative psychological effects. These data can be added to the substantial and growing body of evidence rejecting that notion. Taken together with data showing teens cognitively able to make the difficult decisions of unintended pregnancy, the present research evidence suggests the decision of young women to have an abortion works well for those who so decide.

Thank you for your attention.

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When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status And Subsequent Pregnancy

By Laurie Schwab Zabin, Marilyn B. Hirsch and Mark R. Emerson

Summary
A group of 360 black teenage women of similar socioeconomic background who sought pregnancy tests from two Baltimore family planning providers was followed for two years to determine if those who obtained abortions were adversely affected by their abortion experience. After two years, the young women who had terminated their pregnancies were far more likely to have graduated from high school or to still be in school and at the appropriate grade level than were those who had decided to carry their pregnancy to term or those whose pregnancy test had been negative. Those who had obtained an abortion were also better off economically than were those in the other two groups after two years. An analysis of psychological stress showed that those who terminated their pregnancy had experienced no greater levels of stress or anxiety than had the other teenagers at the time of the pregnancy test, and they were no more likely to have psychological problems two years later. The teenagers who had obtained abortions were also less likely than the other two groups to experience a subsequent pregnancy during the following two years and were slightly more likely to practice contraception. Thus, two years after their abortions, the young women who had chosen to terminate an unwanted pregnancy were doing as well as (and usually better than) those who had had a baby or who had not been pregnant.

The young women in the abortion group were neither directly nor indirectly any more likely than those in the control groups to suffer a change for the worse psychologically. In fact, they experienced less negative change than the other teenagers.

Introduction

For the past decade and a half, approximately 40 percent of U.S. teenagers who have conceived each year have elected to terminate their pregnancies.[1] Among women younger than 16, 1.7 abortions have occurred for each live birth in the last several years; thus, in this age-group, pregnancy termination is more common than childbirth.[2]

The effects of childbearing upon adolescent mothers have been scrutinized and enumerated, and independent adverse effects upon schooling, economic and social status, marital stability, maternal and infant health and future fertility have been documented; furthermore, the children born to teenage parents have been shown to suffer deficits as well.[3] Recent evidence suggests that some early differentials in outcome between teenage mothers and their peers are overcome or diminish with time[4] but that many of the problems experienced by their offspring are long-lasting. Thus, the early stresses upon young mothers are of enduring importance, whether or not they continue into the mothers' later lives.

Although almost as many young women terminate their pregnancies as carry them to term, there has been little research examining the effects of abortion that is comparable to that described above for adolescent childbearing. Only a small number of studies have focused on adolescents who conceive, and only a few have compared the experiences of teenagers who choose abortion to those of women of similar ages and similar social and economic backgrounds who choose to bear a child. Most studies of the sequelae of abortion, whatever the age of the woman, examine the effects of abortion on subsequent fertility[5] or psychological outcome.[6]

There appears to be a consensus that abortion rarely has adverse psychological sequelae, whatever the stage at which the pregnancy is terminated.[7] When negative psychological effects have been reported, they often appear to have been related to other factors. The woman's prior emotional condition plays a major role,[8] as does marital status: Unmarried women are more likely to experience negative sequelae,[9] perhaps because they do not have the support system that married women have. Many studies have indicated that family support for abortion is salutary, but when significant others do object, such opposition is strongly related to adverse effects.[10] The wantedness of the pregnancy can also have much to do with abortion's impact: Women terminating an unwanted pregnancy may find their course of action more beneficial psychologically than carrying a pregnancy to term,[11] and may experience a lower incidence of psychosis.[12] Not surprisingly, a woman who terminates a wanted pregnancy (for genetic reasons, for example) is likely to suffer more serious and prolonged effects.[13] Because the overwhelming majority of adolescent pregnancies occur among unmarried women and are not intended,[14] these differences are important when the implications of abor-

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tion for teenagers are being considered.

Some of the psychological effects that have been examined include depression, guilt, happiness, regret and anxiety. There has been one report of an adolescent attempting suicide at about the time she would have given birth had she not obtained an abortion.[15] However, a prospective study found less psychosis associated with abortion than with childbearing.[16] It is difficult to separate the temporary malaise sometimes associated with abortion from the stress of the accidental pregnancy itself, especially because according to most researchers, unhappiness, when it is reported at all, is generally short-lived; the usual feeling following the procedure is one of relief.[17]

Among the few studies that have focused on adolescents, some have followed small groups of teenagers who had abortions, to determine their subsequent contraceptive practice and fertility experience. A 1979 study showed an increased probability of repeat pregnancy during the six months after the outcome of the original pregnancy among those who obtained abortions compared with those who carried their pregnancy to term; however, by two years, this relationship was reversed.[18] Other research has identified no such difference, however,[19] and some have found that among adolescents, both regularity of contraceptive use and use of effective methods appear to increase following abortion.[20]

Serious flaws have been identified in much of the research on abortion sequelae.[21] The lack of suitable controls has been a recurrent problem. When controls have been used, confounding factors have weakened the studies (for example, when controls differed from cases on basic characteristics, such as socioeconomic or marital status). An inability to separate baseline characteristics from sequelae has been another problem. Observation bias has also entered the question when subjective measures of psychological response have been used. Tested indices of psychological function are needed, as well as indices that separate passing moods from underlying traits.

Because intervening events can affect sequelae, it may be necessary to limit the time span under scrutiny, even if, in so doing, some longer term sequelae cannot be addressed. Because some sequelae may be short-term, there is a need for observations to be made at several points in time. The ideal study would be a prospective one in which young women would be enrolled before first intercourse and would be followed through pregnancy and their decision to obtain an abortion or carry the pregnancy to term; they would then be interviewed several times following the outcome. Such a study has been called for by the Surgeon General.[22] However, such a study would clearly need to have an immense sample population and to go on for an extremely long time.

The longitudinal study described here explores the consequences of abortion among adolescents. Designed to overcome specific methodological problems found in earlier research, it represents a compromise, in that we did not enroll subjects prior to intercourse or, necessarily, prior to conception. Rather, they were enrolled before pregnancy was confirmed and were followed over a two-year period. The emphasis of this research is on change; hence, we make a concerted effort to separate preexisting characteristics from sequelae. The research also focuses on one particular segment of the population to guarantee that the subjects and controls come from similar geographic, racial, social and economic backgrounds.

Methodology

A total of 360 young black women were recruited when they came to one of two sites—The Johns Hopkins Comprehensive Child Care Center or Planned Parenthood of Maryland—for pregnancy tests in 1985 and 1986. The young women were all of lower socioeconomic background, 17 years of age or younger and unmarried at that time. None had a baby of her own to care for. Only three had ever given birth; two had had stillbirths and one had had a child who was no longer living with her.

The respondents fell into one of three groups: those whose pregnancy test came back negative, those whose test was positive and who elected to have an abortion and those whose test was positive and who chose to carry the pregnancy to term. The young women with positive pregnancy tests who had an abortion represented the study group. Those who elected to carry the pregnancy to term represented one control group; they are a logical sample to compare with the abortion group, since they were diagnosed as being pregnant at the same provider sites but chose the alternative outcome. However, the longer one follows them into the future, the less the comparison reflects the experience of childbearing vs. the experience of abortion, and the more it reflects the effects of motherhood itself. The negative-test group serves as another comparison group: They were similar to the abortion group in that they came for a pregnancy test at the same time and place, and by their suspicion of pregnancy, they acknowledged their sexual exposure. Furthermore, because at their follow-up interviews they were not raising a child as a result of their exposure at baseline, they were in many important ways more comparable to the abortion group than were those with a child.

The young women gave consent to participate in the study, were enrolled and provided extensive baseline data before they or their interviewers knew the result of their pregnancy test. All were followed up at six-month intervals for two years, making it possible to identify time-limited sequelae within that period. Extensive year-one and year-two interviews were administered in person; limited information was collected by telephone at six and 18 months.

Of the original 360 participants, 26 have been entirely omitted from this report: Fourteen were lost to follow-up and cannot, therefore, be assigned to an outcome group with any certainty, and 12 miscarried. (The latter group is too small for separate analysis.) Thus, there were 334 teenagers included in the baseline reports—141 who terminated their pregnancies, 93 who carried them to term and 100 who had negative pregnancy-test results. Over 90 percent of the baseline sample was included in the year-two follow-up—122 in the abortion group, 88 in the childbearing group and 92 in the negative-test group.

Closed-ended interviews were used to collect information on household structure, education, jobs and economic well-being, health, growth, sexual and contraceptive behavior and conception and fertility. Although this information was gathered retrospectively, these baseline data were not affected by pregnancy because they were collected before the outcome of the pregnancy test was known. In addition, the respondents were given several psychological tests, including the abbreviated Rosenberg Self-Esteem Scale,[23] items from the Rotter Locus of Control scale[24] and the Spielberger State-Trait Anxiety Index (STAI).[25] The STAI was the only portion of the instrument that was not orally administered by the interviewer; it was completed by the respondent, with the interviewer on hand to answer questions if asked. The psychological portion of the baseline data could, of course, have been affected by the stress of a potential pregnancy, a problem that is addressed below.

By concentrating on *change* in characteristics rather than on characteristics at any

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Table 1. Percentage of respondents, by school status and time period, according to study group

School status and time period	Study group		
	Abortion (N=120)	Child-bearing (N=86)	Negative preg. test (N=92)
Currently in school or graduated			
At baseline	99.2	90.7**	94.6
At 1 year	92.5	74.7**	83.5
At 2 years	90.0†	68.6**†	79.3*†
Behind grade for age			
At baseline	35.6	51.2	52.8*
At 1 year	39.2	52.7	56.6*
At 2 years	41.5	57.1*	57.3*
Negative educational change			
At 1 year	13.5	31.6**	26.9*
At 2 years	17.8	37.3**	37.4**

*Difference between this group and abortion group significant at p<0.05.

**Difference between this group and abortion group significant at p<0.01.

†Two-year trend significant at p<0.01.

Note: In this table and tables 2–4, Ns refer to the number of respondents interviewed at baseline and at two years; a somewhat smaller number were reached at one year.

one time, we attempt to avoid the confusion of antecedents and consequences. It is assumed that a change occurring subsequent to the event that is significantly different in size or direction from that found among those who do not experience the event can be treated as a consequence of the event. However, we have collected information in enough areas of these young women's lives so that alternate explanations for observed change can also be explored. Furthermore, by collecting baseline data before the index pregnancy is diagnosed, we also report on the original characteristics of the groups so that their choice of outcome, as well as their paths following the event, can be better understood. In addition, the results of the study cannot be considered applicable to the general population. Rather, the study was designed to provide a close-up picture of individuals of similar background directly before and for a few years after the event in question.

Baseline Characteristics

At baseline, the three groups were similar with regard to most variables; detailed information on the the results of the baseline interviews is reported elsewhere.[26] There were few differences in religion, although the percentage who were Roman Catholic was almost three times as high in the abortion group as in the childbearing group. The groups were almost identical in terms of the teenagers' mean age at the first visit (16.1 years).

Each respondent was asked to identify the woman who had "raised" her, whether or not that woman was her biological mother. The marital status of the women so identified did not differ between the three groups. The mothers (or surrogate mothers) of the teenagers in the abortion group were somewhat more likely to be working, to have graduated from high school and to have been older at first birth than were the females who had raised the teenagers who carried to term; however, none of these relationships were statistically significant. The mothers or surrogate mothers of the abortion group were significantly more educated than were those of the negative-test group (mean highest grades achieved, 12.3 and 11.7 years, respectively), although the mean educational level of neither group differed significantly from that of the parents or guardians of the childbearing group (11.9 years). Approximately 80 percent of all the subjects lived with their biological mothers, and almost all in each group lived at home with their biological mother, stepmother or foster mother.

There is some evidence that the members of the abortion group were more carefully supervised: Significantly more of them reported curfews on weekdays and on weekends (72 percent) than did teenagers in the childbearing and negative-test groups (54 percent and 66 percent, respectively). Similarly, there were indications that those who chose abortion were somewhat better off than the others economically, at least when that was measured by the ratio of working adults to others in the household. (We used the proportions of working members of the household as a summary measure of economic well-being because this is one of the few economic measures that adolescents could be expected to know.) This measure was computed in two ways: the ratio of working adults to all adults in the household, and the ratio of working adults to all household members. The first measure revealed no significant differences between the groups; differences in the second case (0.31 in the abortion group vs. 0.25 and 0.26 in the childbearing and negative-test groups, respectively) were not quite statistically significant (p=0.06). This nonsignificant tendency toward greater financial well-being among teenagers who chose abortion is reflected in other economic measures reported elsewhere.[27]

Educational variables discriminated significantly between the groups at baseline but did not suggest differences in the expectation of high school completion. Almost all subjects had been in school during the year preceding their pregnancy test, and although significantly fewer members of the childbearing group were still in school at the time of the first interview, they nonetheless expected to finish 12th grade. The baseline data suggest many similarities between the childbearing and negative-test groups that are explored elsewhere.[28] Fewer members of the abortion group had repeated a grade, and fewer expected to terminate their education at high school completion.

Status Two Years Later

In comparisons between baseline and two years later, only those respondents for whom year-two data were available are included in the baseline estimate. In the tables that follow, the year-one information is included to illustrate trends, but the sample is somewhat smaller because some young women interviewed at two years were missed at the year-one interview. (Interrelationships among variables—for example, among educational and economic variables—await future analyses.)

• *Educational status.* Although there were only small differences between the groups at baseline in the percentage who were in school, the differences at one year were dramatic, and they increased at two years (see Table 1). Not surprisingly, most of the change occurred in the first year; as more young women graduated, smaller percentages were available to experience this change. Furthermore, in the childbearing group, the first year may be the critical one, when the pregnancy takes its immediate toll. However, the numbers are worse for this group at two years: The percentage who were in school or who had graduated continued to decline more than it had for the other two groups.

The changes were not as great in the proportions of teenagers who had fallen behind their appropriate grades over the two years. (High school graduates are included among those at correct grade for age.) This is because over half of the childbearing and negative-test groups were already behind at baseline; time forced only a few more into their ranks. Nonetheless, it is clear in the summary variable—negative educational change—that the effects of early childbearing reported in the literature were already occurring at the year-one follow-up and were increasing by the second year. By two years after the pregnancy test, 18 percent of the abortion group

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had either left school before graduation or, if they were still in school, had failed to progress the expected two years. In contrast, over 37 percent of the childbearing and negative-test groups had experienced such a negative educational change. These differences cannot be explained by the pregnancy per se or by events responsible for the pregnancy, because they were significantly less likely to affect the teenagers who conceived at the same age but terminated the unintended pregnancy.

None of these differences could have been predicted based on the teenagers' educational expectations at baseline; all had expected to complete high school. The fact that they followed different educational paths is not surprising, in view of the differentials in their prior expectations for education beyond high school, and to some extent in their prior achievement. For example, the long-term expectations of the childbearing and abortion groups were significantly different at baseline: Fewer than 53 percent of the childbearing and negative-test groups expected to continue their schooling after high school, compared with 73 percent of the abortion group (not shown). More of both control groups were already behind in school for their ages, reflecting the higher proportion who had repeated grades in the past. However, grade-point averages of the three groups were extremely close (79.8 for the abortion group, 79.3 for the childbearing group and 79.5 for the negative-test group); many of the students who experienced a negative educational change had planned to continue into higher education; and few (three out of the entire sample) had expected to terminate their education before high school graduation. Thus, the negative change they experienced was not in line with their baseline expectations.

Using data from young women whose year-one interviews fell during summer vacation, we explored one more measure of the respondents' ability to live up to their own expectations: whether they expected to return to school in the fall. All of the abortion group, 90 percent of the childbearing group and 88 percent of the negative-test group said that they expected to do so. However, among all of the young women interviewed over the summer, 93 percent of the abortion and 88 percent of the negative-test group but only 65 percent of the childbearing group actually were in school six months later. At the 18-month interviews, then, we discovered that among those who had expected to return, 93 percent of the negative-test and abortion groups and 72 percent of the childbearing group were able to meet their own expectations. (One teenager in the negative-test group who had not expected to return to school did in fact return, and one who had expected to did not.) Thus, it was the teenagers who chose to carry their pregnancy to term who experienced the greatest risk of failing to meet their own educational expectations.

• *Economic well-being.* The economic well-being of the abortion group did not deteriorate as did that of the childbearing group; whereas differences between the groups were not statistically significant at baseline, they were significant both one and two years later (see Table 2). One would have expected the ratio of working adults to all members of the household to change when a baby was added, and differences between the abortion group and the childbearing group, which were not significant at baseline, did indeed become significant at one and two years. When the effect of the presence of the baby was removed by computing the ratio of working adults to all *adults* in the household, differences remained significant in both follow-up periods. According to this measure, the members of the childbearing group appear to have fallen further behind (even though they had improved very slightly in the second year), because the abortion group's status continued to improve, so that the differences between these two groups increased over time.

• *Psychological sequelae.* These have been particularly difficult to study because of problems in establishing a true baseline against which to measure them. Only a longitudinal study of a randomly selected group of young women that begins long before their exposure to abortion could permit the performance of an accurate psychological appraisal, uncontaminated by the effects of a suspected pregnancy. The numbers required for such a study would remain sufficient only if one began with an extremely large sample and waited a very long time. On the other hand, once women are exposed to the need for a pregnancy test, there is legitimate concern that a true picture of baseline psychological status, free of the stress of unwanted conception, is no longer possible.

This prospective study, in which baseline data were collected while the teenagers awaited the results of their pregnancy test, could not answer this challenge by removing the stress of the occasion. However, we could attempt to control for this stress by separating each respondent's transient psychological state from her underlying psychological trait. We attempted to do this by using the STAI, and there is good evidence that the STAI did indeed make such a separation. Table 3 shows that at the baseline interview, a stressful time in the young woman's life, the state measure was significantly higher (p=0.00) than the trait for each of the three groups. One and two years later, on the other hand, the state and trait scores were no longer significantly different. In each case, the state score was dramatically lower than at baseline; the trait scores were also lower, suggesting that they were not totally unaffected by the stress of the moment, but the differences, although significant, were very much smaller. If we rely

Table 2. Ratio of number of working adults to total number of household members and to total number of adult household members, by time period, according to study group

Ratio and time period	Study group		
	Abortion (N=120)	Child-bearing (N=86)	Negative preg. test (N=91)
Working adults to all members			
At baseline	0.307	0.254	0.249*
At 1 year	0.397	0.206**	0.286**
At 2 years	0.461†	0.264**	0.313**†
Working adults to all adults			
At baseline	0.601	0.512	0.497
At 1 year	0.623	0.486*	0.517*
At 2 years	0.714†	0.528**	0.540**

*Difference between this group and abortion group significant at p<0.05.
**Difference between this group and abortion group significant at p<0.01.
†Two-year trend significant at p<0.01.

Table 3. Respondents' percentile rankings, by type of anxiety measure and time period, according to study group

Measure and time period	Study group		
	Abortion (N=116)	Child-bearing (N=83)	Negative preg. test (N=84)
State			
At baseline	74.6	74.2	71.0
At 1 year	45.6	50.6	52.1
At 2 years	43.6†	48.3†	47.8†
Trait			
At baseline	56.8	62.4	62.9
At 1 year	48.3	51.2	59.5**
At 2 years	45.7†	52.0*†	53.2*†

*Difference between this group and abortion group significant at p<0.05.
**Difference between this group and abortion group significant at p<0.01.
†Two-year trend significant at p<0.01.

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Table 4. Respondents' scores, by psychological measure and time period, according to study group

Measure and time period	Study group		
	Abortion (N=119)	Child-bearing (N=87)	Negative preg. test (N=92)
Self-esteem			
At baseline	3.21	3.11	3.13
At 1 year	3.31	3.20	3.23
At 2 years	3.37‡	3.25‡	3.23**†
Locus of control			
At baseline	2.88	2.81	2.83
At 1 year	3.00	2.87*	2.93
At 2 years	3.00‡	2.88*	2.96‡

*Difference between this group and abortion group significant at $p<0.05$.
**Difference between this group and abortion group significant at $p<0.01$.
†Two-year trend significant at $p<0.05$
‡Two-year trend significant at $p<0.01$.

on the trait score, then, we can make some estimate of a young woman's anxiety level that will not have been unduly influenced by the stress of the pregnancy at the time of her admission to the study.

In all three groups, the state measures were understandably high at baseline; those who elected abortion were similar in their state measure to the childbearing group. Among the abortion patients, the state measure one and two years after the pregnancy test was nonsignificantly lower than among either of the other groups and was nearer to the national STAI norm for high school females.[29] Although stress was high while the teenagers awaited the results of their tests, the decision to have an abortion apparently did not lead to a higher level of anxiety. The trait measure suggests that the members of the abortion group were normally less anxious people and remained so at the later dates. There was no statistically significant difference between the abortion and childbearing groups in the magnitude of the change between the year-one and year-two interviews.

Two other psychological measures—the Rosenberg Self-Esteem Scale and a measure of locus of control that was based on an abbreviated Rotter inventory*—were administered to the participants as well. There were nonsignificant differences between the groups at baseline (see Table 4): The abortion group's ratings on self-esteem and locus of- control were nonsignificantly higher than those of the other two groups. All three groups experienced small but significant increases in mean self-esteem, and the abortion and negative-test groups showed significant increases in locus of control, indicating greater internalization.

Because a minimal increase in anxiety or decrease in self-esteem or a minimal externalization of locus of control may be of little substantive importance, and since most of the sample experienced a positive change in psychological state, we computed the percentage of each group who experienced an adverse change in all three measures (not shown). Only 5.5 percent of the two control groups and an even smaller proportion (4.0 percent) of the abortion group experienced such changes during the first year, a clear indication that the young women who had elected abortion were at no short-term psychological disadvantage. After two years, the abortion group was hardly changed: Only 4.5 percent had experienced a negative psychological change in two years' time. The childbearing group had not changed either, but in the negative-test group, almost 10 percent of the teenagers had experienced a decline in all three psychological measures.

We next explored whether there was a relationship between the psychological and educational variables. (Some researchers have suggested a possible relationship between psychological status and educational expectations and have proposed that childbearing may be related to lower levels of self-esteem.[30]) Could the young women who experienced a negative change in their educational careers subsequent to the pregnancy test have been identified in advance through the psychological variables reported here?

The present data confirm a relationship between self-esteem and educational expectations. In each group, those who aspired to a four-year college education (or more) had significantly higher self-esteem scores than did those who were content with a high school education (not shown). Similarly, the few members of the abortion group who experienced a negative educational change over the two-year period were much more likely to have had self-esteem scores below the median of the sample at baseline than the majority who suffered no adverse change (significant at $p=0.01$). They were also more likely to have had scores showing less internalization of control and to have been above the median on the anxiety scale, although these differences were not significant. They do not, however, demonstrate more psychological change (not shown).

Thus, the young women in the abortion group were neither directly nor through an intervening change in educational career any more likely than those in the control groups to suffer a psychological change for the worse during the observation period. In fact, they experienced slightly less negative change than did those in the childbearing or negative-test groups. Any differences in psychological status between those in the abortion group whose education stayed on track and those who dropped out of school were preexisting and did not appear to have been a consequence of their abortion experience.

This was not the case among those in the childbearing group: Those who suffered a setback in their education were only marginally lower in self-esteem and locus of control at baseline than were those who suffered no educational setback, and were no higher in anxiety, but these differences tended to widen over the two years of observation. Those in the childbearing group who experienced a negative change in their educational progress were more than four times as likely to suffer a negative psychological change as were those who stayed on their educational course (10.0 percent vs. 2.3 percent).

Subsequent Pregnancy

The above findings indicate that the abortion group did not experience negative educational, economic or psychological consequences, but even the small amount of change seen in these data is not random; subsequent pregnancy is an important intervening variable. There are several different ways to estimate the incidence of subsequent pregnancy in the years after the teenagers entered the study. Clearly, over a two-year observation period, there is more time for a woman to conceive again if she terminates the first pregnancy than if she carries it to term, and even more time for those whose pregnancy test was negative. By controlling for the number of months following the outcome, we can set up an analysis in which all young women are exposed to the risk of pregnancy for a similar period of time. The longest period of exposure available for comparison is 18 months after the outcome of the index pregnancy test. (Most who carried to term had delivered by six months after the test.) The percentage of respondents experiencing a conception within that time period was greatest in the negative-test group (58 percent) and lowest in the abortion group (37 percent), while those in the childbear-

*The Rotter inventory measures the degree to which the respondent believes herself in control of her life (known as the degree of internalization) and the extent to which she believes herself a victim of external forces.

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ing group experienced a 47 percent risk of conceiving during the same exposure period.

Table 5 shows that if the abortion group is divided among those who did or did not conceive subsequently, the proportion who suffered a negative educational change becomes trivial among those who were not pregnant over the two-year period. Almost all of the observed negative change reported earlier occurred among the 37 percent who had experienced a repeat pregnancy. Among those who had not become pregnant again, only eight percent experienced a negative educational change, while among those who had become pregnant again, 22 percent had left school without graduating, 59 percent were behind in grade for age and 34 percent suffered some negative educational change.

Thus, a subsequent pregnancy plays a key role: Those who did not conceive again were at negligible educational risk subsequent to their abortion, while those who became pregnant were at a level of risk that paralleled and even exceeded that experienced by some of the young women who bore a child. By two years, almost half of those in the childbearing group had had another conception; these teenagers had a nonsignificantly increased risk of negative educational change. Table 5 also demonstrates the clear high-risk status of the negative-test group: More eventually conceived than did not, and educational progress was disturbed without regard to pregnancy.

Of course, many of the subsequent pregnancies reported here had not yet reached an outcome by the two-year point. This is especially the case when the first pregnancy was carried to term. When respondents whose subsequent conceptions had already culminated in a birth were compared with those who had terminated a subsequent pregnancy or those who were currently pregnant, the results suggest that the subsequent birth of a baby to those in the childbearing group was associated with a much more pronounced adverse change in education (not shown). Having another baby was also associated with greater deficits in economic well-being. This was not the case in the abortion group: Those who conceived again appeared to be almost equally at risk of greater deficits in these areas, whatever their pregnancy outcome.

A subsequent birth was associated not only with negative educational change, but with psychological deficits as well (although such changes remained relatively rare). Whereas only 3.4 percent of all members of the abortion group experienced a negative psychological change, 9.5 percent of those who had had an abortion and subsequently carried a pregnancy to term experienced a negative change in all three psychological measures reported here over the two-year period.

