A federal court dissolved an injunction against enforcement of a new law in South Dakota that requires abortion doctors to screen women for coercion and other factors that increase the risk of psychological complications after abortion.

As of July 1, physicians must now screen women for coercion and other risk factors for psychological complications before scheduling an abortion.

The law contains elements of the Elliot Institute’s model legislation, which was the first in the nation to create civil liability for abortionists who fail to screen women for coercion and other risk factors.

“This is an important step forward in protecting the rights of women who are facing unwanted, unsafe, and unnecessary abortions,” said Dr. David Reardon, a leading researcher in the field of abortion complications and director of the Elliot Institute.

He noted that while in every other area of medicine doctors routinely screen for risk factors, abortionists have dropped this practice.

“Abortion providers have excused themselves from the normal practice of screening expected everywhere else in medicine by embracing a radical view of patient autonomy,” he said. “Therefore, they have ignored screening for risk factors on the grounds that questioning regarding risk factors is intrusive, unnecessary, and inserts the physician into an abortion decision which belongs exclusively to the woman.”

In a 2003 law review article on the lack of appropriate pre-abortion screening, Reardon was the first to advocate for statutes, like the one passed in South Dakota, which would establish a duty to screen for risk factors for psychological complications.

Among dozens of risk factors that have been well-established in the medical literature and were identified in the review, one of the most significant risk factors was being pressured or coerced to undergo an abortion to please other people, such as one's parents or partner.

The problem of women being pressured into unwanted abortions is far more common than is generally realized. One study of women who had abortions found that 64 percent of American respondents reported being pressured to abort by someone else.

Reardon said that in most of these cases, women end up undergoing unwanted abortions that violate their own moral beliefs or maternal desires. Women who abort in such circumstances face significantly higher rates of subsequent substance abuse, depression, sleep disorders, suicide, and other negative psychological reactions.

Working with attorneys and other advocates for women hurt by abortions, Reardon and the Stop Forced Abortions Alliance drafted model legislation that would give women the right to redress when doctors fail to screen for known risk factors associated with abortion complications and properly inform women of their unique risk profiles.

Portions of the “Prevention of Coerced and Unsafe Abortions Act” were passed in Nebraska in 2010 and in South Dakota in 2011. Both statutes were challenged in federal courts by Planned Parenthood.

In Nebraska, the attorney general agreed to a court stipulation to not engage in any state enforcement of the statute, but it remains in effect for private enforcement by individual women seeking damages under the statute.

In South Dakota, an injunction stopping the law from being enforced was issued in 2011. It was dissolved by the federal court ruling this week, following an amendment to the statute passed by the legislature in 2012.

“This federal court ruling confirms once again that it is appropriate and necessary to allow women to hold abortionists accountable for negligent pre-abortion screening and counseling,” Reardon said. “It is our hope that the other 48 states will quickly move to protect women from unwanted, unsafe and unnecessary abortions by passing their own versions of our model bill.”

* * *


A U.S. Court of Appeals has ruled that abortion providers can be required to disclose risks associated with abortion, even if the attending doctor believes the associated risk is only incidental to the abortion and not a direct result of it.

At issue was a South Dakota statute requiring abortionists to disclose to patients that women who have abortions are “at increased risk for suicide ideation and suicide.” This provision was challenged by Planned Parenthood, which argued that such a disclosure was untrue and misleading in the absence of irrefutable evidence that abortion is the direct cause of suicidal behavior.

Planned Parenthood admitted that numerous studies show a statistical association between abortion and suicide. For example, an eight-year study of the entire population of women in Finland found that the risk of suicide among women who aborted was six times higher in the following year than that of women who had given birth and three times higher than that of women who had not been pregnant.

But Planned Parenthood’s experts argued that such statistical associations did not prove a direct causal link between abortion and suicide. They argued that the higher rate of suicides might be due to prior psychological issues that predispose women who were already suicidal to have more abortions. If that were true, the observed statistical association would be incidental, not causal.

In an en banc ruling — a ruling from the entire bench instead of a panel of judges — the 8th U.S. Circuit Court of Appeals rejected Planned Parenthood’s argument in an 8-4 decision, observing that “[i]t is a typical medical practice to inform patients of statistically significant risks that have been associated with a procedure through medical research, even if causation has not been proved definitively.”

