The Politicization of Abortion and the Evolution of Abortion Counseling

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The field of abortion counseling originated in the abortion rights movement of the 1970s. During its evolution to the present day, it has faced significant challenges, primarily arising from the increasing politicization and stigmatization of abortion since legalization. Abortion counseling has been affected not only by the imposition of antiabortion statutes, but also by the changing needs of patients who have come of age in a very different era than when this occupation was first developed. One major innovation—head and heart counseling—departs in significant ways from previous conventions of the field and illustrates the complex and changing political meanings of abortion and therefore the challenges to abortion providers in the years following *Roe v Wade*. (*Am J Public Health*. 2013;103:57–65. doi:10.2105/AJPH.2012.301063)

"Our patients are not coming to 'exercise their constitutional rights.' They want to talk about prayer and forgiveness."

—*Claire Keyes, Daily Beast*[1]

WHAT SHOULD STAFF IN abortion-providing facilities say to abortion patients prior to the procedure? This seemingly simple question is of course not simple at all, in light of the deep social and political divide over abortion that continues to characterize the contemporary United States, some 40 years after legalization. This conflict has inevitably had consequences for how abortion is organized as a service. Beyond their efforts to overturn *Roe v Wade*,[2] opponents have sought in numerous ways to regulate the delivery of abortion, including staff interactions with patients. State legislatures, for example, have passed laws that mandate that patients be forced to view their ultrasounds and hear detailed descriptions of their fetus's development; numerous states have also dictated scripts—often containing untrue statements—that clinic staff must deliver to patients.[3]

Abortion rights supporters, and particularly those who work in abortion-providing facilities, vehemently reject opponents' arguments that such regulations are in abortion patients' interest; rather, they argue, these requirements exist to make access to abortion more difficult and the experience more upsetting. Although they reject what they see as politically driven restrictions, however, those involved in abortion provision are not in complete agreement about what precisely the abortion experience should be for patients. In particular, opinions differ about what the nonmedical component of abortion should be, that is, the talking, or counseling, portion of the abortion visit. Alissa Perrucci, author of a recent highly regarded book on abortion counseling, has commented on the "lack of consensus on the breadth and depth of responsibility that abortion providers have toward working with patients' emotions."[4]

What is commonly referred to as counseling in the abortion setting actually involves three separate functions: obtaining informed consent, which includes ruling out coercion; patient education, which involves explaining the actual technical aspects of the procedure and possible complications; and counseling, which

involves addressing the patient's feelings about her forthcoming procedure.[5] The first two functions are fairly straightforward (albeit often compromised by legislative mandates), but counseling practices have varied considerably among different abortion-providing settings and have changed over time.

The field of abortion counseling has evolved considerably from its origins in the abortion rights movement of the 1970s. The field has faced significant challenges, primarily from the increasing politicization and stigmatization of abortion since legalization. Abortion counseling has been affected not only by the imposition of antiabortion statutes, but also by the changing needs of patients who have come of age in a very different era than when this occupation was first developed. One major innovation, head and heart counseling, departs in significant ways from previous conventions of the field and illustrates the complex and changing political meanings of abortion—and therefore the challenges to abortion providers—in the years following *Roe*.

Abortion counseling can be viewed as a case study of a new occupation, created by one social movement—the abortion rights movement of the 1970s—but sharply affected by another, the antiabortion movement that shortly followed. Abortion counseling can be understood as a movement-affiliated occupation that ultimately found itself torn between the political needs of the larger abortion rights movement and the emotional needs of many of the individuals served by the provider wing of that movement. To understand the history of abortion counseling and its current challenges, I conducted interviews with 25 veteran abortion counselors who have worked in this field since the years surrounding the *Roe v Wade* decision in 1973.[6]