About half of the subsequent pregnancies occurring during the 18-month interval among those in the abortion group resulted in childbirth; the others either had not come to term by the year-two follow-up or had been terminated. One-third of the new conceptions among those in the childbearing group had resulted in another birth by the time of the year-two interview, as had well over half of the conceptions among those in the negative-test group. Although the respondents were all two years older than at entry, most did not want these pregnancies. Almost 58 percent of the young women in the negative-test group who became pregnant had not wanted to conceive at any time during the two-year period; in the childbearing and abortion groups, 75 percent and 80 percent, respectively, of pregnancies conceived during the observation period were similarly unintended. Overall, 31 percent of the young women in the negative-test group had conceived unintentionally; this level of unwanted pregnancy is rather similar to those in the childbearing and abortion groups (24 percent and 27 percent, respectively).

Finally, we examine whether differentials in contraceptive use as reported by the young women accounted for the variations in pregnancy during the observation period. Table 6 indicates that within the abortion and negative-test groups,

Table 5. Percentage of respondents, by school status, according to study group and to whether or not they experienced a subsequent pregnancy

School status	Study group and subsequent pregnancy status					
	Abortion		Childbearing		Negative preg. test	
	Subs. preg. (N=41)	No subs. preg. (N=77)	Subs. preg. (N=33)	No subs. preg. (N=37)	Subs. preg. (N=50)	No subs. preg. (N=41)
% in school or graduated at 2 years	78.0	97.4**	60.6	69.4	78.0	80.5
% behind grade for age at 2 years	58.5	30.7**	57.6	58.8	53.2	61.0
% experiencing negative educational change	34.1	8.0**	45.2	31.4	34.7	41.5

**Difference between subgroups significant at p<0.01.

Table 6. Percentage distribution of respondents, by contraceptive-use status between one-year and two-year interviews,† according to study group and whether or not they experienced a subsequent pregnancy

Contraceptive-use status	Study group and subsequent pregnancy status								
	Abortion			Childbearing			Negative preg. test		
	All (N=117)	Subs. preg. (N=40)	No subs. preg. (N=75)	All (N=88)	Subs. preg. (N=33)	No subs. preg. (N=38)	All (N=90)	Subs. preg. (N=48)	No subs. preg. (N=41)
% who did not use	5.1	10.0	2.7**	5.7	3.0	10.5	10.0	12.5	7.3*
% who used sometimes or very few times	17.9	32.5	9.3**	26.1	42.4	18.4	41.1	52.1	29.3*
% who used always or most of the time	76.9	57.5	88.0**	68.2	54.5	71.1	48.9	35.4	63.4*
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

†Or, in the case of respondents who could not be interviewed after one year, between baseline and two-year interview.

*Difference between the group with a subsequent pregnancy and the group with no subsequent pregnancy significant at p<0.05.

**Difference between the group with a subsequent pregnancy and the group with no subsequent pregnancy significant at p<0.01.

Note: The Ns in the childbearing subgroups do not add to the total because not all women were exposed for a full 18 months before the two-year interview; the Ns in the other two groups do not add to the total because a few women did not provide information on subsequent pregnancy.

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there were significant differences in contraceptive use (in the expected direction) between those who conceived during the 18 months following the baseline outcome and those who did not. Among those in the childbearing group, the difference was almost as great, but was not statistically significant (p=0.06). There was, however, a highly significant difference between the abortion and negative-test groups: The low levels of contraceptive use seen in the table explain the high conception rate in the negative-test group. Members of the childbearing and abortion groups did not differ significantly in terms of contraceptive use, although consistent contraceptive use appeared more common among those who terminated their baseline pregnancy.

A few respondents who were not practicing contraception told us that they wanted to conceive (or, at least, that they had wanted to conceive at some time during the observation period). Although the small number of cases necessitates extreme caution in interpreting the data, it would appear that 84 percent of the abortion group who did not want to become pregnant used contraceptives all or most of the time, and among the majority who successfully avoided conceiving, this proportion was 94 percent (not shown). Although significant associations between contraceptive use and wantedness appeared in all groups, there were no subgroups in the childbearing or negative-test groups in which contraceptive use appears to have been as consistent as it was among the large number of young women in the abortion group trying to avoid pregnancy.

Multiple Regression Analysis

The above results suggest that the abortion group was doing as well as or better than the other two groups in all respects at the year-two follow-up. We noted previously that they had some advantages at baseline. Although these were often small, some were statistically significant; it was of interest, therefore, to determine if the members of the abortion group were doing better at follow-up, and if so, whether their better outcomes could be fully attributed to their baseline educational, economic or psychological status and not to their different experiences following the index pregnancy tests.

A series of regression models was proposed to test this hypothesis in relation to negative educational change, negative change in economic well-being and negative change in all three psychological variables. The importance of group status was consistently confirmed in relation to educational change. Measures of achievement (grade-level status for age), educational status (in school or graduated) and educational expectations (highest level of schooling expected) were added singly or in several combinations. In each case, membership in the abortion group rather than in the childbearing group, or in the abortion group rather than in the negative-test group, remained statistically significant in a positive direction, confirming the bivariate relationships reported above.

Similarly, in a model that included a mix of background variables measured at baseline—the education of the female parent or guardian, maintenance of a curfew, self-esteem, anxiety trait and grade-level status for age—membership in the abortion group remained significant and positive in relation to educational change.

With respect to negative change in adult job ratios, the function of group membership was also clear, again reflecting the bivariate findings. Membership in the abortion group relative to the childbearing and negative-test groups remained significant in models that included the ratios in Table 2, as well as in models in which the family's receipt of food stamps and a social services check were included. Thus, the two-year improvement reported in the abortion group's well-being remained significant even when differences in their baseline characteristics were controlled for.

Similar models showed that although group membership was not significant in relation to negative psychological change, no other baseline variables were either. All of the groups changed significantly over time in all of their psychological measures, with the exception of locus of control among the childbearing group. Furthermore, there was a high level of correlation between change in one measure and change in another. However, in none of the index groups did the level of change appear significantly different from the level of change in another, which is reflected in both the bivariate and multivariate analyses.

Conclusion

The abortion group, then, appears to have been doing well. Few have experienced a negative change in life course. The positive position of the abortion group relative to the other two groups is attributable to three factors: First, they were slightly (but usually nonsignificantly) better off at the outset in their educational and economic prospects. Second, they had no reason to deteriorate in the educational or economic variables we examined, and they showed no evidence of negative change. Third, the rare deficits experienced by the abortion group were triggered by a subsequent pregnancy, as they were with the negative-test group, and the relative status of the abortion group improved in the course of the intervening years because fewer of them experienced another pregnancy.

Although it has been demonstrated that abortion is a safe procedure for adolescents, presenting less medical risk than childbirth,[30] some have proposed that the procedure may have adverse psychological effects. Although this study tapped only three dimensions of psychological well-being, the results suggest that such a hypothesis should be rejected. The young women who chose abortion did not differ significantly from their peers in most respects at baseline and at follow-up were doing well (in both absolute and relative terms) on each of the psychological measures we used. Because they have stayed on course with their education and have put no additional economic burden on their families, there is reason to believe that in time, they will be in an even better position relative to the other groups.

The data presented here also confirm the effects of childbearing on education, showing that the adverse consequences of early motherhood begin immediately, and even though the pace of negative change slows in the second year, the continuing success of the abortion group increases the differential. While baseline characteristics might have predicted long-term differences in educational achievement, they would not have predicted the fact that so many members of the control groups dropped out before completing high school. Baseline characteristics did suggest the high risks to which the young women with negative pregnancy tests would be exposed in the observation period. We have discussed this group in more detail elsewhere,[31] noting not only their resemblance to those in the childbearing group but also the fact that the proportion among them who wanted to conceive a child during their teenage years was higher than in either of the other groups. The emerging economic deficits of the childbearing and negative-test groups relative to the abortion group also confirmed the latter group's more positive experience. In addition to the effects of a subsequent pregnancy on education, we have noted in the abortion group a significant difference at baseline in self-esteem between the respondents who did or did not experience some negative change in their educational careers. Although direct effects of self-esteem

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on subsequent conception cannot be demonstrated, the findings described here suggest that the use of an abbreviated, validated Rosenberg Self-Esteem Scale might be helpful at an initial abortion interview to identify high-risk individuals.

The results of our two-year study underline the need for better contraceptive counseling. We discuss elsewhere[32] the serious implications of these data for counseling following a negative pregnancy test, and there is clear evidence here that those who choose to carry their pregnancy to term also need intensive contraceptive support. The importance of better contraceptive education and counseling following pregnancy termination is also clear. The percentages of the three groups who conceived during the observation period, and the contraceptive behavior associated with those pregnancy rates, suggest that the abortion group was doing better than the childbearing group and much better than the negative-test group. However, 37 percent still conceived, only one in five because they wanted to do so (at any time during the observation period, not necessarily at the time of conception).

The percentage of negative educational change experienced by the members of the abortion group who subsequently had a child during the observation period was almost identical to that experienced by the childbearing group; the negative educational change experienced by the other members of the abortion group was trivial. And while the overall level of negative psychological change was minimal, those in the abortion group who subsequently conceived and bore a child experienced almost three times the change observed among other members of the abortion group. These differences suggest the importance of avoiding another conception. Finally, the similarities between the childbearing subgroup of the abortion group and the original childbearing control population tell us that the few negative consequences we have observed are almost certainly consequences of motherhood, not the sequelae of abortion.

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33. Ibid.

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Nos. 88-805, 88-1125 and 88-1309

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

STATE OF OHIO,
Appellant,
v.
AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,
Appellees.

On Appeal from the United States Court of Appeals for the Sixth Circuit

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JANET HODGSON, MD., *et al.*,
Petitioners and *Cross Respondents*,
v.
THE STATE OF MINNESOTA, *et al.*,
Respondents and *Cross Petitioners*.

On Writs of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF FOR *AMICI CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION, NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC., AND THE AMERICAN JEWISH COMMITTEE IN SUPPORT OF PETITIONERS/CROSS-RESPONDENTS IN NOS. 88-1125, 88-1309 AND IN SUPPORT OF APPELLEES IN NO. 88-805

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Attachment No. 4B
February 20, 1990

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BRIEF FOR *AMICI CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION, NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC. AND THE AMERICAN JEWISH COMMITTEE IN SUPPORT OF PETITIONERS/CROSS-RESPONDENTS IN NOS. 88-1125, 88-1309 AND IN SUPPORT OF APPELLEES IN NO. 88-805

INTEREST OF *AMICI CURIAE*[1]

The American Psychological Association (APA), a nonprofit scientific and professional organization founded in 1892, is the major association of psychologists in the United States. APA has more than 75,000 members, including the vast majority of United States psychologists holding doctoral degrees. APA's purposes are to advance psychology as a science and profession, and to promote human welfare.

The National Association of Social Workers, Inc. (NASW), a non-profit professional association with over 120,000 members, is the largest association of social workers in the United States. NASW is devoted to promoting the quality and effectiveness of social work practice, to advancing the knowledge base of the social work profession and to improving the quality of life through utilization of social work knowledge and skills.

The American Jewish Committee (AJC) is a national organization founded in 1906 for the purpose of protecting the civil and religious rights of Jews. The AJC believes that this goal can best be accomplished by helping to preserve the constitutional rights of all Americans, including access to abortion on a voluntary basis.

The parental notice and waiting period requirements at issue in these cases are premised upon the States' as-

[1] The parties have consented to the submission of this brief. Their letters of consent are on file with the Clerk of this Court.

sumptions that, in relevant ways, minors are more psychologically vulnerable than adults, that they are immature and unable to make competent choices concerning abortion, and that such requirements will foster intrafamily communication and cooperation while not harming the adolescents affected. The validity of these legislative assumptions has been tested through empirical research conducted by social scientists. Social science research is also relevant to the arguments of the professionals, pregnant minors, and parents who challenge these requirements that the laws unduly burden minors' rights to choose whether to carry a pregnancy to term or abort. Much of the relevant research has been conducted by members of *amicus* APA; that research is presented in this brief.[2]

SUMMARY OF ARGUMENT

Most younger adolescents and many older adolescents voluntarily inform one or both parents about their pregnancies, and seek their counsel about the abortion decision. Where such consultation is voluntarily sought, adolescents are often benefitted. Mandatory parental notification laws have no effect on this group of pregnant minors, however; only those minors who otherwise would *not* involve their parents in the abortion decision are directly affected by these laws.

The empirical research suggests that such adolescents typically have good reasons not to involve their parents in the abortion decision. They may fear a hostile, even violent, reaction to the news that they have been sexually active and are now pregnant. In many cases, they may be from dysfunctional families in which one or both parents

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[2] Counsel gratefully acknowledge the assistance of APA members Bruce Ambuel, Ph.D., William Gardner, Ph.D., Julian Rappaport, Ph.D., and Lenore Walker, Ed.D., and APA staff members Brian Wilcox, Ph.D., and Janet O'Keeffe, Dr. P.H., in the preparation of this brief.

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may be absent, or in which child abuse, including [illegible]ial abuse, has taken place. For such reasons, or simpl[illegible]ing to protect their own informational privacy—an appropriate concern for adolescent females—pregnant minors in a State with a parental notification law may delay making the abortion decision, increasing the risk to their health of undergoing the procedure or leading to *de facto* decisions to carry to term. Point I.

Mandatory parental notification may actually undermine the very state interests it is meant to advance. In those families in which the minor daughter has chosen not to inform her parents, state-mandated notification is unlikely to produce greater intrafamily understanding or communication, and may well precipitate a family crisis or exacerbate existing family problems. Moreover, there are no data to suggest that adolescents are less capable than adults of making the abortion decision on their own. Furthermore, abortion itself, as a rule, relieves the stress associated with unwanted pregnancy rather than generates distress a parent (particularly one a minor would prefer to exclude from the process) could ameliorate. Point II.

Even with a bypass procedure, which in virtually every case results in affirmation of the minor's abortion decision but which itself deters some adolescents from seeking an abortion, parental notification laws unduly burden an adolescent's right to choose. *Without* a bypass procedure, the majority of pregnant adolescents who are competent to choose for themselves, and the significant number who would be placed at increased risk by notifying one or both parents, are faced with an intolerable choice: foregoing their right to abortion and becoming adolescent parents, on the one hand, or risking their physical or psychological health by complying with the notification statute, on the other. For these reasons, the Ohio and Minnesota statutes are both unconstitutional.

INTRODUCTION

These cases concern the constitutionality of Minnesota Statutes § 144.343 (1)-(7) ("the Minnesota statute") and Ohio Amended Substitute House Bill 319 ("the Ohio statute").[3] With certain exceptions, both statutory schemes prohibit a physician from performing an abortion upon a minor unless notice has been provided to the minor's parents. The Minnesota statute requires that the minor notify *both* parents 48 hours in advance of the procedure (whether or not her parents are living together or are or ever were married); unless judicially mandated, the scheme does *not* provide a judicial bypass through which mature minors or minors whose best interests would not be served by notification may be relieved of this obligation.[4] The Ohio statute requires notification of one parent, and establishes a bypass procedure that has been found unduly burdensome by the lower courts.

With or without a judicial bypass procedure, government certainly could not compel an *adult* to notify her parents or other third parties 24 or 48 hours before undergoing an abortion, because the burdens thereby imposed on the right to choose whether to abort or carry to term would not be justified by sufficiently weighty countervailing state interests. *See Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 67-72 (1976) (*Danforth*) (spousal veto of abortion decision ruled unconstitutional); *Doe v. Bolton*, 410 U.S. 179, 201 (1973) (third party veto of abortion decision ruled unconstitutional); *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 449-450 (1983) (*Akron I*) (24-hour waiting period unconstitutional). The validity of imposing such burdens on adolescents depends

[3] The key provisions of the Ohio statute are codified at Ohio Rev. Code Ann. §§ 2151, 2912.12, and 2505.073 (Page Supp. 1985).

[4] In the event a court invalidates the no-bypass provision, the statute provides that a bypass procedure will go into effect. This "backstop" provision was in effect for several years prior to the district court's final ruling.

upon whether doing so furthers state interests suffici[illegible]y to alter the balance.

This Court has recognized that "[t]he need to preserve the constitutional right and the unique nature of the abortion decision, especially when made by a minor, require a State to act with particular sensitivity when it legislates to foster parental involvement." *Bellotti v. Baird*, 443 U.S. 622, 642 (1979) (*Bellotti II*). Thus, although it has asserted that "during the formative years of childhood and adolescence, minors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them," *id.* at 635, the Court has been careful to reject a State's *per se* claim that *all* adolescents are incompetent and immature. Both in the abortion context and in other cases dealing with minors, the Court has taken a more individualized approach in assessing the competency and maturity of minors to make important decisions.[5]

Specifically, this Court has never suggested that all adolescents are incompetent to decide whether to have an abortion. To the contrary, the Court has recognized that

[5] Outside the abortion context, see *Fare v. Michael C.*, 442 U.S. 707, 727 (1979) (Court applied such factors as adolescent's age, experience, education, background, and intelligence, in concluding that a 16-year old "voluntarily and knowingly waived his Fifth Amendment rights."); *id.* at 734 n.4 (Powell, J., dissenting) (recognizing that each case must be judged on its own merits, including an evaluation of the "minor's age" and "actual maturity."); *Globe Newspaper Co. v. Superior Court*, 457 U.S. 596, 608 (1982) (it violated first amendment to statutorily exclude press and public from courtroom during testimony of all victims of sexual offenses under age 18; the Court opted for case-by-case determination, including an analysis of the "minor victim's age, psychological maturity and understanding, [and] the desires of the victim."); *cf. Stanford v. Kentucky*, 109 S. Ct. 2969, 2979 (1989) (plurality opinion) (permissible for State to execute 16-year-old in cases in [illegible] adolescent has a developed moral sense).

the legal status of "minority" encompasses wide ranges of age and maturity levels. *See Danforth*, 428 U.S. at 75. It is only "immature minors" whom the Court perceives as sometimes lacking "the ability to make fully informed choices." *Bellotti II*, 443 U.S. at 640.[6] Thus, a mature minor's decision to have an abortion may not be made subject to her parent's veto. *Akron I*, 462 U.S. at 440; *Bellotti II*, 443 U.S. at 642-643; *Danforth*, 428 U.S. at 74-75. Indeed, the Court has held that "a blanket determination that all minors under the age of 15 are too immature" to make a decision related to procreation is unconstitutional. *Akron I*, 462 U.S. at 440.

The constitutionally recognized difference between immature and mature minors, *see Bellotti II*, 443 U.S. at 643-644 and n.23, is relevant in evaluating the relative benefits and burdens of a statute that requires all adolescents to consult with their parents before obtaining an abortion.[7] As discussed below, *see* Point II, *infra*, there is no empirical evidence to suggest that adolescents by about age 14 are less competent to consent to abortion than adults, or that at least some younger adolescents do not possess similar competence.[8]

[6] *See Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 490-491 (1983) (the State's interest is limited to "protecting immature minors").

[7] In related contexts, the "mature minor" doctrine permits a child to consent to medical treatment if he or she is capable of appreciating its nature and consequences. *See* Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSGOODE HALL L.J. 115, 117-120 (1973); *see also H.L. v. Matheson*, 450 U.S. 398, 450 n.49, 453 (1981) (Marshall, J., dissenting), and cases cited therein.

[8] Indeed, it is difficult to reconcile the idea that minors are less competent than adults to consent to abortion with the fact that state law typically allows a minor parent—whatever her age—to consent not only to the health care of her child, but to her own health care as well, including abortion. *See* J. MORRISSEY, A. HOFFMAN, and J. THROPE, CONSENT AND CONFIDENTIALITY IN THE

ARGUMENT

I. COMPELLING DISCLOSURE TO HER PARENTS OF A MINOR'S PREGNANCY AND DECISION TO HAVE AN ABORTION IMPOSES A SUBSTANTIAL BURDEN ON THE MINOR'S RIGHT TO CHOOSE.

A. Parental Notice Provisions Most Directly Affect Those Adolescents Who—For A Variety Of Compelling Reasons—Believe They Cannot Consult With Their Parents About The Abortion Decision, And Unduly Burden Their Right To Obtain An Abortion.

Most adolescents, and younger adolescents in particular, can profit from *sympathetic* guidance from a parent or other adult concerning important choices, such as decisions concerning pregnancy. Research demonstrates that most minors—especially young adolescents aged 11-14—generally do consult their parents about their pregnancies, regardless of legal mandates.

Thus, one study found that approximately three-fourths of minors aged 15 or younger voluntarily informed their parents before they obtained an abortion,[9] and 25% of this group reported that their parents suggested the abortion.[10] In States requiring that minors either inform parents or obtain their consent prior to obtaining an abor-

HEALTH CARE OF CHILDREN AND ADOLESCENTS 43 (1986) [hereinafter MORRISSEY, HOFFMAN and THROPE].

[9] Torres, Forrest & Eismann, *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 Fam. Plan. Persp. 284, 287-290 (1980) [hereinafter *Telling Parents*]. *See generally* Mnookin, Bellotti v. Baird: *A Hard Case in* IN THE INTEREST OF CHILDREN: ADVOCACY, LAW REFORM, AND PUBLIC POLICY 149, 240-241 (R. Mnookin ed. 1985) [hereinafter Mnookin]; Clary, *Minor Women Obtaining Abortions: A Study of Parental Notification in a Metropolitan Area*, 72 Am. J. Pub. Health 283, 284 (1982) [hereinafter *Clary*]; Rosen, *Adolescent Pregnancy Decision-making: Are Parents Important?* 15 Adolescence 44 (1980) [hereinafter Rosen].

[10] *Telling Parents, supra* note 9, at 290; NATIONAL ACADEMY SCIENCES, RISKING THE FUTURE: ADOLESCENT SEXUALITY, 1

tion, young adolescents rarely use judicial bypass procedures.[11] Older adolescents who are unusually ambivalent about the abortion decision and who perceive themselves as relatively incompetent decisionmakers also are likely to voluntarily involve their parents in the decision.[12] In general, however, older adolescents fully competent to decide medical questions for themselves do not consult their parents about abortion as frequently as do young adolescents.[13]

Parental notice laws result in later, more hazardous, and more expensive abortions, and in minors carrying to term. In Minnesota, the district court found that the burdens of parental notification—even with bypass procedures available—cause "[s]ome mature minors and some minors in whose best interests it is to proceed without notifying their parents . . .to carry to term." *Hodgson v. Minnesota*, 648 F. Supp. 756, 763 (D. Minn. 1986). In Massachusetts, a smaller jurisdiction where it is less difficult to travel out-of-State to obtain an abortion, mandatory parental notification did not change the number of women who became pregnant, gave birth, or obtained abortions.[14] But the law did force approximately one-

NANCY, AND CHILDBEARING 113 (1987) [hereinafter NAS REPORT]. Only 8% of 17-year-olds who obtain abortions report that they did so at their parents' suggestion. *Telling Parents, supra* note 9, at 290.

[11] Nearly 90% of minors who use judicial bypass procedures are aged 16-17. Donovan, *Judging Teenagers: How Minors Fare When They Seek Court-authorized Abortions*, 15 Fam. Plan. Persp. 259, 261 (1983) [hereinafter *Judging Teenagers*].

[12] *Rosen, supra* note 9, at 48.

[13] In a large, multi-state study, the proportion of minors who decided, without parental consultation, to carry to term was similar to the proportion who decided to seek an abortion without parental consultation. *Rosen, supra* note 9, at 46. *See, e.g.*, Brittain, *Adolescent Choices and Parent-Peer Cross-Pressures*, 28 Am. Soc. Rev. 385 (1963) [hereinafter Brittain].

[14] *See* Cartoof & Klerman, *Parental Consent for Abortion: Impact of the Massachusetts Law*, 76 Am. J. Pub. Health 397, 400 (1986).

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third of the minors in the State seeking an aborti[illegible] leave the State and obtain the abortion in a jurisd[illegible]n without a parental consent statute. *Id.* [15]

Thus, mandatory parental notification creates substantial obstacles for many adolescents choosing to abort their pregnancies: they may have fewer, later, or more expensive abortions because they wish to avoid notifying one or both of their parents.

B. Mandatory Parental Notification Harms Some Adolescents Who Otherwise Would Not Involve Their Parents In The Abortion Decision.

Both courts and social scientists have identified the reasons mandatory notification has these deleterious effects. On the basis of a detailed record, the *Hodgson* court found that after five years of operation the compelled notice required by the Minnesota statute almost always had a negative impact, frequently harming the child's welfare. 648 F. Supp. at 764, 768-769. The court found as a matter of fact that compelled two-parent notification in families with a non-custodial or absent parent was typically disruptive, and led to violence and abuse in dysfunctional families. *Id.* at 769.[16]

Data support the district court's findings. One study of parental reaction to adolescent daughters' pregnancies showed that such an announcement typically evoked an initial response of anger and disappointment, and triggered a crisis in the family.[17] And anger is not the only response an adolescent need fear. A major government study has estimated that in 1986, more than one million

[15] Approximately twice as many women chose to leave the State to obtain their abortions as chose to utilize the judicial bypass. *Id.* at 398, 399.

[16] Appendix to Petition for a Writ of Certiorari in *Hodgson v. Minnesota*, No. 88-1125, filed January 4, 1989 at 141a (testimony of Dr. Lenore Walker).

[17] *See, e.g.*, Osofsky & Osofsky, *Teenage Pregnancy: Psychosocial Considerations*, 21 Clinical Obstetrics & Gynecology [illegible]61 (1978).

children and adolescents nationwide had already experienced demonstrable harm as a result of abuse or neglect.[18]

In light of the relatively widespread nature of intrafamily abuse, it is not surprising that in about one-third of cases in which adolescents do not inform their parents about their pregnancy and planned abortion, they are motivated by fear of physical punishment or some other severe reaction.[19] Research on domestic violence has demonstrated that pregnancy does not deter and may even precipitate physical attacks by batterers.[20] Adolescents may particularly fear telling their parents about a pregnancy if it is the result of sexual abuse. Research indicates that such abuse—both extrafamilial and intrafamilial—is disturbingly common.[21] Compelling parental in-

[18] NATIONAL CENTER ON CHILD ABUSE AND NEGLECT, U.S. DEP'T HEALTH AND HUMAN SERVICES, STUDY OF NATIONAL INCIDENCE AND PREVALENCE OF CHILD ABUSE AND NEGLECT: 1988 at xx (1989) [hereinafter HHS STUDY]. This figure is considered to be a minimum estimate because the incidence of abuse is substantially underreported. *Id.* at 7-2. *See generally* Gelles & Strauss, *Behind Closed Doors—Violence in the American Family,* 35(2) J. Soc. Issues 15, 24 (1979) [hereinafter Gelles & Strauss].