The court noted that federal rules for labeling of prescription drugs require a warning to be included “as soon as there is reasonable evidence of an association of a serious hazard with a drug; a causal relationship need not have been proved.” (emphasis added, 21 C.F.R. § 201.80(e))

The “standard practice” in medicine, the court wrote, is to “recognize a strongly correlated adverse outcome as a ‘risk,’ even while further studies are being conducted to investigate which factors play causal roles.” The court went on to sharply criticize Planned Parenthood’s “contravention of that standard practice,” concluding that “there is no constitutional requirement to invert the traditional understanding of ‘risk’ by requiring, where abortion is involved, that conclusive understanding of causation be obtained first.”

“This is an extremely important ruling,” said David Reardon, director of the Elliot Institute and an advocate for new laws requiring abortionists to screen for risk factors associated with abortion complications.

“It not only upholds the right of states to require full disclosure of risks, it rejects the widespread practice within the abortion industry of concealing risks which, they claim, have not been conclusively proven to be solely due to the abortion itself,” he said. “Nowhere else in medicine is this the standard for disclosing risks. Only abortion providers claim that their treatment must be presumed innocent until proven guilty beyond a reasonable doubt.”

According to Reardon, the ideological claim that a “woman’s right to abortion” trumps all other medical considerations has caused abortion providers to disregard the standard requirements surrounding not just risk disclosure but also any evidence-based risk-benefits assessment.

Ignoring Risk-Benefits Analysis Is Malpractice

“Everywhere else in medicine, it is the obligation of proponents of a treatment to first prove that the treatment is effective in achieving health goals for specific groups of patients,” Reardon said. “Doctor are then expected to compare these proven benefits with the risks associated with each patient’s unique risk profile. Only in cases where this risk-benefits assessment favors...
treatment should the doctor then recommend the treatment.”

But when it comes to the abortion decision, risk-benefits assessments have been displaced by a radical view of a woman’s unhindered “right to choose,” even if the abortion decision is ill-informed, Reardon said.

“And abortion counselors are trained to facilitate what they presume is a woman’s choice, not to question it,” he said. “As they see it, any efforts to second guess this are themselves a threat to the purity of an unfettered ‘freedom of choice.’”

This institutional perspective, he said, has made abortion providers “completely indifferent” as to whether or not abortion actually helps women in any specific ways.

“After 30 years of abortion on request, there are literally no studies showing that abortion produces any statistically significant benefits in women’s lives,” said Reardon, whose studies of abortion’s effects on women have been published in numerous medical journals. “There are no measurable benefits for women in general or for specific groups of women. This makes it impossible for doctors to fulfill their traditional role of providing medical advice based on a reasonable risk-benefits assessment.”

Reardon said that this is why this new ruling is especially important and may eventually bring an end to one-size-fits-all, assembly-line abortion practices.

“The appeals court soundly rejected Planned Parenthood’s claim that normal medical standards regarding risk disclosure don’t apply to abortion,” he said. “In doing so, it laid the foundation for states to reassert all the normal standards of medicine in regard to abortion. This ruling specifically acknowledges the obligation to disclose all significantly associated risks.”

Reardon said the ruling was a major step toward reforming the inadequate disclosure practices in the abortion industry.

“The rationale provided for this reform also lays the groundwork to require abortion providers to practice all the steps normally involved in medical decision making,” he said. “This means efforts to require screening for significantly associated risk factors and for providing each woman with a risk-benefits assessment are also likely to be upheld by the federal courts.”

He said that “once women are finally given an evidence-based risk-benefits assessment, the number of unsafe and unnecessary abortions performed each year will plummet.”

Information about the Elliot Institute’s model legislation can be found at the Stop Forced Abortions web site at www.stopforcedabortions.com.

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**Contacting Your Lobbyists and Legislators About Our Model Bill**

A federal court (see pp. 1-3) has upheld the right of states to require abortionists to screen for coercion and other risk factors associated with a higher risk of negative emotional reactions to abortion.

