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Planned Parenthood Is Guilty of Negligent Screening

David C. Reardon, Ph.D.

Congressional hearings into Planned Parenthood following the release of the undercover videos should look beyond the deceptive fetal tissue donation forms they ask women to sign. These misleading disclosure forms typify a larger pattern of deception and exploitation.

An even more shocking abuse lies in the fact that Planned Parenthood abortionists know that the *majority* of women entering their abortion clinics have *multiple* risk factors for psychological maladjustments following an abortion. But they don't screen for these risk factors, much less give each patient a medically informed assessment of risks versus benefits based on each woman's unique risk profile.

Specifically, Planned Parenthood is guilty of negligent pre-abortion screening and counseling. This isn't by accident. It's not an oversight. It is a practice designed to advance their own financial and sociopolitical interests.

Plus, under current law, they can get away with it. Loopholes in the law allow abortion providers to evade any financial liability for psychological problems that are triggered or aggravated by abortion.

In short, while Planned Parenthood claims it is simply promoting a "pro-choice" alternative, what they are actually doing is promoting a "poor-choice" alternative. Women deserve better.

Abortion Has Known Risks

Compared to similar women who give birth, women who abort experience significantly elevated rates of psychiatric disorders,¹⁻⁹ substance use,^{4-5, 10-11} suicidal behaviors,^{4-5, 12-14} post-traumatic stress disorders,^{6, 15-16} sleep disorders,¹⁷ a worsening of general health,¹⁸ and elevated rates of recourse to medical treatments.¹⁹⁻²⁰ In addition, each exposure to abortion reduces a woman's life expectancy.²¹

Most notably, besides all these risks, abortion also lacks any measurable benefits. Specifically, not a single study has identified any statistically significant benefits for women who have abortions compared to women who give birth to unplanned pregnancies . . . or compared to any other group of women.²²

This is the conclusion of Dr. David Fergusson, a self-described pro-choice atheist,²³ based on his own systematic review of the literature, including his own 30-year longitudinal study of 1,265 subjects who have been studied from birth through 30 years of age.

Fergusson isn't a biased pro-lifer. In fact, his conclusions have not led him to advocate against abortion in any way. He has no moral objections to it.

But as a scientist, Fergusson argues against the intellectual fraud of abortion providers who perform abortions based on the spurious claim that it will produce some hoped for or imagined psychological benefits for women compared to giving birth. There is not a shred of scientific evidence to

support such optimism. No claimed benefits of abortion have ever been statistically validated. But abortion does have known risks.

Some Women Are Known to Be At Higher Risk

Research has consistently shown that there are certain groups of women who are most vulnerable to negative reactions to abortion.

In fact, even the hand-picked team of pro-choice psychologists who issued the Report of the American Psychological Association Task Force on Mental Health and Abortion in 2008 acknowledged the following 15 risk factors which can be used to identify the women who are at greater risk of psychological problems after an abortion:²⁴

- "terminating a pregnancy that is wanted or meaningful"
- "perceived pressure from others to terminate a pregnancy"
- "perceived opposition to the abortion from partners, family, and/or friends"
- "lack of perceived social support from others"
- "low self-esteem"
- "a pessimistic outlook"
- "low perceived control"
- "a history of mental health problems prior to the pregnancy"
- "feelings of stigma"
- "perceived need for secrecy"
- "exposure to antiabortion picketing"

Planned Parenthood knows that the majority of women have multiple risk factors.

- “use of avoidance and denial coping strategies”
- “feelings of commitment to the pregnancy”
- “ambivalence about the abortion decision”
- “low perceived ability to cope with the abortion prior to the abortion”

Indeed, this list makes clear that one needs to carefully parse the APA’s summary conclusion that “among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy.”

This highly nuanced assertion was widely misrepresented as concluding that there are no mental health risks to abortion. But look again.

First, the APA claims abortion has “no greater” risks compared to delivery—referring mostly to the incidence rate for post-partum depression. It doesn’t claim any benefits, only comparatively equal risks.

Secondly, and more importantly, even this modest claim of “safety” is limited to:

- *adult* women (excluding adolescents)
- those whose pregnancies are *unplanned* (excluding those who had any openness to or desire for pregnancy)
- those who have only a *single* abortion (excluding those with multiple exposures to abortion)
- those for whom the abortion is entirely *elective* (excluding those who experienced any pressure or coercion, or those for whom fears of health complications led to a therapeutic abortion), and
- those who abort in the *first trimester* (excluding those who abort after 12 weeks gestation).