[19] Clary, *supra* note 9, at 284. Even if an adolescent misjudged her parents' response, the perception may be more important than the reality in causing adolescents to delay seeking medical assistance or making a decision whether to abort.

[20] Gelles, *Violence and Pregnancy: A Note On The Extent Of The Problem And Needed Services,* 24 Fam. Coordinator 81 (1975).

[21] *See generally* D. FINKELHOR & ASSOC., A SOURCEBOOK ON CHILD SEXUAL ABUSE (1986); HHS STUDY, *supra* note 18, at xx-xxi. *See also* Moore, Nord & Peterson, *Nonvoluntary Sexual Activity Among Adolescents,* 21 Fam. Plan. Persp. 110, 111 (1989) (data from the 1987 National Survey of Children indicate that 9 percent of 17-year olds, 7.5 percent of 16-year olds, 6.3 percent of 15-year olds and 5.8 percent of girls 14 and under have experienced nonvoluntary sexual intercourse; adolescent girls with parents who abuse alcohol and drugs were two to three times more likely to have experienced nonvoluntary sexual intercourse; sixty-eight percent of white females with three or more risk factors had been sexually abused before or during adolescence); Russell, *The Incidence and*

volvement in such instances, particularly if the pregn is the result of incest, is likely to intensify or exacerbate an already traumatic and emotionally volatile situation.

Moreover, in many cases involving older adolescents, compelled disclosure will burden a young woman's interest in informational privacy.[22] The protection of privacy and the maintenance of control over personal information in sexual matters is an especially vital concern of adolescent females.[23] As the *Hodgson* district court found, based upon presentation of empirical research and clinical experience, assertion of privacy is a mark of maturity and psychological adaptation among adolescents. *Hodgson v. Minnesota,* 648 F.Supp. at 767, 775. Depriving an adolescent female of autonomy in making the abortion decision often imposes far more stress on her than does making the decision itself or undergoing the medical procedure. *Id.* at 763-764.

Prevalence of Intrafamilial and Extrafamilial Sexual Abuse of Female Children in HANDBOOK ON SEXUAL ABUSE OF CHILDREN 19, 25 (L. Walker, ed. 1987) (research on a probability sample of 930 women found that 16 percent reported at least one experience of intrafamilial sexual abuse before the age of 18 and 12 percent had been sexually abused by a relative before 14 years of age; 31 percent reported at least one experience of sexual abuse by a non-relative before the age of 18).

[22] This interest is partially responsible for the rarity of parent-daughter discussions about sexual matters. Adolescents' discomfort in initiating or participating in such discussions, *see* Dubbe, *What Parents Are Not Told May Hurt: A Study Of Communication Between Teenagers And Parents,* 14 Fam. Life Coordinator 96, 97, 98 (1965); *see generally* Fox & Inazu, *Mother-Daughter Communication About Sex,* 29 Fam. Rel. 347 (1980), reflects, in part, a developmentally appropriate concern with privacy.

[23] *See* Melton, *Decision Making by Children: Psychological Risks and Benefits in* CHILDREN'S COMPETENCE TO CONSENT 21 (G. Melton, G. Koocher & M. Saks eds. 1983); Parke & Swain, *Children's Privacy in the Home: Developmental, Ecological, and Child-Rearing Determinants,* 11 ENV'T & BEHAV. 87 (1979); Wolfe, *Childhood and Privacy in* CHILDREN AND ENV'T 175 (I. Altman & J. Wohlwill eds. 1978); Laufer & Wolfe, *Privacy as a Concept* *Social Issue,* 33(3) J. Soc. Issues 22 (1977).

Many States recognize the need to respect minors' privacy—and their competence—in making sensitive and important decisions concerning their health and future. Most States presume a minor competent to consent without parental notification to treatment for sexually transmitted diseases, mental health treatment, and medical treatment related to pregnancy, and recognize the crucial role confidentiality plays in permitting minors to obtain access to vitally necessary health services.[24] Minnesota singles out abortion as requiring parental notification. Minn. Stat. § 144.343(1). Additionally, States typically allow minors, whatever their age, to consent to their own health care once they become parents.[25]

Thus, parental consent laws risk causing harm to many of the adolescents they are intended to protect. For a variety of legitimate reasons—fear of domestic physical or psychological violence or appropriate concern for personal privacy—many adolescents will delay or avoid their decision to abort or carry to term, or go out of State to obtain the abortion if feasible, rather than comply with the notification requirement.

C. Minnesota's Two-Parent Notification Requirement Places Extraordinary Burdens On Many Adolescents.

Minnesota's requirement that *both* parents be notified is directed at those adolescents who would voluntarily consult one parent, but would not voluntarily speak with both parents before obtaining an abortion.[26] It imposes often insurmountable barriers. Due to high levels of marital dissolution and the high incidence of out-of-wedlock childbearing, the great majority of adolescents have lived at least for a time in single parent families. It is estimated

[24] *See generally* MORRISSEY, HOFFMAN & THROPE, *supra* note 8.

[25] *Id.* at 43.

[26] In many cases, *two* parent notification may override the judgment, not only of the adolescent, but of one of her parents, that one parent should not be notified.

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that by age 17, 70 percent of white children bo[rn in] 1980 will have spent at least some time with only one parent, and 94 percent of black children will have lived in one-parent homes.[27] Moreover, data obtained from the 1981 Current Population Report indicated that in 1980, 2.3 million or 3.7 percent of all unmarried noninstitutionalized children under the age of 18 were not living with either of their parents.[28]

Data from a nationally representative sample of children aged 11-16 indicates that when an adolescent lives apart from one of her parents, she frequently has little contact with the absent parent.[29] Over one-third of the children living with their mothers in one-parent homes have had no contact at all with their absent father during the previous five years, or are unaware if their father is alive or dead.[30] Over half have had no contact in the previous year.[31] And the little contact that occurs tends to be purely social, not involving counseling about life decisions.[32] "Coparenting among formerly married couples is more of a myth than a reality in all but a tiny fraction of families. [Nonresident parents] typically give up decision-making authority and exercise little direct in-

[27] Hofferth, *Updating Children's Life Course*, 47 J. Marriage and Fam. 93, 93 (1985).

[28] Montemayor and Leigh, *Parent-Absent Children: A Demographic Analysis of Children and Adolescents Living Apart from their Parents*, 31 Fam. Relations 567, 567 (1982).

[29] Furstenberg, Nord, Peterson and Zill, *The Life Course of Children of Divorce*, 48 Am. Sociological Rev. 656, 663 (1983).

[30] *Id.*

[31] *Id. See also* Seltzer & Bianchi, *Children's Contact with Absent Parents*, 50 J. Marriage and Fam. 663 (1988).

[32] Furstenberg & Nord, *Parenting Apart: Patterns of Childrearing After Marital Disruption*, 47 J. Marriage and Fam. 893, 902 (1985) [hereinafter Furstenberg & Nord]. Lack of involvement by the non-custodial parent is also evidenced by the small proportion of absent fathers who contribute to their children's support. *See* U.S. DEPT. OF COMMERCE, CURRENT POPULATION REPORTS, SPECIAL STUDIES, CHILD SUPPORT AND ALIMONY: 1985 (P-23, No. 154, 1989) at 1.

fluence over their children's upbringing." [33] Thus, in many instances, mandating parental disclosure would force the involvement of a disinterested parent in potentially disruptive ways. Most troubling is the potential for serious harm to both the mother and the adolescent if an absent father with a history of abusive behavior is notified.[34] In such families, mandatory two-parent notification may be particularly damaging.

Moreover, even in two-parent homes, it is very common for fathers to be completely uninvolved in providing information or giving advice about sexual matters to their daughters. Research has shown that the limited sex education that occurs in the home is usually done by the mother.[35] Moreover, the district court in *Hodgson* found that in many cases compelled two-parent notification had inhibited rather than advanced voluntarily initiated intrafamily communication. 648 F. Supp. at 777-778.[36] Thus, there is no reason to believe that requiring adolescents who would not otherwise do so to speak with their fathers about their abortion decision would promote any kind of beneficial family interaction, and reason in many cases to fear that harm may ensue.

D. An "Arbitrary And Inflexible" Waiting Period—Whether 24 Or 48 Hours—Places Greater Burdens On Adolescents Than It Does On Adults.

The 24-hour and 48-hour waiting periods here at issue impose even greater burdens on adolescents' right to ob-

[33] Furstenberg & Nord, *supra* note 32, at 903.

[34] Domestic violence—both wife battering and child abuse—is not uncommon in American homes. Gelles & Strauss, *supra* note 18. In Minnesota alone, there are an average of 31,200 assaults on women by their partners each year. DEPT. OF CORRECTIONS, MINNESOTA PROGRAMS FOR BATTERED WOMEN (January 1985).

[35] Rozema, *Defensive Communication Climate as a Barrier to Sex Education in the Home*, 35 Fam. Relations 533 (1986).

[36] The court found that some adolescents were dissuaded from contacting one parent because only the consent of both parents would eliminate the need for judicial proceedings.

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tain an abortion than do similar provisions this Court struck down as applied to all women. In *Akron I*, this Court concluded that the State "failed to demonstrate that any legitimate state interest is furthered by an arbitrary and inflexible [24-hour] waiting period," and held that such a waiting period was unconstitutional. 462 U.S. at 450. The Court noted that the waiting period increased the cost and risk of obtaining an abortion, *inter alia*, because scheduling difficulties effectively delayed the planned abortion more than 24 hours. *Id.*

Such burdens on the right to obtain an abortion are particularly onerous for adolescents.[37] Adolescents already obtain abortions later in pregnancy than older women, and the risk of complications increases with each week of delay.[38] Thus, the additional state-imposed delay needlessly compounds the health risks adolescents already encounter.

II. THE SUBSTANTIAL BURDENS IMPOSED BY COMPELLED NOTIFICATION AND WAITING PERIOD PROVISIONS ARE UNCONSTITUTIONAL.

This Court has asserted, as a guiding principle, that:

> [W]hen a State, as here, burdens the exercise of a fundamental right, its attempt to justify that burden as a rational means for the accomplishment of some significant state policy requires more than a bare assertion, based on a conceded complete absence of supporting evidence, that the burden is connected to such a policy.

[37] *See Indiana Planned Parenthood v. Pearson*, 716 F.2d 1127, 1143 (7th Cir. 1983) ("the same objections to the waiting period for adults listed in *City of Akron* apply to waiting periods for minors"); *Hodgson*, 648 F. Supp. at 765 ("[t]his statutorily imposed delay frequently is compounded by scheduling factors such as clinic hours, transportation requirements, weather, a minor's school and work commitments").

[38] *See* Russo, *Adolescent Abortion: The Epidemiological Context in* ADOLESCENT ABORTION: PSYCHOLOGICAL & LEGAL ISSUES 55-67 (G. Melton ed. 1986) [hereinafter Russo]; NAS REP *supra* note 10, at 114, 277.

Carey v. Population Services Int'l, 431 U.S. 678, 696 (1977). The right to secure an abortion is fundamental, *Roe v. Wade*, 410 U.S. 113 (1973), protected at a minimum against imposition of "undue burdens," *Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3063 (1989) (O'Connor, J., concurring). There can be no serious question, for the reasons set forth above, that the statutes at issue impose a substantial burden on all minors that would be unconstitutional if imposed on adults. *See* p. 4, *supra*.

The States have asserted three general purposes in defense of mandatory notification statutes, which in other contexts have been recognized by this Court:[39] promoting a family role in the child-rearing process, Cross-Petition for Writ of Certiorari in No. 88-1309 at 3; assuring that the decision to abort is an informed one, *id.*; and promoting the adolescent's emotional stability, particularly as it relates to "the minor's psychological sequelae that may attend the abortion procedure," *Hodgson*, 648 F. Supp. at 766. In *Hodgson*, after hearing evidence about the manner in which the Minnesota law operated for five years, the trial court found as a matter of fact that none of these interests was promoted. The scientific evidence supports the district court's findings.

A. The Evidence Suggests That Mandatory Parental Notification Statutes Do Not Foster Productive Intrafamily Communication.

As demonstrated in Point I, *supra*, the scientific and record evidence suggests that mandatory parental notification statutes are actually *destructive* of the family role in child-rearing. The productive communication patterns of a normal family that these laws purport to promote are based upon trust and the voluntary desire to

[39] *See Danforth*, 428 U.S. at 75 (family role in decisionmaking); *Bellotti II*, 443 U.S. at 635 (decisionmaking competence); *H.L. v. Matheson*, 450 U.S. 398, 412 (1980) (psychological consequences of abortion).

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share or to know; compelled or coerced communicati lacks these qualities.[40]

B. There Is No Empirical Support For The Proposition That Compelled Parental Disclosure Will Help Ensure That The Minor's Decision To Obtain An Abortion Is A Capable One.

These burdensome regulations also might be defended as needed to ensure that the pregnant woman is making an informed choice. Whether the laws' burdens are justified in light of this purpose should turn in substantial part on whether the scientific evidence supports the State's assumptions about the competence of minors to make decisions about pregnancy.

The Court has yet to define precisely what the capacity to make informed choices means.[41] It has, however, never relied upon a definition of capacity to consent that focuses on the choice made,[42] focusing instead on the individual's cognitive capacity to make the decision to abort, *i.e.*, the ability to understand the nature of the procedure, its risks, benefits, consequences, and possible alternatives. Perhaps the most complete statement of this Court's position on competency appears in *Danforth*, 428 U.S. at 104 (Stevens, J., concurring in part and dissenting in part): "The Court assumes that parental consent

[40] *See generally* D. CURRAN, TRAITS OF A HEALTHY FAMILY (1983).

[41] *But see* 45 C.F.R. Part 46 (DHHS rules regarding consent to biomedical and behavioral research including consent to research with children); Weithorn & Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 Child Dev. 1589 (1982) [hereinafter Weithorn & Campbell]; Bersoff, *Children as Research Subjects: Problems of Competency and Consent in* THE RIGHTS OF CHILDREN 186 (J. Henning ed. 1982).

[42] Of approximately 1.1 million teenage pregnancies annually, about 40% are terminated by abortion. By any objective standard the decision to abort is one that a reasonable person, including a reasonable adolescent, could make. NAS REPORT, *supra* note 10, at 1, 15, 261; Alan Guttmacher Institute, *School Sex Educatic Policy and Practice*, 3 Issues in Brief 1 (1983) [hereinafter A

is an appropriate requirement if the minor is not capable of understanding the procedure and of appreciating its consequences and those of available alternatives." [43] Both psychological theory and significant and substantial evidence developed by social scientists bear on the empirical question whether adolescents possess the requisite capacity to consent under this formulation.

1. *Psychological theory and research about cognitive, social and moral development strongly supports the conclusion that most adolescents are competent to make informed decisions about important life situations.*

Developmental psychologists [44] have built a rich body of research examining adolescents' capacities for understanding, reasoning, solving problems and making decisions, especially in comparison to the same capacities in adults. Research consistently supports the conclusion that there is a predictable development during late childhood and early adolescence of the capacity to think rationally about increasingly complex problems and decisions. Although there are several competing theories of cognitive development, these theories each recognize that a revolution in rationality occurs during early adolescence.

The specific reasoning abilities that develop during early adolescence are closely akin to the capacity to consent, and include the capacity to reason abstractly about

[43] *See also Bellotti II*, 443 U.S. at 640 ("ability to . . . take account of both immediate and long-range consequences"). The concern that a minor have adequate *information* about her decision, as opposed to the capacity to choose based upon such information, *see Bellotti II*, 443 U.S. at 643, is less a component of the adolescent's competency than of the physician's legal and ethical duty to provide all material information to the patient. *See* Wadlington, *Consent to Medical Care for Minors: The Legal Framework in* CHILDREN'S COMPETENCE TO CONSENT 57 (G. Melton, G. Koocher & M. Saks eds. 1983).

[44] Developmental psychologists are scientists who study cognitive, perceptual, personality, social and emotional development along the life span of individuals.

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hypothetical situations; the capacity to reason about multiple alternatives and consequences; the capacity to consider more variables and combine variables in more complex ways; and the capacity for systematic, exhaustive use of information.[45]

Competent decisionmaking is also dependent on social and personality development including the development of personal values, identity, autonomy, and the ability to resolve social dilemmas. Research in social and personality development contradicts the stereotype of adolescence as a period when young people are paralyzed by a struggle for identity, social confusion and rebellion against parents. In fact, by middle adolescence (age 14-15) young people develop abilities similar to adults in reasoning about moral dilemmas,[46] understanding social rules and laws,[47] reasoning about interpersonal relationships [48] and interpersonal problems,[49] and reasoning about

[45] For a discussion of these changes from three theoretical perspectives, see B. INHELDER & J. PIAGET, THE GROWTH OF LOGICAL THINKING FROM CHILDHOOD TO ADOLESCENCE (1958); Braine & Rumain, *Logical Reasoning in* HANDBOOK OF CHILD PSYCHOLOGY, VOLUME III: COGNITIVE DEVELOPMENT 263 (P.H. Mussen ed., J.H. Flavell & E.M. Markman vol. eds. 1983); Sternberg & Powell, *The Development of Intelligence in* HANDBOOK OF CHILD PSYCHOLOGY, VOLUME III: COGNITIVE DEVELOPMENT 341 (P.H. Mussen ed., J.H. Flavell & E.M. Markman vol. eds. 1983).

[46] Rest, *Morality in* HANDBOOK OF CHILD PSYCHOLOGY, VOLUME III: COGNITIVE DEVELOPMENT 556 (P.H. Mussen ed., J.H. Flavell & E.M. Markman vol. eds. 1983); Kohlberg, *Moral Stages and Mortalization: The Cognitive-Developmental Approach in* MORAL DEVELOPMENT AND BEHAVIOR: THEORY, RESEARCH AND SOCIAL ISSUES (Lickona ed. 1976); Kohlberg & Hersch, *Moral Development: A Review of the Theory,* 16 Theory into Practice 53 (1977).

[47] Tapp & Kohlberg, *Developing Senses of Law and Legal Justice in* LAW, JUSTICE AND THE INDIVIDUAL IN SOCIETY: PSYCHOLOGICAL AND LEGAL ISSUES 89 (J. Tapp. & F. Levine, eds. 1977).

[48] R. SELMAN, THE GROWTH OF INTERPERSONAL UNDERSTANDING: DEVELOPMENTAL AND CLINICAL STUDIES (1980).

[49] Marsh, Serafica & Barenboim, *Effect of Perspective-ta... Training on Interpersonal Problem Solving,* 51 Child Development

custody preference during parental divorce.[50] By middle adolescence most young people develop an adult-like identity and understanding of self.[51] Furthermore, the majority of adolescents do not repudiate parental values, but incorporate them, during their search for autonomy.[52] Thus, by age 14 most adolescents have developed adult-like intellectual and social capacities including specific abilities outlined in the law as necessary for understanding treatment alternatives, considering risks and benefits, and giving legally competent consent.

There is not as much information about the practical decisionmaking competence of younger adolescents—those aged 11 to 13.[53] Research has indicated that there is considerable variability in cognitive development and decisionmaking competence among adolescents, and there are some 11-to-13-year-olds who possess adult-like capabilities in these areas.[54] It is instructive that young adolescents are deemed capable in many state statutes of giving informed consent to various medical procedures, including mental health services, treatment for sexually transmitted diseases, and surgery related to childbirth. Should they have a child, young adolescents are typically deemed competent to make health care decisions both for themselves

140 (1980); Marsh, Serafica & Barenboim, *Interrelationships Among Perspective Taking, Interpersonal Problem Solving, and Interpersonal Functioning*, 138 J. Genetic Psychology 37 (1981).

[50] Greenberg, An Empirical Determination of the Competence of Children to Participate in Child Custody Decision-Making (1983) (Dissertation Abstracts Int'l).

[51] Harter, *Developmental Perspectives On the Self System in* HANDBOOK OF CHILD PSYCHOLOGY, VOLUME IV: SOCIALIZATION, PERSONALITY & SOCIAL DEVELOPMENT 275 (Heatherington, ed. 1983).

[52] *See* Conger, *A World They Never Knew: The Family and Social Change in* TWELVE TO SIXTEEN 197 (J. Kagan & R. Coles eds. 1972); Brittain, *supra* note 13.

[53] Because few young adolescents become pregnant, it is difficult for researchers to obtain a sample large enough to study the abortion decisionmaking competence of this group.

[54] See sources cited *supra* notes 46-51.

and their child.[55] At a minimum, therefore, a c[illegible]y-case approach to assessing decisionmaking competence among young adolescents is essential.

For all the reasons set forth in this section, the assumption that adolescents as a group are less able than adults to understand, reason and make decisions about intellectual and social dilemmas is not supported by contemporary psychological theory and research.

2. ***Research does not support the States' assumption that adolescents typically lack the capacity to make sound health care decisions, including decisions about abortion.***

There has been substantial empirical research testing adolescents' decisionmaking performance when faced with various types of practical problems involving treatment and non-treatment decisions. Some of these studies specifically compare the performance of adolescents to that of adults in making such decisions.[56] The evidence does not support the assumption underlying notification laws that adolescents lack an adult's capacity to understand and reason about problems and decisions, including medical and psychological treatment alternatives, or the ability to comprehend and consider risks and benefits regarding treatment alternatives.[57]

[55] MORRISSEY, HOFFMAN & THROPE, *supra* note 8, at 43.

[56] Studies comparing adolescents and adults include Belter & Grisso, *Children's Recogniton of Rights Violations in Counseling*, 15 Prof. Psychology 899 (1984) [hereinafter Belter & Grisso]; Grisso, *Juveniles' Capacities to Waive Miranda Rights: An Empirical Analysis*, 68 Calif. L. Rev. 1134 (1980) [hereinafter Grisso]; Lewis, *A Comparison of Minors' and Adults' Pregnancy Decisions*, 50 Am. J. Orthopsychiatry 446 (1980); Weithorn & Campbell, *supra* note 41; Ambuel, Developmental Change in Adolescents' Psychological and Legal Competence to Consent to Abortion: An Empirical Study and Quantitative Model of Social Policy (1989) (Dissertation Abstracts Int'l) [hereinafter Ambuel].

[57] *See, e.g.*, Melton & Pliner, *Adolescent Abortion: A Psyc[illegible]gal Analysis in* ADOLESCENT ABORTION: PSYCHOLOGICAL & LEGA[illegible]S 1 (G. Melton ed. 1986) [hereinafter Melton & Pliner]; We[illegible]rn,

The two most directly relevant studies compared abortion decisionmaking by adolescents and adults at the time they received pregnancy tests in actual treatment settings. Results of both are consistent with the research and theory reviewed above showing that "adolescents are as able to conceptualize and reason about treatment alternatives as adults are." [58] In one study,[59] 16 unmarried adolescents, aged 13-17, and 26 unmarried adult women, aged 18-25, were asked to consider their options for responding to their own pregnancies at the time of their pregnancy tests. Standardized questions were used to determine their knowledge of pregnancy-related laws, sources of advice they had received or expected to seek, the range of factors one could consider in making choices about one's pregnancy, and the reasons for their own

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Children's Capacities in Legal Contexts in CHILDREN, MENTAL HEALTH, AND THE LAW 25 (N. Reppucci & Assoc. eds. 1984); Melton, *Developmental Psychology and the Law: The State of the Art*, 22 J. Fam. L. 445 (1984); Grodin & Alpert, *Informed Consent and Pediatric Care in* CHILDREN'S COMPETENCE TO CONSENT 93 (G. Melton, G. Koocher & M. Saks eds. 1983); Weithorn, *Developmental Factors and Competence to Make Informed Treatment Decisions in* LEGAL REFORMS AFFECTING CHILD AND YOUTH SERVICES 85 (G. Melton ed. 1982); Wald, *Children's Rights: A Framework for Analysis*, 12 U.C. Davis L. Rev. 255 (1979); Ferguson, *The Competence and Freedom of Children to Make Choices Regarding Participation in Research: A Statement*, 34 J. Soc. Issues 114 (1978); Grisso & Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 Prof. Psychology 412 (1978); Schowalter, *The Minor's Role in Consent for Mental Health Treatment*, 17 J. Am. Acad. Child Psychiatry 505 (1978).

Not all older adolescents and not all adults reach the highest levels of competence to consent to treatment, *see* Roth, Meisel, & Lidz, *Tests of Competence to Consent to Treatment*, 135 Am. J. Psychiatry 279 (1977), but there is no substantial support for the proposition that cognitive abilities of the two groups are different.

[58] APA Interdivisional Committee on Adolescent Abortion, *Adolescent Abortion, Psychological and Legal Issues*, 42 Am. Psychologist 73, 73 (1987) [hereinafter Interdivisional Committee Study].

[59] Lewis, *A Comparison of Minors' and Adults' Pregnancy Decisions*, 50 Am. J. Orthopsychiatry 446 (1980).

choices. The study revealed no differences betv the unmarried minors and adults in the decisions the, made or in their knowledge of pregnancy-related laws. Further, when asked to describe factors that could affect one's choice of abortion or motherhood, minors differed very little from adults in the frequency with which they mentioned various considerations and consequences. There were no differences on such factors as the positive emotions associated with mothering, financial concerns, the effect of given choices on one's goals or present lifestyle, or social stigma.

The second highly relevant study examined pregnancy decisionmaking in 15 adolescents aged 14-15, 19 adolescents aged 16-17, and 40 adults aged 18-21, at the time they sought a pregnancy test at a women's health clinic.[60] The sample was representative of various economic, racial and religious backgrounds. Each person participated in an extensive decisionmaking interview conducted by a counselor, which was audio-taped and later rated by trained, independent raters. The four measures used to evaluate decisionmaking competence were suggested by this Court's understanding of competency,[61] and focused on the individual's cognitive and volitional capacity: consideration of risks and benefits including immediate and future consequences; quality and clarity of reasoning; number and types of factors considered; and volition, *i.e.*, making a decision without being coerced by or acquiescing to others. Results showed that minors aged 14 to 17, who considered abortion as an option, equaled adults in all

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[60] Ambuel, *supra* note 56; Ambuel & Rappaport, Developmental Change in Adolescents' Psychological and Legal Competence to Consent to Abortion (1989) (Paper Presented at American Psychological Association Convention, available from *amicus* counsel of record).

