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Can we listen to each others stories and learn from one another?

I am Queensland GP of 20 years experience, including 10 years caring for survivors of trauma and neglect, including domestic violence, in our community. My professional training has included training in attachment, trauma and grief and loss, including perinatal grief. My clinical experience includes caring for women in crisis pregnancy, women many years after abortion and a woman carrying a disabled child to term. I have been privileged to be allowed into the inner worlds of women's hearts, experiences, workplaces and homes in all levels of our community.

I come to this committee with concerns over the level of coercion that women experience in the abortion decision, the risk to medical best practice of ideological and social pressures, and a growing dismissive community response to the unborn child.

Do Women really have free choice when they consider abortion?

A modern understanding of our community would reveal very little government funded support for women in crisis pregnancy. I call on this state to provide comprehensive accessible support for women in crisis pregnancy. **Current provisions for emotional, social and financial resources for women who need support to continue their pregnancy are inadequate**, leaving many feeling that abortion is the only option they can see in the midst of crisis. I see abortion as a last resort decision of a woman who feels alone and afraid. These fears can be myriad – from practical financial and accommodation fears, loss of career and future plans, loss of a partner who threatens to abandon her, loss of sense of her own self, fears about her ability to mother, and so on. This group of women in our community deserve tailored attuned funded care. How can abortion be called a choice by some if other choices are not as readily available?

As a professional working within the Queensland community, I testify that a modern understanding of our community also means **we cannot ignore the reality that many women live lives of oppression**[1] – still financially, emotionally, psychologically and relationally controlled by the men in their lives. Claiming that abortion is a freely chosen modern woman's right is not reflective of the real world my patients live in. Our growing awareness of the number of Queensland women who live within abusive families should be linked to our understanding of the reasons why women ever end up in an abortion clinic. A significant portion of those women who undergo abortion are currently enduring, or have endured in the past violent, abusive or neglectful intimate relationships (including incest and other forms of abuse on those who are young). Abortion on demand removes the protection of the law for these women. The current culture of abortion as a response to crisis pregnancy, without provision of social support or safe havens, means that abortion can be facilitating, or at least hiding, domestic violence in our community. My observation would be that **high abortion rates and demand for abortion are more an evidence of the oppression of women, than their liberation.** Domestic violence and other forms of coercion are inextricably linked to abortion in our community. We cannot ignore this when devising public policy.

[1] Forms of coercion may include partner or family violence, withholding of finances or physical support (for example accommodation), family disapproval or conflict, stigmatizing processes, threats, or withholding of affection or emotional support. Coercion may also come from medical professionals, especially in the case of foetal malformation or referral processes for abortion where ideology or profit and referrer are linked. Women may also experience internal coercion when they believe that they are not able to withstand the intimacy required to carry or mother a child, and may feel they are broken and have lost the sense of self required to feel they can mother resiliently. Coercion may also involve societal constructs that leave a pregnant woman with minimal educational, financial and physical supports or options, or societal stigmatized perceptions of women who carry unsanctioned pregnancy on the presumed loss of future and self that motherhood may entail. Pregnancy in situations of crisis is often the result of other more hidden violations – of consent in sexual relations, of equal say over condom use, over a sense of only being worthwhile as sexual objects, of women prioritizing the men in their life over their own futures and wellbeing and desires and even maternal desires

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My hopes from this committee's deliberations are that the situation of crisis pregnancy could become a key moment for possible community intervention to help women who are in dangerous, oppressive or vulnerable intimate relationships, to find women who are depressed and anxious, to identify survivors of childhood trauma and to protect women and children who have found themselves in crisis.

Suggestion:
Maintain current law that has the potential to protect women from coercion unless the mother's life is at risk until:

- Streamlined, accessible, affordable comprehensive pregnancy support services be established that include perinatal mental health units that help women to adjust to pregnancy (especially those who have experienced abuse and neglect as children themselves) for all women, especially those in crisis.
- Transparent independent processes are enshrined in law that screen and protect women who are experiencing any form of coercion to abort.
- Added protection is in the law against any medical provider who performs an abortion without screening for and supporting women experiencing coercion in their intimate and reproductive lives.

