from Dr. Jan Whitfield

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ACOG *Statement of Policy*

As issued by the ACOG Executive Board

ABORTION POLICY

The following statement is the American College of Obstetricians and Gynecologists' (ACOG) general policy related to abortion, with specific reference to the procedure referred to as "intact dilatation and extraction" (intact D & X).

1. The abortion debate in this country is marked by serious moral pluralism. Different positions in the debate represent different but important values. The diversity of beliefs should be respected.
2. ACOG recognizes that the issue of support of or opposition to abortion is a matter of profound moral conviction to its members. ACOG, therefore, respects the need and responsibility of its members to determine their individual positions based on personal values or beliefs.
3. Termination of pregnancy before viability is a medical matter between the patient and physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities.
4. The need for abortions, other than those indicated by serious fetal anomalies or conditions which threaten maternal welfare, represents failures in the social environment and the educational system.

   The most effective way to reduce the number of abortions is to prevent unwanted and unintended pregnancies. This can be accomplished by open and honest education, beginning in the home, religious institutions and the primary schools. This education should stress the biology of reproduction and the responsibilities involved by boys, girls, men and women in creating life and the desirability of delaying pregnancies until circumstances are appropriate and pregnancies are planned.

   In addition, everyone should be made aware of the dangers of sexually transmitted diseases and the means of protecting each other from their transmission. To accomplish these aims, support of the community and the school system is essential.

   The medical curriculum should be expanded to include a focus on the components of reproductive biology which pertain to conception control. Physicians should be encouraged to apply these principles in their own practices and to support them at the community level.

   Society also has a responsibility to support research leading to improved methods of contraception for men and women.

5. Informed consent is an expression of respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to the support of the patient's freedom within

caring relationships.

A pregnant woman should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion. The information conveyed should be appropriate to the duration of the pregnancy. The professional should make every effort to avoid introducing personal bias.

6. ACOG supports access to care for all individuals, irrespective of financial status, and supports the availability of all reproductive options. ACOG opposes unnecessary regulations that limit or delay access to care.
7. If abortion is to be performed, it should be performed safely and as early as possible.
8. ACOG opposes the harassment of abortion providers and patients.
9. ACOG strongly supports those activities which prevent unintended pregnancy.

The College continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman. Viability is the capacity of the fetus to survive outside the mother's uterus. Whether or not this capacity exists is a medical determination, may vary with each pregnancy and is a matter for the judgment of the responsible attending physician.

Intact Dilatation and Extraction

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

ACOG believes the intent of such legislative proposals is to prohibit a procedure referred to as "intact dilatation and extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; **and**
4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X. Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy.

The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these

were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother.

Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the only option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. **The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.**

Approved by the Executive Board
General policy: January 1993
Reaffirmed and revised: July 1997
Intact D & X statement: January 1997
Combined and reaffirmed: September 2000
Reaffirmed: July 2004
Reaffirmed: July 2007

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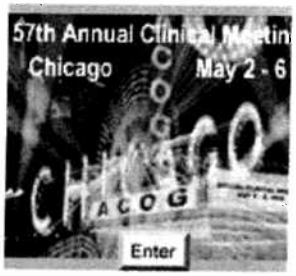

ACOG
Committee on Adolescent Health Care

Committee Opinion

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

The College wishes to thank Richard Guido, MD, and Abigail English, JD, for their assistance in the development of this document.

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Evaluation and management of abnormal cervical cytology and histology in the adolescent. ACOG Committee Opinion No. 330. American College of Obstetricians and Gynecologists.

[PDF format]

Number 330, April 2006

Evaluation and Management of Abnormal Cervical Cytology and Histology in the Adolescent

ABSTRACT: The management of abnormal cervical cytology in adolescents differs from that for the adult population in many cases. Certain characteristics of adolescents may warrant special management considerations. It is important to avoid aggressive management of benign lesions in adolescents because most cervical intraepithelial neoplasia grades 1 and 2 regress. Surgical excision or destruction of cervical tissue in a nulliparous adolescent may be detrimental to future fertility and cervical competency. Care should be given to minimize destruction of normal cervical tissue whenever possible. A compliant, health-conscious adolescent may be adequately served with observation in many situations.