[61] *See Danforth*, 428 U.S. at 104 (Stevens, J., concurring in part and dissenting in part). *See also* Wadlington, *Consent to Medical Care for Minors: The Legal Framework in* CHILDREN'S COMPETENCE TO CONSENT 57 (G.P. Melton, G. Koocher & M. S' 'ds. 1983).

four measures of competence. Taken together these two studies suggest that minors equal adults "in their 'competence' to imagine the various ramifications of the pregnancy decision," [62] and their capacity to make a reasoned choice when facing unplanned pregnancy.[63]

Indeed, the National Academy of Sciences, in a major review of the research, observed that almost all minors who employ judicial bypass procedures to avoid parental involvement are held to be mature, and their decisions to have an abortion are held to be in their best interests.[64] This evidence strongly suggests that many adolescents who choose not to consult with their parents are competent to make the abortion decision.[65]

[62] *Id. See* Lewis, *Minors' Competence to Consent to Abortion,* 42 Am. Psychologist 84 (1987).

[63] In another relevant study, 14-year old minors and adults were presented with four vignettes about individuals suffering from particular medical or psychological disorders. They were given detailed information about the nature, purpose, risks and benefits of the alternative treatments, and were asked to choose among them. The participants were then asked a series of standardized questions about their decisions. In most instances, the responses showed no difference between the adults and the 14-year-olds on any of the scales of competency used in the study—factual understanding, inferential understanding (appreciation), reasoning, choice of reasonable option, and evidence of choice. Weithorn & Campbell, *supra* note 41. For a confirming study, *see* Belter & Grisso, *supra* note 56; Grisso, *supra* note 56.

[64] *See* NAS Report, *supra* note 10, at 194-195. For supporting research *see* Melton & Pliner, *supra* note 57, at 26; Mnookin, *supra* note 9; *Judging Teenagers, supra* note 11, at 259-267; *see also Hodgson v. Minnesota,* 648 F. Supp. at 765, 766-67.

[65] Indeed, it can be seriously questioned whether a notification statute with a bypass procedure in practice does more than expend judicial resources. At worst, it is a source of anxiety, medically harmful delay, and family conflict. Melton, *Legal Regulation of Adolescent Abortion: Unintended Effects,* 42 Am. Psychologist 79, 82 (1987). That so many minors, despite its burdens, choose to undergo a bypass process and succeed in demonstrating their competence and best interests to a judge, dramatizes the fact that *without* a bypass, the burdens of mandatory parental notification would be intolerable.

Thus, empirical studies of treatment and al[illegible] decisionmaking have found no differences between adolescents aged 14-18 and adults in factors related to legal competence.[66] There is therefore no scientific foundation for the States' assumption that adolescents' decisions to have an abortion are generally less thoughtful and informed than adults' decisions.

Moreover, related research indicates that attempts by the State to compel parental consultation in minors' abortion decisions are unlikely to result in better reasoned decisions.[67] One study found that although adolescents who were able to discuss their unintended pregnancy with two or three people they considered sympathetic and supportive decided upon a course of action faster than women with less social support, no benefit accrued from discussing the pregnancy with parents or others considered unsympathetic.[68] Research has consistently shown

[66] Studies have recognized differences between adults and adolescents regarding the decision to have an abortion, but those differences do not reflect upon the relative competence of adolescents (or adults) to make the abortion decision. Instead, the differences appear to be related to minors' and adults' differing social situations. For example, adolescents tend to see their decision as more influenced by consideration of its impact on others, and more frequently involve a parent in the decision. They also tend to take more time to reach a decision, making the added delays caused by notification and bypass procedures even more potentially harmful to the adolescents' health than similar requirements would be to adults' health. *See* Interdivisional Committee Study, *supra* note 58, at 73, and studies cited therein.

[67] Melton, *Minors and Privacy: Are Legal and Psychological Concepts Compatible?* 62 Neb. L. Rev. 455, 470-471 (1983); Zabin & Hirsch, Effects of Abortion and Childbearing on Education and the Psychological Status of Black Urban Adolescents 16 (1988) (Paper presented at Annual Meeting of American Public Health Association, available upon request from counsel of record). *See* Rothenberg, *Communication About Sex and Birth Control Between Mothers and Their Adolescent Children,* 3 Population and Env't 35 (1980).

[68] Ashton, *Pattern of Discussion and Decision-making A[illegible]st Abortion Patients,* 12 J. Biosocial Sci. 247 (1980).

that parents are seldom significant sources of sex education for their children.[69] The findings of many studies suggest that sex is an issue of conflict that rarely elicits open and honest communication between parents and adolescents, and that a general lack of rapport between parents and adolescents contributes to their difficulty in communicating about sex.[70] In many instances, therefore, compelled parental involvement in the abortion decision is not likely to be constructive.

C. There Is No Empirical Support For The Proposition That Mandatory Parental Disclosure Will Assist Minors In Dealing With The Psychological Sequelae Of Abortion.

The scientific evidence also fails to lend any support to the States' assumptions that the psychological sequelae of abortion are more severe for an adolescent than for an adult and that forced parental involvement is therefore necessary to ensure the continuing psychological well-being of the adolescent.

1. *Adolescents who choose to abort are not less stable psychologically than other adolescents.*

The increasingly early biological maturation of adolescents is well documented.[71] A majority of individuals become sexually active during adolescence.[72] Indeed, 40% of today's 20-year-old women have had at least one

[69] Rozema, *supra* note 35, at 532; Bennett & Dickinson, *Student-parent Involvement in sex, birth control and venereal disease education*, 16 J. Sex Research 114, 115 (1980).

[70] *Id.* Parents, not surprisingly, generally disapprove of their children's premarital sexual relations. Marsman & Herold, *Attitudes Toward Sex Education and Values in Sex Education*, 35 Fam. Relations 357 (1986).

[71] Rauh, Johnson, & Burket, *The Reproductive Adolescent*, 20 Pediatric Clinics of North America 1005 (1973).

[72] Marecek, *Counseling Adolescents with Problem Pregnancies*, 42 Am. Psychologist 89 (1987).

pregnancy during their teen years.[73] And there is no empirical support for the supposition that adolescents seeking abortions are drawn from an especially psychologically or emotionally vulnerable subpopulation. Unmarried adolescents who seek abortions are similar in psychological makeup to other adolescents.[74] Moreover, compared to unmarried adolescents who choose to carry to term, those seeking abortions are likely to be somewhat advantaged in terms of social class status, family background and academic achievement.[75] Adolescents who seek abortions, compared to those who choose motherhood, are characterized by a number of traits associated with positive mental health and superior psychological maturity—greater independence, higher academic motivation and aspiration, and more feelings of competence and optimism.[76] Thus, not only is it unproven that as a group adolescents who choose abortions are at special psychological risk, but the opposite is actually shown to be the case.

2. *Much of the stress pregnant adolescents experience is due to unwanted pregnancy, not to abortion.*

More generally, the evidence does not support this Court's assertion that there are "potentially grave emotional and psychological consequences of the decision to abort." *H.L. v. Matheson*, 450 U.S. 398, 412-413 (1980). Three major reviews of the psychological and psychiatric research literature all confirm that for most women who undergo abortion, there are no long-term negative emotional effects.[77]

[73] Russo, *supra* note 38, at 63.

[74] Olson, *Social and Psychological Correlates of Pregnancy Resolution Among Adolescent Women*, 50 Am. J. Orthopsychiatry 432, 436 (1980) [hereinafter Olson].

[75] *Id.*

[76] *Id.*

[77] Marecek, *Consequences of Adolescent Childbearing and Abortion in* ADOLESCENT ABORTION: PSYCHOLOGICAL & LEGAL ISSUES 96

When women experience regret, depression, or guilt following an abortion, such feelings are mild and diminish rapidly.[78] When serious problems do occur, they are most likely to occur among women with prior histories of psychiatric problems.[79] With respect to adolescents, abortion "is neither psychologically harmful nor in other ways damaging to the patient."[80] "Very few teenagers have severe psychiatric complications after induced abortion."[81]

Abortion not only carries a low risk of negative psychological consequences for adolescents, but the psychological sequelae of abortion for adolescents are usually positive, with significant diminution of anxiety and increased feelings of well-being. "The predominant response following abortion is generally relief."[82] Studies of the mental health status of pregnant women before and after abortion show significant reductions in the symptoms of stress,

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(G. Melton ed. 1986) [hereinafter *Consequences*]; Adler & Dolcini, *Psychological Issues in Abortions for Adolescents in* ADOLESCENT ABORTION: PSYCHOLOGICAL & LEGAL ISSUES 74 (G. Melton ed. 1986) [hereinafter Adler & Dolcini]; Shusterman, *The Psychological Factors of the Abortion Experience: A Critical Review,* 1 Psychology of Women Q. 79 (1976) [hereinafter *Shusterman*]. *See generally* Brief for *Amicus Curiae* American Psychological Association in *Webster v. Reproductive Health Services,* 109 S. Ct. 3040 (1989).

[78] Adler & Dolcini, *supra* note 77, at 84.

[79] *Id. See* NAS REPORT, *supra* note 10, at 195.

[80] Olson, *supra* note 74, at 440.

[81] Cates, *Adolescent Abortions in the United States,* 1 J. Adolescent Health Care 18 (1980); *see* C. CHILMAN (ed.), ADOLESCENT SEXUALITY IN A CHANGING AMERICAN SOCIETY (NIH Pub. No. 79-1426) (1978); Bracken, Hackamovitch & Grossman, *The Decision to Abort and Psychological Sequelae,* 15 J. Nervous and Mental Disorders 155 (1974); *see also* David, Rasmussen & Holst, *Postpartum and Postabortion Psychotic Reactions,* 13 Fam. Plan. Persp. 88 (1981) (only 11.4 psychiatric admissions per 10,000 abortions). *See generally* NAS REPORT, *supra* note 10, at 195-196.

[82] Adler & Dolcini, *supra* note 77, at 84 (and references cited therein).

as measured by standardized psychological tests.[83] [illegible]-over, there is no evidence to support the proposition that any distress resulting from an adolescent's abortion would be mitigated by involuntary parental notification.

An abortion removes serious potential constraints on the minor's life and future. After an abortion, the adolescent can resume her normal life and activities in school, at home, and with peers. In contrast, "adolescent mothers are significantly more likely to curtail their education, to be relegated to low-paying jobs, to be single parents, and to be on welfare,"[84] as well as to experience repeat pregnancies and, for those who marry to legitimate the birth, greater marital instability.[85]

As the National Academy of Sciences recently reported, "on the basis of existing research . . . *the contention that adolescents are unlikely or unable to make well-reasoned decisions or that they are especially vulnerable to serious psychological harm as a result of an abortion is not supported.*"[86] Moreover, as noted above, those who need support and can get it from their parents typically seek it voluntarily. For these reasons, it is unsurprising that bypass proceedings invariably result in a ruling favorable to the minor.

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[83] *Shusterman, supra* note 77.

[84] NAS REPORT, *supra* note 10, at 18.

[85] *Consequences, supra* note 77, at 96. Regardless of one's moral position on abortion itself, and *amici* take none herein, the data strongly support the position that abortion is more psychologically benign than carrying to term for almost all adolescents.

[86] NAS REPORT, *supra* note 10, at 277 (emphasis added). "Perhaps the most authoritative form of post-publication review of scientific findings occurs when organizations such as the National Academy of Sciences . . . appoint panels of the most distinguished scientists in the field, provide them with ample time and resources, and commission a state-of-the-art evaluation of a given area of research." Monahan & Walker, *Social Authority: Obtaining, E[illegible]uating, and Establishing Social Science in Law,* 134 U. Pa. [illegible] 477, 501 (1986).

CONCLUSION

Both the Minnesota and Ohio statutes impose significant burdens on adolescents' right to choose whether to abort or carry to term without significantly advancing any of the asserted state interests. In these circumstances, even parental notification statutes that provide for judicial bypass impose unconstitutional burdens on mature adolescents and adolescents whose interests would be better served by not notifying their parents. The judicial process is invariably stressful and virtually always affirms the minor's choice to proceed without parental involvement. Moreover, to mandate parental notification and *not* provide for judicial bypass would be intolerable, leaving minors mature enough to decide for themselves, and those whose best interests would be injured substantially by parental notification, with a choice between suffering this statutorily imposed injury or carrying to term. Such a fearful choice cannot constitutionally be imposed without a substantial reason.

Amici therefore respectfully submit that the decision of the Eighth Circuit should be reversed and the Minnesota statute struck down in its entirety, and that the decision of the Sixth Circuit concerning the Ohio statute should be affirmed.

Respectfully submitted,

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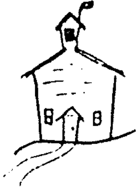
September 1, 1989



Kansas Association for School Health
— Box 4531 —
TOPEKA, KANSAS 66604

Greetings!

My name is Lu Ann Nauman. I am a Past President of the Kansas Association for School Health and the designated person to present our association's testimony.

TESTIMONY ON HB 2663

The Kansas Association for School Health is most supportive of the preservation of family units and the fostering of positive communication among all family members. The organization advocates to preserve, protect, and promote the optimal health of all children and youth and it advocates for the protection of childrens' rights as well as parents' rights.

The decision as to whether to complete a pregnancy or terminate a pregnancy is difficult in many instances and each has long term consequences. However, in the case of a minor child, the Kansas Association for School Health asserts that forcing the minor female to complete a pregnancy with the trauma of labor and delivery and the subsequent responsibility for the child has greater negative impact overall than termination of an unplanned pregnancy. The effect of HB 2663 would predictably result in young women often being so fearful of informing parents of an abortion that the pregnancy would be continued because of feared retaliation.

Much evidence exists which shows the problem child to be at risk physically, mentally, and emotionally. Furthermore, data has clearly shown the negative educational consequences with some sources citing a 50% high school dropout rate when a teen pregnancy occurs.

We cannot legislate family communication and we know that parental notification can have immediate negative consequences with physical and emotional abuse following receipt of an impending abortion. The Kansas Association for School Health recommends a much more sound approach by promoting and implementing comprehensive school health education programs to reduce at-risk behavior among our children and youth, including unplanned pregnancies. The Kansas Association for School Health advocates the protection of childrens' rights as well as parental rights. Childrens' rights are overlooked in this bill.

In summary, this issue was taken very seriously in our organization and the vote was not unanimous but a majority vote concerning parental notification. THIS TAKEN INTO CONSIDERATION, THE KANSAS ASSOCIATION FOR SCHOOL HEALTH URGES DEFEAT OF HB 2663 FOR THE REASONS CITED ABOVE.

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 5
February 20, 1990

Arriane Gump
846 Ford Hall
Kansas State University
Manhattan, Ks. 66506

I'm here today because my friends and I feel it is important that you hear from normal, ordinary Kansas teenagers from fully functional and loving families in relation to these parental notification bills.

We resent what is represented in these bills and we fear their ramifications for our lives.

We resent the fact that at this time in our lives when our bodies are sexually developing and we are being bombarded with sexually encouraging & inciting messages from advertisements, television, movies and music that the legislature is focusing on punishment for

our impulsive sexual actions rather than strengthening sex education & pregnancy prevention programs.

We resent the fact that in these bills only the girl is held accountable & responsible for truth in relation to an unintended pregnancy & for managing the consequences while the guy that probably pressured her for sex and his parents don't even have to know or be involved.

We resent the fact that while we are mature enough to have sex, get birth control without parents permission, considered mature enough to give birth & raise a child.

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we're accused of not being capable of making our own decision to terminate the pregnancy even though it is a much safer medical risk than child birth for our young bodies.

And we resent the fact that the Governor's bill is unfair for our sisters in little rural towns in Kansas, for there will be no way to use judicial by pass without everyone in town knowing it.

We fear the ramifications of this bill for girls in dysfunctional families - if they know they can't tell, believe me their life risks are real. The abuse they will suffer with this sort of revelation to their parents

FSA
6-3
2-20-90

will only compound their problems and potentially leave them on the street, pregnant, beat up, and then what? But most of all I fear the ramifications for girls like me who have grown up in wonderful Kansas families with so much love, attention, devotion and high expectations - our parents have spent all their time, money & energy on our development we'd rather risk our lives like Becky Bell did than tell because of the hurt, pain, embarassment & disappointment it would mean for our parents

So please — Keep us safe

Keep it legal for us to make our choices

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6-4
2-20-90

My name is Gayle Bennett. I am co-organizer of the Manhattan Unit of the Religious Coalition for Abortion Rights. I am also a thirteen-year veteran teacher at Manhattan High School and the mother of two teenaged daughters. With me today are ...

Proponents of parental notification speak about the importance of involving parents in a young woman's decision making. They speak eloquently about the need for family communication and support. However, parental notification is actually a thinly disguised attempt to discourage and prevent a young woman from having a safe and legal abortion if that should be her choice.

In most major cities in Kansas "Free Pregnancy Testing Centers have sprung up. These centers are run by "Pro-Life" or Anti-Choice groups whose agenda is to discourage young women from seeking abortions. Personnel at these centers provide information about carrying a pregnancy to term, giving the baby up for adoption, or raising it as a single parent. Anti-abortion pamphlets are distributed and anti-abortion videos are shown.

When I visited one of these centers, I was told that they do nothing that legally requires parental consent, and parental notification is not required although it is urged. My daughter could set up an appointment at one of these centers, get a pregnancy test, be told the results, and be persuaded to carry the pregnancy to term, give the baby up for adoption, or raise it as a single parent all without my knowledge, let alone my consent. In fact, should I question her decision, these centers would find her a temporary home or at the very least provide her with a "Support Friend" who would preempt my role for the duration of the pregnancy. Any decision a young woman would make in this

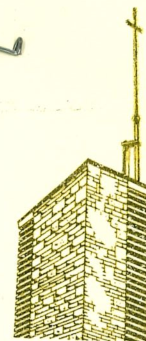
HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 7
February 20, 1990

situation would affect her family significantly, but notification advocates feel that notification should be required only for abortion, not for the decision to keep or give the baby up. This presumption clearly contradicts their claim for the sanctity of family communication.

Some notification advocates claim that a young woman must be protected from her own immaturity. Supposedly she is too immature to decide to have an abortion, but she is mature enough to decide to give her baby up for adoption or indeed to raise it as a single parent!

Most young women seeking an abortion will have talked with one or both parents about their decision. Many are accompanied by a parent when the procedure is done. If the young woman has not told her parents, we must respect the fact that she has a good reason. She knows better than the state how the news of her pregnancy will be received by her parents. Will they be supportive? Will they beat her? Will they kick her out of the house? Will they force her to carry the pregnancy to term to "teach her a lesson?" The young woman knows best the answers to these questions.

Many of us parents have worked hard to ensure that our children will turn to us with serious problems. But in dysfunctional families, notification could be extremely dangerous. Laws must not be written that further jeopardize teems already caught in traumatic circumstances.



College Hill United Methodist

February 14, 1990

Ginger Barr, Chairwoman,
The Federal & State
Affairs Committee
State Capitol
Topeka, KS 66612

Dear Chairwoman Barr and Members of the Federal & State Affairs Committee:

RE: Parental Notification regarding the right to Abortion Services

My name is George Gardner and I am senior minister of College Hill United Methodist Church in Wichita. I am submitting my testimony to you because of my concern about the issue of Parental Notification for Abortion Services.

As a minister I would like to think that this issue would not be a subject for discussion. It would be my hope that young people and parents would have open communication in such a way that any issue or problem could be discussed within the family circle. However, having been a minister for thirty years in the state of Kansas, I am realistic enough to know that open communication between children and parents cannot be automatically assumed. Let me illustrate this with the following:

> I recall a young woman who became pregnant by her father. She came to me wanting to know what to do. At my suggestion we made an appointment to visit with both her mother and father. The father denied the daughter's charge and the mother accused the daughter of having lied to cover up a boyfriend relationship. The young woman was ejected from the home. Several years later the mother came to me and said, "I was wrong. I rejected my daughter to protect my marriage with her

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 8
February 20, 1990

2930 EAST FIRST STREET / WICHITA, KANSAS 67214 / (316) 683-4643

> father. I knew she was telling the truth but I could not face it."

I would also like to say that sometimes communication is not possible even when the family openly discusses mutual problems. Let me illustrate:

> I recall from my personal experience the young woman who came to me and said, "I value my parents too much to tell them I am pregnant." I worked to encourage open communication with her parents, but she continued to refuse because of what she felt would bring shame to her family. It is important here to understand that this was a very strong and supportive family, but in this young woman's mind, it was because she loved them that she would not involve them in her problem. This event took place in our state prior to the legislation which allows a woman the right to choose abortion services. At that time the option she chose was to marry and then because she was married, it was permissible for her to seek an abortion. Both the young woman and young man in this case were college students and could not support a child at that time in their lives. Sadly, neither felt the openness to share their situation with their families. What of their marriage? After college graduation, their wedding was celebrated in the church and the parents never knew or know now that they had been married in college.

These two illustrations are legion in my ministerial experience. It occurs to me that where parents and young people can communicate, issues will be openly discussed and legislation such as Parental Notification is not necessary. But in many cases, as indicated by the above illustrations, Parental Notification for Abortion Services is not feasible or even practical. So often young people are not in a position where they can speak to their parents. It is at this place that a young person will often seek out a teacher, counselor, priest, rabbi, or minister for their counsel.

It is at this point that a young person needs the freedom to decide with whom to speak, who can keep their confidence, and who can give them options for their situation. If young people have the freedom, they are

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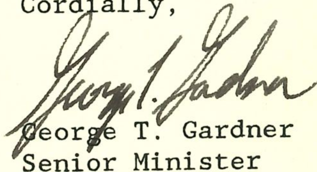
given the opportunity to not only communicate with their parents, but in a family situation where this is not possible, to seek counsel to help them in their immediate situation.

Parental Notification is one of those issues which on the surface seems very positive, but it is far too simplistic to deal with the real life situation of young people. Issues of reproductive choice need to belong to the young men and women facing these decisions.

Perhaps some day if we ever have an ideal world, an issue such as Parental Notification will not need to be debated. But until that day arrives, we as a society need to understand that young people facing reproductive choices cannot always speak to their family members. Let us help them with difficult choices by giving them the freedom to seek counsel and to deal with their lives in the most realistic way possible.

Thank you for reading my testimony.

Cordially,



George T. Gardner
Senior Minister

GTG/llh

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2-20-90

LEAGUE OF WOMEN VOTERS OF KANSAS
919½ South Kansas Avenue   Topeka, KS 66612   (913) 234-5152

February 20, 1990

STATEMENT IN OPPOSITION TO THE CONCEPT OF MANDATING PARENTAL NOTIFICATION.

Chairman Barr and Members of the Committee:

I represent the League of Women Voters of Kansas, a 70-year old organization dedicated to study and action on a wide range of governmental issues.

As we have stated before, in this room, the selection of options available to women, of all ages, who face the condition of unintended pregnancy, should remain a private and personal matter. We doubt that governmental regulations of abortion would contribute toward solving the major problem which is, still, unintended pregnancy.

Requiring notification of minors' parents creates a significant burden on a young womans' right to an abortion, as it delays or dissuades teens from seeking medical care, increasing their health risks.

Adolescents already delay seeking medical care until relatively late in pregnancy, so they are more likely than older women to have a 2nd trimester abortion.

All of us have heard that parental notification "worked" in Minnesota because the number of teenage abortions and pregnancies dropped between the years of 1981 and 1986. At the same time, Minnesota record-keeping also shows a parallel decline in birth and abortion rates for 18 and 19 year olds who were not covered by the restrictions of the notification law.

Perhaps it is more appropriate to conclude that other factors must have contributed to some modifications in the sexual activity of young people. Greater awareness of sexually transmitted diseases, as well as increased use of contraceptives, may have contributed to the welcome drop in the numbers of teenage abortions during those years before the law was struck down.

In closing, let me say again, League believes that the state's most effective role should be as educator in helping to prevent unintended preganancies. Why not increase the use of school classrooms, health departments, radio, TV, newspapers.... whatever will reach our kids..

Thank you for the opportunity to present our statement to you today.

Myrna Stringer, LWVK Lobby Coordinator
Barbara Reinert, LWVK Lobbyist

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 9
February 20, 1990

STATEMENT CONCERNING HOUSE BILL NO. 2779

by Karen S. Sexton

Thank you for the opportunity to speak before you today on a topic of monumental importance to the young women of the state of Kansas. I am an advanced level masters degree student in the School of Social Welfare at the University of Kansas. As a student I have spent many hours counseling women of all ages in regard to complicated pregnancy decisions. Since January of 1989 I have facilitated support groups for women who have experienced an abortion.

I am here today to urge you emphatically, not to pass a bill that would require young women to notify their parent/s or guardian/s about their decision to have an abortion. I plan to describe to you the damage this action could cause in the lives of our Kansas youth.

Please consider the information provided in an article by Zakus and Wilday (Social Work in Health Care, Vol. 12(4), Summer 1987). In this article it is pointed out that "Teenagers have consistently waited until later in their pregnancy to seek termination by abortion." The article also says, "Second trimester abortions are higher risk for medical complications than first trimester ones...They are generally considered to be more traumatic, physically and psychologically, for the patient."

I present this information to you since this bill before us today would bring about further delays in some teenager's

abortions and therefore, create unnecessary physical and psychological trauma.

The dangers I have mentioned here are very real to me since I have talked to young women about their experiences and have heard from them stories that they cannot report to you themselves because of social stigma and condemnation.

Some young women tell me that they come from loving and supportive families who are willing to support them with their pregnancy decisions. In these families the unplanned pregnancy becomes a time when they can pull together and grow closer in their understanding of one another.

On the other hand, when I ask some young women if they have talked about their pregnancy with a parent or family member, they look at me with a stark and overwhelming look of terror and say, "They would kill me!" Some of these young women have been beaten in a manor many of us would not be able to comprehend. Some of them have been forced into sexual liaisons with family members. Many of them have been afraid to seek help from anyone, but finally reach a clinic with the help of a school counselor. When they do reach a clinic or doctor's office, they are usually well advanced in their pregnancy and have little time to spare before they reach a point in their pregnancy when they must experience a more complicated procedure if they choose to have an abortion.