Notably, the *vast majority* of women having abortions have one or more of these risk factors. For example, approximately 64 percent of women with a history of abortion report that they felt pressured by one or more people to do so.²⁵ In addition, approximately half of all women aborting on any given day have a prior history of abortion.²⁶

Further, about 15 percent of abortions are for adolescents, and about 8 percent of abortions are after the first trimester.²⁷ Throw in the need for secrecy, ambivalence, or any of the other 15 risk factors acknowledged by the APA, and it’s clear that most women having abortions have two or more of these risk factors.

Planned Parenthood’s Own Research on Risk Factors and Screening

The APA Task Force was by no means the first to recognize that negative reactions to abortion may be anticipated on the basis of prior personality traits (such as low self-esteem or prior history of depression) or identifiable circumstances (such as feeling pressured to abort or feelings of commitment to the pregnancy).

For example, in 1973, Planned Parenthood itself published a study identifying several pre-existing risk factors that could be used to identify the women who were most likely to experience subsequent psychopathology and other negative symptoms as measured 13-16 months later.²⁸

Based on these findings, the researchers recommended that computer-scored “screening procedures to identify such [higher risk] patients could easily and inexpensively be instituted by hospitals and private physicians” at a cost of less than a dollar each.

Did Planned Parenthood implement these pre-abortion screening recommendations? No. In fact, they are opposed to screening for statistically significant risk factors.²⁹

Negligent Screening Hurts Women But Enriches the Abortion Industry

Bottom line: Planned Parenthood knows that the *majority* of women coming into abortion clinics have *multiple risk factors* for post-abortion psychiatric distress. But there is no systematic screening for these risk factors. Why?

First, because abortion providers have a financial incentive to spend the least amount of time with each woman. One of their highest goals is to provide fast, cheap abortions. Planned Parenthood’s *one-size-fits-all abortion counseling* is incompatible with individualized screening that would then require individualized counseling.

Second, from the viewpoint of population control zealots, many of the same risk factors that predict which women will have the most emotional problems after an abortion actually align with the same criteria for women they historically argued should be sterilized—including, for example, women with prior mental health issues.³⁰

Third, the goal of providing cheap, no-questions-asked abortions is an integral part of Planned Parenthood’s historic and deeply-

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rooted eugenic population control agenda. After all, if abortion, as a social engineering tool, can be used to reduce the burden on society caused by the birth of “unfit” children, keeping abortion on request affordable to the poor is a “social good.”

Advancing the “social good” of fewer births, especially among the marginalized, may explain why Planned Parenthood’s counseling practices minimize disclosure of abortion risks.³¹

It may also explain why some abortion counselors deliberately reinforce the arguments of the partners, parents, employers or others pressuring women to abort in order to persuade ambivalent patients that abortion is the “best option” for everyone.³²

Negligent Pre-Surgical Screening is Unique to the Abortion Industry

Everywhere else in medicine, doctors screen for risk factors, precisely to identify those subgroups of patients for whom a possible treatment option may be contraindicated or is unlikely to produce the desired benefits.

For example, Lasik surgery is a common elective procedure performed nearly four million times per year. But ethical physicians do not perform it without appropriate pre-surgical screening.

Indeed, pre-surgical screening for Lasik patients results in approximately 25 percent of patients being declined for Lasik treatment on the initiative of the attending physician³³—precisely because the doctor’s own best medical judgment is that it will not benefit the patient.

But do abortionists turn away women with multiple risk factors for abortion complications, or even discourage these most vulnerable women from having abortions? No.

The simple fact is that abortionists seldom turn away patients. If you have the money, they will do the abortion.

In fact, abortionists will typically deny any responsibility for determining if an abortion is more likely to benefit or harm a woman’s well being. They insist they are not social workers—that the “choice” is the woman’s alone and they are just there doing her bidding.

But such a “buyer beware” medical service is an inversion of normal medical ethics. It is analogous to a woman walking into a doctor’s office and saying, “I have a lump in my breast and need a mastectomy,” and the doctor responding, “Okay. Jump up on the table and I’ll take it right off.”