Now is the time to pass similar laws in the 48 states which do not have any requirements for pre-abortion screening.

Please get the ball rolling in your state by contacting the pro-life and pro-family lobbyists who are already working in your state and are already planning their legislative strategies for 2013.

Please call and urge them to make the Elliot Institute’s Prevention of Coerced and Unsafe Abortions Act their top legislative priority for 2013.

**What to Say**

You don’t have to be an expert to explain the bill. In fact, the following sample script should be enough to catch their attention and convince them that it is worth investigating. We’ve broken down the script into some easy talking points for you.

“Hi, can I speak to the person in charge of lobbying or legislative initiatives?”

(If they are not available) “Can I get an email address?”

(When talking to the right person) Are you aware of the new kind of abortion regulation that creates liability for negligent pre-abortion screening?

“Forms of this this model bill have been been passed in two states: Nebraska and South Dakota.

“Last month a federal court lifted the temporary injunction against the law in South Dakota, recognizing that states have a right to put into law a standard of care for adequate pre-abortion screening for coercion and other risk factors for psychological problems after abortion.

“I’m hoping that you will make the Prevention of Coerced and Unsafe Abortions Act your top legislative priority for 2013.

“Can I get your email address to email you a link to the model legislation and the fact sheets and support documents?

“I’ll email you some more information. In the meantime, you can go right now to view most of the materials you will need at www.stopforcedabortions.com.”

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**Keep Up to Date!**

Get the latest news, articles and resources by joining our free email list at www.afterabortion.org/joinlist.htm.

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Continued on page 4
I’m all in favor of informed consent—particularly in the case of abortion, where the stakes are so high. A lack of informed consent can lead to the death of a cherished child and the devastation that this causes to women.

But I’ve listened to years’ worth of tapes of National Abortion Federation meetings, and from their discussions I have an idea of how abortion mills work to circumvent informed consent laws. The typical approach is to tell the woman something like this:

Anti-choice forces have passed a law requiring us to try to intimidate you and make you feel as guilty as possible for making the choice that is best for you. They have prepared misleading materials that we’re required to offer you. Do you want to look at them?

What woman is going to say yes to that?

I can imagine similar scenes with required ultrasounds:

Anti-choice forces have mandated that we offer to subject you to an intrusive ultrasound procedure and try to bully

Continued on page 11

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**Empower Women, Not The State**

Christina Dunigan

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**Contact Your Legislators**, from page 3

**After You Call**

**Step 1:**

When you email the promised followup information, please send a carbon copy (cc) to elliotinstitute@gmail.com.

If you like, you can cut and paste the paragraphs below to use in the body of your email:

*Thank you for agreeing to look at the Prevention of Coerced and Unsafe Abortions Act.*

*Right now, abortionists have established their own standard of care for pre-abortion screening for psychological risk factors. That standard of care is, “If none of us screen for risk factors, then that is the standard of care — and none of us can be held liable for doing less than our peers.”*

*This is why abortionists routinely ignore all the well documented risk factors for psychological problems after abortion.*

*The solution to this problem is simple. By putting the standard of care for proper screening into statute and giving women the right to hold abortionists accountable for failing to screen for these risk factors, we can put an end to one-size-fits-all counseling that ignores each woman’s unique risk profile and results in over a million unwanted and predictably unsafe abortions each year.*

*A federal court has recently upheld the right of states to set standards for pre-abortion screening for risk factors.*

*The Elliot Institute’s revised model legislation reflects the principles in this ruling. You will also find fact sheets and key points at www.stopforcedabortions.com.*

*I urge you to make passage of this legislation a priority in 2013.*

**Step 2:**

Mark your calendar and call back or send an email in one to two weeks to ask what their thoughts are. This is especially important if they have not looked at the materials you sent. Also, a little persistence goes a long way in helping people to consider new ideas!

**Finding the Lobbyists Most Likely to Help**

You may have to do a little research to find the lobbyists typically associated with abortion legislation in your state, but the list below will give you a good start. Ask anyone you talk to in these groups if there is anyone else, or any other influential group in the state, that you should also contact.