Professional experience:
I have encountered so many women who have felt pressured by others or their life circumstances to abort their unborn child. There are many who have felt they have no option but abortion – teenage women, a woman who felt she could not have any more children and was coping with an abusive husband, women who have felt career pressure, young women whose partners and parents have abandoned them. These women describe feeling cornered, hopeless, alone and vulnerable. They have expressed to me that they have made a decision against their core wishes because of fear of loss of relationship or their circumstances. I have met women who were forced to have an abortion to hide the pregnancy from incest; another who saw relief from abuse when she was pregnant; a woman whose partner told her to abort and refused financial support for her as she had 'chosen' to keep the pregnancy; women who describe deciding to abort in order to keep their romantic relationships, or in response to direct requests from the partner to abort, some who describe feeling 'dead on the inside' as a result of their own decision to abort, and others who in response to experiencing no partner, or family support feel totally isolated and despite ambivalence at the abortion clinic, are not provided any other options but to abort. Some have come to me months later whispering that they feel they had murdered her child. Other circumstances of coercion I see are the result of childhood neglect and abuse where the women feel powerless and unworthy of their own wishes being cared for – the experience of sexual exploitation and powerlessness continues into their adult lives, even within committed relationships. Some have ongoing risk taking in their sexual lives, including pregnancy, and then feel extremely disconnected or ambivalent experiences towards their pregnancies that mean they feel unable to mother. These are all real experiences for women in our community.

At the same time, I am aware of the experience of women who are able to access perinatal and maternal infant health services that look after attachment trauma, as well as women who have access to trauma specific therapy. My experience in my clinical practice, is that it is possible to treat women and families who are traumatized. It is possible to teach new empowered ways of relating to others that mean women feel freed from oppression from within and without. It is possible, with community support for women to go from feeling unable to negotiate her sexuality, unable to negotiate contraception, or unable to mother, to feeling empowered to do so. This state has specialist mental health units[2], working using the latest research

[2] https://www.health.qld.gov.au/qcpimh/

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to work with attachment disruption[3], and the community and individual forces that impact on a woman's mental health when she is pregnant, including past abuse, insecure attachment and loss and trauma. The expertise of these units needs to be consulted when considering increased access to abortion in our community.

Do doctors have freedom to practice in the situation of crisis pregnancy?

Medical obstetric training would regard pregnancy as a situation where the doctor needs to address the needs of two patients. This is scientifically robust and inclusive and is an underpinning of good quality antenatal care. Social expectations with regard to options or choice or rights in crisis pregnancy have at times been diametrically opposed to this medical approach to pregnancy.

The framing of this debate as the de-criminalising of a medical procedure completely ignores those medical paradigms that would not consider abortion a medical procedure (except when the mother's life is at risk). This medical paradigm would in no way sanction the current justification before the parliament to increase access to abortion in our state all the way till birth. It would suggest **this is a social ideological decision that cannot be justified medically**[4]. I make special note that this is not just about 'conscience rights' or even religious freedom for doctors, it is about being free to practice medicine based on the scientific evidence they consider directly involved in each area of their practice.
Any law where medical decision making will be coerced by societal pressures (including the risk of legal or professional retribution as is already happening in other Australian states) if a doctor acts on his understanding of the science, is a dangerous precedent in modern democracy. Medical practitioners do many services on behalf of their community, but our **separation from social directives on how we practice is one of the things that keeps us ethical safe contributors to our community.** In Victoria, Australia, doctors are already being forced to participate against their medical training, for example, to abort a baby for being female[5]. This is not a medical procedure.

I also have concern that **exposure to this procedure is already traumatizing medical personnel**. At a fundamental level, medical practice has an underlying ethos of protection and healing of the the vulnerable and preserving life. The Hippocratic oath urges practitioners to 'do no harm'[6]. This means that in situations where abortion is 'on demand' (namely the patient's demand) medical practitioners are being exposed to situations that are fundamentally at odds with their clinical practice and their internal motivations for their work. This is already traumatizing doctors.