Simply doing what a patient asks for, without any evaluation of risks or options, is not the practice of medicine . . . it is medical malpractice.

But this is exactly what Planned Parenthood and other abortion providers are guilty of. They are facilitating and encouraging women of all ages and education levels to self-diagnose. Moreover, they do not even assist in the self-diagnosis process!

Instead, abortionists insist that women seeking abortions already know everything they need to know . . . as if an innate knowledge

of abortion’s risk factors and risk/benefit ratios is embedded in women’s DNA. They even go so far as to insist that laws requiring full disclosure of all statistically significant medical research on risks and risk factors associated with abortion are an insult to women’s intelligence.

In short, Planned Parenthood believes in abortion on request, no questions asked. No matter the circumstance, whenever a woman comes for an abortion, their response is, “Jump up on the table and we’ll take it right out.”

Is such blind obedience to their self-diagnosis what women really want from their doctors? Many, perhaps most, are highly uncertain what to do and are facing intense pressure from others or their circumstances. And clearly the vast majority have no prior education regarding abortion risk factors and all the medical studies examining risks associated with abortion.

What we do know, with certainty, is that women overwhelmingly want to be informed of all statistically significant risks, especially when considering elective surgeries like abortion.³⁴

Abortionists Use Unified Negligence to Evade Liability

Ironically, *Roe v. Wade* rejected the idea that women have an absolute right to abortion precisely because it is a medical procedure that inherently has risks. The *Roe* decision concluded with the emphatic statement that “the abortion decision in all its aspects is inherently, and primarily, a medical decision, and *basic responsibility* for it must rest with the physician. If an individual practitioner abuses the privilege of *exercising proper medical judgment*, the usual remedies, judicial and intra-professional, are available.”³⁵ [emphasis added]

Put another way, if abortion is contraindicated due to any physical, psychological, or social reasons,³⁶ the Supreme Court recognizes that physicians have a right and duty to refuse to perform an unsafe or unnecessary abortion. In this regard, if doctors fail to exercise “proper medical judgment,” the *Roe* Court declared, they should be exposed to “the usual remedies” of lawsuits, loss of their licenses, or even criminal prosecution.

So, if abortionists aren’t screening for known risk factors, as I have asserted, why aren’t they being sued by the hundreds of thousands of women entering post-abortion counseling programs every year?

Unfortunately, abortion providers are protected from any meaningful liability because of two loopholes in tort law.

First, the “standard of care” for pre-abortion screening is defined by the common practice of abortion providers themselves. So, as long as all abortion providers agree to ignore the psychological risks of abortion, or at least refuse to testify against other abortion providers who neglect to screen for these risk factors, it is nearly impossible for injured women to prove that they were given substandard, much less negligent, medical care.

The simple fact is that abortionists seldom turn away patients.

As long as abortion providers all simply perform abortions on request—without screening and without offering each woman a medically informed risk/benefit analyses—it is extremely hard for a malpractice attorney to prove negligent screening. If the standard of care is low enough, there is no risk of plaintiffs proving negligence.

Second, and even more problematic, tort law generally precludes recovery of damages for emotional distress unless it is the result of physical injury.

For example, if you suffer emotional distress after almost being hit by a car, you can't sue. Only if you are hit are you then entitled to damages for pain, suffering, post-traumatic stress and sleep disorders.

Thus, absent any physical injury following an abortion, abortionists are shielded from any liability for psychological injuries attributed to abortion. This simplifies the math: no liability = no need for screening + more abortions + more profit + more injured women.

The Solution: Put the Standard of Care for Screening into Statute

As we have seen, even pro-abortion mental health professionals, and Planned Parenthood's own publications, have acknowledged the existence of risk factors for post-abortion psychological problems. For the reasons discussed above, these risk factors are routinely ignored by abortion providers, at least in part because there is no financial downside, only an upside, for doing so.

It doesn't have to be that way. The standard of care for pre-abortion screening can be put into statute.³⁷ This would eliminate the burden on plaintiffs to find abortion providers to testify that the defendant's pre-abortion screening was negligent. At the same time, tort law can be amended to require doctors to give women an informed medical opinion based on their unique risk profile and to give women a right to sue for negligent screening and psychological injuries associated with abortion.

Bill Clinton famously opined that abortion should be "safe, legal, and rare." It is obvious that pre-abortion screening should be employed to identify the women at greatest risk of unsafe abortions.³⁸ If it so happens to be true that the majority of women are at risk, then perhaps this will also make abortions rare.