Your State National Right to Life Affiliate
http://www.nrlc.org/states/index.html

Your State Family Policy Council
http://www.frc.org/state-policy-organizations

Your State Catholic Conference Director
http://www.catholic.org/clife/conference/

Your State Eagle Forum Affiliate
http://www.eagleforum.org/misc/states/

Your State Concerned Women for America Affiliate
http://www.cwfa.org/state.asp

You can also contact your state legislators, especially any you may know who care about protecting the rights and lives of women and unborn children who are harmed by abortion.
Women who have abortions are 81 percent more likely to experience subsequent mental health problems, according to a new study published by Britain’s Royal College of Psychiatrists. The greatest increases were seen in relation to suicidal behaviors and substance abuse.

The meta-analysis examined and combined results of 22 studies published between 1995 and 2009 and included data on 877,181 women from six countries. All 22 studies revealed higher rates of mental health problems associated with abortion for at least one symptom, and many for more than one symptom.

Using a standardized statistical technique for combining the results of multiple studies, the meta-analysis revealed that women with a history of abortion face higher rates of anxiety (34 percent higher) and depression (37 percent higher), heavier alcohol use (110 percent higher) and marijuana use (230 percent higher), and higher rates of suicidal behavior (155 percent higher).

The study also found that women who delivered an unplanned pregnancy were significantly less likely to have mental health problems than similar women who aborted unplanned pregnancies. Women with a history of abortion were 55 percent more likely to have mental health problems than women who did not abort an unplanned pregnancy.

The meta-analysis was conducted by Dr. Priscilla Coleman, a research psychologist at Bowling Green State University in Ohio.

A statistical estimate of the overall population attributable risk revealed that up to 10 percent of mental health problems among women might be attributable to abortion.

According to Elliot Institute Director Dr. David Reardon, who has published more than a dozen studies investigating abortion’s impact on women, publication of this quantitative meta-analysis is long overdue.

“This is the first objective comparison of all the major studies,” Reardon said. “The tables demonstrate that when you put the results of all these various studies side by side in a standardized way, there is a remarkable consistency in the trend of findings.

Despite the differences in study design, which have different strengths and weaknesses, the studies are all consistently pointing in the same direction.”

According to London’s Daily Mail, “[P]ublication in the peer-reviewed British journal is a signal that the psychiatric establishment is now taking seriously the possibility that abortion is a cause of anxiety, depression, alcoholism, drug abuse and suicide.”

* * *

Rehash of Abortion Safety Claim Ignores All Evidence to the Contrary

David C. Reardon

Hundreds of news articles appeared this week claiming, once again, that the best medical evidence shows that abortion is safer than childbirth. The rash of articles were all tied to a blatant piece of propaganda published in Obstetrics and Gynecology by Dr. David Grimes, an abortion provider and chief propagandist for “medical proof” of abortion’s safety.

The new study repeats the same discredited practice of simply comparing nationally reported maternal mortality rates with Center for Disease Control (CDC) reported deaths associated with abortion. Sounds reasonable, until you learn that there is no accurate or formal mechanism for reporting abortion-related deaths. Indeed, the rules regarding completion of death certificates specifically exclude identifying abortion as a cause of death.

At least in part, this is why CDC officials have admitted that maternal mortality rates and abortion mortality rates “are conceptually different and are used by the CDC for different public health purposes.”

In other words, the CDC numbers on abortion-related deaths cannot be meaningfully compared to maternal mortality rates. CDC methods simply do not rely on a uniform method of collecting data on abortion related deaths.

In short, Grimes used a very incomplete record of abortion-associated deaths and compared it to a complete record of deaths associated with non-abortion pregnancies, and found that the death rate is lower. Therefore, he concludes, abortion is safer than childbirth.

As they say: junk in, junk out.

But fortunately we are not stuck with only the CDC’s haphazard yardstick for measuring abortion-related deaths. In the last 15 years, a number of record-based studies have been conducted that do provide an objective, identical standard for comparing abortion-associated deaths with natural pregnancy-associated deaths.

Using this method, the National Research and Development Center for Welfare and Health in Finland reported that 94 percent of deaths associated with abortion (in the first year alone) are being missed in national data reports on abortion. The same researchers found that women are four times more likely to die in the year following abortion than women who give birth. Similar findings were reported in a record-based study of California women.