This bill punishes young women by either requiring them to contact potentially abusive parents or to go through a laborious

and frightening legal system that serves only to condemn and not to serve. The department of social and rehabilitation services is already overburdened and short staffed with too few financial resources. This bill is unworkable since there is no way SRS can meet the extra demand of counseling minors in the critical time frame necessary for safe abortion services. A week can make the difference between a simple uncomplicated procedure and a two day complicated procedure.

Please imagine for a moment how it would have felt, when you were 14 years old, to face an SRS worker who is pressed for time, the embarrassment of discussing an unplanned pregnancy with strangers, and the extreme anxiety of waiting while other people made critical decisions about your life. Many teenagers would rather go through an illegal abortion and risk their life than to face this kind of humiliation.

I also propose that this bill would seriously limit the physicians, nurses and social workers who currently work with young women in regard to pregnancy decisions. Young women who are poor, disadvantaged, and/or abused would once again suffer in the two tiered system where those who have money have services and those who don't seek back alley butchers or self induce an abortion with knitting needles or pills.

Limitations on abortion services do not prevent abortions-- they only make them lethal! While you consider this bill I plead that you remember the eyes that I have seen who plead for our help-- not our condemnation.

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2-20-90

Marilyn Harp
President, Board of Directors
Planned Parenthood of Kansas
February 20, 1990

Testimony concerning Parental Notification
House Bills 2663 and 2779

I am Marilyn Harp, Board President of Planned Parenthood of Kansas. I am here today testifying on behalf of that organization. I am also an attorney, practicing law in Wichita.

Planned Parenthood of Kansas is the local affiliate of the oldest and largest, voluntary family planning organization in the country. We are here testifying today on behalf of nearly 600 teenage patients of our medical clinics in 1989, and the thousands of teens we saw in educational settings last year.

I would like to speak first to the ideas presented in House Bill 2663, introduced by Representative Lucas and co-sponsors.

While this bill has been called a "parental notification" bill, the name is erroneous. The effects of this bill are so broad that this title doesn't fit.

Look first at the section defining abortion - "an act, procedure or use of any instrument, medicine or drug ... with the intent and result of producing the premature expulsion of the life of the preborn child." By definition, the preborn child includes all stages of development after fertilization. The effect of these two definitions is quite broad. The medical community is not certain just how some birth control methods work. However, it is widely held that all IUD's and many forms of birth control pills work after fertilization. Parents would have to be notified before a physician could prescribe these forms of birth control to teens.

This proposed legislation does exactly what many extremists in the anti-abortion movement want to accomplish. It would remove from many Kansas women forms of birth control that are safely and widely used now. It moves us backward 25 years to the heart of the legislation that the Supreme Court ruled Unconstitutional in Griswold vs. Connecticut. House Bill 2663 wants to make birth control illegal.

Next, look at the "findings" contained in Section 1 of the proposed legislation.

The legislature would find that "there exist compelling and important state interests in protecting minors against their own immaturity". While the state would be working to protect minors against their own "immaturity" in deciding whether to terminate the pregnancy, it supposes that they are mature enough to accomplish the difficult task of raising the child that is born.

The legislature also would find that "the medical, emotional, and psychological consequences of abortion are serious and of indeterminable duration, particularly when the patient is a minor". This finding is in direct opposition to a recent study conducted by Laurie Schwab Zabin of the Johns Hopkins School of Hygiene and Public Health for the National Institutes of Child Health and Human Development, and reported by the Alan Guttmacher Institute in Family Planning Perspectives. The study found that teenagers who become pregnant and have abortions are likely to be better off financially and have fewer emotional problems than those who carry their pregnancies to term. The teens were recruited for the study through two Baltimore clinics. They were divided into three groups: those who were pregnant and had abortions, those who carried their pregnancies to term and those who were not pregnant. The study followed these women for two years. The study also found that the group that had the abortions were more likely to graduate or progress in their education that the other two groups. They also were more likely to use birth control consistently than either of the other groups and, thus, less likely to become pregnant again.

Finally, the legislature would "find" that "parental consultation regarding abortion is desirable and in the best interest of the minor". The testimony you will hear today will be filled with examples of young women who know their families, who know the pressures on their mothers, who know the rage of their fathers or step-fathers. These women fear things far worse than "grounding" or a termination of the relationship with their boyfriend. These women fear actual violence on themselves or their mothers. They fear that their mistake will be the last straw that tumbles a family member on another binge of drinking or another bout with mental illness. For these women, parental consultation is not desirable and in their best interest.

Under current law, House Bill 2663 is not Constitutional. Since 1979, the U.S. Supreme Court has recognized the need for all parental notification laws to have a judicial by-pass, a mechanism for teens to get court approval to waive notification of their parents. While this issue is presently before the Supreme Court, it would be premature to suppose that that the Court will reverse itself altogether and eliminate the judicial by-pass requirement.

Finally, House Bill 2663 makes no provision for minors in SRS custody. It specifically eliminates SRS as a "parent". So, unless we assume all teens in SRS custody are emancipated and entitled to make their own decision, this bill would prevent any of these young women from obtaining an abortion, since the notice requirement of the bill could not be met.

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Testimony on H.B. 2663 & 2779
Marilyn Harp

I now want to turn to the issue of parental notification in general, as it is encompassed in both House Bill 2663 and House Bill 2779.

As you consider this legislation, realize that most parents already know of their daughter's pregnancy and of their decision to have an abortion. National statistics back up what is said by local clinics. An Alan Guttmacher Institute publication reports a 1980 study that 75% of minors age 15 and younger have told at least one parent. The average for all minors is 55%.

Because a number of other states have parental notification laws, we can view the affect of these laws in those states. Newsweek magazine quotes statistics from Minnesota, which had a parental notification law from 1981 until 1986, when a Federal district court found it Unconstitutional. Soon after the law took effect, the birth rate in Minnesota climbed 38.4% for 15 to 17 year olds, while the birth rate for 18-19 year olds, not covered by the regulation, rose just .3 percent. Parental notification has the effect of more young women - more 15 to 17 year olds - having children.

Where teenage pregnancy is a problem, this type of legislation is not a solution. Kansas ranks 19th in the nation in the rate of white teen pregnancies, 7th in the nation in the rate of black teens who become pregnant.

While some view the benefits of parental notification purely from the "benefit" of reducing the number of abortions, you must look at the situation more broadly.

- only half of the women who become mothers at 17 or younger finish high school
- few (less than 8%) of teen mothers relinquish their babies for adoption
- the babies born to teenagers in 1986 will cost the U.S. $5.5 billion over the next 20 years
- two-thirds of teenage mothers live below the poverty level, dependent on ADC and other government programs, recently cut because of funding shortages.

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Some legislatures have expressed support for parental notification because of comparison with parental consent needed for less important medical procedures. When the Supreme Court ruled the right to an abortion was protected under a "right to privacy", it gave this medical procedure a special medical status. That status is not given to headache relief or ear piercing. Thus, parental consent can be required for "less" important things. Parental consent loses for teenagers the right to privacy available to older women. In addition, parental notification is not needed now, nor is it proposed for prenatal care, family planning or giving a child up for adoption. Parental consent has the effect of making one option for dealing with an unwanted pregnancy more burdensome than the option of giving birth or relinquishing the child for adoption. The state does not take a neutral position among options, but requires parental notification for only one option pursued by the teen.

The practicality of parental notification procedures in complicated by family structures today. Alan Guttmacher Institute statistics show that 30% of girls 15-17 years old don't live with both their parents. Half of these girls have had no contact with one parent in the past year. The Kansas preference for giving divorced parents "joint" custody of minor children means that many parents have legal custody, but no real contact with their children. In addition, 5% of teenage girls don't live with either parent. These statistics indicate a large number of girls would have difficulty finding both parents to give the actual notice required by these laws.

This committee should also be concerned about any delays that may be involved in notice to parents. While some assume that all parents will discourage their daughters from obtaining an abortion, this is clearly not going to be the case. So, some abortions, delayed by the notice requirement will occur. While abortion is not an unsafe procedure, it is safest and cheapest when done early. Parental notification laws do create delays. In Minnesota, after parental notification the proportion of minor having abortions in the second trimester (after 12 weeks) went up 12%. The 18 years and older patients having second trimester procedures went down 1%.

The judicial bypass procedure in House Bill 2779 could take up to 4 weeks, if the maximum of all time limits was used. This length of delay has an affect on the teenagers involved. In addition, it may be Unconstitutional. In the Akron Center case, now before the Supreme Court, the Appeals Court ruled a three week bypass procedure Unconstitutional, because it took too long.

One other problem with the judicial bypass procedure is the requirement that the notification requirement is waived, if SRS or the Court does not meet the proscribed deadlines. This does not leave the medical provider with anything in writing that waives the notice. It is very likely, given the penalties involved, that providers will be willing to proceed without written permission to do so.

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Finally, the alternatives to notice include a notarized statement from the parents that they have been informed. The notary requirement has been examined by Courts and found Unconstitutional because of the delay involved in getting to a notary and the loss of confidentiality and breach of privacy involved in having a notary witness the signature.

Consequences of parental notification are that kids lives will be torn part by their parent's reaction. If passed, the State must create services to provide immediate help to these young, pregnant girls who will be thrown out of their homes when the notice comes and also long-term resources to rebuild these family relationships.

The irony of these parental notification bills is best seen in its effect on a percentage of pregnant teens. Some teenagers find love lacking in their homes. Their solution is often to get involved in intimate relationships before they are ready to handle the consequences. They hope in this relationship to find the love they are lacking. Then, if they get pregnant, they are sent back to that family for "love and support" to deal with the consequences of an unintended pregnancy. These teenagers cannot handle the consequences of a parental notification law.

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February 20, 1990

Presentation: Charlotte Elder, R.N.

House of Representatives
State of Kansas
State and Federal Affairs Committee
Ginger Barr - Chairperson

For 10 years I had the privilege of serving as a Public Health Nurse here in Shawnee County. During my years as a field nurse, I was able to be with families in their homes, in schools and in their churches and communities. In addition to making home visits, I served as the nurse for the Shawnee County Youth Center, taught child care classes at the Teen Aid School, provided nursing care in the Shawnee County Jail, and spent three years as supervisor of the Health Department outpatient clinics. These clinics included areas of Communicable Disease, Sexually Transmitted Diseases and Family Planning. I taught expectant parents classes providing instruction on delivery, parenting, normal growth and development. For 5 years I was able to watch some parents begin their career as parents.

Over the years my assignments allowed me to be confidant, teacher, helper, observer, and student of the family process. I observed families at work, at play, in crisis, and on the other side of crisis.

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 12
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One family crisis was the pregnancy of a teenager.

I was surprised at the number of different and effective ways a teenage pregnancy was dealt with.

I learned over the years there were different patterns in the way families dealt with this crisis. The patterns seemed to fall into the following styles.

Some families confronted the crisis "head on". Mother realized daughter's menstrual cycle had changed, brought it up with the daughter, they approached Dad - sought outside counsel and came to a decision.

Another style was for someone to "go tell Grandma". "Someone" could be a suspecting brother, an intuitive mother, or the teen herself. Grandma seemed wise, and informed the mother, who might never mention it to daughter until later years, if then. Grandma guided the situation as she did in other family matters. She used her judgement with regard to who should or should not be informed. Grandma discussed the situation with the granddaughter and in the background with the mother. Decisions were made and the crisis was resolved.

Another style was for the entire family - brothers, sisters, Mom, and Dad - to be aware of daughter's morning sickness and

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change in behavior. Support and caring were immediately forthcoming but not necessarily in the form of words. A brother would offer her a ride to school and fit his schedule to hers. A sister would loan her favorite clothes that before had not been available. Extra money came in small amounts from Mom "in case she needed anything". Dad gave Mom extra money in case Sis needed something. She was told she could borrow the car, or if she didn't feel well enough to go to school, Dad would provide an excuse. Most often an aunt or friend was called. Sis is "sick", would you come and talk to her? In these families the behavior had well understood meaning. Support was being given, guidance was being provided, all without formal notification.

In the above parenting styles, even in a non-talking family, if the daughter chose to terminate the pregnancy, money was arranged for by someone in the support network who acquired the funds. These non-direct styles of parenting puzzled me then, and do to this day. However, I have been able to watch some of these children grow into adulthood and I must say those parents turned out some pretty fine people.

I also observed dysfunctional families operate with unspoken rules. In fact the members of the dysfunctional family are much more accurate with their understanding of unspoken rules because a miscalculation is so much more serious. The teenager faced with a pregnancy knew it was essential that it be dealt

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with in a way that would cause the least upheaval and damage to her fragile family. If telling a violent father was going to prove harmful to her mother, she would never do that. If telling a volatile mother would endanger a little brother, she would not do that.

It surprised me to see the strength some of these teens possessed. At all costs they could not and would not risk the safety and well being of members of their own family. They turned to a person they had trusted in the past. Sometimes it was a teacher or a coach. Sometimes they sought the help of public agencies, their grandparents or even parents of friends.

I observed that all parents approached the teenage pregnancy the same way they had approached other serious family matters. If it was their style to talk about a crisis - they talked. If their style was to involve Mom only in a crisis - that is what they did. If an involvement of Grandma or a preacher was the norm - they were signaled. If guiding someone through a crisis with unspoken communication was their style - that is what they did.

These were loving and caring families. The religious teaching continued. The moral code was passed on. The families individual expectations were very clear to their children. The crisis was handled in a way in which the parents could function

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at their best. I realized the different styles of parenting had deep roots, significant meaning, and for many families good results.

The parenting style developed by the parents, their parents, and the parents before them had allowed them again to sustain a disappointing and serious situation without fracturing the family relationship.

In the families I saw there was no absence of the knowledge of the pregnancy. That knowledge came not from an outside source but from their well honed skills of observing their childrens change in habit, health, behavior. Parents know when someone is up late crying, or spending hours worrying, or in the bathroom with "the flu".

Using their individual parenting styles they successfully got through the crisis of a teen pregnancy. Sometimes the pregnancy was terminated, sometimes it was continued. Occasionally an adoption occurred.

Using their own strength and individual parenting styles the parents drew upon the wisdom of people who had been trustworthy and helpful in the past. They utilized family and community resources, and made their way through this crisis.

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There are those in our state who wish everyone dealt with an unplanned pregnancy in a uniform way. This is a private and personal crisis and parenting during a crisis is a highly personal and private affair. To invite the government behind their closed doors would limit and interrupt their parenting capabilities and options.

Thank you for your time and thank you for listening.

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2-20-90

Charlotte Elder, RN

Birthplace: Norton, Kansas, September 20, 1944

Marital Status: Married

Children: Debbie, Brad and Sherry

Education: Morland High School, Morland, Kansas 1963
Kansas Wesleyan, Salina, Kansas, RN Degree, 1965

Publications: WHEN IT'S YOUR KID! THE CRISIS OF DRUGS, 1978, P. 99, Publisher Lowell Press.

Experience: Topeka-Shawnee County Health Department, Public Health Nurse

Home Visiting, 1965-1966
Instructor of Expectant Parents' Classes, 1967-1972
Instructor at Florence Crittendon Home
(Maternal and child health classes), 1967
Nurse for Shawnee County Youth Center, 1970-1972
Counseling in Mental and Physical Health; Classes on Venereal Disease, Human Sexuality and Normal Adolescent Growth and Development
Nurse for Jail Infirmary, Shawnee County Jail, 1971
Teen Aid Public School for Pregnant Teenagers, 1971
Counseling and teaching; Classes on Maternal and Child Health, Preparation for Labor and Delivery, Mothering, Infant Care, Normal Growth and Development
Representative/Participant in Drug Abuse Conference University of California at San Francisco, 1973
Nurse for Drug Abuse Program, 1971-1975
Observer at Fort Worth Federal Drug Rehabilitation·Facility Representative of Topeka-Shawnee County Health Department funded by Drug Enforcement Agency, Federal Government, 1973

Topeka-Shawnee County Health Department, Out-Patient Clinic Supervisor, 1972-1975

Counseling with children and their parents
Supervisor of all out-patient clinic programs including: Tuberculosis, Venereal Disease, Drug Abuse, Communicable Diseases, Family Planning, Adolescent Services and Youth Health Services

Private Practice; Glenn O. Bair, M.D., client load primarily heroin addicts, Memorial Hospital, 1974-1977

Adolescent Clinic, Youth Health Services, Inc., St. Francis Hospital and Medical Center, 1977-1979

Office Manager for Glenn O. Bair, M.D., Topeka, Kansas, 1975 to date

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Nurse Associate for Internal Medicine Practice, Glenn O. Bair, M.D., Topeka, Kansas, 1975 to date

Director PMS Clinic, 1982 to date

Nursing Consultant to Brighton Place Nursing Home, 1983 to date

Lecturer, Pittsburg State University, June, 1989

Community Services:

Lecturer for many high schools and junior high schools in Shawnee County, 1970-1975. Lectures on venereal disease, drugs, family planning, and adolescent development

Co-Teacher, classes for parents of drug abusers, 1972

Numerous speeches on drug abuse to civic clubs, PTA's and school boards, 1972-1974

Panelist on Drug Abuse, Regional Nurse's Association, 1972

Teacher of In-Service Education courses in several community hospitals on the nurse's role in the drug using patient, 1972-1975

Consultant, Community Addictive Treatment Center, 1975-1977

Individual and Family Therapist, Supervision of Adolescent Program, Suite 400, 1975-1977

Board of Directors, Carriage House, 1979

Co-Conducted In-Service Nurses' Training for USD 501, Jan. 1983

Presentation to the State of Kansas, Department of Social and Rehabilitation Services, Topeka Area Office, Social Service Staff, regarding Premenstrual Syndrome, April, 1983

Member of Malpractice Screening Panel, Review of Nursing Malpractice case, October, 1983

Presentation at the YWCA regarding Premenstrual Syndrome, October 1983

Presentation: Kansas Association for Marriage and Family Therapy-Sixth Annual Fall Conference, Nov. 16, 1984, Wichita, Kansas

Presentation: Second Annual Conference: The Mental Health Session and Private Practice, Feb. 16, 1985, Washburn Univ.

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Speech: PMS-Association of Operating Room Nurses, St. Francis Hospital and Medical Center, Topeka, Kansas, Feb. 7, 1986

Speech on PMS to Family Planning Seminar, Emporia, Kansas, April 7, 1986

Speech: Sixth Annual Kansas Nutrition Conference: "New Dimensions in Diet and Treatment of Premenstrual Syndrome", Feb. 19, 1987, Manhattan, Kansas

Speaker: Women's Day-Labette County Junior College, Parsons, KS, March, 1987

Speech: Juvenile Protection Court Services, Shawnee County, Oct. 30, 1987

Speaker: Pittsburg State University, Co-presenter with Dr. Glenn Bair, Psychological Aspects of PMS, June 9 & 10, 1989

Memberships: Member of the Working Committee of the Steering Committee of The Dalton Society, May, 1987-1990

Trustee, The Dalton Society, 1987-1990

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TRANSCRIPTION
KAREN BELL
Before the HOUSE FEDERAL & STATE AFFAIRS COMMITTEE
February 20, 1990

I would just say that my life is over because my daughter is dead. Her and I were the best of friends. We talked about everything. She didn't really believe in abortion, she wanted to live and get married and have children. But she fell in love with a boy and when she got in trouble, she went to him and he said, "Get the hell out of my life, I don't want you". She did --- forever.

Then she went to Planned Parenthood and I am very thankful for them. And they told her, "Becky, you must tell your mom or your dad if you want an abortion.

She said, "I can't because I love them too much. They are my life. I won't hurt them. I won't tell."

Becky, the next thing you can do is go to a judge who is known to be pro-life and plead. She was scared to death, she couldn't even get to the south side of town. She was just a young kid. Then the next choice was, or you can go where it is legal, Becky. You can go to Kentucky or Kansas or any of those other places. I mean they are known, the children know, it is on the street.

She couldn't go, she didn't have any money and she couldn't drive and she couldn't get away from me because I watched her like a hawk. She was my baby, my life, and I think, why did this happen? I didn't know laws, I didn't care because -- not me, I'm the best mom in the world. I was home all the time, counseling. I'm a teacher. I go to church. Not anymore because my girl is dead and I think because of the law. It gave her no choice -- she was desperate. She went to a party on Saturday night, she said, which wasn't even like Becky because she never even went out. And when she came home, she said, "Mom I just want to go to bed and go to sleep." She went to work the next day, and the next day after that she went to school. To a Catholic school. She came home and she went to bed and she never got up again.

She never told <u>anyone</u> what she did on that Saturday night. Becky couldn't kill anything or hurt anything. I know that she didn't do something to herself but somebody said, "Becky, we'll fix it so you can stay home with your mom and dad. Everything will be O.K." She hemorrhaged and died in the hospital on Friday. And the last thing she said to me was, "Mom, I love you." She didn't think she was going to die and we didn't either. And when we came back, it happened. And that's the last thing I can remember, "Mommy, I love you" and it comes from a family that loved each other not a family that didn't

like each other. Becky believed in God, she believed in everything. She didn't want to hurt anything but she wanted to be with mom and dad in the end.

And I said, "Why didn't you tell your brother?"

Bill (son) said, "Mom, I would have told you and Dad because I would have been afraid for my sister." We loved each other so much we didn't want to hurt each other and Becky is in a graveyard. She was the best kid in the world, my little girl. And if it can happen to us, God help you all sitting there, and looking, it can happen to you. And if you have a daughter, think about it when she falls in love for the first time. And you gentlemen, remember the girls you get in trouble. I think all of you remember those days of love. Thank you.

Planned Parenthood®
Of Kansas, Inc.

TO: **Members of the House Federal and State Affairs Committee**

FROM: Marian Shapiro, Director, Planned Parenthood of Kansas, Hays Clinic

RE: Mandatory Notification Requirements

My name is Marian Shaprio and I appreciate the opportunity to testify before this committee. My husband and I have lived in Hays and reared our two children there for the past 18 years. I have had 14 years experience as a pregnancy counselor and sexuality educator. I am certified by the **American Association of Sex Educators, Counselors and Therapists.** Having worked with many pregnant teens, and often their parents, I believe I can provide you with relevant information about the problems and needs of minors when contemplating an abortion and the important part their parents play in this crisis.

Everyone would prefer that young women would make important decisions about pregnancy with the love and support of their parents. **The majority of teens do have love and support from their parents!** Usually a very scared young woman comes in to our office for a pregnancy test. If the test is positive, our first step is to encourage the minor to tell her parents. For some this is a natural next step and they need little encouragement. For many it is a difficult thing to do. I explain to them that theire is no one in the world who loves you as much as your parents do and give them the opportunity to take home a letter I wrote for parents to help the minor break the news. (This letter is attached for you to read.) Some teens don't need a letter like this and some have told me that the letter really helps. **But a few teens adamantly insist that there would be an absolute disaster if they told their parents. In some sad cases the teenager is right and there is no mature adult to provide love and support to them.** A dramatic example of this happened to a former colleague of mine, Don Shaw, formerly a Kansas high school coach and now administrator of the sexuality education program for the Denver school system. **A pregnant student came to him for help and he advised her, as I do, to go home and talk to her parents. She said, "you don't know my parents. Telling them will definitely make things much worse." He told her he knew it was hard to fact the music but insisted it is best for parents to know, so they can helpyou. The next day she came to school with black eyes and all beaten up. Her father had thrown her across the room into the wall.**

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2226 East Central Wichita, Kansas 67214-4494 316 263-7575

In several situations the **boy's** parents or the **grandmother** of the teen were more supportive and approachable than her own parents. In one case, a teen living in a foster home chose not to confide in her mother who had been hospitalized several times for depression and was not a stable resource for her. Instead she confided in a family for whom she did babysitting and they supported her through her decision. Teenagers, many times, know their family situation best!

In stark contrast to these sad, lonely teenagers without love and support is the family I saw last week. It was so touching to see tears of love and caring stream down the faces of the father, mother, sister and boyfriend who accompanied one scared young woman to my office. They were all solidly ready to support her and see her through. Thank goodness this is more typical than the teens who fear going home with a problem and have no support. I've found, often, that the number one concern for young women is fear of hurting and disappointing their parents. More than a few teen suicides have occurred because the pregnant teen could not face the anticipated disappointment of her parents. **The question boils down to who decides this young woman's fate: the young woman who must live with the decision for the rest of her life? the young woman's parents? or the State of Kansas?**

Forcing teens to tell their parents will certainly not magically create love and support. There are dysfunctional homes with abusive parents, alcoholic parents, immature and emotionally unstable parents who are not able to support, nurture or help their children in trouble and may even harm their children. Teens and counselors need the flexibility to make alternative arrangements, if that is in the child's best interest ...keeping in mind that the **majority of minors do go to their parents.**

Many who push for legislation to prevent abortion by requiring parental notification, or consent, do so to prevent abortion and to harass teens, which may delay the pregnancy long enough so the teen must deliver the baby.**Their next step is to completely prevent birth control.** There may be some who are acting on the false assumption that if parents are aware that their daughter is planning to have an abortion they will want to stop her. (There are parents who will also force their daughter to get an abortion against her will.) Many parents say, "I never in a million years thought I would ever take my daughter for an abortion. I have always been against abortion. But now that it is **my** daughter, I think it is the only choice. When minors have a baby at such a young age.. the majority of teen mothers do not finish school; are forced into obtaining welfare to care for both themselves and their baby, which will leave them in a lifetime cycle of poverty: both the child mother and her baby; etc.

The truth is: most people think they are against abortion until they or someone they know needs the abortion. A perfect example of this was the mother who came to me recently. Her daughter had decided to have an abortion (after she and I discussed all the alternatives). Her daughter appeared at peace with her decision...she was not quite 16 and her biggest concern was to not hurt her mother. When the mother came in she told me she had a strong religious background and had real problems with abortion. The mother knew this was her daughter's decision to make, not hers, and stated she would support her daughter, but, again, abortion was hard for her to accept. After exploring her feelings, I suggested forgetting her daughter for a minute. I asked the mother, "if it were **you** who was pregnant at 15, what do you think **you** would want to do?" After a thoughtful silence she replied, "you know, I think I would make the same choice my daughter did." The mother told her daughter of this realization, which was a tremendous relief to the daughter, and appeared to bring them much closer as they went through this crisis together.

With that I will close. Thank you for the opportunity of appearing before you today. I would be happy to answer any questions you might have.

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Planned Parenthood®
Of Kansas, Inc.