What I do know is this: "poor-choice" advocates are profiting from countless women who will continue to undergo unwanted, unsafe, and unnecessary abortions. Planned Parenthood officials should be grilled by congressional investigators on why and how they justify their failure to establish a systematic methodology for pre-abortion screening and counseling which will properly protect women from unwanted, unsafe, and unnecessary abortions.

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References

1. Giannandrea S a M, Cerulli C, Anson E, Chaudron LH. Increased

risk for postpartum psychiatric disorders among women with past pregnancy loss. *J Womens Health* (Larchmt). 2013;22(9):760-768. doi:10.1089/jwh.2012.4011.

2. Broen AN, Moum T, Bødtker AS, Ekeberg O. The course of mental health after miscarriage and induced abortion: a longitudinal, five-year follow-up study. *BMC Med*. 2005;3:18. doi:10.1186/1741-7015-3-18.

3. Munk-Olsen T, Bech BH, Vestergaard M, Li J, Olsen J, Laursen TM. Psychiatric disorders following fetal death: a population-based cohort study. *BMJ Open*. 2014. doi:10.1136/bmjopen-2014-005187.

4. Fergusson DM, Horwood LJ, Boden JM. Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence. *Aust N Z J Psychiatry*. 2013;47(9):819-827. doi:10.1177/0004867413484597.

5. Coleman PK. Abortion and mental health: Quantitative synthesis and analysis of research published 1995-2009. *Br J Psychiatry*. 2011;199(3):180-186.

6. van den Akker O. The psychological and social consequences of miscarriage. *Expert Rev Obstet Gynecol*. 2011;6(3):295-304. doi:10.1586/eog.11.14.

7. Reardon DC, Cogle JR, Rue VM, Shuping MW, Coleman PK, Ney PG. Psychiatric admissions of low-income women following abortion and childbirth. *CMAJ*. 2003;168(10):1253-1256.

8. Coleman PK, Reardon DC, Rue VM, Cogle J. State-funded abortions versus deliveries: a comparison of outpatient mental health claims over 4 years. *Am J Orthopsychiatry*. 2002;72(1):141-152.

9. Fergusson, D. M., Horwood, L. J., & Boden, J. M. (2008). Abortion and mental health disorders: Evidence from a 30-year longitudinal study. *British Journal of Psychiatry*, 193(6), 444–451.

10. Coleman PK. Induced abortion and increased risk of substance abuse: a review of the evidence. *Curr Womens Health Rev*. 2005;1(1):21-34. doi:10.2174/1573404052950311.

11. Steinberg JR, McCulloch CE, Adler NE. Abortion and mental health: findings from the national comorbidity survey-replication. *Obstet Gynecol*. 2014;123(2 Pt 1):263-270.

12. Shadigian E, Bauer ST. Pregnancy-associated death: a qualitative systematic review of homicide and suicide. *Obstet Gynecol Surv*. 2005;60(3):183-190.

13. Morgan CL, Evans M, Peters JR. Suicides after pregnancy. Mental health may deteriorate as a direct effect of induced abortion. *BMJ*. 1997;314(7084):902; author reply 902-903.

14. Tischler C. Adolescent suicide attempts following elective abortion. *Pediatrics*, 1981; 68(5): 670-1

15. Daugirdaite V, van den Akker O, Purewal S. Posttraumatic Stress and Posttraumatic Stress Disorder after Termination of Pregnancy and Reproductive Loss: A Systematic Review. *J Pregnancy*. 2015;2015:1-14. doi:10.1155/2015/646345.

16. Zulcic-Nakic V, Pajevic I, Hasanovic M, Pavlovic S, Ljuca D. Psychological problems sequalae in adolescents after artificial abortion. *J Pediatr Adolesc Gynecol*. 2012;25(4):241-247.

17. Reardon DC, Coleman PK. Relative treatment rates for sleep

disorders and sleep disturbances following abortion and childbirth: a prospective record-based study. *Sleep*. 2006;29(1):105-106.

18. Ney PG, Fung T, Wickett AR, Beaman-Dodd C. The effects of pregnancy loss on women's health. *Soc Sci Med*. 1994;38(9):1193-1200. doi:10.1016/0277-9536(94)90184-8.