(The figure at the end of this article shows the age-adjusted relative risk of death in the year following a birth, miscarriage or abortion compared to the rate of death among women not pregnant. The results are from a multi-year study of all women in Finland, linking death certificates to central registries for pregnancy outcomes. It clearly shows abortion is associated with an elevated risk of death, while carrying to term is associated with a lowered risk of death.)

He said the APA’s conclusion is misleading precisely because it is nuanced to describe the minority of abortion cases, those for adult women, having a single abortion, for whom there is no pressure to abort.

“Reading between the lines, it is actually an admission that the majority of abortions may be problematic, but it was never reported that way,” he said.

He added that “regarding the APA’s additional nuance that there is insufficient evidence to prove that abortion ‘in and of itself’ is the sole cause of mental illness, proving that any experience is the sole cause of mental illness is nearly impossible. So framing the issue as requiring proof that abortion is the sole cause of mental illness sets an impossibly high standard.

Continued on page 7
based studies or reviews, published in the last 12 years, demonstrates that they are not seeking to advance knowledge or even to refute these other studies.

Instead, they were publishing a mere propaganda piece, one that can succeed only if they and the public ignore two things: first, all the record-based studies finding the opposite results; and second, the CDC’s own warning that its abortion mortality data is not complete, comparable to, or even “conceptually” reconcilable with maternal mortality data.

The most damning evidence of the authors’ biases is that their “review” of the evidence totally ignores numerous record-based studies using data from both the United States and Finland — studies that clearly show that abortion is associated with significantly higher mortality than both childbirth and not being pregnant.

For a complete review of the literature on mortality rates related to abortion and childbirth, readers should study “Deaths Associated With Abortion Compared to Childbirth: A Review of New and Old Data and the Medical and Legal Implications.”

* * *

Studies Cited:


Mental Health Controversy, from page 6

“However, no informed person can deny that abortion can be a contributing factor which can trigger, aggravate, complicate, and/or delay recovery from mental illness. To deny this fact would require you to deny the that women are intelligent, self-aware persons who know why they are grieving.”

Reardon believes this new review is much more objective and useful for informing physicians, nurses, mental health care workers, and the public about what the research really reveals.

“The APA could have and should have used an objective approach like this one,” he said. “Instead, they deliberately obscured the clear trend in research findings by employing highly subjective reasons to dismiss, ignore, or obscure findings which did not mesh with their preconceived conclusions.

“This new review proves that when you use a standardized method of laying out the results of all the studies side by side, the trend is unmistakable.”

Reardon noted that the reliability of the APA Task Force report is further called into question by the fact that the task force chair, Dr. Brenda Major, has refused to allow her own data on abortion and mental health to be reanalyzed by other researchers.

“This behavior is especially egregious since it violates the APA’s own ethics rules requiring data sharing,” he said.

* * *

Learn more about the APA Task Force Report and the controversy surrounding it at www.abortionrisks.org.

Special Contributions

In memory of
Claire Johnson
Lillian Kober

Gifts can be made to the Elliot Institute to honor or remember loved ones, and will be acknowledged in this newsletter unless otherwise requested.
In the wake of the new study published by Britain’s Royal College of Psychiatrists showing that abortion is linked to elevated rates of mental health problems (see p. 5), the Elliot Institute is calling for congressional hearings to investigate the risks of abortion to women.

The study published in *British Journal of Psychiatry* found that 10 percent of mental health problems among women, including 35 percent of suicidal behaviors, may be attributable to abortion. These findings were based on the combined results of all studies published between 1995 and 2009 that met strict inclusion criteria. The resulting analysis included 877,181 women from six countries.

Women who aborted were 81 percent more likely to experience mental health problems compared to all other control groups, and 55 percent more likely to have problems compared to women who delivered an unplanned or unwanted pregnancy.

In light of these findings, we are calling for congressional hearings to investigate why these and similar findings have been systematically excluded from government health advisories and government-funded health care programs.

**Known Risk Factors Routinely Ignored**

A 2008 report by the American Psychological Association Task Force on Abortion and Mental Health identified 15 risk factors for susceptibility to more mental health problems after an abortion. Any health care agencies accepting federal funds should be required to screen patients for these and other known risk factors before abortion.