Dear Parent,

I don't know you, but I have just talked with your daughter. With her permission I am sending this letter through her to you. She came to my office to find out if she is pregnant. Our test came out positive, indicating that she is pregnant. She is facing a crisis in her life and needs your understanding and support at this time.

There are many things that worry a young single woman with an unplanned and unexpected pregnancy. She worries about how to handle becoming a mother when she is not married, probably has not finished school, and maybe has no job. She may wonder if she will have any help from the young man she is involved with and how he will react. Will he resent her, stick by her, or run away from the responsibility as so many do? She may wonder if their relationship is stable enough to even wish for marriage.

Probably the most common worry that I've heard expressed in my years of experience counseling young women is, "How am I ever going to tell my parents? They will be so upset, so hurt, or so mad." Some worry that they will be rejected or kicked out of the house. They worry about where they will find the money to pay for having a baby and supporting the two of them. Or they may consider terminating the pregnancy and wonder how they can pay for an abortion or get to the doctor if it's an out of town trip.

As parents, this is probably as much of a crisis for you as it is for her, and even more of a shock. Maybe you were not even aware that your daughter was sexually active. It is usually very difficult for us as parents to think of our own children as sexual beings with strong feelings.

A common reaction from parents hearing this shocking news is to hit the ceiling initially. Then, once they've had time to adjust to the news and calm down, they often make every effort and sacrifice to help their daughters.

Often parents blame themselves. They feel they must have made a mistake somewhere along the way. How could this have happened? Let me assure you that pregnancy has happened in the closest of families, in the most devoutly religious families, in rich families and poor families. It is not useful or helpful at this time to try to place blame. Do not blame yourselves as parents! Your daughter is growing up in a society where she is exposed to very strong peer pressure and much exposure to sex on television, movies, and books. She has an adult body now, even if she is not a fully mature adult in your eyes. Unfortunately most young people lack adequate knowledge about reproduction, sexuality, feelings, values, relationships, decision making, and contraception.

I'm sure you care about your daughter very much, since you cared enough to read this long letter. And she obviously cares about you or it wouldn't be so hard for her to face you with this news and anticipate the hurt and disappointment in your face.

She has a tough time ahead of her and she needs your support now. Many of us have said to our kids, "We'll always love you no matter what happens." Kids are never sure whether we mean this. Now you have a chance to prove it.

If you would like to talk to a counselor, either alone or with your daughter, please call me at Planned Parenthood. I am here to listen, to offer support, to refer for medical services, or anything else I can do to help. If you feel angry, scared, hurt, or shocked, it may help to vent these feelings, so you can go on to be helpful and supportive of your daughter. Other people who might be helpful are your clergyman or woman, physician, or a social worker.

I hope that in time everything will work out for all concerned. Please call me if I can be of any assistance.

Sincerely, Marian Shapiro

Wichita — 2226 East Central, Wichita, Kansas 67214-4494 316 263-7575
Hays — 122 East 12th, Hays, Kansas 67601 913 628-2434

FSA
14-3
2-20-90

mony Before the Committee on Federal and State Affairs
Opposition to Notification Bills H2663 and H2779
February 20, 1990

Margo Smith
Director of Counseling
4401 West 109th Street
Overland Park, KS 66211

My name is Margo Smith. I have a Master's Degree in counseling and fifteen years' experience counseling women in the first and second trimester of pregnancy, about their problem pregnancies. I am also responsible for the training and on-going education of all counseling staff members.

The counseling sessions, which are mandatory at our clinic, are approximately one to one and a half hours long and cover five very important topics:

1. the patient's decision to have an abortion and alternatives to abortion,
2. an explanation of the abortion procedure,
3. follow-up care,
4. an explanation of the consent form and possible risks,
5. future birth control.

The procedure is explained in great detail so that the patient understands what will be taking place and approximately how it will feel. Patients are shown the instruments that are used and pictures of the reproductive organs to help facilitate an understanding of the procedure. Patients are given written instructions and watch a film on post-procedural aftercare, and the counselor reviews these instructions with them before they are dismissed from recovery. The counselor reads aloud the consent form and then explains in layperson language what those risks are and what consequences might occur as a result. The counselor also discusses various methods of birth control with the patient and helps her select a future method she would feel comfortable using. If the patient selects birth control pills, she watches a film that explains how pills work to prevent pregnancy, how to take pills properly, and what risks and side effects may occur.

By far the major emphasis in the counseling session is placed on the patient's decision to terminate the pregnancy. The counselor never just assumes that the patient wants an abortion because she has made an appointment. The counselor explores with the patient her reasons for not wanting to continue the pregnancy, and

her reasons for rejecting adoption or parenthood. If a patient expresses any doubts about the decision, she is given adoption, OB care, and counseling referrals and is told she will have to reschedule when she has had more time to explore her feelings and her alternatives. The counselor is also very concerned about the patient's emotional well-being after the procedure, so she explores with the patient what support she has from her partner, family, and friends. Most important is the patient's statement to the counselor that abortion is her choice. **If she tells the counselor that she is opposed to abortion, but is being pushed into terminating the pregnancy by her partner, family, or friends, the counselor then explains to her that it is policy not to perform the abortion.** She is then given information on counseling referrals, adoption, and OB care.

At a 2-week check-up after the procedure the patient's feelings about the abortion are reassessed. The availability of the clinic to help with questions or concerns is stressed to the patient throughout the experience.

Teenaged patients are also required to tell the counselor whether or not their parents have been informed of their pregnancy and the decision to have an abortion. The large majority of teen patients have told their parents and, in most instances, those parents become very supportive.

Patients who have not told their parents give a variety of reasons for not letting their parents know. Most teens are concerned that their parents will be disappointed in them, and would be embarrassed or ashamed to let their parents know. Typically, a teenage woman will tell you that she is the "good girl" in the family who is expected to get good grades, accomplish great things in the future, and never do anything to disappoint her parents, or tarnish her image. While she might not fear reprisals or opposition to her decision to have an abortion from her parents, she never the less will go to great lengths to avoid telling them that she has had sex and is now pregnant.

Some teens are victims of rape or incest and do not want to tell their parents because they are convinced their parents will not be supportive, especially if another family member is involved in the pregnancy. Many teens have told me that their parents have threatened them with all kinds of possible punishments if they have sex and get pregnant. Parents have been known to tell teen daughters they will put them in "corrective institutions," disown them, beat them, throw them out of the house, or prevent them from seeing their boyfriend. Some parents carry out such threats and others are merely attempting to scare their teenaged sons and daughters enough to prevent them from having sex. Regardless of the parents' intent, teenagers believe these threats, and they consequently often delay dealing with the pregnancy until they have reached the second or third trimester.

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Many patients are convinced that their parents, if they knew they were pregnant, would try to prevent them from having an abortion, and, in some cases, parents do try to prevent the abortion. I am reminded, in particular, of one teenaged patient I talked to some months ago. She came from Iowa and was dropped off at our clinic by a friend; as a result, she had no transportation to her motel. I was particularly concerned about her staying in Kansas City overnight by herself and asked why her parents weren't with her or helping her. She stated that her mother, who was taking care of the patient's eighteen-month-old son, was totally opposed to abortion and regularly picketed abortion clinics in the Iowa area. I told her that it sounded as though her mother would at least be supportive and help her raise another child if she chose to continue this pregnancy. At that point, she started crying and told me that she was pregnant by her stepfather, her mother's current husband, who was currently serving time in jail because he had sexually and physically abused her. She said her mother knew of the abuse; however, she did not know of the pregnancy but would still oppose the abortion even if she knew.

I am here testifying in opposition to parental notification on behalf of this teenaged women and others like her who would be ill-served by forcing parental notification for abortion.

I have concluded through my experience as a counselor that we should place the mental and physical health and safety of our young women above the issue of "parental rights".

FSA
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2-20-90

Planned Parenthood®
Of Kansas, Inc.

My name is Belva Ott. I am Director of Governmental Affairs and Community Relations for Planned Parenthood of Kansas, Inc. I would like to have my opposition to all parental notification and/or consent legislation stated for the record. Planned Parenthood of Kansas, Inc., supports the right of a woman to make individual, private decisions without any governmental interference. Planned Parenthood of Kansas, Inc., represents over 12,000 supporters, in addition to over 7,500 patients.

Respectfully submitted,

Belva Ott

Belva Ott
Director of Governmental Affairs
2-20-90

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 16
February 20, 1990

2226 East Central Wichita, Kansas 67214-4494 316 263-7575

George R. Tiller M.D. DABFP Medical Director
Cathy Reavis R.N., N.P. Director of Nursing
Elana Fritchman Administrative Director
Peggy Jarman Public Relations

Women's Health Care Services P.A.

5107 East Kellogg • Wichita, Kansas 67218 • (316) 684-5108

To; Members of the Federal and State Affairs Committee
From: Peggy J. Jarman
Regarding Parental Notification

Under the guise of promoting family communication, parental notification laws have been proposed. In practice, parental consent and notification laws significantly increase health risks to minors by causing medical services to be delayed and by impairing the ability of health care providers to give quality care. These laws punish young women for becoming pregnant. They do not promote family integrity, improve parent-child communication or help with the minor's decision making process. There is specific data from a five year history of a parental notification law in Minnesota from which we can learn. The evidence overwhelmingly proved that Minnesota's five year experiment with minor's lives was a dismal and unmitigating failure. Minnesota's parental notification law raised the teenage birth rate, created more teenage mothers with stunted and dependent lives, added a new generation of unwanted children with their attendant problems, increased the number of second trimester abortions for minors, and reduced the number of individual doctors willing to provide abortion services for minors. The law compromised sound medical care by creating a process that forced counselors to focus on reducing the anxiety of going to court rather than on the medical and emotional needs of their teenage patients. Family communication is not helped by forced notification. Major national, medical, health and professional organizations that have examined this issue have all concluded that forced notification is destructive and unethical. These laws are doomed to failure: love and communication between family members cannot be created by criminal statues. Studies show that the majority of pregnant minors voluntarily divulge their situation to at least one parent.

W.H.C.S.
Team Care

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 17
February 20, 1990

Those experienced with counseling teens agree that there are good reasons for those who choose not to communicate with their parents, but rely instead on the skilled and impartial support of counselors and others who are outside the emotionally charged and all too often dysfunctional family network. Judicial intervention, as an alternative to parental notification, only delays procedures and adds further trauma to an already extremely difficult situation.

Parents can ensure communication with their daughters about abortion by creating an atmosphere of openness and support. If minors do not tell their parents about abortion, it is because they know their home situation better and more intimately than the governor or legislators in Topeka. It cannot be assumed that the lack of family communication is the result of the absence of a parental notification law. Legislators recognized this when they enacted specific laws allowing consent at any age for the treatment of sexually transmitted disease or pregnancy care. The motivation for parental consent/notification laws, regardless of how they are disguised, is to limit abortions. They do not represent good public policy from a medical, an economic or a pyschological point of view.

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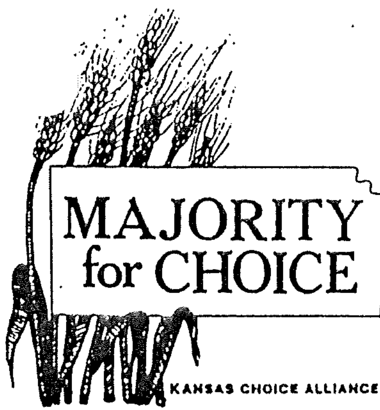
2-20-90



Statement for the House Federal
and State Affairs Committee

AAUW

ACLU OF KANSAS AND WESTERN MISSOURI

B'NAI B'RITH WOMEN

CHOICE COALITION OF GREATER KC

COMPREHENSIVE HEALTH FOR WOMEN

JEWISH COMMUNITY RELATIONS BUREAU

NCJW, GREATER KC SECTION

NOW (KANSAS)

NOW (KC URBAN)

NOW (SE KANSAS)

NOW (WICHITA)

NOW (CAPITOL CITY)

PLANNED PARENTHOOD OF GREATER KC

PLANNED PARENTHOOD OF KANSAS

PROCHOICE ACTION LEAGUE

RCAR OF KANSAS

WICHITA FAMILY PLANNING

WICHITA WOMENS CENTER

WOMEN'S HEALTH CARE CENTER

YWCA OF TOPEKA

YWCA OF WICHITA

RE: Parental Notification bills HB2663 and HB2779

FROM: The Kansas Choice Alliance
Beth Powers, Lobbyist

DATE: February 20, 1990

The Kansas Choice Alliance is a coalition of groups from across Kansas who hold pro-choice positions. Our combined membership totals over 85,000 Kansas voters.

The Alliance opposes parental notification and consent legislation of any kind.

Planned Parenthood®
Of Kansas, Inc.

My name is Margot Skinner and I am a member of the Board of Directors of Planned Parenthood of Kansas, Inc. I want it stated for the record that Planned Parenthood of Kansas, Inc., with over 12,000 supporters and over 7,500 patients, opposes any and all parental notification and consent legislation. This type of legislation is an unnecessary interference in individual private lives by a government body.

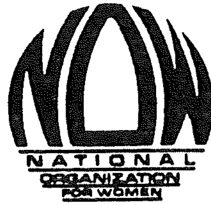
Respectfully submitted,

Margot Skinner

Margot Skinner
Member, Board of Directors
2-20-90

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 19
February 20, 1990

2226 East Central Wichita, Kansas 67214-4494 316 263-7575

KANSAS 

February 20, 1990

I am Jodie Van Meter, lobbyist for the Kansas chapters of the National Organization for Women. The members of NOW, men and women of Kansas, wish to be on the record in their opposition to House Bills 2663 and 2779 as well as any other bill which would impose restrictions of parental notification and/or consent on the fundamental right of a minor to choose to terminate a pregnancy.

I respectfully submit this document for the record in the hearing of the House Federal and State Affairs Committee. Thank you.

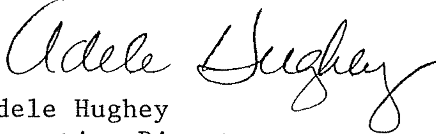
Jodie Van Meter
KNOW Lobbyist
117 S.W. 10th
Topeka, Kansas 66612
913-354-8254

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 20
February 20, 1990

COMPREHENSIVE HEALTH FOR WOMEN
Adele Hughey, Executive Director
4401 West 109th Street/I-435 & Roe
Overland Park, KS 66211
(913) 345-1400

My name is Adele Hughey and I represent Comprehensive Health for Women in Overland Park, Kansas. I would like to state for the record that we are opposed to any and all parental notification and/or consent legislation.

Respectfully submitted,



Adele Hughey
Executive Director
2-20-90

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 21
February 20, 1990

PROCHOICE ACTION LEAGUE
2324 E. Douglas
Wichita, KS 67214
(316) 267-4922

My name is Brenda Leerskov, and I represent over 15,000 Kansas citizens who are a part of ProChoice Action League. I would like it stated in the record that our organization opposes parental notification and/or consent legislation.

Respectfully submitted

Brenda Leerskov

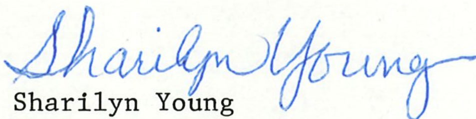
Brenda Leerskov
Public Affairs Director
2-20-90

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 22
February 20, 1990

Planned Parenthood®
Of Kansas, Inc.

My name is Sharilyn Young and I am Executive Director of Planned Parenthood of Kansas, Inc. This represents over 12,000 supporters as well as over 7,500 patients who come to us for their reproductive health care. I would like it stated as part of the record that Planned Parenthood of Kansas, Inc, opposes any and all parental notification and consent legislation. Instead of counterproductive laws that damage families, we need a society-wide commitment to reducing teen pregnancy. We need comprehensive sexuality education in schools and community settings; funding for low-cost, confidential birth control services for teens; and broad, meaningful job opportunities that will motivate young people to avoid threatening their futures with premature pregnancies.

Respectfully submitted,



Sharilyn Young
Executive Director
2-20-90

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 23
February 20, 1990

2226 East Central Wichita, Kansas 67214-4494 316 263-7575

TO: Rep. Ginger Barr, Chairperson, and Members, House Committee on Federal and State Affairs

FROM: Gordon Risk, M.D., President, American Civil Liberties Union of Kansas

DATE: 2/20/90

RE: Parental notification in cases of abortion

The state has an interest in promoting the health of its citizens. For minors, this typically means obtaining the consent of a parent or guardian for permission to undertake a medical procedure. As the state has recognized, however, if obtaining parental consent would inhibit or prevent the minor from obtaining indicated medical treatment, parental consent is waived. Thus, consent is waived in situations of medical emergency. Nor is it needed to undertake treatment of a sexual transmitted disease, the state recognizing that a requirement that the parents be involved might inhibit the minor from acting in his or her own best interest and obtaining the needed treatment. The state's interest in the health of the minor may thus mean bypassing the parents. As you will hear first-hand and as the U.S. Supreme Court recognized when it mandated the judicial bypass procedure, involvement of the parent or parents in the pregnant teenager's decision to abort may not be in the minor teenager's best interest, without regard to whether that "involvement" takes the form of notification or consent. (1)

A parental notification statute was in effect in Minnesota during the years 1981-85, during which time the percentage of minors getting second trimester abortions increased by 12%. (2) This increase in second trimester abortions for minors in Minnesota was contrary to the national pattern. As the district court noted in the Minnesota case, "a second trimester procedure entails significantly greater costs, inconvenience, and medical risks" (3) for the woman. During these same years, the number of pregnancies ending in abortion decreased in the 10-17 year old age group, while increasing for all other women (4), indicating that the Minnesota parental notification law had the effect of compelling minor women to carry their pregnancies to term. Government compelled childbirth is precisely the invasion of rights that was repudiated in Roe v. Wade. Teenagers, particularly young teenagers, have a two and a half times greater risk of death from continued pregnancy or childbirth than adult women. The same is true for rates of morbidity related to childbirth when compared to abortion. (5) The certain result of a parental notification bill would be an increase in the morbidity and mortality rates among pregnant teenagers and an increase in the number of unwanted children. This is a profound violation of a pregnant teenager's right to be treated with due process by the state.

As the National Research Council of the National Academy of Sciences noted in 1987: "On the basis of existing research, therefore, the contention that adolescents are unlikely or unable to make well-reasoned decisions or that they are especially vulnerable to serious psychological harm as a result of an abortion is not supported. On the contrary, research has shown that for most abortion patients, including adolescents, relief is a frequent reaction. Nor has research documented that legally required parental involvement helps teenage girls cope better with their choice to terminate the pregnancy. There is no evidence that it reduces the probability of subsequent unwanted pregnancies or serves any other purpose than to ensure that the parents are

aware of what their adolescent daughters are doing.(6) There is, however, growing evidence that parental statutes caused teenagers to delay their abortions, if for no other reason that they must undergo the de facto waiting period associated with finding a lawyer and gaining access to the courts." (7) "A delay of [a week or more] increases the medical risks associated with the abortion procedure to a statistical significant degree." (8) Parental notification statutes violate the state's interest in the health and welfare of the pregnant teenager and her right to equitable treatment.

(1) Akron, 462 U.S. at 427 n.10
(2) Appendix A4 - A5 (ACLU Reply Brief for Petitioners, Hodgson v. State of Minnesota)
(3) Hodgson, 648 F. Supp. at 763
(4) Appendix A1-A3 (One can see from these tables that the pregnancy rate for all young women decreased during the years 1981-85. There was no selective decrease for those affected by parental notification as some have alleged.)
(5) Parental Notice Laws, ACLU Reproductive Freedom Project, p. 4 (1986)
(6) New York Times, Jan. 25, 1990, p. A11. "A Federally financed study of unmarried sexually active teenage girls has found that those who obtained abortions did better economically and educationally and had fewer subsequent pregnancies than those who chose to bear children. Those who had abortions even fared better than those who were not pregnant at the start of the research project....It found that 4.5% of those chosing abortion experienced an adverse psychological change two years after the event as against 5.5% of those who have children and 10% of young women with negative pregnancy tests. This indicates that while the decision to have an abortion provided few psychological benefits, it did not, as anti-abortion groups often claim, cause any emotional damage."
(7) Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing. C. Hayes, Ed. (A publication of the National Academy of Sciences.)
(8) Hodgson, 648 F. Supp. at 763

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2-20-90

Exhibit A

Percentage of Pregnancies Ending in Abortion in Minnesota, 1975-87*

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
10-17 yr. olds:													
No. of abortions:	1507	2060	2274	2186	2308	2327	1820	1564	1432	1395	1570	1545	1648
No. of pregnancies:	3958	4391	4573	4271	4364	4315	3714	3307	2987	3031	3122	3133	3249
% of pregnancies ending in abortion:	38.1%	46.9%	49.7%	51.2%	52.9%	53.9%	49.0%	47.3%	47.9%	46.0%	50.3%	49.3%	50.7%

(*chart continued on next page*)

* Numbers of pregnancies and abortions for 1975 to 1986 are taken from the Brief of AAPS as *amicus curiae* at 11a (Table 1). Numbers for 1987 are taken from *Minnesota Health Statistics: 1987*, published by the Minnesota Department of Health at 72 (Table 34). A copy of *Minnesota Health Statistics: 1987* has been lodged with the Clerk for the convenience of the Court by Counsel for Petitioners.

* AAPS = AMERICAN ACADEMY OF PHYSICIANS AND SURGEONS

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	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
18-19 yr. olds:													
No. of abortions:	1758	2511	2693	3054	3293	3380	3064	2799	2547	2586	2531	2372	2306
No. of pregnancies:	6494	7017	7347	7738	8057	8301	7697	7052	6223	6112	5958	5493	5596
% of pregnancies ending in abortion:	27.1%	35.8%	36.7%	39.5%	40.9%	40.7%	39.8%	39.7%	40.9%	42.3%	42.5%	43.2%	41.2%
20-24 yr. olds:													
No. of abortions:	2702	3643	4528	5066	5683	6054	6047	5963	5487	6032	6067	5724	5576
No. of pregnancies:	22001	22431	24524	25058	26747	28093	27820	27256	24943	25032	24585	22792	21634
% of pregnancies ending in abortion:	12.3%	16.2%	18.5%	20.2%	21.2%	21.5%	21.7%	21.9%	22.0%	24.1%	24.7%	25.1%	25.8%

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
25-54 yr. olds:													
No. of abortions:	2161	2895	3529	3872	4355	4716	4881	5180	5012	5525	5812	6035	6183
No. of pregnancies:	31145	32837	36282	37849	40423	42198	43804	45003	44581	46748	48250	48544	50797
% of pregnancies ending in abortion:	6.9%	8.8%	9.7%	10.2%	10.8%	11.2%	11.1%	11.5%	11.2%	11.8%	12.0%	12.4%	12.2%

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2-20-90

Relative Risk of Second Trimester Abortions†

Total Number of Abortions

Age Group*	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
	Year											
10-17	1507	2060	2274	2186	2308	2327	1820	1564	1432	1395	1570	1545
18-19	1758	2511	2693	3054	3293	3380	3064	2799	2547	2586	2531	2372
20-24	2702	3649	4528	5066	5683	6054	6047	5963	5487	6032	6067	5724
25+	2161	2895	3529	3872	4355	4716	4881	5180	5012	5525	5812	6035

Number of Abortions Performed After 12 Weeks Gestational Age

Age Group	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
	Year											
10-17	270	470	474	403	432	510	365	322	334	360	361	333
18-19	228	426	464	449	460	562	462	425	419	489	441	435
20-24	275	446	512	505	591	681	625	631	626	786	723	668
25+	189	306	368	302	327	403	363	412	370	461	458	516

† This Exhibit uses raw data provided by the Minnesota Department of Health as reproduced in the Brief of AAPS as *amicus curiae* at 23a-24a (Table 3).

* Definition of symbols: "<" = ages less than; "+" = and ages above; "x/y" = formula for calculating ratio.

Percentage of Abortions Performed After 12 Weeks Gestational Age

Age Group	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
	Year											
<18	17.9	22.8	20.8	18.4	18.7	21.9	20.1	20.6	23.3	25.8	23.0	21.6
18-19	13.0	17.0	17.2	14.7	14.0	16.6	15.1	15.2	16.5	18.9	17.4	18.3
20-24	10.2	12.2	11.3	10.0	10.4	11.2	10.3	10.6	11.4	13.0	11.9	11.7
25+	8.7	10.6	10.4	7.8	7.5	8.5	7.4	8.0	7.4	8.3	7.9	8.6
18+	10.5	13.0	12.5	10.5	10.3	11.6	10.4	10.5	10.8	12.3	11.3	11.5

Ratio of Percentages of Minors and Adults

Age Group	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
	Year											
<18/ 18+	1.71	1.75	1.67	1.76	1.81	1.88	1.94	1.96	2.15	2.10	2.04	1.88

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24-5
2-20-90

115-5

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 25
February 20, 1990

Fact Sheet

Planned Parenthood® Federation of America, Inc.
810 Seventh Avenue New York, New York 10019 (212) 541-7800
2010 Massachusetts Ave. NW Washington, DC 20036 (202) 785-3351

BORN UNWANTED:
DEVELOPMENTAL CONSEQUENCES FOR CHILDREN OF UNWANTED PREGNANCIES

Unwanted childbearing has long been linked with adverse consequences for mothers, couples, families -- and most of all, for unwanted children themselves.

Several studies -- conducted in nations as diverse as the U.S., Czechoslovakia, and Sweden -- have documented the long-term developmental problems suffered by children whose mothers did not want to bear them. The findings point to a multitude of emotional, educational, and functional disorders that worsen as children reach adulthood. These difficulties befall even children born to healthy, adult women who have stable marriages and adequate economic resources. For the majority of unwanted children who are born to poor, unhealthy, unmarried, teen mothers, the problems are exacerbated.

While it cannot be proven that these problems afflict <u>all</u> children who are born unwanted, all the difficulties reported here were demostrated by one or more reliable studies. Most of the studies focus on women who sought abortions and were denied them by law or by circumstance. Thus, the findings paint a clear and disturbing picture of what would become of hundreds of thousands of American children if access to adequate family planning and abortion services in the U.S. were to be restricted.

Crippling emotional handicaps

Studies describe children who are born unwanted as more likely to be emotionally crippled for life -- problem-prone in their present lives and at risk of ongoing maladaptation in the future (1).