I also have concern about the ideological bias in much of the research and clinical debate in this area. Even in the research literature, a dismissive attitude to practitioners who hold the opposing view is notable in the way that statistics are reported, topics of research are chosen, investment in research is directed, and differing opinions suppressed or even ridiculed. I would **urge the parliament to be aware that there is currently no medical consensus about best practice in the situation where a woman requests termination for social or mental health reasons.** There is no consensus in the current research about risk factors,

[3] The literature on attachment and the evidence about insecure and disorganized attachment and its effect on parenting skills is well established. The insights from this literature is used to care for children in our psychiatric and foster care system, as well as in childcare and educational settings, and maternal and infant mental health encounters. Breakdown in maternal-child bonding has far reaching impacts into the next generation and can be impacted by perinatal loss. Attachment is a deeply human experience of being welcomed, delighted in and encouraged to grow. It is a key component of developing a safe sense of who we are in relationship with others and a stable sense of self. Disordered or insecure attachment is a contributor to mental ill-health, inadequate parenting, difficulty managing emotions and self-soothing, as well as difficulty maintaining safe relationship boundaries (putting people at risk of tolerating invasion or neglect

[4] This medical decision making is based on sound science in the area of genetics, obstetrics, perinatal mental health and maternal attachment. There are those who would also not refer for abortion for medical reasons of risk to the mother of future preterm birth, breast cancer and post abortive grief based on current research.

[5] (http://blogs.news.com.au/heraldsun/theperch/index.php/heraldsun/comments/gender_selective_abortion_sick/)

[6] Practitioners have been trained to assess the biological realities of a situation and make decisions based on that rather than the social or emotional pressures surrounding crisis decisions – this means that the social reasons for abortion are not medically convincing when the practitioner is aware of the reality of a healthy foetus they know they are harming in the process of abortion.

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contraindications and indications for this procedure[7]. There is a growing literature suggesting a link between abortion and breast cancer, preterm birth and post abortion distress and yet my patients report these potential risks are not part of standard informed consent[8]. This is not good quality science. In normal informed consent, doctors would inform women about all risks, including those where the science is still contentious, especially when this is a high prevalence procedure. But in this ideologically divided area those contentions are not revealed to women in crisis or in public education of the community. These issues with scientific rigor have direct impacts on the informed consent processes that women undergo as part of everyday abortion practice in Queensland.

As I have already stated I am very aware of the societal pressures on women and their doctors that can result in the desperate choice to abort. I believe that medical practitioners need to be protected from ideological and social pressure to conduct procedures on our community that they consider are not medically justifiable.

Suggestions:

- Enshrine in law the protection of those that continue to see two patients to care for in any pregnancy and cannot medically justify this procedure on demand.
- Make clear defined protections for all people potentially traumatized by their involvement in abortion procedures – from students, cleaners, nurses, doctors and other medical personnel.
- Clarify the requirements to give information on all potential risks to the mother and all information on the gestation of the child (including ultrasound) so each woman has full informed consent.
- Initiate cross-ideological research into areas of public health concern regarding abortion and its impact on women (e.g. coercion, breast cancer, preterm birth, post abortion psychological distress, informed consent processes). This may need to be conducted by researchers who do not have prior ideological preconceptions in this area or in teams that include a representative cross section of ideologies.
- Offer good quality perinatal loss support to all post abortive women in recognition that they have suffered loss worthy of care.

<u>Professional experience</u>:
The highly politicized nature of this debate means that even medical questioning of abortion and its safety is linked to not affirming women's equality (or even of hating women). This means usual medical decision making and giving of informed consent – including the significant evidence of potential harm to the mother and her future pregnancies, is not standard practice. I have certainly been in clinical situations where despite

[7] http://wp.patheos.com.s3.amazonaws.com/blogs/warrenthrockmorton/files/2008/09/abortion-mh-editorial-2008.pdf Royal College of Psychiatrists points out contention in the science and their position on the risk of mental health in abortion.
[8] This science has been confirmed in numerous countries, including India and Russia where the ideology of researchers is not so contentious, and yet their research is not included in the discussion on this topic for ideological reasons. In any other area of science, this level of concern would lead to large scale prospective studies based in mammogram clinics and abortion clinics – these studies have not been done in Queensland.

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no medical indication for the procedure, social pressures are difficult to resist. I note that the rate of late term abortions is going up in Victoria since the law has changed[9]. As I practitioner, I need the protection of the law in this situation.

