

**UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT**

PLANNED PARENTHOOD MINNESOTA, NORTH DAKOTA, SOUTH DAKOTA AND
CAROLE E. BALL, M.D.,
Plaintiffs/Appellees/Cross-Appellants,

v.

MIKE ROUNDS, GOVERNOR, AND MARTY J. JACKLEY, ATTORNEY GENERAL,
IN THEIR OFFICIAL CAPACITIES, AND ALPHA CENTER ET AL.,
Defendants/Appellants/Cross-Appellees,

ALPHA CENTER, BLACK HILLS CRISIS PREGNANCY CENTER,
D/B/A CARENET, DR. GLENN RIDDER, M.D., AND ELEANOR LARSEN, MA, LSWA,
Intervenors/Appellants/Cross-Appellees.

On Appeal from the United States District Court for the
District of South Dakota, Southern Division
No. Civ. 05-4077-KES (Karen E. Schreier, J.)

**BRIEF FOR AMICUS CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION**

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STATEMENT OF INTEREST

The American Psychological Association (“APA”) is a voluntary nonprofit scientific and professional organization that represents the field of psychology in the United States. With over 152,000 members, it is the largest association of psychologists in the United States and includes the vast majority of psychologists holding doctoral degrees from accredited U.S. universities. The APA’s mission includes advancing the creation, communication, and application of psychological knowledge for the betterment of society and improvement of people’s lives. In furtherance of these goals, APA also regularly appoints task forces comprised of leading scholars in the subfields of psychology, as well as research methods, to review, evaluate, and report on social science research that bears on important topics of public and scholarly interest.

In 2008, the APA published the Report of the APA Task Force on Mental Health and Abortion (“APA Report”). This Report was based on the Task Force’s extensive review of then-existing studies examining the relationship between abortion and mental health. The Report was cited by both Appellees and the District Court in support of the conclusion that increased risk of suicide and suicidal ideation (*i.e.*, thoughts of suicide) are not known medical risks of abortion.

The APA submits this amicus brief to respond to Appellants’ criticisms of the APA Report and in support of the District Court’s conclusion that, consistent

with the findings of the APA Report, increased risk of suicide and suicidal ideation are not known medical risks of abortion.

INTRODUCTION

In 2005, the South Dakota Legislature passed a law requiring a doctor to inform a patient seeking an abortion that a “known medical risk” of abortion “to which the pregnant woman would be subjected” is “[i]ncreased risk of suicide ideation and suicide.”¹ Appellants claim that “abundant scientific evidence ... establishes a significant relationship between abortion and subsequent suicide and suicide ideation,”² and that this purported relationship is sufficient to demonstrate that the required warning in the South Dakota statute is not misleading or wrong. In fact, as the APA Task Force’s authoritative review of the scientific literature demonstrates, “increased risk of suicide and suicidal ideation” are *not* “known medical risks” of abortion. The District Court thus correctly concluded that the required disclosure is misleading, inaccurate, and unconstitutional.

STATEMENT OF FACTS

A. Background On The APA Report

In 2006, the APA’s Council of Representatives established the Task Force on Mental Health and Abortion (“Task Force”), and charged it with “collecting,

¹ S.D. Codified Laws § 34-23A-10.1(1)(e)(ii).

² State’s Br. 41.

examining, and summarizing the scientific research addressing the mental health factors associated with abortion, including the psychological responses following abortion, and producing a report based upon a review of the most current research.”³

This review followed a similar review conducted in 1989, in which a panel of experts convened by the APA reviewed the scientific literature on the psychological effect of legal, elective, first-trimester abortions on women in the United States. The 1989 review panel concluded that it was rare that a woman experienced a “severe negative reaction[] after [a] legal, nonrestrictive, first-trimester abortion[].”⁴ The panel recognized that while some women experienced severe distress or psychopathology following an abortion, the research did not show that these symptoms were causally linked to the abortion. The scientific community relied on the 1989 APA Report as the definitive scientific statement on the link between abortion and mental health.

Since the 1989 APA Report, new studies have been published that address the association between abortion and women’s mental health. Conflicting reviews of the published studies prompted the APA’s Council of Representatives to

³ APA Report 3.

⁴ Adler et al., *Psychological Responses After Abortion*, 248 Science 41, 43 (1990).

convene the new Task Force to review the literature published since the 1989 report. After two years of extensive review of the relevant studies in which the Task Force critically and objectively evaluated the quality of the scientific research on the issue and its conclusions, the Task Force issued its report.⁵

1. Background of the Task Force members

The APA Board of Directors selected six members of the psychology research community to serve on the Task Force on the basis of their research areas and expertise. Drs. Brenda Major and Nancy Felipe Russo were members of the 1989 Task Force and have conducted extensive research in the area of reproductive health. Dr. Linda Beckman, who also has significant experience researching reproductive health issues, was highly recommended to the Board of Directors by members of the 1989 Task Force who were unable to participate on the 2006 Task Force. Drs. Mary Ann Dutton and Carolyn West were specifically selected in light of their work related to violence/trauma, sexual behaviors, and minority

⁵ See American Psychological Association, *Report of the Task Force on Mental Health and Abortion* (2008), available at <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>. The State is wrong to assert that the Report should not have been admitted by the District Court because eight of the nine tables were not included with the study. State's Br. 63. Tables 1A-5 were not included in the initial release of the APA Report because they had not yet been finalized. Nevertheless, the Task Force's main discussion and conclusions regarding the various studies were in the Report's text, not the tables; therefore, the District Court was able to assess them in reviewing the APA Report.

populations. Finally, Dr. Mark Appelbaum was selected for his expertise as a methodologist, whose participation was viewed as critical because some of the most important questions the Task Force addressed in the Report related to the methodological soundness of the research studies in the Task Force's review.