- o Mental handicaps at birth are significantly more common among children who were born unwanted (2).
- o Unwanted children and young adolescents are nearly twice as likely to receive psychiatric care for both mild and severe psychological disorders (3, 4).
- o In their teen years, unwanted children tend to be emotionally immature relative to their chronological age (5).
- o By age 18, more unwanted than wanted children suffer borderline psychoses and other disturbances requiring treatment (5); in their early 20s, they are more likely to be dissatisfied with their mental well-being and to want or undergo psychiatric treatment (3).

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- Throughout childhood and into young adulthood, they suffer from poor social adjustment: significantly more often than wanted children, they are rejected or not chosen as friends by peers and schoolmates, who often describe them unfavorably (as cowards, braggarts, loners, show-offs, etc.) (1, 5).

- Unwanted children are twice as likely as wanted children to be less adaptive to frustration and stress (1), a handicap that continues into adulthood (3).

- The probability of emotional disturbance and social maladaptation increases significantly if the unwanted child is an only child (1) or the child of an unmarried, poor, or less educated mother (6).

Stunted intellectual and educational development

While unwanted children are generally found to be no less intelligent than wanted children, they are far less able to live up to their intellectual capabilities (3). They are more likely to:

- dislike school in their early years, and perform significantly worse scholastically (1, 2, 5)

- be consistently viewed as less intelligent by mothers, teachers and classmates, despite intelligence tests similar to those of wanted children (1)

- as gradeschoolers, be described by their teachers as less diligent, less able to concentrate or take initiative, less obedient and conscientious, and more excitable and demanding (1, 2)

- get lower grades (2), particularly in language skills (1, 5)

- as adolescents, perform increasingly poorly in school and be less likely to excel under increased school pressure (3)

- in early adulthood, continue to be lower-level achievers than wanted children (3) -- regardless of socioeconomic status, they are less than half as likely as wanted children to pursue higher education (4).

Mothers of unwanted children in their early 20s continue to be significantly more likely to express dissatisfaction with their children's educational attainment (3).

Patterns of antisocial behavior

Children born unwanted are:

- more than twice as likely as wanted children to have a record of juvenile delinquency (4)

- up to four times more likely to have a record of adult criminal activity (4, 5)

- nearly three times more likely to be repeat offenders in early adulthood (3)

- o compared to wanted children who break the law, more likely to be convicted of more serious offenses (3)

- o more likely to abuse alcohol and drugs in youth and early adulthood (3, 4, 5)

- o up to six times more likely to receive some form of welfare between ages of 16 and 21 (4, 5)

<u>Troubled home and family life</u>

Children born unwanted are more likely than wanted children to have unhappy relationships with their parents that continue into adolescence:

- o Parents of unwanted preschoolers are more likely to describe their children as naughty or bad-tempered (3);

- o unwanted teens are more likely to perceive their mothers as aloof and maternally disinterested, and to feel neglected or rejected by them (3);

- o adolescent boys in particular feel their mothers are less satisfied with them, perceive their parents' marriages (if they <u>are</u> married) as less happy, and consider themselves to be insufficiently informed about sexual matters, especially contraception (3);

- o and unwanted teen girls are far more likely than wanted girls to experience their fathers as hostile or neglectful (2).

Unwanted children also are more likely to suffer insecure home conditions, e.g., having their parents divorce or die before the children are 15 years old, or having parents who never marry (4, 5).

<u>Abuse or neglect by parents</u>

Some researchers suspect a strong link between unwantedness and child abuse. This subject has not yet been studied in depth, and the existing findings are scientifically inconclusive. However, anecdotal observations suggest that unwanted children may be at increased risk of suffering:

- o abuse, particularly in situations where their birth places financial strain on the family (7, 8, 9, 10).

- o malnourishment, neglect or abandonment by their parents in early childhood (8, 10)

- o removal to foster homes or institutions because of parental neglect, abuse, mental or physical illness, divorce, or economic hardship (7)

- o psychiatric disorders traceable to parental rejection (7).

<u>Dissatisfaction and dysfunction in adult life</u>

A longitudinal study (3) that compared the development of wanted and unwanted children from birth through their early twenties found that, as young adults:

- o More than twice as many "unwanteds" as "wanteds" said they had encountered more problems in their lives than anticipated.

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- Nearly three times more "unwanteds" than "wanteds" described themselves as unhappy and unable to cope with their problems.

- Adults who were born unwanted continued to feel their parents were dissatisfied with them and let them know it.

- The "unwanteds" tended to be less satisfied with their jobs and wages, more often in conflict with supervisors, and unhappy with co-worker relationships.

- The "unwanteds" had fewer friends and more often felt disappointed by them; they were more likely to report repeated disappointments in love and relationships, and to describe love as creating "more trouble than pleasure."

- They were more likely to have had their first sexual intercourse before age 15 and with a casual acquaintance; they also had had many more sexual partners on average than the "wanted" adults.

- Married female "unwanteds" were far more likely than their "wanted" female counterparts to express marital dissatisfaction and a desire to "do it all over again" by not marrying or by marrying a different partner; they tended to blame themselves for marital unhappiness.

- Female "unwanteds" with children were more likely to say their pregnancies were unwelcome, took longer to develop an attachment to the fetus during pregnancy, and were less likely to take an extended maternity leave from work once their children were born.

SOURCES

NOTE: Studies (1), (2), (3), (4), and (5) are particularly recommended for additional reading, as they provide the most recent and most comprehensive data. These studies compare the children of women who sought and were denied abortions with control groups of wanted children, in some cases pair-matched for sex, age, socioeconomic status, number of siblings, parents' age, and other factors. Both groups were followed at least into early adulthood, with extensive data drawn from personal interviews as well as psychological, medical, educational, and institutional records.

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Fact Sheet

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TEEN PREGNANCY: THE FACTS

The number of teen pregnancies in the United States is at least twice that of other industrialized nations. The results are overwhelming - poverty, curtailed education and greater physical risks for the teenaged mother and her child.

— By age 19, eight in 10 males and six in 10 females will have had intercourse.

— Most teens wait at least nine months after first intercourse before coming to a clinic for contraceptives or advice; in fact, 35% of the teens who come to family planning clinics for the first time do so because they suspect they are pregnant.

— Half of teen pregnancies occur within six months of first intercourse.

— Only one-third of teens who have sex use birth control regularly; one-third use it inconsistently; and another third never use it. If they use a contraceptive method, they are most likely to use the pill (62%) followed followed next by condoms (22%).

Pregnancy

— More than 1 million (1,031,040 in 1985) teens become pregnant each year at a rate of 113.2 per 1,000 teenagers. At least 20% of the male partners of these teens are also teenagers.

— Over 80% of teen pregnancies are unintended.

— Four in 10 young women will become pregnant at least once before they are 20 years old.

— Before age 18, 20% of white women and 40% of black women will become pregnant.

— The rate of pregnancy among black teens has been decreasing, while the rate of pregnancy among white teens has remained the same.

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Abortion

— Forty percent of all teen pregnancies (418,740) end in abortion.

— Teens account for more than a quarter of all abortions performed (and almost 13% of all births).

— Forty percent of pregnancies among white teens result in abortion, compared to 34 percent among non-white teens.

— Because teens tend to deny that they could be pregnant, they are more likely to have later abortions than older women.

Childbirth

— More than half of all teen pregnancies (477,705 in 1985) end in live births (While the remainder end in miscarriages or spontaneous abortion).

— In 1985, there were 9,848 babies born to unmarried mothers who were 14 or younger.

— Only 31% of births to teens are to married teens 18 or 19 years of age.

— And 22.7% of those births were second or higher order births (CDF).

— Two-thirds of babies born to teens result from unintended pregnancies.

— Virtually all (93%) teens who have live births keep their babies. Fewer than 8% of teen mothers relinquish their babies for adoption.

— The birth rate among black teens is double that among white teens, indicating that young black women are more likely to continue their pregnancies and more likely to get pregnant.

Health Consequences

— The younger the mother, the more likely she is to suffer complications from pregnancy, including anemia, toxemia and miscarriage.

— The maternal mortality rate for young mothers is more than double that for mothers 20-24; the maternal mortality rate among young black mothers is double the rate for young white mothers (16.6 to 7.6).

-- The younger the mother, the more likely her baby will have a low birth weight, a major cause of health problems later and of infant mortality. Her baby also is more likely than babies of older women to suffer from birth defects and mental retardation.

-- Pregnant teens are three to four times more likely than married, older and non-poor women to receive no prenatal care or very late prenatal care because they cannot afford such medical services or they do not realize the need for such care.

-- Only 49% of mothers younger than 18 obtained prenatal care in the first trimester of pregnancy.

Social Consequences

-- Only half of all teen mothers ever finish high school.

-- Teen mothers who marry are three times more likely to be separated or divorced within 15 years than women who postpone childbearing until their 20s.

-- Children of teen mothers tend to have lower IQs and often have to repeat grades because of the lack of proper care and attention.

-- Teen mothers usually have more children than women who postpone childbearing until their 20s.

-- Daughters born to teen mothers are more likely to become teen mothers themselves.

Teenage Pregnancy and Poverty

-- Two-thirds of families headed by women whose first birth came before 20 live below the poverty level.

-- The U.S. spends over $18 billion annually in health and other services for families started by women who gave birth while in their teens.

-- Babies born to teenagers in 1986 will cost the U.S. $5.5 billion over the next 20 years (Each of those babies will cost an average of $14,852 by the time he/she is 20).

America Speaks on Teen Pregnancy

A 1985 poll commissioned by Planned Parenthood and conducted by Louis Harris Associates found that:

-- 84% of Americans agree that teenage pregnancy is a serious problem.

-- 76% who have children aged six through 18 have talked with their youngsters about sex and favor open discussion relating to

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sexuality-related matters; but only 33% say that birth control was part of the discussion.

- 62% think a more open discussion of sexual topics in society would lead to fewer teenage pregnancies.
- 85% agree that sexuality education should be taught in public schools.
- 67% favor requiring public schools to establish links with family planning clinics so that teenagers can learn about contraceptives and obtain them.
- 78% think that television should present messages about birth control as part of its programming.

American Teens Speak

A 1986 poll commissioned by Planned Parenthood and conducted by Louis Harris Associates looked to teenagers themselves for some of the answers to the teen pregnancy problem and found that:

- teenagers who have the fewest resources, and are thus the most vulnerable are also most likely to start having sexual intercourse very young.
- Teenagers say that social pressure is the chief reason why so many of their peers do not wait to have sexual intercourse until they are older (But they deny this was the case for them).
- Teenagers who have had intercourse say that "unexpected sex" -- with no time to prepare -- is the most frequent single reason why they and so many of their peers do not use birth control.
- Contraceptives are most likely to be used by those teenagers who can see they have a lot at stake and who know they stand to lose a lot by being involved in an unintended pregnancy.
- Two-thirds of American teenagers (68%) have at some time talked to their parents about sex and how pregnancy is caused. But only one-half of those (33% of all teenagers) had talks that included the subject of birth control.
- Teenagers who have had a comprehensive sex education course at school are more likely to use birth control regularly if they have sex.

SOURCES:

National Research Council, ("Risking the Future," 2nd volume, 1986)
Alan Guttmacher Institute
U.S. Department of Health and Human Services, Vital Statistics
PPFA/Harris Poll 1985
PPFA/Harris Poll 1986 ("American Teens Speak")

Fact Sheet

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THE EMOTIONAL EFFECTS OF INDUCED ABORTION

Research studies indicate that emotional responses to legally induced abortion are largely positive. They also indicate that emotional problems resulting from abortion are rare and less frequent than those following childbirth.

Anti-family planning extremists, however, are circulating unfounded claims that a majority of the 25 percent of pregnant American women who choose to terminate their pregnancies (1) suffer severe and long-lasting emotional trauma as a result. They call this largely nonexistent phenomenon "post-abortion trauma" or "post-abortion syndrome." They hope that terms like these will gain wide currency and credibility despite the fact that most studies have found abortion to be a relatively benign procedure in terms of emotional effect except when pre-abortion emotional problems exist. (2)

The many studies of the emotional effects of abortion do not measure precisely the same variables in regard to culture, time, demographics or the socioeconomic and psychological situation of women who seek abortion. Since the results of these studies cannot be combined or "averaged out," the following data illustrate, in general, the conclusions of the overwhelming majority of more than fifty of the worldwide studies that have measured the emotional effects of abortion since its legalization in the U.S. in 1973.

ABORTION AS A POSITIVE COPING MECHANISM

o For most women who have had abortions, the procedure represents a maturing experience, a successful coping with a personal crisis situation.(3) The event provides them with an opportunity to reconsider their attitudes and relationships and thus achieve more rewarding emotional lives. (4)

o Of all women who have first-trimester abortions, up to 91 percent report a sense of relief following the termination of pregnancy. (3)

o Up to 98 percent of the women who have abortions have no regrets and would make the same choice again in similar circumstances. (4)

POSTOPERATIVE DEPRESSION RELATED TO ABORTION

o Post-abortion blues, like postpartum blues, are most often due to causes of stress other than the abortion. (5) They occur most often in those who experience emotional distress during pregnancy as well as those with a history of pre-menstrual tension. (6)

o Mild, transient, immediately postoperative depression which quickly passes occurs in up to 20 percent of all women who have had abortions. (7) (8) A similar depression occurs in up to 70 percent of women immediately following childbirth. (9)

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deliveries. (10)

o Between one and six percent of women who have abortions experience depression of a lingering nature. (4) A similar depression occurs in up to ten percent of women after childbirth. (9)

SERIOUS PSYCHIATRIC DISTURBANCES FOLLOWING ABORTION

o Women who are at risk for enduring, severe psychiatric disturbances following abortion are those with previous psychiatric or abnormal obstetric histories as well as those expressing ambivalence toward abortion. (11) Even before their pregnancies, many of these women develop psychosomatic disorders or symptoms of psychological exhaustion. (12)

o Less than five percent of the women who have abortions are at risk for serious consequences. (11)

o Serious psychiatric disturbances after abortion are less frequent than after childbirth. For example, rates of postpartum psychosis are reported as high as 19 per 10,000 and as low as 10 per 10,000. Reports of the rates of post-abortion psychosis range from 18 per 10,000 to as low as 2 per 10,000. (13)

o Rates of postpartum psychosis have been shown to decrease in societies that legalize abortion. (Ibid)

WHEN ABORTION IS REFUSED

o The mental health of women faced with unwanted pregnancy is at greater risk when they are compelled to deliver than when allowed to choose abortion. (10) Their children have more genetic malformations, have insecure, divorce-fraught childhoods, perform worse at school, have more psychosomatic symptoms, are often registered with welfare officials and often need psychiatric treatment. (14)

o A study in Sweden indicated that 24 percent of women who applied for and were refused abortion seven years earlier had not yet been able to adjust emotionally. Another 53 percent had been able to adjust but with difficulty. Only 23 percent could be described as well-adjusted. (5)

o A recent study indicates that less than half of the women who elect to terminate a pregnancy would <u>not</u> have an illegal abortion if that were their only recourse. Fifty-eight percent are uncertain or would have an illegal abortion if that were their only alternative. (15)

SOME PRE-ABORTION VARIABLES THAT AFFECT EMOTIONAL OUTCOME

o Women who expect to cope well with abortion, do. (16) Women having a high degree of social, partner and parent support for their decisions experience much less distress or regret over their decisions. (Ibid, 13) However, emotionally unstable women with unstable living conditions will most likely react to an unwanted pregnancy in a disturbed fashion — whether they bring their pregnancies to term or not. (17)

o The fact of becoming pregnant, rather than the abortion itself, is often the predominant cause of guilt or emotional disturbance. (4)

o Women who find it difficult to elect abortion report more guilt following the abortion. (3)

o Those who choose abortion because of genetic disease may suffer more serious emotional effects and may have a greater need for counselling than those who elect abortion for socioeconomic or psychological reasons. (18) However, the emotional consequences are probably more acute after the birth of a defective child than following the abortion of a defective fetus. (14)

o Women who are persuaded by their partners against their own wishes to elect abortion experience greater feelings of guilt. (3)

o Women who become pregnant because of contraceptive failure tend to be more depressed after an abortion -- and remain so longer than women who do not use contraceptives and become pregnant. (19)

THE INFLUENCE OF RELIGIOUS BELIEF ON ABORTION AND ITS EMOTIONAL EFFECTS

o Because some conservative or fundamentalist religions are opposed to contraception as well as to abortion, women who are influenced by them run a greater risk of becoming unintentionally pregnant than those attached to more liberal religions. Because such women have more unwanted pregnancies, these women elect abortion more often. (2)

o The conflict between a woman's desire for no more children, and her religious beliefs, may cause her to suffer more remorse following the abortion. (3)

ABORTION AND THE MATERNAL INSTINCT

o Women who have had abortions have been known to score higher in areas of autonomy and nurturance than women who have not. (20)

o More than 77 percent of women who have abortions express a desire for children in the future. (7)

o There is no relationship between anxiety during pregnancy and having had a prior abortion. (20)

o There is no evidence of inadequate maternal function or attitude toward children born to women who have had a previous abortion. (Ibid)

ABORTION AND CONTRACEPTION

o Abortion is not seen by women who elect it as a preferred, or desired, form of contraception. (7)

o Women's experience with abortion increases their desire for effective contraception. (Ibid)

o Studies have indicated that while 70 percent of women used no form of birth control before their first abortion, only nine percent failed to use a contraceptive method after their abortion. (1)

EFFECT OF ABORTION ON SEXUAL AND OTHER RELATIONSHIPS

o The majority of women who elect abortion are in positive relationships with their male partner. Their request for abortion

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o Marital harmony is found to be unaffected by abortion. In fact, sexual relationships in marriage seem to be improved by it. In one study of women who had had abortions, 59 percent reported that their sexual relationships pre-abortion had been satisfactory; 74 percent reported that their sexual relationships post-abortion were satisfactory. (4)

o Often, relationships with people other than the sexual partner are also changed after abortion. Eighty-seven percent of the changes reported in one study were for the better. (Ibid)

o Another study shows that eight weeks after abortion:

- 70 percent of the subjects were continuing in the pre-abortion relationship; 5 percent had established new relationships; and

- 20 percent now had no sex partner.

- Forty-five percent described their feelings toward their partners as unchanged; 39 percent felt closer to their partners; and

- 16 percent felt less close to their partners or described varying feelings.

- Forty-six percent felt the quality of the relationship was unchanged; 16 percent felt the relationship had improved; and 10 percent felt the relationship had deteriorated.

- Ninety-eight percent of partnered women had resumed sexual intercourse. (11)

THE EMOTIONAL EFFECTS OF ABORTION ON THE MALE PARTNER

o While there is considerable emotional involvement in abortion for the male partner, real and typical psychopathological symptoms such as depression and behavioral disorders are rare. (22)

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For further information, contact:

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Fact Sheet

Planned Parenthood® Federation of America, Inc.
810 Seventh Avenue New York, New York 10019 (212) 541-7800
2010 Massachusetts Ave. NW Washington, DC 20036 (202) 785-3351

ABORTION: FACTS AT A GLANCE

HOW MANY

* Approximately 1.5 million abortions are performed each year in the United States.

* A quarter of all pregnancies are terminated each year by abortions.

* Approximately 91% of all abortions are performed during the first trimester; 9% are performed in the second trimester, and; 0.01% are performed after 24 weeks

* In 1973, the first year abortion was legal in every state, 744,610 abortions were performed.

* Planned Parenthood clinics performed 111,189 abortions in 1988, approximately 7.5 percent of the U.S. total that year.

WHO

* The majority of abortions performed in the United States are obtained by:

  - young women -- (62%)
  - white women -- (70%)
  - unmarried women -- (81%)

* Women aged 18-19 continue to have the highest abortion rate of any age group (60 per 1,000).

* Poor women are about three times more likely than are women who are financially better off to have abortions.

* The desire to complete school or to continue working are common reasons women give for choosing to abort an unplanned pregnancy.

* 70% of women having abortions say they intend to have children in the future.

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* About half of the women having abortions had become pregnancy even though they were using some form of contraception, either because of inconsistent or incorrect use or because of a method failure.

SAFETY

* The overall risk of dying from legal abortion has dropped from about 4 deaths per 100,000 abortions in 1972 down to 0.5 per 100,000 in 1985 — an eight-fold decrease.

* Abortion is one of the safest and most commonly performed surgical procedures. Today, women rarely die from legal abortions, and they experience complications in less than one half on one percent of abortions.

* Legal abortion is twice as safe as tonsillectomy and ten times safer than appendectomy.

* Vacuum Aspiration or Suction Curetage, the method used for 91 percent of all abortions, is twice as safe as the method traditionally used before, sharp curettage, which accounts for the increased safety of the procedure. That women are having abortions much earlier and physicians are being trained in the abortion procedure also contribute to the increased safety.

ILLEGAL ABORTION

* Until 1845, abortion before quickening was legal in all states. But in those years before sterilization of medical instruments, abortion was a dangerous procedure.

* In 1845, states began passing laws to ban or severely restrict access to abortion — in order to protect women's lives, not to protect fertilized eggs or fetuses.

* By the 1960's most states had passed restrictive abortion laws.

  In 15 states and the District of Columbia only the person performing the abortion was subject to legal action.

  But 18 states had established criminal penalties for women who had abortions and for those who helped or counseled women regarding abortion.

* In the 1940's it has been documented that an average of 1,000 women each year died from complications of illegal abortions.

* In the 1950's it is estimated that between 600,000 and 1.2 million illegal abortions were performed annually in the United States.

* During the late 1960's and early 1970's, when abortion had become much safer for women:

    — 17 states repealed or reformed their abortion laws to make abortions more available.

    — Reform bills were introduced in 28 other states.

    — The Supreme Court's 1973 landmark decision in Roe v. Wade was the culmination of a progressive trend.

ABORTION AROUND THE WORLD

* There is no country in the world where abortions do not occur.

* Of the estimated 50 million abortions induced worldwide each year, slightly more than a third are illegal.

* Complications arising from pregnancy and illegal abortion are the leading killers of women in their twenties and thirties in the developing world.

* 39 percent of the women in the world live in societies where laws forbid them from making their own reproductive decisions.

* It is conservatively estimated by the World Health Organization that 200,000 women worldwide die every year from abortions that are illegal and unsafe.

# # #

CONTACTS: Donald Singletary, Kathleen Stack, Roberta Synal
PPFA Media Relations Office: 212-603-4660

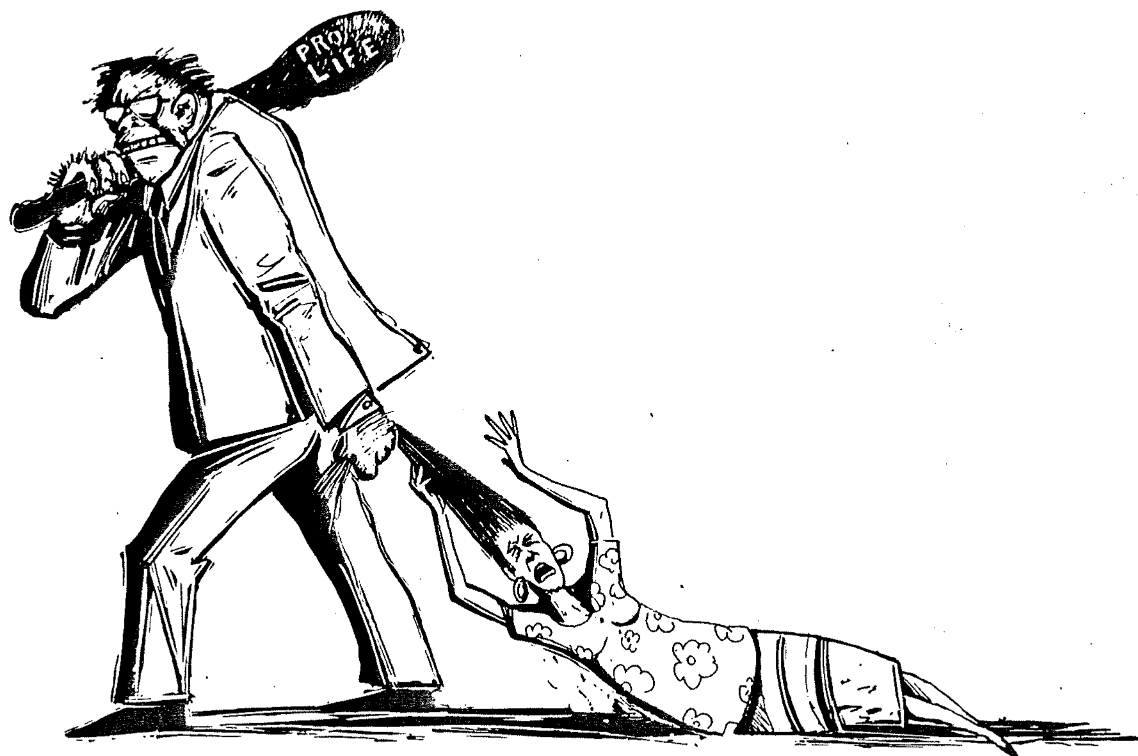
"AB-FACTS" 11/89

FSA
89-2
2-20-90

N[illegible]otification means more teen mo[illegible]ns

Republics abound in civilians who believe ... that any measure, though it were absurd, may be imposed on a people if only you can get sufficient voices to make it a law.

— Ralph Waldo Emerson



Peter Kuper

Boosters of laws requiring parents to be notified if a minor daughter seeks an abortion say that such laws promote family unity and discourage youthful immaturity. If there were any evidence that this is true, I would support such laws.

I am, after all, the father of three daughters, two of whom still are minors. Should one of them become pregnant and consider an abortion, I would want to be involved in her decision.

I would want to make certain that she understood the consequences both of bearing the child and of aborting it. I would want, above all, to rally to her side so that she would not have to endure this traumatic situation alone.

But the evidence suggests that parental notification laws don't promote family unity or maturity in minor children. If anything, such laws promote family disunity and youthful immaturity. That's why I hope that the parental notification bill now before the Kansas Legislature never becomes law.

The bill's preamble asserts "compelling and important state interests" in promoting family unity and discouraging youthful immaturity. (Presumably, this would include the immaturity of the young man whose role in creating a teen pregnancy is indispensible. The bill fails to make this clear.)

But one who reads the bill closely must conclude that its true purpose is to force minor girls who become pregnant to bear their children.

Felon physicians

The bill would make felons of physicians who perform abortions on minor girls without first making certain that both parents have 48 hours' notice of the abortion, in writing. They'd serve an indeterminate prison term and pay a fine of up to $10,000.