Instead, abortion clinics are routinely ignoring these risk factors and putting women at risk because they face no liability for any of the psychological consequences of abortion.

To address these concerns, the Elliot Institute has launched a campaign calling for congressional hearings on abortion and women’s health.

The hearings should also examine the lack of any major national studies on the subject, despite a 22-year-old recommendation by then-Surgeon General C. Everett Koop for just such a study.

The question of abortion’s impact on women’s health last became a major national issue in 1989 when Koop responded to request from President Regan for a report on the subject. Koop told Regan that no definitive conclusions could be drawn because of the low quality of research available at that time, and suggested that the best way to gather definitive evidence would be for the government to fund a 10-year, national longitudinal study.

Reardon said Koop’s recommendation was blocked by abortion advocates, including the American Psychological Association, which adopted an official policy to advocate for abortion rights in 1967. They argued it was a waste of money, but perhaps they were afraid the research would confirm what large numbers of women were already reporting: that abortion was causing or aggravating more emotional problems than it solved.

While the new study published by the Royal College of Psychologists should finally provide the impetus needed to fund such research, the process also needs to be protected from politicization. The only way to do this is to acknowledge that abortion is inextricably politicized, and to set up congressional oversight to ensure that researchers on both sides of the political divide participate in the study design.

Further, there is usually bureaucratic resistance in government agencies to undertake such research unless there is specific legislation and congressional oversight directing the effort.

The political debate surrounding congressional hearings would also spark public discussion about abortion’s impact on women and the importance of support for recovery programs. And while the mainstream media and science and medicine editors have tended to spike stories about research linking abortion to mental health problems, extensive congressional hearings may help ensure that news is at least covered by political reporters.

**Join the Petition Campaign**

You can join our campaign by signing our petition to Congress to hold hearings on abortion and mental health. Sign the petition form online at http://afterabortion.org/?p=6216. You can also request a petition form by mail at Elliot Institute, PO Box 7348, Springfield, IL 62791, or by email at elliotinstitute@gmail.com.
A

ccording to the March of Dimes, more than half a million babies are born prematurely in the United States alone each year. Yet most people—including women at risk of abortion and their loved ones—are unaware that abortion has been linked to an increased risk of preterm birth among subsequently born babies.

In a paper published in the British Journal of Obstetrics and Gynaecology in 2009, a Canadian research team examined data from 37 studies and found that having a prior abortion increased the risk of subsequent preterm birth by 35 percent, while having more than one prior abortion increased the risk by 93 percent.1 (Preterm birth is defined as a birth that takes place before 37 weeks gestation.)

In other words, children whose mothers had a previous abortion were more likely to be born prematurely, putting them at greater risk for problems such as low-birth weight (which has been linked to physical and developmental problems), epilepsy, autism, mental retardation2 and cerebral palsy. A research team looking at data from 2002 estimated that prior abortions led to 1,096 cases of cerebral palsy among babies born prematurely that year.3

There are risks to the mother with preterm birth as well, as other studies have found that women who give birth at less than 32 weeks double their lifetime risk of breast cancer.4

Evidence linking abortion and preterm birth continues to pile up, researchers and advocates say. Another paper published in 2009 found that found that having a previous abortion raised a woman's relative odds of having a subsequent birth at less than 32 weeks by 64 percent.5

Further, as far back as 2006 the Institute of Medicine included "prior first trimester abortion" on a list of risk factors associated with premature birth.6 However, as Brent Rooney, Director of Research for the Reduce Preterm Birth Coalition, has pointed out, abortions continue to be performed despite the strong evidence of risks—and in the absence of any evidence showing the procedure to be harmless.

“"In the ‘Court of Medicine’ a ‘defendant’ new surgery or new drug is presumed guilty of serious adverse side effects until by strong evidence it is demonstrated to be innocent,” Rooney noted. Yet 50 years after the development of the suction abortion procedure, he said, there has never been a “‘study of studies’ or systematic review” that has proven that abortion does not cause premature birth. Instead, the evidence seems to be pointing in the opposite direction.