ORIGINS OF ABORTION COUNSELING

Abortion counseling as a distinct component of the abortion visit had its roots in the early 1970s, before *Roe,* in the first freestanding clinics established in New York City and Washington, DC, both of which had by then legalized abortion. The motivation of the clinic founders (mainly physicians) to incorporate a specific counseling function into abortion care stemmed from the dearth of knowledge about delivering this procedure to large numbers of healthy women. Before the early 1970s, legal abortions had been largely confined to a few women, typically very ill or carrying severely compromised fetuses, who went before therapeutic abortion committees in hospitals and had their abortions performed under general anesthesia.[7] Abortion legalization in New York and Washington coincided with two medical developments: the introduction of the vacuum suction machine to US physicians and localized anesthesia methods that increased the safety of abortion and made it feasible to offer outpatient procedures in freestanding clinics.[8] At a landmark medical meeting on abortion in 1968, doctors sympathetic to abortion expressed concerns about what it would be like to provide outpatient abortions to large numbers of women who would be coming from all over the country and shortly thereafter returning to their home communities.

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These physicians realized, often to their discomfort, that legal abortion was unique as a medical procedure, in that otherwise healthy women were themselves diagnosing their condition and its solution, rendering the physician a mere "technician." Some of those at the meeting bristled at the idea of acting as a "rubber stamp," in the words of the famed obstetrician–gynecologist Alan Guttmacher,[9] and expressed confusion as to whether it was an appropriate role for the physician to discuss the social, psychological, and

moral aspects of abortion with the patient, along with the medical ones. The response by Robert Hall—another leading physician advocate for legal abortion of that era—is one that seems to have carried the day: "She [the patient] should receive some guidance (but) not necessarily from a doctor."[10] As the first freestanding abortion clinics were established, the founders drew on allies from the feminist health community to work as counselors. These were typically women in their 20s, who had been a crucial part of the political coalition to legalize abortion and who, often, had themselves undergone an abortion.[11]

ADVOCACY VS PROFESSIONALISM

In this formative period, two different, if overlapping, models arose regarding what this new occupation of abortion counseling should comprise. Many of the feminist activists who were among the first counselors to be hired, particularly in New York, understood their job as primarily political. They saw their task as advocacy for the abortion patient: that is, to protect her from facilities that the counselors perceived as unsafe or overpriced. Inside the clinic, the counselor's role was to guide the patient throughout the abortion process, attending to both her emotional and her physical needs.

Counselors adhering to this advocacy model would meet out-of-town patients at the airport, accompany them to the clinic, inform them of all that would be occurring, and answer any questions. During the abortion itself, the counselor would continue this advocacy by speaking on a patient's behalf to the doctor, and sometimes to clinic management, about any distress she might experience. As a counselor from that period recounted, some years later, to a researcher,

> It blows my mind, thinking about it now, about how much power we [counselors] had. . . . The doctors were just terribly nervous about the whole thing and were willing to listen to us—about what kind of counseling services there should be, about all kinds of things. If one of the doctors they hired was causing too much pain or saying disgusting things to patients, we'd run into the director's office and get him fired.[12]

Indeed, the chapter on abortion in the 1973 edition (though not later editions) of the feminist health classic *Our Bodies, Ourselves* states, "Probably the most important person you would come in contact with during an abortion would be the abortion counselor."[13]

The atmosphere surrounding this form of advocacy counseling in the early 1970s was overtly political, with the victory of legal abortion viewed by the newly hired counselors as inseparable from the women's liberation movement of that era. As Cathy, who worked in one of the first legal abortion clinics in a major northeastern city, described in an interview the culture of her clinic and its first generation of counselors,

> We were jubilant when *Roe* became the law of the land. And the fervor and joy that we brought to our work was very evident. . . . There was almost a giddiness about women's rights and women's bodies. . . . Women's liberation was very much part of the whole group of us.

The feminist politics that many of this first generation of advocacy-oriented counselors brought with them to their work also led to skepticism about, if not aversion to, more conventional forms of therapy in the clinic. As Barbara, who opened a clinic on the West Coast with a friend shortly after *Roe,* put it,

> From the very beginning, we used the word "counseling" only because we didn't have another word for it, and it came out of our mouths only every once a while. But mostly we used the word "advocate." . . . We were women's advocates, we did information sharing, we did informed consent. . . . We thought counseling was patronizing. We always thought that women should come to us as they are and our role wasn't to fix them. . . . They didn't need fixing! They needed tools, they needed information, they needed to take control over their lives.