Background

The past decade has seen a remarkable increase in the knowledge of the natural history of cervical dysplasia, the role of human papillomavirus (HPV) in cervical cancer, and the development of new technologies for cervical cancer screening, specifically HPV testing and liquid-based cytology. This new information prompted the American Cancer Society (ACS) to develop new guidelines pertaining to cervical cancer screening (1). Based on the natural history data and the rarity of cervical cancer in the population of women younger than 21 years, the ACS recommendations for initial Pap testing changed, and the new criteria have been endorsed by the American College of Obstetricians and Gynecologists (ACOG) (2). Adolescents should undergo their first Pap test approximately 3 years after the onset of vaginal intercourse or no later than age 21 years. The decision about the initiation of cervical cytology screening in an adolescent patient should be based on the clinician's assessment of risks,

Obstet Gynecol 2006;107:963–8.

including 1) age of first sexual activity, 2) behaviors that may place the adolescent patient at greater risk for HPV infection, and 3) risk of noncompliance with follow-up visits. Obtaining a complete and accurate sexual history, therefore, is critical (3).

The new information also prompted ACOG to develop new guidelines on the management of abnormal cervical cytology and histology (4). Some of these guidelines are unique for adolescents. The objectives of this Committee Opinion are to 1) highlight when the management of abnormal cervical cytology in adolescents differs from that for the adult population and 2) identify characteristics of adolescents that may warrant special considerations. It is important to avoid aggressive management of benign lesions in adolescents because most cervical intraepithelial neoplasia (CIN) grades 1 and 2 regress. Surgical excision or destruction of cervical tissue in a nulliparous adolescent may be detrimental to future fertility and cervical competency. Care should be given to minimize destruction of normal cervical tissue whenever possible. A compliant, health-conscious adolescent may be adequately served with observation in many situations.

Natural History of Human Papillomavirus

Most women infected with HPV are asymptomatic. The virus is detected by an abnormal Pap test result, HPV test result, or the presence of clinically evident genital warts, and most likely will resolve without treatment. In natural history studies of adolescents with newly acquired HPV infection, the average length of detectable HPV is 13 months. In most adolescent patients with an intact immune system, an HPV infection will resolve within 24 months (5). Further evidence that the HPV infection will resolve without treatment comes from the high rates of resolution of CIN 1 and CIN 2, 70% and 50% respectively (6–9).

Managing Abnormal Cervical Cytology in Adolescents

The new guidelines provided by ACOG address the therapy of cytologic and histologic abnormalities. These guidelines are based on best evidence when possible and expert opinion when limited data are available. For some but not all of the abnormalities, the guidelines have specific recommendations for care of the adolescent population that may differ from recommendations for adults and are summarized in Table 1. The following recommendations are unique to the adolescent population and address the clinical situations that can be managed by cytologic follow-up, HPV testing, colposcopy, or a combination of these approaches. A positive HPV test result refers to the presence of high-risk HPV DNA as determined by Hybrid Capture II. Testing for low-risk HPV types has no role in cervical cancer prevention.