And even as the evidence linking abortion and preterm birth continues to pile up, women and their loved ones are not being told of the risks. The result is that women and girls will end up undergoing abortions without having the information needed to make a decision—which is a form of coercion. And it puts the mothers, their unborn children and any future children they may have at risk.

* * *

Learn more: Access the world's most extensive online library of studies on the physical and psychological effects of abortion at www.AbortionRisks.org.

Citations

Why Prior Abortions Raise Autism Risk
Brent Rooney, M.Sc.

In 1999, Professor Larry Burd and colleagues reported that women with prior induced abortions had a three times higher risk of delivering a newborn later diagnosed with autism.1 In the 1960s, the U.S. autism rate for newborns was approximately 1 in 10,000, but the rate skyrocketed to 1 in 110 in 2009 according to the Centers for Disease Control.

Is it biologically plausible that prior maternal induced
abortions elevate a newborn baby's autism risk? In a word, yes. This is because of two mechanisms -- preterm birth (very preterm and extremely preterm) and raised parental age at delivery. Six significant studies report that prior induced abortions boost extremely preterm birth risk (under 28 weeks' gestation).

Extremely preterm babies have about 25 times the autism risk as do full-term (at least 37 weeks' gestation) babies. The older the parents are at delivery, the higher the autism risk. In a 2001 study of French women, Dr. Henriet reported that French women with more than one prior induced abortion had 2.4 times (i.e. 140% higher) the risk of maternal age over 34 at delivery compared to women with zero prior induced abortions.

Michael Ganz estimates that the lifetime cost (medical costs + non-medical costs + reduced income) of a U.S. newborn with autism to be $3.2 million.

Should abortion providers wait for "conclusive" proof of the abortion-autism risk before warning women of a possible increased autism risk? My understanding of U.S. law is that patients must be warned of a serious adverse risk of a treatment for which there is credible evidence ("credible" evidence is well short of so-called "conclusive" evidence). One hundred percent "conclusive" evidence in the field of medical research (in particular, epidemiology) for a purported risk factor does not and can not exist (in statistical jargon, the Gaussian distribution can never provide 100 percent confidence of higher risk or 100 percent confidence of lower risk).

For those who want to dig deeper into the subject of autism, read the 2010 book The Age of Autism (Olmsted & Blaxill). Certainly, the authors much suspect that mercury in vaccines is a likely cause of autism. I suspect that both oral contraceptives and prior induced abortions elevate autism risk; and more generally, that anything that undermines a young woman's health raises her risk of delivering a newborn later diagnosed with autism.

* * *


Citations

Everyone Wanted, from page 6

offer was a post-it note with a phone number hastily scribbled on it.

You can read the rest of Green’s story at LiveAction’s blog at http://liveaction.org/blog/exclusive-former-abortion-clinic-worker-speaks-out-for-life/.

Research suggests that her observations about women coming for abortions believing they “had no other choice” and the lack of help and options offered is very accurate. A survey of American and Russian women who had abortions, published in the Medical Science Monitor, found that:

- 64 percent of American respondents reported they were pressured by others to abort;
- More than 50 percent said they were uncertain or needed more time to make a decision;
- 79 percent said they were not given any information about abortion alternatives;
- 84 percent said they did not receive adequate counseling before abortion; and
- 67 percent said they received no counseling before abortion.

As Green points out, the solution is to provide real support to pregnant girls and women:

We need to do better. We need to provide real resources to pregnant mothers facing an unplanned pregnancy. The women and babies of our country deserve better.

Did You Know?

Most abortions are unwanted or coerced. Learn more about the epidemic of unwanted, coerced and forced abortions. Visit www.TheUnChoice.com for information, research, personal stories, free resources to download and share, and more.
Empower Women, from page 4

you into thinking that you’re doing something wrong by exercising your right to choose. You can opt out if you prefer. Do you want to be subjected to the anti-choice guilt trip?

None of this should come as any surprise. We know abortionists lie to convince women to abort. Why should we expect them to stop lying just because we’ve passed a law mandating that they pass out a pamphlet or read a script?

The problem of putting power in the hands of the state rather than the woman brings a multitude of undesired consequences.