Yet during this same period a more professionalized concept of the role of abortion counselor was being developed, one that focused more sharply on counseling techniques and that put the patient's feelings at the center of the abortion experience. This model was most strongly associated with Washington, DC's Preterm Clinic (one of several Preterm Clinics operating in that period) which quickly became known as a major training center for abortion workers from all over the country. As a 1976 Preterm manual stated,

> The new element [in freestanding abortion clinics] is the introduction of a counselor in full partnership with the medical team that is concerned with emotional and physical aspects of patient care. Counselors are trained to work as co-professionals with the physician and other medical staff.[14]

Terry Beresford, author of several influential works on abortion

counseling[15] and a leading trainer until her recent retirement, became involved in abortion work while at the DC Preterm Clinic, where she ultimately became director of staff development. Beresford and the clinic's first medical director, a fervent champion of in-depth counseling, developed their own approach, as Beresford recalled in an interview:

> You would help the person decide if they were clear about their decision, you'd help to weed out people who were being coerced and you would be preparing the patient to be relaxed and comfortable for an outpatient procedure. . . . So every women would be seen for at least up to an hour, as needed. . . . The model was to help the patient do some self-exploration so she reaches understanding of herself, her feelings, and her options, and can then take an action, and is assisted in taking that action. . . . Your job as a counselor is to affirm her competency and her sense of self-worth, and her ability to act on her understanding.

In short, the model of counseling initially developed at Preterm was not just about abortion per se. The model also used the experience of the abortion decision—"often the first important decision a woman may have had to make in her life," as Beresford and other counselors frequently put it—as a vehicle to lead the woman to confront other important issues in her life.

Beresford acknowledged that as the abortion field grew, the very expansive view of counseling that had been developed at Preterm became difficult, if not impossible, to sustain, for several reasons. One was clinic flow—that is, patients needed to be moved predictably and smoothly through the abortion process, so doctors, whose salaries were the most expensive element in the clinic budget, would not be kept waiting. As security and other costs began to rise, the hiring of adequate numbers of counselors became one of the easiest items in the clinic budget to cut. Beresford explained,

> So the goal of counseling changed. . . . At Preterm, the goal had been to make this experience life changing for the woman. Later, the goal became, "don't let anybody get through who's really disturbed or doesn't know what they're doing.[16]

Beresford expressed both wistfulness that the original Preterm model was lost—"We used to get letters from people that would make you weep about what the experience had meant to them, it changed their lives"—and recognized that such a model, where patients were offered up to an hour of individual counseling, and sometimes more, could not be replicated elsewhere or indeed, continued even at the several Preterm Clinics themselves.

Beresford, after her Preterm experience, worked at Planned Parenthood of Baltimore, Maryland. In the late 1970s, she inaugurated the first training sessions for abortion counselors that drew participants from across the country. These workshops, beyond the practical skills they developed, helped to forge an occupational identity and sense of community for counselors in both independent clinics and Planned Parenthood facilities.

One attendee at a Beresford workshop was Anne Baker. She started work in a newly opened midwestern abortion facility in 1976 after graduating college. The physician-owner of the clinic thought his facility would be more reputable if counseling were provided, and that would increase referrals, Baker said in an interview. She described her early days in the clinic as a time of discovery. She and two other newly hired counselors learned on the fly:

> It was trial by error. There was nothing written about abortion counseling. We would just go in and talk to the woman, and we'd come out, and at the end of the day we'd get together and we'd discuss the women we saw, what they said, what we said to them.

Despite being given considerable freedom by the clinic manager to devise their own protocols for counseling, Baker and her colleagues quickly became frustrated by the time pressures they felt—in particular, not to keep the clinic doctor waiting, if a particular counseling session was taking up too much time—a tension that exists in many clinics to this day.