Management Considerations

Atypical Squamous Cells of Undetermined Significance

Atypical squamous cells of undetermined significance (ASC-US) is a cytologic abnormality that in many cases identifies a woman harboring HPV infection. In the adolescent population, the prevalence of HPV in ASC-US will be higher than its prevalence in the older population. The risk of invasive cancer in adolescents approaches zero, and the likelihood of HPV clearance is very high. The preferred method of triage for patients with ASC-US who have undergone liquid-based cytologic screening is testing for high-risk HPV and, for those with a positive test result, triage to colposcopy. The ACOG guidelines address the high rate of HPV clearance by allowing less expensive alternative care than immediate colposcopy for adolescents with ASC-US and a positive high-risk HPV test result. Adolescents with atypical squamous cells and high-risk HPV-positive results may be monitored with cytology twice at 6-month intervals or a single high-risk HPV test at 12 months. If repeat cytology test results are abnormal, or there is evidence of persistent HPV, colposcopy should be performed. These alternatives are equally sensitive for the detection of CIN 2, CIN 3, or cervical cancer; avoid the expense of colposcopy and biopsy; and allow for the clearance of CIN and HPV (10). Immediate colposcopy is an acceptable alternative for the management of the adolescent who tests positive for ASC-US and HPV. Adolescents with ASC-US who have an HPV test result negative for high-risk HPV DNA should have a Pap test in 12 months.

Low-Grade Squamous Intraepithelial Lesions or Atypical Squamous Cells: Cannot Exclude High-Grade Squamous Intraepithelial Lesions

The Atypical Squamous Cells of Undetermined Significance/Low-Grade Squamous Intraepithelial Lesions Triage Study (ALTS) has demonstrated that the patients with the cytologic report of low-grade squamous intraepithelial lesions (LSIL) and ASC-US behave in a very similar manner with regard to the clearance of HPV and the risk for developing CIN 2, CIN 3, or cervical cancer. Because of the similarity in natural history of these two reports, the ACOG recommendations for treatment of LSIL are identical to those for ASC-US-positive HPV. Adolescents with an LSIL test result can be monitored by repeat cytology at 6-month intervals or by a high-risk HPV test in 12 months. These individuals should undergo colposcopy for any cytologic abnormality or the persistence of HPV infection at 1 year. Immediate colposcopy is an acceptable alternative for adolescents with LSIL Fig.1).

No studies specifically address atypical squamous cells: cannot rule out high-grade squamous intraepithelial lesions (ASC-H) in adolescents. Because of a lack of specific evidence and the higher rate of CIN 2, CIN 3, and cervical cancer in individuals with ASC-H, the adolescent with ASC-H should undergo immediate colposcopic evaluation.

High-Grade Squamous Intraepithelial Lesions

High-grade squamous intraepithelial lesions (HSIL) are a significant cytologic abnormality that requires colposcopic evaluation because of a much higher rate of histologically confirmed CIN 2, CIN 3, or cervical cancer. Colposcopy with endocervical assessment is the recommended treatment for adult and adolescent women with HSIL. In the adult population, ACOG guidelines include a "see and treat" alternative for individuals with HSIL using a loop electrosurgical excision procedure (LEEP). Although this is an acceptable alternative in the adult, it should be avoided in the adolescent population. A significant number of adolescents with HSIL will have CIN 2 on biopsy. Because of the high rate of resolution of CIN 2 in adolescents and the low rate of cervical cancer, adolescents with biopsy-confirmed CIN 2 with adequate colposcopy and normal histology test results on endocervical assessment may be monitored without intervention. The specific method of follow-up should be individualized by the health care professional. A reasonable approach to the follow-up could be either cytology or colposcopy at 4–6-month intervals.

Postcolposcopy Diagnosis of CIN 1 or Less in an Adolescent With HSIL Cytology

Because interobserver variability is most pronounced in younger women (11), the risk of invasive cancer is extremely low, and the likelihood of spontaneous resolution of CIN 1 or CIN 2 is high, follow-up with colposcopy and cytology at 4–6 months may be undertaken (12), as long as the colposcopy is adequate and the endocervical assessment is negative. Excision is an acceptable alternative to colposcopic follow-up, but it is known to increase the risk of cervical stenosis and preterm labor.

Atypical Glandular Cells

The Bethesda 2001 system for reporting cytologic abnormalities separates atypical glandular cells (AGC) into "not otherwise specified" (NOS) and "favor dysplasia." The cytology report further classifies the abnormalities based on the probable location of the cell of origin (endocervix, endometrium, or unknown). The prevalence of AGC cytology in the adolescent population is very low, and most of these abnormalities will arise from the squamous component of the cervix (13). Because of the rare nature of this diagnosis, a gynecologist with expertise in managing cervical dysplasia should manage cases of AGC cytology in the adolescent. The adolescent with AGC should undergo a colposcopy and endocervical sampling. Endometrial sampling would not be used in most adolescents unless they are morbidly obese, they have abnormal uterine bleeding or oligomenorrhea, or there is a suspicion of endometrial cancer.