The following brief biographical summaries are a snapshot of some of the contributions each member has made in the fields of psychology and psychiatry:

Brenda Major, the Chair of the Task Force, received a Ph.D. in social psychology from Purdue University and has been a professor for more than thirty years. She is an internationally renowned scholar who has been President of the Society of Personality and Social Psychology and is President-Elect of the Society of Experimental Social Psychology. She has served on numerous editorial boards of professional journals, has acted as an ad hoc reviewer for over twenty publications, and has received millions in research grant funding. She has published more than 100 articles in peer-reviewed journals focusing on stress and coping, resilience, and stigma.

Linda Beckman received a Ph.D. in psychology from the University of California, Los Angeles and has served as a professor and researcher for almost thirty years. She has published three books, thirteen book chapters, and authored or co-authored over 100 articles. Her areas of expertise include reproductive technology, access to quality health care and contraception, decision making, and

sexual behavior. She has also been a member, consultant, reviewer, and co-chair of numerous committees and advisory groups within her field.

Mary Ann Dutton is a professor and researcher at Georgetown University Medical Center. She has a Ph.D. in clinical psychology from the University of Utah. Her expertise is in the area of trauma, interpersonal violence, sexual assault, sexual abuse, low-income and minority populations, and community-based mental health interventions. She has published nearly fifty articles in peer-reviewed journals, authored a book, edited a book, and has authored or co-authored over twenty book chapters.

Nancy Felipe Russo received her Ph.D. in social and developmental psychology from Cornell University in 1970 and is currently a Regents Professor at Arizona State University in the Department of Psychology. She has authored or co-authored fifteen books, fifteen book chapters, and over 100 publications, including peer-reviewed journal articles, reports, reviews, abstracts, and editorials. She has an extensive background and wealth of expertise on reproductive choice and abortion, violence, women's mental health, and ethnic minority issues. She has also served as an editor, associate editor, and reviewer for numerous journals, is president-elect of the Society for General Psychology, and has received many distinguished awards.

Carolyn West has a Ph.D. in clinical psychology from the University of Missouri, St. Louis. She is an Associate Professor of Psychology at the University of Washington, Tacoma, where she teaches courses on family violence, human sexuality, and psychology of women. She has lectured and presented papers at over 100 conferences. She has also authored two books, and authored or co-authored over forty peer-reviewed journal articles and book chapters.

Mark Appelbaum received his Ph.D. in quantitative psychology with a concentration in behavioral statistics from the University of Illinois. He is currently a Professor in the Department of Psychology at the University of California, San Diego. His work has focused on the use of quantitative methods and data analytic approaches to the study of a wide range of problems encountered in psychology, medicine, and education. In addition to his work on quantitative methods, he has conducted major studies of non-maternal child-care, health and human behavior, architecture of brain and mind, HIV transmission in risk populations, and educational policies and outcomes. He has been a leading researcher for more than thirty years. He is a founding editor of a major psychology publication, *Psychological Methods*, and was editor of the *Psychological Bulletin*. He has published over sixty-five articles, as well as authored or co-authored numerous studies in his field.

The Task Force members—three of whom had not worked on research questions relating to abortion prior to their work on the Task Force—are highly esteemed in the scientific community. Each brought their specific and extensive expertise to fulfilling the Task Force’s mission.

2. The Task Force’s review

The Task Force undertook a thorough, two-year process for reviewing and evaluating the then-existing studies analyzing the relationship between abortion and mental health. The Task Force “considered its mission not only to review, but also to critically and objectively evaluate the quality of the scientific evidence without regard to the direction of its findings in order to draw conclusions about the mental health implications of abortion based on the best scientific evidence available.”⁶

First, the Task Force searched for relevant studies—*i.e.*, English-language, peer-reviewed articles published since 1990⁷—using key word searches (including “suicide” and “suicidal ideation”)⁸ in two widely used and comprehensive scientific journal databases. The Task Force also reviewed the reference sections

⁶ APA Report 6.

⁷ The 2008 APA Report only reviewed literature that was published after the 1989 APA Report.

⁸ Although the South Dakota statute refers to “suicide ideation,” the correct clinical term is suicidal ideation.

of the articles identified during the key word search for additional relevant studies, and several studies were brought to the attention of the Task Force by reviewers that were not found during the key word search.⁹ These steps ensured that the Task Force cast the widest net in collecting the relevant studies for the review, a key component of any legitimate systemic literature review.¹⁰

Second, a minimum of two task force members read the abstract of each article and determined independently whether the study should be included in the comprehensive review, based on the following four criteria. Each study had to (i) be of a quantitative nature; (ii) be published in a peer-reviewed journal; (iii) include at least one post-abortion measure related to mental health; and (iv) focus on induced abortions (as opposed to spontaneous abortions).¹¹

Third, after the abstract review, two task force members then read each article in full and made a second determination of whether the articles continued to meet the four criteria. Each article which met the four criteria was then coded,

⁹ APA Report 21.

¹⁰ Dr. Priscilla Coleman's criticism that the Task Force did not use "more stringent criteria" to collect studies is unfounded. See Declaration of Priscilla Coleman, dated Sept. 16, 2008, State's Exhibit ("SA") 1792 ("Coleman Sept. 2008 Decl."). Not only does this criticism contradict Dr. Coleman's assertion that the Task Force failed to evaluate all of the relevant studies, but using more stringent criteria would have undercut the Task Force's goal of a broad review by *reducing* the total number of studies reviewed by the Task Force and thus limiting its review.

¹¹ See APA Report 21.

summarized, and further evaluated by at least two other task force members. No task force member was allowed to evaluate his or her own work. No studies were excluded based on whether they found or did not find negative mental health consequences of abortion.

Finally, the Task Force organized the articles based on whether the study included a comparison group of women who did not have an abortion.