19. Østbye T, Wenghofer EF, Woodward CA, Gold G, Craighead J. Health services utilization after induced abortions in Ontario: a comparison between community clinics and hospitals. *Am J Med Qual*. 2001;16(3):99-106.

20. Berkeley D, Humphreys PC, Davidson D. Demands made on general practice by women before and after an abortion. *J R Coll Gen Pract*. 1984;34(263):310-315.

21. Coleman PK, Reardon DC, Calhoun BC. Reproductive history patterns and long-term mortality rates: A Danish, population-based record linkage study. *Eur J Public Health*. 2013;23(4):569-574. doi:10.1093/eurpub/cks107.

22. Fergusson DM, Horwood LJ, Boden JM. Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence. *Aust N Z J Psychiatry*. 2013;47(9):819-827. doi:10.1177/0004867413484597.

23. Grimm, N. Higher risk of mental health problems after abortion: report. *Australian Broadcasting Corporation*. 03/01/2006.

24. Major B, Appelbaum M, Beckman L, Dutton MA, Russo NF, West C. Report of the APA Task Force on Mental Health and Abortion. Washington, DC: American Psychological Association; 2008. <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf>. see pages 11 and 92.

25. Rue VM, Coleman PK, Rue JJ, Reardon DC. Induced abortion and traumatic stress: a preliminary comparison of American and Russian women. *Med Sci Monit*. 2004;10(10):SR5-R16.

26. Cohen, Susan A. Repeat abortion, repeat unintended pregnancy, repeated and misguided government policies. *Guttmacher Policy Review* 2007 10(2):8-12.

27. Centers for Disease Control and Prevention. (2013, November 29). Abortion Surveillance—United States, 2010. (See Tables 3 and 5). See more at: <http://www.childtrends.org/?indicators=teen-abortions#sthash.EOAd8JkH.dpuf>

28. Robert Athanasiou et al., Psychiatric Sequelae to Term Birth and Induced Early and Late Abortion: a Longitudinal Study. *Fam. Plann. Perspect.* (1973); 5; 227-31.

29. Abourezk, K. Planned Parenthood files suit over Nebraska abortion law. *Lincoln Journal Star*. June 28, 2010.

30. Chase, Allan. *The Legacy of Malthus: The Social Costs of The New Scientific Racism* (New York: Knopf, 1977).

31. Sobie, A. *All Abortion Risks Must Be Disclosed, Appeals Court Rules: Argument to Invert Traditional Medical Standards Rejected*. AfterAbortion.org. July 26, 2012.

32. Reardon, David. *Aborted Women Silent No More* (Chicago: Loyola University Press, 1987).

33. Ulene, V. Life with Lasik: a closer look. *Los Angeles Times*, June 16, 2008. And also, Neergaard, L. Lasik worries? Some may see better with alternatives. *Fox News*. April 28, 2008 .

34. Coleman PK, Reardon DC, Lee MB. Women's preferences for information and complication seriousness ratings related to elective medical procedures. *J Med Ethics*. 2006;32(8):435-438. doi:10.1136/jme.2005.014274.

Research Links Abortion, Pregnancy Complications

A new study has found that having a single induced abortion or miscarriage can lead to complications in future pregnancies.

The study, published in the *Journal of Maternal Fetal and Neonatal Medicine*, examined deliveries for 15,000 women in Tel Aviv who were giving birth for the first time, of whom 1,500 had a previous abortion or miscarriage before 13 weeks.

Reports the Daily Mail:

About seven percent of women with a prior abortion or miscarriage had labor induction, compared with about five percent of women pregnant for the first time.

Cesarean deliveries were performed for 25 percent of women with a prior terminated pregnancy, compared with 18 percent of the other women.

Retained placenta after birth — where the placenta fails to deliver — occurred with about seven percent of women who had a history of miscarriage or abortion, compared with roughly five percent of the other women.

Lead author Dr. Liran Hirsch told the Daily Mail that pregnancy loss is “a very common event,” and that the findings “should be taken into account together with other parameters when assessing the risk for adverse outcome.”

Other studies have also found that induced abortion can impact later pregnancies, including an increased risk of infertility and preterm birth, which has been linked to an increased risk of mental impairment, autism, cerebral palsy and epilepsy disorders in children.

35. *Roe*, 410 U.S. at 166.