Treatment of Dysplasia in Adolescents

Cervical Intraepithelial Neoplasia 1

Depending on the time from HPV exposure to evaluation, the

adolescent who is infected may have a normal cervix, a mildly abnormal cervix, or biopsy-confirmed CIN 1. Assuming that CIN 2 or greater has been ruled out by colposcopy, prospective studies of an adult population demonstrate that the risk of CIN 2 or greater developing over a 2-year period is 10% (10). In the adolescent population, the rate of resolution of CIN 1 is extremely high (greater than 85%). Therefore, management without therapy is the preferred recommendation for CIN 1 (14). This approach not only reduces the cost of delivering care to the adolescent but also avoids some of the potential risks of therapy, such as an increased rate of cervical stenosis, premature rupture of membranes, and preterm labor (15). The American College of Obstetricians and Gynecologists specifically states, "Observation provides the best balance between risk and benefit and should be encouraged" (4). Cervical intraepithelial neoplasia 1 in adolescents should be monitored using a protocol of either repeat cytologic testing at 6 and 12 months or of HPV DNA testing at 12 months. Colposcopy should then be performed for any abnormal cytology results or for positive high-risk HPV DNA results.

For those few individuals who require therapy for CIN 1, a variety of options are available. Randomized prospective clinical trials have demonstrated that cryotherapy, laser therapy, and LEEP are equally effective interventions for the treatment of CIN 1 (16). When therapy is required, the type of intervention is based on the geometry of the cervical lesion as well as the clinical recommendations of the clinician who is caring for the patient. Care should be taken to remove the least amount of cervical tissue that is necessary to eradicate the lesion.

Cervical Intraepithelial Neoplasia 2

Cervical intraepithelial neoplasia 2 is a significant abnormality that has classically required therapy. A variety of studies, including the ALTS trial, have demonstrated that this lesion may have a significant rate of resolution (up to 40%) in adults. This rate of resolution is suspected to be higher in adolescents. Based on these data and expert opinion, CIN 2 can be managed in adolescents with either observation or ablative or excision therapy. The adolescent patient who is monitored without therapy should be an individual deemed to be reliable regarding follow-up and have a good understanding of the nature of the abnormality and its risks. Follow-up can be individualized, with colposcopy or cytology every 4–6 months being a very conservative approach.

Cervical Intraepithelial Neoplasia 3

Cervical intraepithelial neoplasia 3 is a significant cervical abnormality. Despite the fact that cervical cancer is very rare in the adolescent population, the natural history of CIN 3 in this population has not been examined. Therapy is recommended for all women with CIN 3. Randomized prospective clinical trials have demonstrated that cryotherapy, laser therapy, and LEEP are equally effective interventions for the treatment of CIN 3. In one of

the largest follow-up studies of women having undergone outpatient ablative therapy of CIN, four cases of microinvasive cervical cancer and five cases of frankly invasive cancer were subsequently diagnosed among 3,783 women (17). Because of these considerations, some authors have recommended that excision be used for the management of biopsy-confirmed CIN 3, especially for large lesions that are at increased risk of having microinvasive or occult invasive carcinoma. The type of intervention is based on the geometry of the cervical lesion as well as the clinical recommendations of the health care provider.

Special Considerations for Colposcopy

Consent

The minor undergoing a colposcopic examination represents a unique situation in that the abnormal Pap test result frequently is obtained during confidential screening for sexually transmitted diseases (STDs) or during counseling for contraception. Both interactions frequently occur without the knowledge of a parent or guardian.