I have also met many women who express regret or disquiet about their abortions many years later. I have met a woman who told me it would be her aborted son's 18th birthday as she remembered his due date, and she wondered if he would have had blue eyes. Another woman who experienced lifelong infertility after an abortion in her youth. A woman recently who had 6 terminations and 4 live births – all with the same man. She sees her terminations as something that had to happen, but is now describing difficulty connecting to her youngest 2 children as she feels ambivalent about her choice to have these children. I have met a grandmother who expressed her joy at the life of her grandson whose mother was on the way to the abortion clinic, when a call from grandmother helped her feel strong enough to continue the pregnancy against the partners wishes.

I spoke this week with a former patient who is a medical practitioner who gave consent for me to share her traumatic experience in a rural Australian public hospital, in about 2004. She described the hospital's practice of wrapping aborted infants who had been born alive in cloths or blueys and putting them "on a shelf in the pan room to die". She said when she became aware of this, she started going into the pan room to hold each baby until he or she breathed their last. She said that she had done this with several infants. She said she found it difficult to cope with – especially because on the floor above in the neonatal unit, they would work to save babies of the same gestation or weight. This is a very distressing example where a practitioner has already been forced against her medical training and ethos to participate or witness abortion. I believe that this procedure adversely affects those who feel they are implicated in referral or direct involvement with abortion and may affect which students choose medicine in the future. It would have stopped me studying medicine.

How does our community remain inclusive of disability and those in pain?

The way we treat the most vulnerable humans in our community matters. It has significant implications for how we see ourselves when we are imperfect, not useful, not strong and not welcomed. In my work with trauma survivors, I observe that this inner attitude towards weaknesses and imperfections has significant impact on mental health. If we are to hold a position of integrity, then **we need to intentionally welcome weak powerless unwanted human beings. To not do so impacts on all of us.**

The community attitude to the unborn child has become less embracing - the unborn child, despite being more understood through ultrasound, being able to experience pain, and more capable of survival with medical support, has gone from protected and included to being on the 'outside' of our inclusive community. In a modern community that has increasing social fragmentation, where women are increasingly left to carry the result of two people's sexual activity, access to support to both mother and child is a compassionate necessity for a community wishing to serve and care for its citizens of all ages and in all locations (including the womb).

Another example of the modern loss of communal embrace toward our community is in our response towards those infants who have potential disability. I call on this state to **integrate its abortion policy with its disability policy**. We cannot look disabled people in the eye and tell them we consider them equally valuable and worthy of love and life, yet at the same time encourage women to abort babies on the grounds of their potential disability. The current fragmented disintegrated approaches to this problem are certainly the result of our culture, our social values, our increasing disrespect for those who are not physically or intellectually well. How can we judge some humans as less worthy of life than others? Having supported women who carry children with disability through life, and a woman who decided to deliver her son who would not live long into the arms of her loving family, and being aware of the research confirming high rates

[9] http://realchoices.org.au/2016/06/victorian-stats-now-available/

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of post abortive psychological sequelae after termination for fetal abnormality. I am convinced that any decision to end the life of a child – no matter how disabled – is not a medical, but a social decision.

Suggestion:

- That our community intentionally discuss the humanity of the unborn – radical 'progressive' assumptions about the unborn's humanity are taking our culture by stealth. These assumptions are not in line with the general community's understanding, with science, with our increased attachment and investment in the unborn in other areas (eg 4D ultrasound or increasing prevalence of finding out the sex or naming the unborn) or with many other philosophical positions (including medicine). This proposed law change enshrines one dominant discourse over others, without an inclusive discussion of what the community wants.
- That those clinicians and researchers and people with lived experience as parents and sufferers of disability be included in any legal frameworks that are developed to deal with their rights under abortion law. Perhaps this group of people might also be the best placed to evaluate the rights of the unborn in cases where mothers have 'chosen' not to proceed with the pregnancy.

In Summary:
I note that those calling for a repeal of abortion from the criminal code are calling for protection of women who present in great distress regarding their pregnancies. I am fully aware of the many societal and relational coercive processes that may have led a woman to feel she has no other option. I am aware of the distress those medical practitioners may feel when they encounter these women. But I would suggest that the parliament has a duty to care for the whole community, for women who are oppressed into abortion, for the unborn, for medical practitioners, and for the attitude of the community as a whole towards pregnant women in crisis.