36. A physician's determination whether to abort should be made “in light of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well being of the patient.” *Colautti v. Franklin*, 439 U.S. 379, 394 (1979). Family size, financial concerns, mental health, and physical health are all issues in making a medical recommendation for abortion. “All these are factors the woman and her responsible physician necessarily will consider in consultation.” *Roe*, 410 U.S. at 153. The duty to evaluate this medical decision is especially weighty, because, “Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.” *Harris v. McRae*, 448 U.S. 297, 325 (1980).

37. See the Prevention of Coerced and Unsafe Abortions Act at www.StopForcedAbortions.org.

38. Reardon DC. *Making Abortion Rare: A Healing Strategy for a Divided Nation*. Springfield IL: Acorn Books; 1996.

What I've Learned From Working With Women Facing Abortion

Alliance of Pro-Life Students

I've learned that the word "choice" is often the last word a woman in a crisis pregnancy feels applies to her when she's looking for an abortion.

As I put down my mobile, having spoken to yet another distraught woman for over an hour, I look at the time and realize it's gone 10 p.m. I yawn and stretch—it's been another very long, emotionally draining day. I listen carefully to see if there's anyone else upstairs who may have accidentally overheard my conversation.

Thankfully, it appears not. The privacy of the woman I've been speaking to is crucial as she's in an extraordinarily difficult situation and I'm one of only four people on the planet who currently knows she's pregnant. Also, I'm staying with family members who don't know I work with women seeking abortions.

It's a difficult subject, you see, and one that elicits extremely strong emotional reactions from almost everyone, which ever side of the debate they stand on. As someone who naturally tries to avoid confrontation at all costs, I find it very hard to explain to people that the majority of the "women in need" that I work with came to me seeking an abortion.

My father, who does know, begged me to find some other charitable work: "Go and dig a well or something! No one can argue that that's a good thing to do!" In some ways, I would love to. It would be a lot simpler and I would be significantly less of a social outcast.

I've always been a good girl, and never felt remotely inclined to do anything controversial before. The thing is, having stepped into this strange, unseen world full of extraordinarily courageous women in the most difficult circumstances, with nowhere else to turn, I don't think I will ever really leave.

Having worked with hundreds of women seeking abortions over the last few years, I've learned a great deal about life. As a recent article written by a trainee abortion doctor attests, "pregnancy at the wrong time, with the wrong person, or in the wrong situation, can be a very lonely and unsympathetic place to be."

I've spoken to women from every conceivable background, ages ranging from early teens to late 40s, and each has their own story explaining why they're pregnant, and why they want an abortion. It is never a decision that is taken lightly, and there is always a very compelling reason why the woman is seeking an abortion.

There is also an almost universal, overwhelming sense that they have "no choice" and that given the crisis they're in, abortion is the only possible option. Far from empowered, this leaves most

women I've spoken to feeling utterly wretched.

As an example, I have spoken to many women who are seeking an abortion because their boyfriend or husband wants them to. Some are have been married for years and already have "enough" children—their husband wants them to further their career rather than waste time and money on another baby. Some are very young, with a boyfriend who doesn't feel he can commit financially or emotionally to supporting a child.

A significant number of their partners are abusive and have threatened physical or psychological violence. Most were using contraception. Many are convinced that, although they would like to keep the baby, their partner will leave them if they do. Almost all feel that they have no choice, that abortion is the only answer.

Let's look at the problem, though. In a crisis pregnancy like those described above, the crisis is the situation that the woman is in, not the pregnancy. The crisis is the fact that her workplace is prejudiced against

pregnant women, or that she feels she has to do what her partner says, or that she is not financially stable, or that her boyfriend won't commit, or that she is in an abusive relationship, or that she is being threatened with homelessness.

These are the crises—the pregnancy is simply acting as a magnifying glass, allowing us to see more clearly the problems that are already lurking. The pregnancy is not the crisis, and while stopping the pregnancy may mask the problems that it has highlighted, it will not stop them.

One woman I encountered spent the majority of the consultation sobbing, begging me to tell her boyfriend that she was not eligible for an abortion. She desperately wanted to keep her baby, but he had decided that she wasn't going to. Despite being married to someone else, he was in control of her finances, her housing and her visa. She was completely dependent on him and he was physically and emotionally abusive. I told him that she was not eligible for an abortion so he grabbed her arm and pulled her out of the building.