Minors undergoing a colposcopic examination might find it helpful to have parental involvement for the procedure. However, colposcopic examinations are considered evaluation for STDs, and minors generally are allowed to consent for diagnosis of STDs (18). For that reason, parental consent, although preferred, should not be required. If parental consent is not obtained, consent for the examination should be obtained from the minor and indicated in the medical record.

The issues regarding parental consent for biopsy or therapy for cervical dysplasia are more complicated. The need for consent depends on whether the biopsy or therapy is considered part of STD evaluation and treatment and on the specifics of state law. Even if the minor legally can consent, the law may not ensure confidentiality. Some states allow minors to consent for STD care but give the health care provider discretion to disclose information to parents, particularly if it is necessary to protect the minor's health (18).

Biopsy and therapy for cervical dysplasia are more invasive than a colposcopic examination and carry a higher risk of complication. They also are likely to generate a bill, which can compromise confidentiality. These issues need to be considered when determining whether parental consent should be obtained, even if it is not legally required, before providing biopsy or therapy for a minor. Medical care providers throughout the United States provide such care without parental consent under the umbrella of the treatment of STDs. Any health care provider who delivers such care should be fully informed of their state laws and established local standards of care.

Screening for Sexually Transmitted Diseases

The adolescent population represents an at-risk population for cervical infection, specifically chlamydia and gonorrhea. Little evidence exists to support the routine screening of the cervix for chlamydia and gonorrhea before performing a colposcopy. Screening for STDs should be based on the ACOG guidelines for screening adolescents who are sexually active (19, 20).

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ACOG *Statement of Policy*

As issued by the ACOG Executive Board

STATEMENT ON PROVIDING EFFECTIVE CONTRACEPTION TO MINORS

The never-married, never-pregnant, sexually involved female has not yet been reached with effective contraception. The laws of some states indirectly prohibit this service for minors and thereby prevent the gynecologist from serving them or place the physician in legal jeopardy if he does so.

The American College of Obstetricians and Gynecologists believes that:

1. The unmarried female of any age whose sexual behavior exposes her to possible conception should have access to the most effective methods of contraception.

2. In order to accomplish this, the individual physician, whether working alone, in a group or in a clinic, should be free to exercise his best judgment in prescribing contraception and therefore, the legal barriers which restrict his freedom should be removed.

3. These restricting legal barriers should be removed even in the case of an unemancipated minor who refuses to involve her parents. A pregnancy should not be the price she has to pay for contraception. On the other hand, in counseling the patient, all possible efforts should be made to involve her parents.

4. The contraceptive services should be offered whenever possible in a broad spectrum counseling context which would include mental health and venereal disease.

5. Every effort should be made to include male partners in such services and counseling.

Approved by the Executive Board
May 1971
Reaffirmed July 1987

To: Lindsay Holmes
From: Jackie Cason
Date: Friday, March 13, 2009

Dear Representative Holmes,

Though I gave oral public testimony on HB35 on Wed. 3/11/09, many legislators had already left the room. I am writing as well so that my story might inform the judiciary committee's decisions on this important legislation, and I hope you'll hear me out. The saddest part of my story is that it is an ordinary one. I am a survivor of child sexual abuse, and my story is the story of 1 in 5 young girls/women. I hope you will listen to it as a representative anecdote for many young women who experience similar abuse. (http://www.sciencefriday.com/pages/2005/May/hour1_051305.html. I will attach a recent article that suggests 20% of females are sexually abused.)

I grew up in a very ordinary family. My dad was the blue-collar breadwinner, and my mom remained at home all the way up passed my high school years. They were loving and attentive, interested in my life, not perfect, but I always knew they loved me. In spite of that, I was molested for 4-5 years, starting when I was 11 and had been menstruating for less than a year, so I was only recently passed from being a girl into a woman.