I believe this debate needs to be framed in a new way.

I believe our community needs to go one step better than abortion – in its protection of women's freedoms and rights. To undertake to provide real social support and the latest in attachment focused mental health interventions to women in our community coping in violent, coercive homes, who have lost a sense of their own agency and capacity to manage their intimate relationships including their parenting decisions. I believe our community needs to actively celebrate pregnancy and motherhood as worthwhile empowering experiences of womanhood and provide embracing connection for women in crisis.

The rhetoric of abortion as a freedom, a right, as risk-free empowering decision does not match with my modern clinical experience or the literature.

I believe the Queensland community needs to ask if it is ready to proactively decide what its planned attuned response will be to a woman who is isolated and vulnerable in crisis pregnancy. This debate, I hope, could be about whether our community has enough compassion to embrace and connect with a woman in crisis, often abandoned by all close family, and struggling with significant ambivalence and fear. Instead of a dismissive surgical procedure in the supposed service of the modern woman's freedom, **I call on our community to be a place of integrity and warm creative embrace towards women and children in crisis in Queensland. I think we can do it!**

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Relevant academic literature:

- Perinatal mental health care should be standard care of pregnant women in our community[1, 2].
- Hall [3] in her study of intimate partner violence and termination of pregnancy cites a lifetime risk of domestic violence in those who attend abortion clinics of 25% and says 'violence can lead to pregnancy and to subsequent termination of pregnancy and that there may be a repetitive cycle of abuse and pregnancy."
- Coercion influences decisions to abort. [4]
- Some women choose to abort against their moral or maternal desires. [5]
- Domestic violence is a risk factor for abortion [6]
- Prevalence of domestic violence and coerced sex [7] [8] [9] [10].
- Withholding of affection and support has significant impact on abortion rates. [11]
- Women can feel pressured by medical expectations. [12]
- Or by community expectations. [13]
- Herman [14] maintains that women may be rendered captive by the invisible barriers of economic, social, psychological and legal subordination.
- Manninen [15] has likened the current pressures in the abortion debate as similar to the dehumanizing in racial vilification. These pressures have a direct impact on medical practice and decision making in medicine.
- Significant evidence raising awareness of the risk of negative mental health outcomes and statement that abortion for mental health reasons for abortion "are not currently supported by population-level evidence".[10] Suggests "*Until sound evidence documenting mental health benefits of abortion is available, clinicians should convey the current state of uncertainty related to benefits of abortion in addition to sharing the most accurate information pertaining to statistically validated risks."* This evidence matters.[16]
- Lanfranchi [17] summarises the current state of the evidence of a breast cancer abortion link.
- Evidence of very preterm birth after induced abortion. http://www.ncbi.nlm.nih.gov/pubmed/15777440
- Pro-choice researchers have revealed that 28% of women regret their decision and 31% say they would not have the abortion again [18].
- Risk factors for complicated grief include features that are common in abortion processes – including: conflicted relationships, close relationship between mourner and the lost, relationships which were dependent and confiding and close, weak parental bonding in childhood, damaged sense of security due to child abuse/neglect, poor social support network, sudden unexpected loss, disenfranchised grief (lack of recognition complicates grief as well as reducing sources of support)and perceived avoidability. [19]
- Psychological risks after abortion cannot be dismissed as simply the result of preexisting mental disorders. [20]
- Psychological distress after abortion for fetal abnormality is significant.[21]
- There is international evidence of increasingly dismissive attitudes to life among the medical community in areas where the distinction between the life giving and life taking roles of the doctor are combined.[22]
- 'Hush. A liberating conversation about abortion and women's health.' is an informative documentary film from a pro-choice point on view on this topic.