3. Nature of the studies examined

Overall, the Task Force identified fifty empirical papers that were published in English, in peer-reviewed journals, post-1989 that compared the mental health of women who had an induced abortion to the mental health of comparison groups of women, although not all of these studies included an appropriate comparison group.

In addition, the Task Force identified and reviewed twenty-three studies that did not include a comparison group.¹² While the absence of a comparison group means that such studies do not address the question of relative risk, the Task Force concluded that these studies can be “useful for identifying factors that predict individual variation in women’s psychological experience following abortion,” and can help address questions relating to the “prevalence of harm associated with

¹² *Id.* at 22.

abortion to the extent that their sample is representative of the population to which it wants to generalize.”¹³ These studies may also suggest other variables that account for the presence of mental health problems in some women who had abortions.¹⁴

4. Peer review of the Task Force’s APA Report prior to publication and approval

The Task Force circulated an initial draft report to twenty-six outside reviewers, identified based on both expertise and expression of interest in the Report. The APA boards and committees were also invited to identify and appoint individuals to review the preliminary draft of the Report. The initial list of reviewers contained thirty-three names, and the APA contacted all of the potential reviewers on the list. Twenty-one outside reviewers ultimately submitted detailed responses to the Report, which were considered during a subsequent revision process.

¹³ *Id.* at 72.

¹⁴ Dr. Coleman’s criticism of the Task Force for limiting its review of studies that did not include comparison groups only to U.S. studies because of cultural variation ignores scientific methodology. Coleman Sept. 2008 Decl., SA 1792. Drawing conclusions about the prevalence in a particular population of a mental health problem following a procedure based on samples that are, for cultural reasons, not representative of that particular population (*e.g.*, women in the United States) can result in misleading conclusions.

The revised draft was then reviewed and vetted by fourteen APA boards and committees and then presented to the APA Council of Representatives for the Council's approval. The APA Council of Representatives is the policy-setting body of the APA, comprised of 164 members, all of whom hold doctoral degrees in psychology-related fields. These multiple reviews provided the series of checks and balances that helped ensure that the Report met the APA's highest standards for scientific integrity.

B. Methodological Problems Affecting Research On Abortion And Mental Health

In its evaluation of the relevant literature, the Task Force conducted a close and critical examination of the studies that assessed post-abortion mental health. The Task Force members identified a range of methodological problems in these studies. Identifying methodological limitations in any research study is of critical importance, because such limitations undercut the studies' conclusions. The Task Force's determination of the conclusions that could be drawn from each study depended on the nature and severity of the methodological problems present in each study. The following sections briefly summarize some of the more significant methodological problems that the Task Force found in many of the studies that examined post-abortion mental health.

1. Failure to include appropriate comparison groups

The Task Force identified the best studies as those that included appropriate comparison groups.¹⁵ An appropriate comparison group is composed of individuals who are similar in all key respects to the individuals being studied, except for the characteristic or event being examined—in this context, for example, comparing a group of women who have abortions to women who are denied or unable to obtain an abortion and carry to term an unwanted pregnancy. The purpose of comparison groups is to rule out alternative explanations for a study's findings. If two groups being compared differ from each other in several key ways, in addition to whether their members had an abortion, then it is not possible for the researchers to determine whether the mental health effects they observe are related to abortion or to some other difference between the groups. Controlled studies, in which the two groups being compared are highly similar except for the presence of abortion, allow researchers to make more defensible conclusions regarding the effects of abortion on mental health. Therefore, the Task Force sought to identify studies that included comparison groups composed of women who did not have abortions, but who were similar in all other key respects to the women who had abortions.

¹⁵ See APA Report 14-15.

Failing to use appropriate comparison groups becomes especially problematic when wantedness of a pregnancy is not controlled for in the comparison group. As the Task Force explained, the studies that examined women's responses following an induced abortion for fetal abnormality found that the women experienced "negative psychological reactions equivalent to those experienced by women who miscarry a wanted pregnancy or who experience a stillbirth or death of a newborn, but less severe than those experienced by women who deliver a child with life-threatening abnormalities."¹⁶ Therefore, studies that group together women who terminate wanted pregnancies with women who terminate unplanned pregnancies (92% of U.S. abortions) and then compare the combined abortion group to women who carry wanted pregnancies to term will likely bias the results towards a finding of negative mental health impacts in the abortion group as compared to the delivery group.¹⁷

2. Failure to control for co-occurring risk factors

One of the most serious methodological problems present in the studies reviewed by the Task Force was the failure to take into account risk factors for mental health problems that were present prior to the pregnancy that resulted in

¹⁶ *Id.* at 4.

¹⁷ *Id.* at 7.

abortion.¹⁸ Determining whether an outcome flows from the abortion versus other factors that affect a woman who has an abortion—*i.e.*, the adverse circumstances and characteristics known to be more prevalent among women who have an unwanted pregnancy in the first place—becomes almost impossible when these co-occurring risk factors are not controlled for in the research design. Another study recently published by Robinson et al., highlighted this methodological flaw. “Studies that do not take into account preexisting or co-occurring stressful circumstances in the lives of women having abortions may attribute emotional distress to the abortion when it is actually due to those other circumstances.”¹⁹ This conclusion was mirrored by the Task Force’s own analysis that “[i]t was particularly difficult to detect these co-occurring conditions and their consequences from secondary data analyses of data sets collected for other purposes.”²⁰

Substantial research literature has found that systemic and personal characteristics that predispose women to have unintended pregnancies also predispose them to have psychological and behavioral problems.²¹ Greater

¹⁸ *Id.* at 16.

¹⁹ Robinson et al., *Is there an “Abortion Trauma Syndrome”? Critiquing the Evidence*, 17 Harv. Rev. Psychiatry 268, 270-271 (Aug. 2009).