You might ask yourself, why didn't my parents or my family know? How do these things happen in ordinary families? Do all cases of abuse happen in families like the Pilgrims? My sister was working nights, doing piecework for Bell Helmets, putting fiberglass on motorcycle helmets. It was hard and dirty work. My parents were buying new property and developing it with five houses, still trying to run a business as usual. Everyone was occupied, and I was going to my sister's in the afternoon to help babysit her kids and get dinner started, before their dad came home from work. As a preteen, I was filling in the gap between the day shift and the swing shift as so many families do. You can imagine the rest, and it went on for years at different times. I was very shy, lacked some self-esteem, and felt physically incapable of sharing the secret.

How DO these things happen? You should realize that sexual predators are intelligent. They can spot weak and vulnerable victims for their purposes. They can gain access because they are trusted members of families. (He worked for my dad and was around frequently). Predators seek shy, less secure young people and then give them positive attention and flatter them frequently. These predators may groom their prey for months or years and will take advantage of a girl's natural self-consciousness about her emerging sexuality and will lead her to believe that her family would reject her if she told the secret. And victims sometimes believe and fear rejection. But mostly, it would be the feelings of shame that silence victims. This kind of story happens all the time, in unlikely places, to twenty-percent of the children, primarily females.

On the lucky side, at least I didn't get pregnant because the predator had already had a vasectomy. But pregnancy could happen to someone else in this all too ordinary scenario.

Had I gotten pregnant, could I have told my parents? I don't think so. You know, I've often played out alternative "what-if" scenarios, and I've asked what would have happened if I'd told. On the one hand, it might have saved my sister from many more years of domestic violence, which escalated after my dad died. I wonder if my dad would have killed him, literally. My dad was a hunter and had ready access to guns and the ability to use them decisively. Who wouldn't understand the passion that could drive a father to murder the man who was psychologically abusing one daughter and molesting a younger one? You might even want to acquit him of his revenge, but he wouldn't have been acquitted.

I couldn't tell my sister because her husband was the one molesting me. I couldn't tell my brothers because, I don't know, we just didn't talk about stuff like that. I might have gone to my middle sister who was 5 years older, but she was going through her own growing pains. Planned Parenthood or an organization like that might have been my only option.

Even now, I am uncomfortable talking or writing about this.

I come before you today healed, but not completely whole. The damage done to my spirit is permanent. But still, I am well enough to pursue happiness and a fulfilling life. I selected a mate who is generous and kind, I've been married 23 years, and I'm most proud of my three sons. Most importantly, I speak openly with them about human sexuality. They have attended the Our Whole Lives program, and we try to be sure the conversation stays open.

However, if I had borne a child from that horrific episode in my life, I would have been reminded of those many days and nights every time I looked that child in the eye. It would have harmed me further to force me to tell my parents, because I could not have brought myself to tell them. I would have waited, until I was past the first trimester. I would have delayed acting until it was too late. Though I'd like abortion to be rare, I think it should happen as early as possible in a situation like this. I might even have committed suicide. Though I can't be certain what I would have done, I can tell you that I discovered my cervix when I was 13. I didn't know what it was, and in my ignorance I imagined it to be a cancerous tumor that would certainly kill me by the time I was 18. The sad part is that I saw the justice in that. I thought that I deserved to die.

What would have changed my experience? Not HB35, because I never got pregnant. What might have enabled me to confide in my parents, who would have protected me from further assault? They might have reached me, and I might have reached out to them if they had begun a conversation about sexuality much earlier in life, a conversation free of shame and embarrassment. I would have known not only that what was happening was wrong but that I had recourse. I might have gone running into their arms, and they would never have considered rejecting me. I know that now. I didn't know that then. But I might also have seen my father spend his latter days in prison, at least a 50-50 chance I'm sure. My mom MIGHT have been able to stop him, but he could be violently tempered at times, and this would have been one of them.

If the state is going to compel a conversation in the event of a crisis pregnancy, then the state should go all the way and compel a lifelong conversation about healthy sexuality, age appropriate of course. Insist that parents accompany their minor children to human sexuality night at the community council or the local school. Force them to communicate, but don't lead them to believe that they can get away with near-silence on the topic and then rely on the state to force a conversation after it's too late. That might have saved me, and it might save young girls from being like me. It might empower them to embrace their sexuality as part of who they are, not feel shame, and allow them to grow comfortable talking about their bodies and the physiological changes that occur naturally through life. Who knows, they might even grow up to become healthy senior citizens who enjoy a sex life without shame. We're never too old to learn.