The big one is that we already know we can’t trust the state to look after the well-being of abortion-vulnerable women. Abortion supporters in positions of power and influence have a long history of looking the other way, from the greased palms of the illegal era to the Kermit Gosnells of today. Why should we think that they’d be any more willing to enforce informed consent and ultrasound laws?

Putting power in the hands of the state rather than the woman also plays neatly into the abortion-advocacy narrative of pro-lifers as mean and controlling and just wanting to bully women.

Putting the power in the hands of the women would eliminate these problems. And how can that be done?

Right-to-redress bills, as championed by David Reardon and Feminists for Life, would allow the woman to sue the pants off any abortionist for failing to provide adequate informed consent. She would not have to prove any injury. In fact, she would not have to prove anything. It would be incumbent on the offending abortionist to demonstrate that he had indeed provided appropriate informed consent.

All the law has to do is define what types of information must be provided—a clear understanding of risks, an accurate depiction of the unborn baby that would be killed, a realistic prognosis regarding any health problems in the mother or the baby, resources available to address her problems in a less drastic way and, perhaps most important of all, over half a century of research indicating that fear and ambivalence in early pregnancy are normal and typically self-limiting.

Fetal homicide bills put additional power behind these right-to-redress laws. Giving the woman the power to press charges for the murder of a child if vital information is withheld from her would have abortionists shaking in their shoes. It certainly would make them less cavalier about making glib statements dismissing the humanity of the unborn child.

The final advantage to the approach of empowering the woman is that it would force abortion advocates to reveal their real agenda—disempowering women in order to achieve their own financial, social, or political ends. It would turn the tables, clearly showing that it is the abortion advocates, not the pro-lifers, who are hell-bent on imposing their values on women.

* * *

Researcher Christina Dunigan runs the Real Choice blog and the Cemetery of Choice at WikiSpaces, documenting the deaths of women from abortion both pre- and post-Roe.

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LiveAction has posted the story of Jewels Green, a woman who underwent a coerced abortion at 17 and later spent several years working at an abortion facility in Pennsylvania.

Here’s an excerpt:

*My first baby would be 22 this week.*

I was a 17-year-old drug-using high school drop-out, but when the lady wearing scrubs told me I was pregnant, I already thought of myself as a new mother.

Everyone wanted me to get an abortion... except me.

I actually stopped using drugs, went to the library and checked out a book called Under 18 and Pregnant and started to read it to prepare. I scheduled my first prenatal check-up. My boyfriend was relentless. I am deliberately omitting the details of the violence, both real and threatened, but I finally caved in to my boyfriend’s insistence to not have our baby.

On January 4, 1989, he took me to the abortion clinic, but I literally ran out in the hope of saving my baby. Two days later, on January 6, 1989, at 9-1/2 weeks gestation, I had an abortion.

It nearly killed me. No, not the surgical procedure, the psychological aftermath. I attempted suicide three times after my abortion and finally ended up in an adolescent psychiatric ward of a community hospital for a month to recover.

I was coerced into having an abortion and thought that by becoming a counselor at an abortion clinic, I could help others like me really talk out their feelings on the issue, truly explore their options, and help them make an honest, informed decision—or help them leave an abusive situation. ...

After two years working at the clinic and starting college as a psychology major, I was trained as a counselor. The “counseling” experience was not what I had hoped.

Nearly every pregnant woman coming to an abortion clinic for “options counseling” had already made up her mind, but just wanted to check out the facility and have her questions answered and perhaps her fears allayed. And most of the women coming in felt they had no other choice. A few were truly ambivalent.

This is where the pro-choice movement and clinics fail. Sure, we had a little notebook with the names and numbers of two local adoption agencies, but we were never trained or taught how the adoption process works so we could explain it to women. We had the phone number of the local WIC office, public assistance, etc., but again, knew nothing about the process should anyone ever ask for details.

If a pregnant woman wanted to learn more about these other choices, the best the “options counselor” could offer was a note with a hastily scribbled phone number on it.

I was excited to leave the clinic and attend college, but felt guilty afterwards. I was not a good counselor and felt that I should have been able to help my patients find their own paths.

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Continued on page 10