²⁰ APA Report 16.

²¹ *Id.* at 13; *see also* Robinson et al., *supra* n.19, at 270.

exposure to these factors, such as poverty and intimate-partner violence,²² among women who have abortions may put such women at a higher risk for negative mental health outcomes.²³ For example, studies have shown that “[w]omen at particularly high risk for unintentional pregnancy and women who obtain abortions tend to be young, unmarried, and/or poor, as well as women of color.”²⁴ Other studies have also found that systemic risk factors such as exposure to sexual or physical abuse during childhood or intimate-partner violence, including rape, are also correlated with a greater likelihood of both unintended pregnancy and abortion.²⁵

Likewise, Costa, Jessor, and Donovan (1987) found that personal risk factors, including smoking, using alcohol or illicit drugs, engaging in early sexual intercourse, and having unprotected sexual intercourse, put women at risk for unplanned pregnancies and abortions.²⁶ Notably, these personal risk factors “put

²² See APA Report 12.

²³ *Id.*

²⁴ *Id.* at 13.

²⁵ *Id.*

²⁶ *Id.*

[women] at risk for mental or physical health problems, *whether or not a pregnancy is aborted or carried to term.*”²⁷

All of these co-occurring risk factors “must be considered in order to make sense of any mental health problems observed subsequent to abortion”;²⁸ the failure to adequately control for these co-occurring risk factors makes it impossible to interpret the meaning of any observed correlations between abortion and mental health problems.²⁹ This problem was especially apparent in studies that conducted secondary analyses of data sets where such co-occurring factors were not adequately assessed.³⁰

3. Sampling issues

Third, many studies suffered from sampling problems that limited the generalizability of their findings. Some studies recruited women “without concern for the degree to which they represented a definable population,” while others were based on samples from studies conducted for other purposes.³¹

²⁷ *Id.* at 14 (emphasis in original).

²⁸ *Id.* at 12; *see also* Robinson et al., *supra* n.19, at 270-271.

²⁹ APA Report 91.

³⁰ *See, e.g., id.* at 42-43 (concluding that Reardon et al. (2004) failed to control for history of drug use prior to first pregnancy).

³¹ *Id.* at 16 (reviewing, among others, the Medi-Cal studies).

4. Incorrect interpretations/generalizations

Significantly, many studies also incorrectly interpreted or generalized the data. For example, several studies improperly inferred causation from correlation.³² Although correlation is a necessary prerequisite for causation, the simple existence of a correlation, by itself, does not provide a sufficient scientific basis for making causal inferences. More specifically, based solely on data showing a relationship between abortion history and mental health variables (*e.g.*, substance abuse and depression), these studies inappropriately concluded that abortion **caused** these mental health outcomes to occur. Such an analysis is deeply flawed as a scientific matter, because not only is it possible that the causation flows the other way (*e.g.*, women who use drugs have been shown to be likely to have unwanted pregnancies and abortions), but it is also very possible that a third variable correlated with both incidence of abortion and poor mental health (*e.g.*, poverty or exposure to violence) is responsible for both outcomes and thus the apparent correlation.³³ The Task Force reviewers were careful to identify studies that wrongly extrapolated causation from research that only shows correlation.

³² *Id.* at 19.

³³ *See id.*

5. Measurement of reproductive history and problems of underreporting

The Task Force also found that many studies misrepresented a woman's reproductive history by establishing abortion status based on self-reporting, which typically underreports abortions.³⁴ Women who are Black, Hispanic, Catholic, low-income, and aged 20-24 are particularly susceptible to underreporting.³⁵ Despite the potential for bias caused by underreporting, most of the studies reviewed by the Task Force did not test for a possible underreporting bias.

6. Attrition

Attrition—which is defined as the loss of cases during the course of a research investigation—is another methodological issue the Task Force found in several of the studies assessing post-abortion mental health.³⁶ High attrition rates can bias results when the attrition is not random but rather biased in a specific direction. As the Task Force explained,

In the case of abortion ... underestimation of the prevalence of distress in the final sample would occur if women who were most upset by the abortion were more likely to be lost to a follow-up than those who were retained in the sample. Similarly, overestimation of the prevalence of distress would occur if women who were

³⁴ *Id.* at 17.

³⁵ *Id.*

³⁶ *Id.* at 18.

least distressed by the abortion were likely to be lost to follow-up.³⁷

Despite this potential for bias, only a few studies that the Task Force reviewed tested for biases in attrition.³⁸

7. Methodological limitations play a key role in assessing the studies researching post-abortion mental health

Overall, the Task Force concluded that most of the studies examining the relationship between abortion and mental health have been susceptible to one or more serious methodological or interpretational flaws.³⁹ The significance of these methodological problems cannot be understated. A failure to account for wantedness of a pregnancy or basing a research study on a sample that is not representative of a larger population, for example, undermines the ability to

³⁷ *Id.*

³⁸ *Id.* Dr. Coleman claims that the Task Force downplayed the problems with attrition as a methodological weakness in the reports that it reviewed, specifically the studies by Major et al. See Coleman Sept. 2008 Decl., SA 1795. However, the Task Force did not review these studies to draw conclusions about the relative risk of mental health problems following abortions, particularly because those studies did not include comparison groups. Instead, these studies were assessed to identify “factors that predict individual variation in women’s psychological experiences following abortion.” APA Report 72. In any event, the Major et al. studies are among the few to compare the mental health of women who were lost to attrition versus women who stayed in the study after two years. The studies did not find any significant differences in the demographic or psychological variables of the women.