[10] "Overall, the results revealed that women who had undergone an abortion experienced an 81% increased risk of mental health problems, and nearly 10% of the incidence of mental health problems was shown to be directly attributable to abortion. The strongest effects were observed when women who had had an abortion were compared with women who had carried to term and when the outcomes measured related to substance use and suicidal behaviour. Great care was taken to assess accurately the risks from the most methodologically sophisticated studies, and the quantitatively based conclusions reflect data gathered on over three-quarters of a million women. Of particular significance is the fact that all effects entered into the analyses were adjusted odds ratios with controls for numerous third variables." Taken from discussion in Coleman et al (2011)

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1. Austina, M.-P., *Perinatal mental health: Opportunities and challenges for psychiatry.* Australasian Psychiatry, 2003. **11**(4).
2. Ayers, S., *Should perinatal mental health be everyone's business?* Primary health care research & development, 2015. **16**(4): p. 323-325.
3. Hall, M., Chappell, LC., Parnell,B.L, Seed, P.T., Bewley, S., *Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis.* PLOS Medicine, 2014.
4. Coleman, P., Reardon, D., Cougle, *Substance use among pregnant women in the context of previous reproductive losses and the desire for pregnancy.* British Journal of Medical Psychology, 2005. **10**: p. 255-268.
5. Kero, A., Lalos,A., *Ambivalence - a logical response to legal abortion: a prospective study among women and men.* Journal of Psychosomatic Obstetrics and Gynaecology, 2000. **21**(2): p. 81-91.
6. Glander, S.M., Michielutte, R., Parsons, L, *The prevalence of domestic violence among women seeking abortion.* Obstetrics and Gynaecology, 1998. **91**: p. 1002-6.
7. Devries, K.M., Mak, J. Y. T. , García-Moreno, C. , Petzold, M. , *The Global Prevalence of Intimate Partner Violence Against Women.* Science 2013. **340**(6140): p. 1527-1528.
8. Taft, A.J., Watson, L.F., *Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women.* Australian & New Zealand Journal of Public Health., 2007. **31**(2): p. 235-142.
9. Saftlas, A.f., Wallis, A.B., Schocet, T., Harland, K.H., Dickey, P, Peek-Asa, C., *Prevalence of Intimate Partner Violence Among an Abortion Clinic Population.* American Journal of Public Health, 2010. **100**(8): p. 1412-1415.
10. de Visser, R., smith, A., Rissel, c et al, *Sex in Australia: Experience of Sexual Coercion among a representative sample of Australian adults.* Australian & New Zealand Journal of Public Health, 2003. **27**(2): p. 198-204.
11. Adelson, P., Frommer, M, Weiseberg, E., *A survery of women seekign termination of preganancy in New South Wales.* Medical Journal of Australia, 1995. **163**: p. 419-422.
12. Tankard Reist, M., *Defiant Birth. Women who resist medical eugenics.* 2006, Melbourne: Spinifex Press
13. Burke, T., *Forbidden Grief. The unspoken pain of abortion.* 2002, Springfield Illinois: Acorn Books.
14. Herman, J.L., *Trauma and Recovery. From domestic violence to political terror.* 1992, London: Pandora.
15. Manninen, B.A., *Mutual Scorn Within the Abortion Debate: Some Parallels With Race Relations.* Journal of Bioethical Inquiry, 2015. **12**(2): p. 295-311.
16. Coleman, P.K., *Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009.* The British Journal of Psychiatry, 2011. **199**(3): p. 180-186.
17. Lanfranchi, A.E., *Induced Abortion and Breast Cancer.* Issues in Law & Medicine, 2015. **30**(2): p. 143-151.
18. Major, B., et al., *Psychological responses of women after first-trimester abortion.* Archives of general psychiatry, 2000. **57**(8): p. 777-784.
19. Ray, P., *Complicated grief an attachment disorder worthy of inclusion in the DSM 5* Grief Matters, 2005. **9**(2): p. 33-38.
20. Speckhard, A., Mufel, N. , *Universal responses to abortion? Attachment, Trauma, and Grief responses in Women following abortion.* Journal of Prenatal and Perinatal Psychology, 2003: p. 3-37.

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21. Davies, V.et.al., *Psychological outcome in women undergoing termination of pregnancy for ultrasound detected fetal abnormality in the first and second trimesters. A pilot study.* Ultrasound Obstetrics and Gynaecolog, 2005. **25**: p. 389-392.
22. Smith, W., *Culture of Death. Age of Do Harm Medicine*. 2016: Encounter books.