> And when I went to the first three-day workshop that Terry Beresford gave for all of us fledglings across the country, we all had the same complaints: we were being rushed, and we wanted to be able to have more time with the patients, because things would come up. They would start talking about guilt, they would start crying, they would start talking about killing the baby—we couldn't say to them, "'scuse me, I have 10 minutes for this [counseling session]."

Attendance at Beresford's training sessions was a transformative experience for Baker and facilitated her own professional development as an eventual leader in the field. Recalling the "empowering experience" of the Baltimore workshops, she described a boost in confidence in her professional abilities as a counselor, especially in possessing the skills to deal

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with challenging patient issues: "Now when they [patients] brought up guilt, we weren't so afraid of it, we could go into it." Baker compiled a list of counseling techniques that seemed to work particularly well and eventually wrote several influential works on counseling.[17]

Baker also innovated a system of second evaluations, in which patients whom counselors perceived to need extra attention would be seen again by either Baker herself or another senior counselor. This move to second evaluations was an early version of the triage that would be expanded on by the head and heart model of counseling.

THE NOVEMBER GANG

In 1989, a group of about 30 women who worked as counselors or clinic managers in independent clinics (as opposed to Planned Parenthood or hospital-based clinics) began meeting informally to discuss their work and to offer one another personal support. This group (which meets to this day) became known as the November Gang because of the date of its first meeting, which was convened by Charlotte Taft, a longtime counselor and then a clinic director in Texas, and another counselor from Utah.

The immediate precipitant for the first meeting was the Supreme Court decision in *Webster v. Reproductive Health Services*, handed down in July 1989.[18] *Webster*, which allowed extensive new abortion restrictions, also led many to fear an eventual overturning of *Roe.* The original members of the November Gang were alarmed by the possible implications of this ruling and were dismayed that the national pro-choice organizations seemed helpless to respond. However, what drew them to gather in an airport hotel in Dallas, Texas, was not only national abortion politics. The increasing strength of the antiabortion movement, culturally as well as politically, in the 15 years since legalization also deeply concerned them. Meeting participants were increasingly aware of how the antiabortion movement's success in stigmatizing abortion was shaping the responses of their patients, more of whom were now coming to the clinics visibly conflicted.

Robin, a midwestern counselor, colorfully captured the hunger that many of the counselors then felt, both for community building and for confronting the impact of larger abortion politics on their work. As she recalled in an interview, when she heard about that first November Gang meeting,

> It was the first time I was going to leave my two young kids at home. . . . I said I would crawl on my belly over broken glass. . . . I just knew I had to get there.

At these first meetings, those who had been involved in abortion since *Roe,* or in some cases before, acknowledged the challenges presented by some contemporary patients. Robin, for example, remembered drawing a contrast between those she saw in a New York State clinic in the early 1970s and those she was seeing in her midwestern state by the late 1980s:

> When I started, we didn't see patients who were "ambivalent." They would drive through a snowstorm to show up in another state—or they were going to have a baby. It was really crystal clear!

But counselors were now seeing some patients with no memory of, or affinity with, the feminist and pro-choice sensibilities of the 1970s that had animated both clinic staff and many of the first generation of patients. Patients were now more apt to be apolitical, if not politically conservative; religious; poor; and, increasingly, women of color—in short, quite different from the mostly White, college-educated, strongly feminist-identified, mainly secular group of counselors (similar to many of the patients they had seen in an earlier era) that gathered in Dallas in 1989.

In transition were not only the types of patients coming to the clinics, but also the society-wide "feeling rules" governing abortion, to use the formulation of the sociologist Arlie Hochschild.[19] Numerous forces in American society during the 1980s—the presidency of Ronald Reagan,[20] the increasing strength of the National Right to Life Committee and similar organizations, and the widely distributed film *The Silent Scream,* which purported to show a late abortion—were driving a change in the dominant feeling rules regarding abortion from a woman's right to a shameful, immoral, and selfish act.[21]

The impact of these changes at the clinic level, revealed in November Gang discussions, was that noticeably more patients

were showing signs of difficulty with their abortion decision. Arlene, an interviewee who worked in Florida at that time, recalled in stark terms her growing realization of such changes: "Every so often you'd walk through the recovery room and you'd see a woman just falling apart."