³⁹ APA Report 20.

conclude that such studies accurately assess the relationship between abortion and mental health in the general population. Accordingly, in painstaking detail and precision, the Task Force identified the relevant research problems as they related to *every study* in the review.⁴⁰

The Task Force identified “one study [that] stood out from the rest in terms of its methodological rigor”:⁴¹ the Gilchrist et al. (1995) study.⁴² Unlike many of the other studies reviewed by the Task Force, the authors of the Gilchrist study restricted their study to women who had an unplanned pregnancy, allowing for a more appropriate comparison group for addressing the issue of *relative risk* of mental health problems.⁴³ Such a comparison allowed the Gilchrist study authors to assess the issue of relative risk of mental health problems post-abortion because the study compared women of similar situations—*i.e.*, women with an unplanned pregnancy who chose different pregnancy outcomes (abortion and delivery),

⁴⁰ These methodological problems also made it impossible to “simply count the number of studies that show one effect versus another or that calculate effect sizes without carefully considering and weighing the quality of the evidence that produced the effect are inappropriate and often misleading.” *Id.* These limitations demonstrate why Dr. Coleman’s assertion that the Task Force “avoid[ed] quantification of the adverse effects of abortion” (Coleman Sept. 2008 Decl., SA 1791) is misplaced.

⁴¹ APA Report 89.

⁴² *See also* Robinson et al., *supra* n.19, at 274.

⁴³ APA Report 89-90.

including women who had abortions and women who had wanted to obtain an abortion but were denied one. Moreover, the Gilchrist authors also properly relied on established diagnostic categories for measuring psychiatric morbidity and controlled for covariates (*i.e.*, other variables related to the outcome of interest; *e.g.*, including mental health status prior to the pregnancy).

ARGUMENT

I. SCIENTIFIC LITERATURE DOES NOT ESTABLISH THAT SUICIDE AND SUICIDAL IDEATION ARE KNOWN MEDICAL RISKS OF ABORTION

In holding that the South Dakota statute’s warning that increased risk of suicide and suicidal ideation are known medical risks of abortion is untruthful and misleading, the District Court correctly determined that “increased risk of suicide ideation and suicide are [not] ‘known’ risks” of abortion.⁴⁴

A. The Best Scientific Research Indicates That An Adult Woman With An Unplanned Pregnancy Is At No Greater Relative Risk For Mental Health Problems In Having An Abortion As Compared To Its Alternatives

After an extensive review of the available evidence, the APA Task Force determined that “the prevalence of mental health problems observed among women in the United States who had single, legal, first-trimester abortion for non-therapeutic reasons *was consistent with normative rates of comparable mental*

⁴⁴ *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, 650 F. Supp 2d. 972, 983 (D.S.D. 2009).

health problems in the general population of women in the United States.”⁴⁵

Noting that while some women do experience some sadness, grief, and feelings of loss, the Task Force found that there was no “evidence sufficient to support the claim that an observed association between abortion history and a mental health problem was caused by the abortion per se, as opposed to other factors.”⁴⁶

In addition to assessing the issue of prevalence of post-abortion mental health problems, the Task Force also evaluated the studies to assess the relative risk of post-abortion mental health problems as compared to the alternatives. During this evaluation, the Task Force paid close attention to the methodological issues in the studies. For example, the Task Force determined that the methodological limitations of the secondary analyses of medical records and existing public data sets—including the failure to adequately control for co-occurring risks and prior mental health—made it “impossible to determine whether any observed differences between abortion groups and comparison groups reflect consequences of pregnancy resolution or preexisting differences between groups or

⁴⁵ APA Report 4 (emphasis added). As the Task Force’s review shows, Dr. Coleman’s claim that “there is a consensus among most social and medical science scholars that a minimum of 10 to 30% of women who abort suffer from serious, prolonged negative psychological consequences,” Coleman Sept. 2008 Decl., SA 1791, is false, and the citations that Dr. Coleman uses to support this statement do not in fact do so.

⁴⁶ APA Report 91; *see also* Robinson et al., *supra* n.19, at 276.

methodological artifact.”⁴⁷ This problem therefore made it impossible to draw conclusions based on such research regarding relative risks of abortion compared to its alternatives.⁴⁸

In contrast, the Task Force identified one study—the Gilchrist study—that did contain the appropriate comparison group and overall rigor from which to draw conclusions regarding relative risks. The Task Force concluded that this study’s findings—that women who terminated an unplanned pregnancy did *not* have a higher rate of a reported psychiatric disorder than women who had an unplanned pregnancy and carried the pregnancy to term⁴⁹—was the best scientific research available on the issue.⁵⁰

⁴⁷ APA Report 57.

⁴⁸ *Id.*

⁴⁹ The amicus brief in support of Appellants points to rate of deliberate self-harm (“DSH”) in the Gilchrist study as demonstrating an increased risk of suicide and suicidal ideation following induced abortion. Ass’n Amici Br. 8. This position fundamentally misconstrues the findings of the Gilchrist study. First, the vast majority (89%) of the DSH episodes were drug overdoses, not clear acts of attempted suicide. See Gilchrist et al., *Termination of Pregnancy and Psychiatry Morbidity*, 169 British J. Psychiatry 243, 247 (1995). Second, the study found that among women with no previous psychiatric history, the rate of DSH was significantly higher among women who were refused an abortion and subsequently delivered as compared either to women who had an abortion or women who delivered and had not originally sought an abortion (“the delivery group”), and a somewhat higher rate among the women in the abortion group as compared to the delivery group. In addition, the study found that rates of DSH did not significantly differ for the abortion versus delivery groups among women with a past history of

Accordingly, the Task Force determined—based on its entire review—that,

the most methodologically sound research indicates that among women who have a single, legal, first-trimester abortion of an unplanned pregnancy for nontherapeutic reasons, *the relative risks of mental health problems are no greater than the risks among women who deliver an unplanned pregnancy.*⁵¹

Other researchers echo this assessment. For example, Robinson et al., concluded that “[t]he most well controlled studies continue to demonstrate that there is no evidence that induced abortion of an unwanted pregnancy is per se a significant risk factor for psychiatric illness.”⁵²

psychosis or with past history of DSH. As the Gilchrist authors themselves concluded, “[t]he findings on DSH are probably explicable by confounding variables, such as adverse social factors, associated both with the request for termination and with subsequent self-harm,” not due to the abortion itself. *Id.* at 243.