The fact that BPAS [British Pregnancy Advisory Service] performed an abortion on her later the same day is disgusting. In no way was her crisis solved by that abortion. Her child was forcibly removed against her will (even if she signed a consent form) because a man threatened the destruction of her life as she knew it. Silent complicity with abusive boyfriends is not what feminism has fought for.

I completely agree with the trainee abortion doctor when she says,

**Far from empowered,
most women I speak to
feel utterly wretched.**

“As long as unplanned pregnancy exists, we need to help women in this unfortunate situation, not harass them.” I cannot, however, agree that abortion is the way to do this.

My job empowers women by giving them the chance to live independently, ultimately by their own means, away from the fear of abuse or judgement, be that by partners, parents, schools, jobs or other women asking why they didn’t exercise their “right to choose.” It gives them a real choice, where keeping the baby is a realistic option. It helps them escape the crisis that the pregnancy has bought into focus. Surely this should be the focus of society?

Women in the 21st century should not feel they have to enter this secret world where “their mistake” can be “fixed,” no questions asked. They should feel that those who are putting pressure on them will be held accountable and that they have control over their lives.

Their lives may not be easy, but I’ve never spoken to a woman who regretted keeping her child. Their smiles, and the smiles of their children, are the reason that despite everything, I’m glad to have the privilege of answering my phone so late at night. In the short term, abortion may appear to “improve life and prevent harm,” but however difficult and unpopular it is to say it, abortion is not the answer. Stop the crisis, not the pregnancy.

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What’s Happening at the Elliot Institute?

Here are just a few of the projects we’ve been busy with in the past few months:

- The *Scandinavian Journal of Primary Health Care* published a rebuttal letter by Dr. Reardon criticizing a published study by a Danish researcher asserting that childbirth is a threat to psychological health. We’ll have more details in an upcoming issue of the *Post-Abortion Review* (or see our web site at www.afterabortion.org).
- One of our board members, Dr. David Mack, passed away in January. He was a very devout and holy man and we pray that his soul is resting in God’s peace. Please remember his family in your prayers.
- In upcoming news, Dr. Reardon will be traveling to Bosnia in March to be an observer at a week-long post-abortion healing retreat. Please pray for safe travels for him.

* * *

Be a partner in our work! Your tax-deductible donation will help support projects like those mentioned above. To make a donation, see the form below.

In an abortion clinic, there is no doctor-patient relationship. The doctor enters the room, there’s a brief introduction. The patient is already on the table ready to have the procedure done. There is no sort of opportunity for any sort of meaningful relationship to develop. —Former abortionist Dr. Robert Siudmack

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Recommendation for Depression Screening for Pregnant Women Should Extend to Abortion

The United States Preventive Services Task Force has issued a recommendation to screen women for depression before and after pregnancy in an effort to identify women at risk of postpartum depression and other pregnancy-associated mental health illnesses.

Elliot Institute Director David Reardon said that “it is important to identify women who may benefit from early psychological support and treatment.” He is especially hopeful that these recommendations will be applied to all pregnant women, irrespective of pregnancy outcome.

Reardon, the author of numerous studies on psychological treatment rates following birth, abortion, and miscarriage, believes better screening can lead to more timely referrals for support. This can make a huge difference in how women cope and adjust during and after their pregnancies.

Prior pregnancy outcomes can also effect mental health during and after subsequent pregnancies. Numerous studies have shown that prior pregnancy losses (miscarriage or induced abortion)

increase the risk of mental health problems during and after subsequent pregnancies. There are also additive effects. Exposure to multiple losses is linked with a proportional increase in risk of depression during and after subsequent pregnancies.

Abortionists’ failure to provide screening will be impossible to defend.

Reardon has been especially critical of the failure of abortion providers to screen for any of the risk factors listed by the American Psychological Association, that identify women who are likely to have the most severe negative reactions following induced abortions.

The list includes having a history of depression.

“Now that a government task force tasked with reducing complications associated with medical care has identified the importance of screening pregnant women for depression, the failure of abortion providers to provide pre-abortion screening and referrals for counseling will be impossible to defend,” Reardon said.

To learn more about the Elliot Institute’s model legislation that holds abortion providers liable for failing to screen for coercion and other risk factors, visit www.stopforcedabortions.com.

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