The bill would allow physicians to perform abortions without notifying the girl's parents:

- If there were a "bona fide medical emergency" (this term isn't defined);
- If the girl in question had a notarized note from her parents saying she had permission to have an abortion; or
- If the girl declared that the father of the child was 18 or older (in which case the physician would be required to sic the police and social workers on him).

DENNEY CLEMENTS

EDITORIAL WRITER

If none of these exclusions applied and a physician performed an abortion on a minor girl anyway, he or she then would become liable (in addition to jail and a fine) to tens of thousands of dollars in civil penalties. The bill would grant the girl herself, the father of the unborn child and the girl's parents the right to bring such a lawsuit.

The bill's 33 House sponsors include Sedgwick County Reps. George Dean, D-Wichita; Barbara Lawrence, R-Wichita; Darrel Webb, D-Wichita; and Vern Williams, R-Wichita. They obviously want to make certain that no Kansas physician even contemplates performing an abortion on a minor girl.

Laws don't work

As I say, though, I might support the bill (though I'd soften the part that makes felons of physicians) if there were any hope it would discourage minors from being sexually active (the essence of youthful immaturity). I might support it if there were any hope it would force every Kansas family to make certain that its post-pubescent kids — girls *and* boys — understand the consequences of sex (the essence of family unity).

The need for such unity and maturity is huge. The United States has one of the highest teen pregnancy rates in the developed world — more than 1 million a year. But in states that have parental notification laws, as well as in states that don't, teen pregnancy rates still soar — as the bill's supporters surely know. Such laws simply don't work.

According to data presented to the U.S. Supreme Court last November, 42 percent of these teen pregnancies end in abortion. The high court now is considering the constitutionality of Minnesota and Ohio parental notification laws, the models for the Kansas bill. Its decision is expected by July.

Incest, beatings

The majority of these pregnant girls already tell at least one parent they're planning to have an abortion. Those who don't notify their parents usually have a good reason, including incest and the fear of being beaten up.

Should Kansas pass a parental notification law, these girls would have an unpleasant choice: having a back-alley abortion or bearing the children and going on welfare to support them. (The irony here is that Gov. Mike Hayden's proposed welfare cuts, if enacted, would reduce that already paltry level of support.)

The high court last year allowed the states to restrict abortions (though not to ban them). And many Kansas pro-lifers are hoping that the high court, in its decision in the Minnesota and Ohio cases, will allow further restrictions.

For these reasons, legislators this session are coming under enormous pressure to pass the parental notification bill. If they truly care what happens to Kansas' sexually active younsters, they'll resist.

5 In Memoriams

B In loving memory of REBECCA SUZANNE B

Aug. 24, 1971
Sept. 16, 1988
Becky,
You would be celebrating your 18th birthday today - since you were taken from us we want you to know
Some broken hearts never mend
Some memories never end.
Some tears will never dry and
Our love for you will never die.
Loving you always, Joby, Dick, Taylor, Morgan, Gary and Grandma and Grandpa

---

B Eighteen years ago today you were born, our REBECCA SUZANNE B

Aug. 24, 1971
Sept. 16, 1988
Into the world we brought this child,
Sweet innocence, with temper mild.
Eyes of blue and skin so fair,
Full of love and beauty rare.
Charm and wit, with hair of gold.
How we wished
You could grow old. But,
Heaven now you call your home,
Never more this earth to roam.
Heavy are these hearts that stay,
Praying for that long awaited day. When joined again,
No more to part
You'll take this burden
From our heart.
Loving you always and forever,
Mommie, Daddy and Billy

B In loving memory of BECKY B

For her 18th birthday.
COUSINS MEMORY
Now she can fly high as a free-bird.
The only way she could fly, really hurt.
I am glad the last time we ended
With a hug and kiss.
Those are the things I miss.
I wish she was still here.
Oh well, I still love her dear.
With all our love
From Mary Kathryn
Jennie and Aunt Carol

B In loving memory of BECKY B
Happy 18th Birthday.
Thank you for your friendship and the memories that will last with me forever. Love Cara

Indiana NOW

REMEMBER HER YOUNG, HOPEFUL FACE

Becky made a mistake and became pregnant.
She did not want to be a disappointment to her family or friends.
She self-aborted to avoid getting her parents' consent
as required by Indiana law PL-106.
She became very ill and was rushed to an emergency room
by her parents, who did not know what was wrong.
Becky still did not want to be a disappointment to
her parents and remained silent as
medical personnel gave her an antibiotic
and sent her home, where she died.
An autopsy revealed her illegal, botched abortion
and cause of death.

Indiana's PL-106 put the value of a fertilized egg
over the value of Becky's life.

Becky would have been 18 years old on August 24, 1989.

Remember Becky's young, hopeful face and

VOTE AGAINST PARENTAL CONSENT!

P O Box 2264 • Indianapolis, Indiana 46206-2264 • (317)925-4641

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 31
February 20, 1990

WHY PARENTAL CONSENT IS A BAD IDEA

TEENAGERS WILL DIE IN KANSAS

Some teenagers cannot or will not tell their parents they are pregnant. They will seek illegal abortions or try to self-abort so they will not have to confront parents or a judge. There will be deaths from illegal or self induced abortions.

ABORTION WILL NOT STOP. TEENAGERS WILL GO OUT OF STATE TO GET ABORTIONS

In states where parental consent laws have been enacted, there has been a marked increase in teenage abortions in neighboring states. Statistics which show a decrease in teenage abortion are highly misleading.

MORE LATE TERM ABORTIONS

If teenagers must seek parental consent or judicial bypass to have an abortion, they will put off telling their parents, or try to find ways around it. This will result in an increase in late term abortions in Kansas, and pose a greater threat to the health of pregnant teenagers.

YOU CANNOT LEGISLATE FAMILY COMMUNICATION

Teenagers who can communicate with their parents are already doing so. For those who can't or won't, legislation will change nothing. Many pregnant teenagers come from abusive families, and some pregnancies are the result of incest. These teenagers face life threatening consequences if they must obtain parental consent for an abortion.

GOVERNMENT SHOULD STAY OUT OF PRIVATE MEDICAL DECISIONS

The right to seek an abortion has been affirmed by the Supreme Court as a privacy right. Whether an individual chooses to involve the family in a medical decision should not be dictated by the government.

USA Today 1/22/90 c

Parents: Abortion law kills

William and **Karen Bell**, of Indianapolis, will commemorate the 17th anniversary of the Supreme Court's *Roe vs. Wade* decision today by using their daughter's death to help change abortion laws in the USA.

At a special memorial service in Washington, D.C., the Bells will describe how their daughter Rebecca, 17, died in 1988. They blame Indiana's parental consent law. And they hope their story will persuade lawmakers nationwide to stop enacting new consent laws and repeal those laws already in effect.

"Had there not been that law, she'd be here today," William Bell says. "Kids ought to listen to their parents. But how can you legislate morality? It's insane."

Rebecca tried to get a legal abortion near her home, but was turned away because of the law requiring her parents' approval.

She died, apparently from an abortion-related infection, after hemorrhaging for hours and developing pneumonia. "She loved (her parents) so much, she couldn't bear telling them," says her best friend, Heather Clark.

Clark believes Rebecca had a spontaneous abortion. Rebecca's mother thinks the teen-ager had an illegal abortion.

Either way, the National Abortion Rights Action League says Rebecca is the first teen in the USA whose death can be linked to a parental consent law.

The Bells never thought this would happen to their daughter. The blonde-haired, blue-eyed girl was a cheerleader in junior high and always was fighting for some cause.

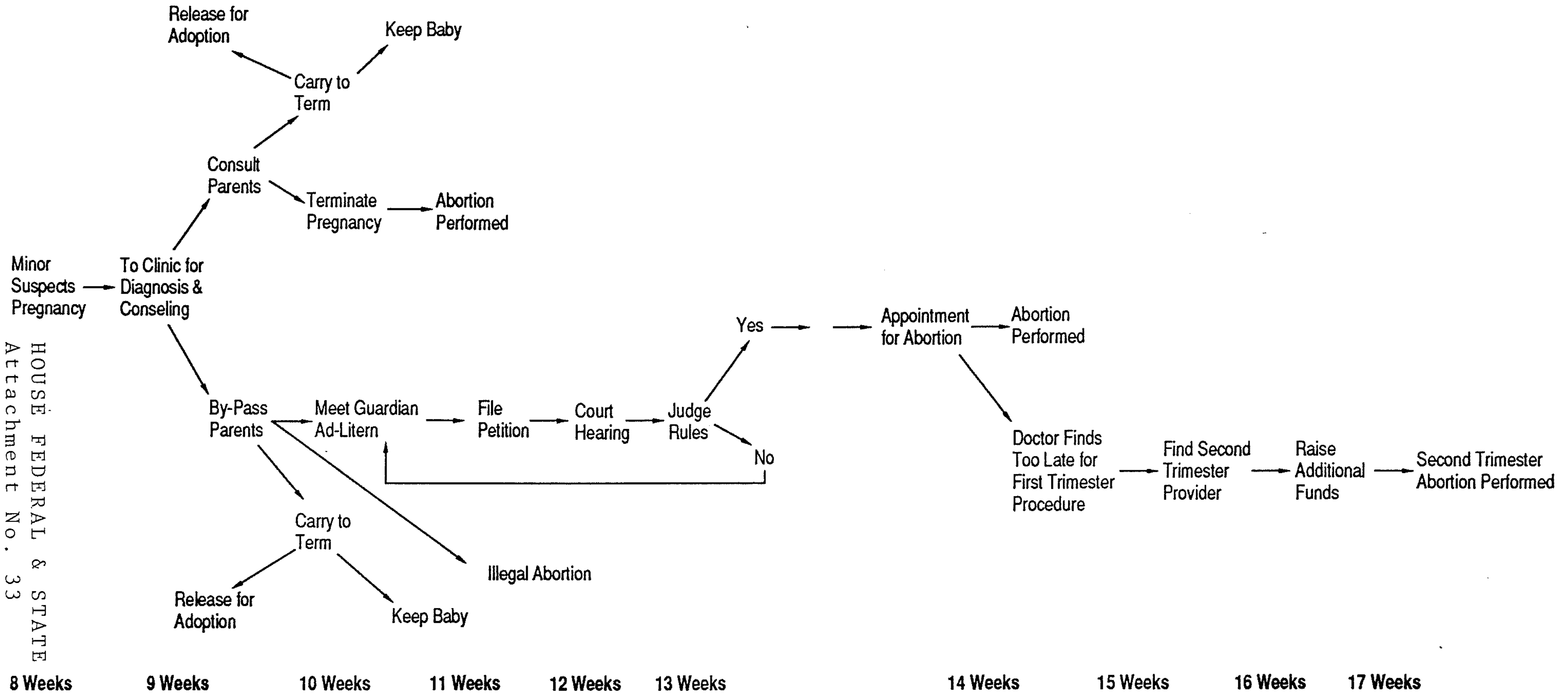
For more than a year, Karen Bell refused to talk publicly about the incident. She now believes that some good can come out of the tragedy. "If you had a beautiful daughter and she was lying in a graveyard, what would you do?" she asks.

"I haven't got anything to lose. I lost it. I've lost my life, my daughter, my only daughter. She died from one mistake."

— Rochelle Sharpe

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 32
February 20, 1990

The Impact of Mandatory Parental or Judicial Involvement



HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 33
February 20, 1990

LANA OLEEN
SENATOR, 22ND DISTRICT
RILEY AND GEARY COUNTIES

LEGISLATIVE HOTLINE
1-800-432-3924

STATE OF KANSAS

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

CHAIRMAN: GOVERNMENTAL ORGANIZATION
VICE-CHAIRMAN: CONFIRMATIONS
LABOR, INDUSTRY AND SMALL BUSINESS
MEMBER: ASSESSMENT AND TAXATION
ECONOMIC DEVELOPMENT
JUDICIARY
LEGISLATIVE EDUCATIONAL PLANNING COMMITTEE
CHILDREN AND YOUTH ADVISORY COMMITTEE
JOINT COMMITTEE ON ARTS AND CULTURAL RESOURCES

CHAIRMAN BARR & MEMBERS OF THE COMMITTEE:

Due to some confusion on yesterday's hearing (I accept the blame) for proponents of parental consent/notification legislation, a young constituent from my district was not called upon to testify.

Kristi Armstrong, a senior from Manhattan High School, made the trip to Topeka and I have attached a copy of her testimony. She expressed to me last night, her admiration for the political process in which we function.

Thank you for your consideration of her testimony.

Sincerely,

Lana Oleen
Kansas Senator

February 20, 1990
Attachment

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 34
February 20, 1990

1631 FAIRCHILD
MANHATTAN, KANSAS 66502
(913) 537-7718

STATE CAPITOL, ROOM 143-N
TOPEKA, KANSAS 66612
(913) 296-7360

PARENTAL NOTIFICATION

February 19, 1990

House Committee on
State and Federal Affairs

Dear Chairperson Barr and Members of the Committee:

I am Kristi Armstrong a senior at Manhattan High School. I appreciate this opportunity to express my opinion on parental consent for minors to receive an abortion.

I feel parents of pregnant minors who are planning to obtain an abortion should be consented. The parents can help the minors look at all the options, they should not make the decision for the minors but open up the lines of communication so a comfortable choice can be made.

The decision to have an abortion is difficult and stressful for adults and even more so for minors who may not know all the options availabe to them. Minors may not have the forsight to realize the physical and psychological complications that an abortion can create. They need support from their parents and family, that is what families are for. Having an abortion is a very emotional experience for minors, who are scared. They see abortion as their only and quickest way out of a problem. They are not thinking of how they will feel in the future. They know that an abortion gets rid of the physical problem but forever in their mind will remain the experience.

Parents have the capability to understand the traumatic nature of a minors pregnancy. They can give advice, emotional stability and above all love that is an important factor when minors have such a burden to deal with. The parents can also provide essential medical information to the physician that minors may not even be aware of.

Once again I believe that the parents must be consented and the health and welfare of the minors must be of upper most importance. The parents of pregnant minors should not make the decision for them but give emotional support and guidance minors may not even know they need from their families.

I would like to thank the committee for their time and for allowing me to address you today.

Kristi Armstrong

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 34A
February 20, 1990

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anned Parenthood. We
at's best for your family.*

What You Can Do To Help

Contact your local Planned Parenthood. They'll tell you how you can:

- Write to your legislators. Let them know you don't want the government interfering with private decisions that are rightfully yours, your child's, or your family's.
- Join a parent education group, parent-child workshop, or other program to encourage comfortable family communication on sexuality issues.
- Work in your community for comprehensive school sexuality education programs, which have been proven to increase the chances that teens will delay having intercourse and to lower students' pregnancy rates.
- Urge the government to provide money and resources for developing new, more effective methods of birth control.
- Persuade other parents to join in working for pro-child, pro-family programs and policies.

...And be sure to pass this brochure along to your friends!

810 Seventh Avenue
New York, New York 10019
212/541-7800

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1750 2/88-10 2.74

8 Arguments For Keeping Government Out Of Your Family's Life

1 2 3 4 5 6 7

Mandatory Consent and Notification Requirements... and What's Wrong With Them

Mandatory consent and notification requirements are laws, enforced in nine states around the country and on the books in 24 others, that thrust the government into the heart of extremely private family decisions. The laws say that a minor (someone under 18 years old) who wants an abortion MUST notify her parents and/or get their written approval; OR she must appear before a judge. In this procedure, called a "judicial bypass," the judge decides whether the minor is mature enough to make her own decision about abortion or, if she is not, whether an abortion would be in her best interests.

These laws may sound good at first: Most people (including Planned Parenthood) think parental involvement in young people's reproductive decisions is a great idea. And most teens facing unwanted pregnancies **do** seek their parents' advice. For these families, the laws are unnecessary. However, as you will learn from this brochure, for the teens who feel they **can't** tell their parents, the laws are terribly damaging.

uments Against
hese Laws

teenagers, such laws are Most minors (especially younger nsult their parents when seeking

mmunication can destroy nall percentage of teens who ir parents in their abortion ave very good reasons:

me from unstable or violent one or both parents may be emotionally abusive, substance usly ill, unemployed — gether.

pregnant as a result of incest.

r that their parents will throw e house if they learn of the

ns already have the cards stacked them, mandatory consent and are devastating. Experts in family gree that while voluntary and ion is good for families, the "family chat" is nearly always s who have been involved in e laws only add to whatever nd violence the teen and her y be suffering. The laws ignore nces and scapegoat teens whose ifficult and complicated.

present troubled teens with lternatives. The small percentage of teens who cannot involve their parents in their abortion decision are left with difficult and often dangerous choices. One study shows that, of the 1.1 million teens who become pregnant each year, mandatory consent and notification could lead 37,125 to seek dangerous illegal or self-induced abortions; an equal number would have unwanted births, which often doom mothers and children to lives of hardship, welfare dependency, and lost opportunities. Thousands more would run away from home or travel to other states for confidential abortions. And thousands would undergo the trauma of the "judicial bypass" procedure.

4. *"Judicial bypass" invades family privacy by giving parental authority to judges and putting teens on trial.* Teens who can't approach their parents are forced to justify a very private decision to judges, courtroom officials, lawyers, and others, who are usually total strangers. Worse, in small towns, they may be acquaintances of the teen or her family — thus jeopardizing her confidentiality, as well as whatever cohesiveness remains in her family. Furthermore, studies show that some judges bully young women with inappropriate, insulting questions, or try to pressure them into a particular decision.

Surely our nation's judges could spend their time more productively — sentencing criminals and turning the wheels of justice, rather than promoting injustice. And teens who feel they can't talk to their parents should be allowed to get help and advice without government intrusion — from health and social service professionals, not from court officials.

5. *"Judicial bypass" threatens teens' health and increases their emotional and financial burden.* "Judicial bypass" procedures are required by law to be prompt, efficient, and confidential. In reality, they are usually a drawn-out series of several appointments and appearances. Often teens who have limited access to transportation must find a way to travel hundreds of miles to court hearings. Delays of several weeks are common. Such delays increase the teen's health risks, since an earlier abortion is a safer one; they sap her emotional stamina at a time of great stress; and they increase the cost of the abortion procedure, adding to her hardship.

6. *"Judicial bypass" discriminates against disadvantaged teens.* Poor, uneducated, rural, and minority teens already have limited access to the court system. Often they don't understand how to negotiate the complex legal system or how to get help. The burdens of mandatory consent and notification laws fall heaviest on these young people.

7. *"Judicial bypass" is illogical.* It puts judges in the paradoxical position of deciding that a young woman is either 1) mature enough to make her own decision about abortion, or 2) too immature for an abortion, but somehow mature enough to continue the pregnancy and become a mother!

8. *Experts agree that the laws are useless and damaging.* The only people who promote mandatory consent and notification laws are extremists who favor punishment over prevention — or people who have not considered the catastrophic impact of these laws on teens and families. In fact, major professional, medical, and social service groups have opposed these laws. Judges, lawyers, and counselors who have experience with these laws conclude that they do **not** lead more teens to communicate with their parents, **nor** do they help teens make appropriate decisions for themselves. They only threaten family unity and harass teens who are already under stress.

What Kinds of Laws and Policies Can Help Teens and Families?

- Parental involvement in teens' sexual and reproductive decisions is ideal; but **family communication can't be legislated.** It **can** be improved through expanded preventive, voluntary measures, like the family communication workshops run by Planned Parenthood nationwide. Establishing comfortable communication about sexuality — beginning in early childhood — is the only way for parents to truly influence their children's sexual behavior.

- Instead of counterproductive laws that **damage** families, we need more government programs to **help** families, particularly troubled ones — programs like day care, family therapy, literacy and vocational training, treatment for the tragedies of drug addiction, alcoholism, and domestic violence.

- And, we need a society-wide commitment to reducing teen pregnancy. We need comprehensive sexuality education in schools and community settings; funding for low-cost, confidential birth control services for teens; and broad, meaningful job opportunities that will motivate young people to avoid threatening their futures with premature pregnancies.

For the sake of our families, all Americans must work to block harmful mandatory consent and notification laws. We must fight for the programs American teens and families **really** need.

Educational Services

Knowledge is power. Nowhere is this more evident than with our youth today— if they have the knowledge necessary to make wise choices for themselves on reproduction, then they have the power to control the quality of their lives and their future. We are committed to providing accurate, current information on reproduction and human sexuality.

Planned Parenthood of Kansas staff provide education through a variety of activities in local communities.

- A total of 323 presentations were made in 1989 to schools, churches and community groups reaching over 8,700 individuals. This represents over 12,000 contact hours of human sexuality education.
- Throughout the year PPK has sponsored workshops for teens, their family, teachers and the clergy focusing on contraception, communication, teen pregnancy prevention, AIDS and other sexually transmitted diseases and human sexual growth and development.

Education

- Abstinence
- Setting Your Sexual Limits
- Assertiveness Training
- Decision Making Skills
- Teenage Pregnancy Prevention
- Human Sexuality
- Parents As Sex Educators
- Contraceptive Methods
- Parent-Child Communication
- Abortion Rights Movement
- Sexually Transmitted Diseases

Counseling

- Abstinence
- Pregnancy
- Adoption
- Parenthood
- Abortion
- Contraception
- Sterilization
- Infertility
- Medical
- Sexually Transmitted Diseases

Advocacy Services

Planned Parenthood of Kansas has taken an active role in working with legislators, elected officials and members of the community to secure their support in preserving reproductive freedom.

We believe choices regarding family size, when to begin a family and contraceptive methods are personal decisions to be made in the privacy of the home, not in the legislature. We support freedom of choice for all women in their decision regarding the management of an unintended pregnancy. We support the right to have a safe and legal abortion, the right to provide education and contraceptive services to women of all ages, and the right to quality reproductive health care services for those who cannot afford to pay.

Our efforts to preserve these rights include:

- Maintaining ongoing contacting and educating with local, state and national elected officials.
- Networking with local community and state organizations that share our commitment to reproductive freedom.
- Composing and distributing ALERTS to PPK supporters urging them to contact their elected officials concerning reproductive rights legislation and family planning funding.

PPK Financial Report, 1989

Income		Expense	
Contribution	$ 10,345	Education	$ 11,918
Education	2,620	Patient Services	184,651
Title X	37,403	Public Affairs	13,899
In-Kind Gifts	637	Management	60,147
Patient Fees	176,071	Fundraising	3,479
Special Events	5,835		
Interest	772		
Total	**$ 233,683***	**Total**	**$ 274,094***

* These figures represent a six-month audit, January through June 1989. A new fiscal reporting period is in progress.

The Mission

To provide comprehensive reproductive and complementary health care services in settings which preserve and protect the essential privacy and rights of each individual.

To advocate public policies which guarantee these rights and ensure access to such services;

To provide educational programs which enhance understanding of individual and societal implications of human sexuality;

To promote research and the advancement of technology in reproductive health care and encourage understanding of their inherent bioethical, behavioral and social implication.

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Planned Parenthood of Kansas, Inc.

Hays Clinic
122 E. 12th Street
Hays, KS 67601
(913) 628-2434

Wichita Clinic
2226 E. Central
Wichita, KS 67214
(316) 263-7575

Planned Parenthood of Kansas, Inc.

Annual Report 1989

Planned Parenthood of Kansas Is...

- committed to improving the quality of life, promoting freedom of choice, providing sound education, counseling, and excellent medical care to those we serve.
- dedicated to the principle that every individual has the fundamental right to make independent decisions about having children—about becoming a parent by choice, not by chance.
- at work locally and statewide to help men and women implement those life decisions.
- the largest provider of family planning and reproductive health services in Wichita and Hays.
- an affiliate, founded in 1972, of the nation's oldest and largest voluntary family planning agency, Planned Parenthood Federation of America, Inc.
- funded by patient fees, donations and government grants.

The Problems We Face...

1. An estimated 7,110 adolescent women (19 yrs & under) in Kansas are at risk of unintended pregnancy (sexually active, no birth control, and low income).
2. 70% of all adolescents between 15 and 20 years have had intercourse, only one third use birth control regularly.
3. Over 7,000 teens became pregnant in Kansas in 1989, two-thirds of these were unintended.
4. Kansas ranks 19th in the nation in rate of white adolescent pregnancy; 7th in black adolescent pregnancy.
5. 8 out of 10 Kansas women who become mothers at 17 or younger never finish high school.
6. The incidence of chlamydia and other sexually transmitted diseases (STD's) continues to increase throughout the state. There have been 160 AIDS deaths in Kansas since 1981.
7. Kansas taxpayers spend over $145 million each year on public assistance, medical care and nutritional programs for families started by adolescents.

...And The Solutions

Unintended pregnancies, sexually transmitted diseases, and AIDS know no boundaries. All of us in Kansas are affected—as individuals, as family members and as neighbors. Everyday we face formidable challenges: to provide Wichita, Hays and other Kansans with quality reproductive health care services and community health education and to protect our right to choose the reproductive health care services needed. PPK offers comprehensive reproductive health care services to all, regardless of age, ethnic background, religion or the ability to pay.

Clinical Services Provided, 1989

	Ellis Co.	Sedgwick Co.	Cowley Co.	Total Patients
Contraception	2,340	2,832	94	5,266
Routine Gynecological Exam (Breast, Pelvic & Pap)	1,185	2,370	70	3,625
Sexually Transmitted Disease Testing	1,834	3,195	54	5,083
Pregnancy Testing & Counseling	436	1,795	23	2,254

Patient Profile, 1989

	Ellis	Sedgwick	Cowley*	Total
RACE				
White	1,294	2,146	81	3,521
Black	17	186	4	207
Asian	4	14	1	19
Am. Ind.	4	12	-	16
No Stats	106	381	-	487
AGE				
10-14	6	33	1	40
15-17	113	424	15	552
18-19	265	524	23	812
20-34	868	1,333	47	2,248
35-44	34	35	-	69
45→	2	3	-	5
No Stats	7	383	-	390
POVERTY LEVEL				
Below 150%	1,125	2,152	82	3,359
Above 150%	167	197	4	368
PATIENT STATUS				
New	536	1,196	40	1,772
Continuing Patients	889	1,543	46	2,478
MEDICAL CARD				
Yes	172	81	14	267
No	1,147	2,274	72	3,493
No Stats	106	384	-	490
EVER BEEN PREGNANT?				
Yes	453	837	37	1,327
No	859	1,516	49	2,424
No Stats	113	386	-	499

** Figures for 3 months only. Clinic closed 3/89*