⁵⁰ The Task Force found the outcome differences between the Fergusson and Gilchrist studies were likely due to sampling and design issues in Fergusson, such as the comparative sample size—6410 in Gilchrist; 48 in Fergusson.

⁵¹ APA Report 92 (emphasis added).

⁵² Robinson et al., *supra* n.19, at 276 (footnotes omitted). Dr. Coleman’s assertion that the Task Force’s findings were based solely on the Gilchrist study is wrong. Coleman Sept. 2008 Decl., SA 1796. The Task Force’s conclusions were based on a thorough evaluation of the many studies assessing post-abortion mental health.

B. The Task Force Analyzed Suicide And Suicidal Ideation In Reviewing Studies On A Broad Range Of Mental Health Issues In Women Who Have Had Abortions

Ignoring the Task Force’s extensive Report, the State alleges that the District Court failed to “point to any analysis of suicide ideation or suicide in the [APA] report”⁵³ and claims that the APA Report’s “only reference” to suicide is an acknowledgement that there was a higher rate of suicide in women who had aborted versus women who had delivered.⁵⁴ The State’s assertions are misleading and overlook a significant portion of the Task Force’s review.

First, the State ignores the fact that the Task Force *did* review studies that assessed suicide following abortion, and concluded that these studies’ correlational finding of a higher rate of violent death—which included accidents, homicide, and suicide—following abortion “is consistent with other evidence indicating that risk for violence is higher in the lives of women who have abortions and *underscores the importance of controlling for violence exposure in studies of mental health associated with pregnancy outcome.*”⁵⁵ Therefore, while the Task Force “acknowledged” the studies’ findings of a higher rate of violent death, including suicide, among the abortion group, the Task Force concluded that this result was

⁵³ State’s Br. 64.

⁵⁴ *Id.*

⁵⁵ APA Report 88 (emphasis added).

not one of causation, but instead correlation. Because no co-occurring risk factors were assessed or controlled for in these studies, other factors may have contributed to both the abortion and the suicide. Thus, these studies do not provide a sufficient scientific basis for drawing any conclusions about the relationship between abortion and suicide.

Second, the Task Force looked at studies addressing mental health problems generally in women who have had abortions. The District Court rightly reasoned that the Task Force's conclusions regarding abortion and mental health problems apply to the symptoms of such mental health problems, including suicide and suicidal ideation.

C. The Task Force Evaluated The Studies Appellants Claim Show That The Suicide Disclosures Are Not Misleading Or Inaccurate And Found Numerous Methodological Flaws

Appellants argue that the District Court ignored studies that support the disclosures required by the South Dakota statute.⁵⁶ But the APA Task Force carefully reviewed and addressed these very same studies, and the District Court took them into account in reaching its decision.

A review of the studies that assessed suicide as one of the variables of post-abortion mental health exposes the danger of using these studies to support the

⁵⁶ State's Br. 51; Intervenor's Br. 72.

disclosures required by the South Dakota statute. The first of these studies, by Gissler, Hemminki, and Lonnqvist (1996),⁵⁷ involved several methodological limitations—all of which were identified and discussed by the Task Force in its Report.⁵⁸ For example, the study did not control for the wantedness of the pregnancy.⁵⁹ In addition, the study did not assess any of the “other critical variables known to co-vary with both pregnancy outcome and mental health (*e.g.*, prior reproductive history, prior mental health problems, violence exposure, etc.).”⁶⁰ Co-vary means that two or more characteristics or events are related. Because exposure to violence, class, parity, and circumstances of the pregnancy co-vary (or are related) with pregnancy outcome and mental health, it is possible that any one of these variables, and not necessarily the abortion, is responsible for the observed mental health effects. Without taking into account the influence of these variables, researchers are not in a good position to assess the relationship between abortion and mental health. Accordingly, due to these concerns relating

⁵⁷ Gissler and other authors published a series of studies from 1996 to 1999 and again in 2004 to 2005, drawing their sample from medical records available in Finland.

⁵⁸ APA Report 29.

⁵⁹ *Id.* at 25, Table 1; *see also* Robinson et al., *supra* n.19, at 272.

⁶⁰ APA Report 29.

to covariance in the Gissler study, the Task Force concluded that the comparisons between the abortion group and the delivery group were “problematic.”⁶¹

In fact, the authors of the Gissler studies themselves cautioned against extrapolating causation from their 1996 study due to its methodological limitations.⁶² The authors therefore conducted a third study, the Gissler and Hemminki (1999) study, to counter the claim that the 1996 study had implied causation between abortion and the recorded deaths.⁶³ The authors emphasized in their 1999 study that the “finding that the risks of accidental death and homicide also increase after an induced abortion and our previous findings that women from lower social classes and single women are over-represented among women committing suicides after an induced abortion, do not support the hypothesis that abortion itself causes suicide.”⁶⁴ Accordingly, the authors themselves reject the interpretation the State and Dr. Coleman have made of the study’s findings.⁶⁵

In addition to the studies published from 1996 to 1999, Gissler published with several authors three more studies in 2004 and 2005—which were also

⁶¹ *Id.* at 25, Table 1.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.* (internal citation omitted).

⁶⁵ State’s Br. 53-54; *see also* Coleman July 2006 Decl., SA 1555-1556.

reviewed by the Task Force—relying on an updated set of Finnish medical records. Contrary to the State’s and Dr. Coleman’s assertions, these studies do not support the statute’s suicide disclosures.