It was admittedly difficult for some of the counselors to acknowledge the ambivalence, if not anguish, of some patients. As one early Gang participant said,

> I think we fought so hard to protect abortion rights that there was a real hesitation on anybody's part to address that [for] some women, abortion might be hurting them. They shouldn't be a candidate for an abortion, or at least they weren't ready to have it on the day they came in.

Similarly, Meg, an East Coast counselor recollected,

> We would talk at great length about "if we are doing such great work, why are we losing politically?" And we realized that we were doing work that was all about access and not about the quality of the experience.

Some at those first meetings even gave grudging credit to antiabortion forces for being more attuned to patients' conflicted feelings. As Meg said,

> They tapped into things that patients were concerned with. . . . I . . . felt bad that they were doing a better job at listening to women than we were . . . and we weren't doing anything. In fact, we were quite adamantly denying that reality.

At these early November Gang meetings, Taft introduced her colleagues to a new model she had developed with her staff: head and heart counseling. As she later explained in an interview,

> A woman comes in, and in her head she says "I know that an abortion is the right decision for me," but her heart is breaking. So she wants an abortion and then she changes her mind, or she's sobbing, or she says, "I think an abortion is killing my baby, but I have to have one anyway." So it became an easy way for us to describe what we were trying to do when we said, "If we can get the woman to connect her head and heart before her abortion, how much healthier will she be afterwards."

CHANGES IN COUNSELING PRACTICE

The core of Taft's argument, which formed the basis of this new approach, is that "just as there may be medical contraindications to providing an abortion . . . there are attitudinal contraindications to providing an abortion as well." These attitudinal contraindications can in most cases, Taft believes, be resolved through counseling, but if they are unresolved, the patient is not an appropriate candidate for an abortion. Taft's staff used a checklist of statements during the patient's first contact to determine whether the woman needed more extensive counseling before an abortion could take place:

1. I'm against abortion but I have no other choice.
2. I don't want an abortion but someone else is forcing me or pressuring me.
3. I believe that having an abortion is the same as murdering a born person.
4. I believe if I have an abortion I will never be forgiven and I will be separated forever from God or my Higher Power.
5. I believe I will regret having an abortion.[22]

Although checking with the patient on the second item, coercion, had long been part of counseling practice, the other issues had not been as systematically addressed by counselors. In Taft's clinic, and in the others that adapted her model, patients whose responses to the statements raised concern not only were given more counseling, but also were asked to do more reflection on their own, with the help of materials supplied by the clinic. Over time, the most widely used of these supplementary materials have become a workbook, developed by a longtime counselor and clinic manager, Margaret Johnston.[23] In this workbook, originally published in 1998, the prospective patient is led through exercises that explore her feelings about abortion, her assumptions about her support system's reaction if she has the abortion or continues her pregnancy, her anticipated emotional reactions about adoption, and so on.

To implement this mode of counseling, many early November Gang attendees had to relinquish their previous commitment to a more unobtrusive approach. As Arlene put it,

> It involved really getting women to talk about where they are in their process, to step away from this, "Her feelings are not my business, if she made it through the door, it's all okay." We had to acknowledge that women were coming in with ambivalence, that some women come into clinics who shouldn't be there, that being able to say no to someone who's not in a good place in their decision is the right thing to do, and we've got to learn the skills to do it.

Clearly, head and heart counseling implied changing several long-standing clinic conventions; the most striking change, rarely done, was sending an ambivalent

patient home for further consideration of her decision.[24] In such cases, most patients returned later, more comfortable with or, in Taft's terminology, more "resolved" about the decision to abort. In some cases, such patients did not return, and counselors acknowledged that it was not known whether they went to another clinic or ultimately decided against an abortion. In some cases, women who had been urged to delay later wrote to the clinic, enclosing pictures of their child and thanking the counselors for helping lead them to this outcome.