I know you are likely to vote against this legislation, but because you are my representative and on the judiciary committee, I wanted to write to your directly to ask you to emphasize my testimony, even though many had already left the room when I told my story.

Thank you for listening.

Jackie Cason

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POLICY FORUM

PSYCHOLOGY

The Science of Child Sexual Abuse

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Child sexual abuse (CSA) involving sexual contact between an adult (usually male) and a child has been reported by 20% of women and 5 to 10% of men worldwide (*1–3*). Surveys likely underestimate prevalence because of underreporting and memory failure (*4–6*). Although official reports have declined somewhat in the United States over the past decade (*7*), close to 90% of sexual abuse cases are never reported to the authorities (*8*).

CSA is associated with serious mental and physical health problems, substance abuse, victimization, and criminality in adulthood (*9–12*). Mental health problems include posttraumatic stress disorder, depression, and suicide (*13, 14*). CSA may interfere with attachment, emotional regulation, and major stress response systems (*15*). CSA has been used as a weapon of war and genocide and is associated with abduction and human trafficking (*2*).

Much of the research on CSA has been plagued by nonrepresentative sampling, deficient controls, and limited statistical power (*16*). Moreover, CSA is associated with other forms of victimization (*17*), which complicates causal analysis of its role in adult functioning. However, associations in larger scale community and well-patient samples have been confirmed after controlling for family dysfunction and other risk factors (*18, 19*), in longitudinal investigations that measure pre- and post-CSA functioning (*20*), and in twin studies that control for environmental and genetic factors (*12, 21*).

Most CSA is committed by family members and individuals close to the child (*1*), which increases the likelihood of delayed disclosure (*22*), unsupportive reactions by caregivers and lack of intervention (*8, 23*), and possible memory failure [(*24, 25*), compare (*26*)]. These factors all undermine the credibility of abuse reports, yet there is evidence that when adults recall abuse, memory veracity is not correlated with memory persistence (*27, 28*). Research on child witness reliability has focused on highly publicized allegations of abuse by preschool operators and has emphasized false allegations rather than false denials (*29, 30*). Cognitive and neurological mechanisms that may underlie the forgetting of abuse have been identified (*31–33*).

Scientific research on CSA is distributed across numerous disciplines, which results in fragmented knowledge that is often infused with unstated value judgments. Consequently, policy-makers have difficulty using available scientific knowledge, and gaps in the knowledge base are not well articulated. We recommend interdisciplinary research initiatives and a series of international consensus panels on scientific and clinical practice issues related to CSA. This can promote (i) increased inclusion of CSA education in the curriculum in medical and mental health fields; (ii) improved education of the public, the media, and professionals who work with alleged CSA victims; (iii) greater visibility and improved dissemination of CSA research; (iv) increased focus on CSA by researchers in a range of disciplines; and (v) improved cost-benefit analyses of intervention, including prevention efforts.

We call on researchers from social science, medical, and criminal justice fields to gather better information on the prevalence (*34*), causes, consequences, prevention, and treatment of CSA. A 1996 report from the Department of Justice (*35*) estimated rape and sexual abuse of children to cost $1.5 billion in medical expenses and $23 billion total annually to U.S. victims. Whereas $2 is spent on research for every $100 in cost for cancer, only $0.05 is spent for every $100 dollars in cost for child maltreatment (*36*). The National Child Traumatic Stress Network is a federally funded network of 54 sites providing community-based treatment to children and their families exposed to a wide range of trauma. The network should be expanded to address the enormous public health consequences of child trauma, and supported to develop new forms of treatment. Even creation of a new Institute of Child Abuse and Interpersonal Violence within the NIH would be justified on the basis of the emotional and economic cost of these problems.

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