Although as with the earlier studies, these studies did not control for wantedness or any other critical variable known to co-vary with both pregnancy outcome and mental health, the Task Force identified the Gissler (2004b) study as the most methodologically rigorous of all the Finland studies.⁶⁶ The 2004b study applied definitions provided by the American College of Gynecology, and analyzed the direct pregnancy-related deaths *separately* from the pregnancy-associated deaths.⁶⁷ “Pregnancy-related” deaths are deaths that occur within one year of the end of a pregnancy from causes related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes; “pregnancy-associated” deaths are deaths that occur within one year from end of pregnancy, regardless of cause of death.⁶⁸ In applying this improved method of analysis, the study’s authors found that once “therapeutic abortions”⁶⁹ were

⁶⁶ APA Report 29.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ A therapeutic abortion is an abortion induced for medically related reasons, such as to protect the mother’s health or because of severe fetal abnormalities. *Id.* at 6.

excluded from the category of pregnancy-associated deaths, women in the abortion group *no longer had higher pregnancy-associated death rates* than women in the delivery group.”⁷⁰ Thus, this study suggests that while there were more overall deaths within a year in the abortion group, there was no difference between the abortion group and the delivery group when the authors compared women who had *elective* abortions with women in the delivery group.

The Gissler studies, therefore, do not support but in fact challenge the accuracy of the South Dakota statute’s suicide disclosures because, as these studies and their authors make clear, increased risk of suicide and suicidal ideation are not known medical risks of abortion. Instead, in instances where the studies have identified an increase in suicide following abortion, it is more likely because of a co-occurring risk factor, not because of the abortion.

Indeed, as noted by the Task Force, the Gissler authors emphasized this point once again in their 2005 study, noting that “their findings do not warrant causal conclusions and emphasize the need for more information on relevant covariates, including ‘mental health social well-being, substance abuse, and socio-economic circumstances’ in further analyses.”⁷¹ Accordingly, the Gissler studies,

⁷⁰ *Id.* at 29 (emphasis added). The study showed that women in the delivery group had higher pregnancy-related deaths than women in the abortion group.

⁷¹ *Id.* at 26, Table 1 (internal citation omitted).

the authors of the studies, and the Task Force’s review all contradict Dr. Coleman’s contention that the “evidence,” including the Gissler 1996 and 2005 studies, supports the conclusion that it is the abortion experience itself and not the “personal or situational variables correlated with both the choice to abort and suicidal behavior” that causes a woman to consider or commit suicide.⁷²

The same problem applies to Dr. Coleman’s reliance on the Reardon et al. (2002) Medi-Cal study, which she asserts establishes that “the weight and form of the scientific evidence indicates that an abortion is often a significant contributing factor in causing suicidal ideation and suicide.”⁷³ The Task Force reviewed this study and concluded that it suffered from numerous methodological issues, which limited the utility of its findings. For example, the study’s authors failed to adequately assess prior mental history, did not control for wantedness, did not include adequate information about co-occurring risks (*e.g.*, health status, violence exposure), and did not include any information about the context for the abortion decision.⁷⁴

⁷² Coleman July 2006 Decl., SA 1552.

⁷³ *Id.* at SA 1558.

⁷⁴ APA Report 22-24.

The State and Dr. Coleman also rely heavily on the Fergusson (2006) study to support their claim that the South Dakota statute's disclosures are appropriate.⁷⁵ Contrary to Dr. Coleman's suggestion that the Task Force ignored the positive features of this study,⁷⁶ the Task Force specifically identified this study as the "most comprehensive of the secondary analysis studies" and acknowledged that it was "unusual in the quality of measurement of the mental health variables, range of outcomes assessed, and number of co-occurring risk factors controlled."⁷⁷ However, the Task Force also identified "several design features [which] limit [the] conclusions that can be drawn from this study."⁷⁸ One of the study's major problems was that it did not control for wantedness.⁷⁹ As discussed above, it is inappropriate and misleading to draw conclusions about the mental health consequences of abortion without considering the "wantedness" of the pregnancy that was terminated.⁸⁰

⁷⁵ *Id.* at 54-55; Table 2.

⁷⁶ Coleman Sept. 2008 Decl., SA 1795.

⁷⁷ APA Report 54.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.* at 55, 90.

Other concerns limiting the conclusions that can be drawn from the study include the following: the study did not separate women who had one abortion from women who had more than one abortion;⁸¹ an underreporting of abortion in the sample;⁸² the use of a comparison group of women who had never been pregnant;⁸³ a small sample size of only forty-eight women; and, finally, a sample size focusing on women less than twenty-one years old, thus “limiting its generalizability to younger women.”⁸⁴ Therefore, although the Fergusson study suggested “that women who have one or more abortions at a young age (< 21) are at greater relative risk for psychiatric disorder compared to women who deliver a child at a young age or women who do not get pregnant at a young age,”⁸⁵ the Task Force cautioned against drawing such a broad conclusion from the study because of its numerous methodological limitations.⁸⁶

In a final attempt to identify a single study that supports the disclosures required by the South Dakota law, Dr. Coleman identified several new studies that

⁸¹ *Id.* at 54.

⁸² *Id.*

⁸³ *Id.* at 89.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.*

have been published since the Task Force issued its report and that she alleges contradict the Task Force's conclusions.⁸⁷ However, the Task Force recently published an update to its 2008 Report,⁸⁸ which included a review of several of the new studies Dr. Coleman cites.

In the updated Report, the Task Force reviewed and discussed in detail the two Pedersen studies from 2007 and 2008 which Dr. Coleman claims "[c]learly" contradict the APA Report.⁸⁹ The Task Force also reviewed the most recent study from Fergusson et al. (2008), which Dr. Coleman asserts provides "additional support" that the required disclosure in the South Dakota statute "is accurate."⁹⁰

After reviewing these three studies and identifying their methodological limitations, the Task Force concluded that while the studies' results indicated that "the risk of mental health problems among younger women in" New Zealand and Norway who have abortions is slightly higher, the studies' methodological limitations made it "unclear to what extent these findings may be linked to young age of these samples, the social context in which abortion occurred, the fact that

⁸⁷ See Coleman Sept. 2008 Decl., SA 1798-1799.

⁸⁸ See Major et al., *Abortion and Mental Health: Evaluating the Evidence*, 64 Am. Psychologist 863 (Dec. 2009).

⁸⁹ See Coleman Sept. 2008 Decl., SA 1798-1799.

⁹⁰ Declaration of Priscilla Coleman, dated Aug. 13, 2009, A2457.

abortion was measured through self-report rather than verified, or the failure of [the studies] to adequately assess whether a pregnancy was wanted.”⁹¹ After assessing these studies and other recent research, the Task Force reaffirmed its prior conclusion that “the relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy for nontherapeutic reasons is no greater than the risk among women who deliver an unwanted pregnancy.”⁹²

II. THE TASK FORCE’S REPORT SUPPORTS THE DISTRICT COURT’S CONCLUSION THAT THE SUICIDE DISCLOSURE IS UNCONSTITUTIONAL BECAUSE IT IS UNTRUTHFUL AND MISLEADING

Given the state of the scientific evidence, the South Dakota statutory language requiring that a physician disclose to a patient seeking an abortion that “increased risk of suicide ideation and suicide” are “known medical risk[s]” “to which the pregnant woman would be subjected” if she has an abortion⁹³ is false and misleading. As discussed in detail above, the Task Force found that there is no evidence to support that a woman with an unplanned pregnancy who has an abortion as opposed to the alternatives will face a higher relative risk of mental

⁹¹ Major et al., *supra* n.88, at 885.

⁹² *Id.*

⁹³ S.D. Codified Laws § 34-23A-10.1(1)(e)(ii).

health problems than if she had chosen the alternatives to abortion.⁹⁴ Therefore, telling a patient that she will be subjected to an increased risk of suicide or suicidal ideation is simply not accurate based on the scientific evidence.

The State has asserted that the South Dakota legislature intended the “suicide disclosures to be given only if an association, and no causation, were shown”⁹⁵ and that “abundant evidence” establishes such an association.⁹⁶ The State argues in the alternative that, even if the suicide disclosures are interpreted to mean causation, the scientific literature establishes such causation and thus the suicide disclosures are not false and misleading.⁹⁷ The State is wrong on both points.

As an initial matter, the State’s fallback position is without a basis in the research, and the State appears to recognize this in its half-hearted argument on causation. As the Task Force Report makes clear, there is simply “no evidence sufficient to support the claim that an observed association between abortion

⁹⁴ *See infra*, at 22-25.

⁹⁵ State’s Br. 42.

⁹⁶ *Id.* at 47.

⁹⁷ *Id.* at 51.

history and a mental health problem was caused by the abortion per se, as opposed to other factors.”⁹⁸

Faced with essentially nothing to argue on causation, the State is left to contend that the research showing a mere “association” between abortion and suicide/suicidal ideation is sufficient to support the statutory language that “increased risk of suicide ideation and suicide” are “known medical risk[s]” of abortion. But this statutory language cannot simply mean “association.” If it did, it would eviscerate the very purpose underlying informed consent: to educate a patient about the actual risks and consequences of a medical procedure. As the Task Force Report makes clear, while some studies have identified a *correlation* between abortion and suicide, all that means is that these two things co-occur in the same population. This says nothing about whether abortion has any effect whatsoever on the likelihood a woman will commit suicide or have suicidal thoughts or rather whether an independent third variable causes both. Indeed, as discussed in detail above, the “best scientific evidence indicates that the relative risk of mental health problems is no greater if they have an elective first-trimester abortion than if they deliver that pregnancy.”⁹⁹ Therefore, according to the

⁹⁸ APA Report 91.

⁹⁹ *Id.* at 90.

scientific research, abortion does not put a patient at a greater risk of experiencing mental health problems than if she chooses to carry the pregnancy to term.

Such a disclosure is analogous to telling a patient seeking an abortion that increased risk of homicide is a known medical risk that she will be subjected to if she has the abortion. Although the Gissler studies found that the two factors, homicide and abortion, may co-occur, to give the patient such a disclosure would be inaccurate and misleading because there is no evidence that the patient will avoid becoming a victim of homicide by choosing not to have the abortion. Similarly, telling a patient that increased risk of suicide and suicidal ideation are known medical risks to which she will be subjected if she has an abortion is inaccurate and misleading because it wrongly conveys the message that having an abortion will somehow increase the chances of suicide or suicidal ideation, which can only be avoided by not having the abortion.

CONCLUSION

For the reasons set forth above, the decision of the District Court should be affirmed.

Respectfully submitted,

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ADDENDUM

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C), the undersigned hereby certifies that this brief complies with the type-volume limitation of Fed. R. App. P. 29(d) & 28.1(e)(2)(B)(i).

1. Exclusive of the exempted portions of the brief, as provided in Fed. R. App. P. 32(a)(7)(B)(iii), the brief contains 8,204 words.

2. The brief has been prepared in proportionally spaced typeface using Microsoft Word 2003 (ver. 11.8313.8221, service pack 3) in 14 point Times New Roman font. As permitted by Fed. R. App. P. 32(a)(7)(C)(i), the undersigned has relied upon the word count feature of this word processing system in preparing this certificate.

3. The CD-ROM submitted with this brief has been scanned for viruses by Trend Micro OfficeScan (ver. 8.0, service pack 1) and is virus-free.

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CERTIFICATE OF SERVICE

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