Yet another change brought about by this new approach concerned the delicate issue of the language used in counseling, which had long vexed the abortion-providing community.[25] As Cathy, one of the original November Gang attendees, reflected in an interview on her realization at an early meeting,

> All of a sudden it occurred to me, why am I not using her language? You know, we were told, you never, never say "baby." And if a patient says "baby," you correct her. You tell her, "It's not a baby, it's cells, it's a fetus," whatever. And after a point, it felt offensive to be denying this woman her own experience, using her own language. And so once that hit me, I remember [realizing] if you can hear that, then you can hear everything else that she's saying.

Similarly, Robin described her decision to take on the potentially explosive issue of patients' occasional use of the word "killing."[26] After her exposure to discussions of head and heart counseling, she changed her previous practice of avoiding such language when brought up by the patient. "If the patient used that language, we didn't correct her. We took the language she used and we talked to her. And what we found was that patients were opening up to us in ways they had not before—because they weren't being corrected, which they might have seen as a criticism."

Meg recalled the difficulties but ultimately the importance of hearing the patients' concerns about killing:

> A woman says, "I feel like I'm killing my baby" . . . we were like, "OK, let's just stick with whatever her reality is and ask how that is for her." . . . We would have conversations about killing, and "Is killing the same as murdering? Is there ever a time when killing is justified?" . . . We could go from there to "Well, you're trying to protect the lives of the three kids you've got." . . . To explore those issues with them in a safe place—you had the feeling you might be the only person they've ever had that conversation with.

Several interviewees acknowledged that these changes in language were difficult to accept for those in the pro-choice movement, even among their own clinic peers. Cathy recollected colleagues' jeers at a national conference when she shared her changed language practices. "There were real fears at that point that we were playing into the hands of antiabortion people, of allowing patients to use that language." Meg similarly recalled her own staff writing to a feminist journal to object to an article she had written urging these language innovations.[27]

Yet another change came with the acknowledgment that many more patients now than in the immediate post-*Roe* period were raising spiritual concerns. Cathy related in an interview,

> That was another thing that was a no-no when I went to school [graduate work in counseling]. You know, "the spiritual or religious stuff had no place in counseling." But that isn't how it was for our patients. . . . They would say everything from "Am I going to burn in hell?" to . . . "What if God decides to punish one of my other children?" It was a major theme for a small percentage of women. In fact it was in some cases the only thing that they were worried about.

Anne Baker, though not formally part of the November Gang, was very influential, through informal contacts with many group members, in establishing the rationale of addressing spiritual issues with abortion patients. Starting in the early 1980s, after hearing so many patients raise religious issues, she invited local clergy to help her largely secular staff deal with such concerns.

> An Episcopal priest came and talked to us. And he was just amazed at what we had to deal with in our counseling sessions. He said, "You are having an incredible opportunity. . . . You're working with these people in the moment of their greatest need for pastoral counseling."[28]

RESPONSE TO CLAIMS OF ABORTION DAMAGE

The development of head and heart counseling was primarily driven by the desire to attend to the emotional well-being of abortion patients. However, another impetus was the growth of several antiabortion organizations that specifically targeted women who regretted their abortions. The best known of these organizations at the time of the November Gang's founding was WEBA (Women Exploited by Abortion), a group started in 1982 by David Reardon, a psychologist who has written widely, and controversially, on the alleged psychological damage suffered by abortion recipients.[29] WEBA, a group now apparently defunct (although similar groups are active), was very effective in staging opportunities for its members to speak about their regretted abortions.

Several of the women I interviewed specifically mentioned their concern about creating recruits for WEBA as an additional motive for identifying ambivalent clients. Anne Baker was forthright about her concerns about WEBA, regarding both the psychological manipulation vulnerable abortion patients might be subjected to and potential harm to the abortion-providing community. Explaining her realization that some clients should not have an abortion the day of the appointment, or perhaps ever, Baker said,

> We felt like we had an obligation also to protect ourselves. . . . We decided early on we are not going to provide fuel for the fire of WEBA So if a woman is crying and distressed and [saying], "Everyone else is trashy but me out in that waiting room and I know I'm going to feel horrible, I'm going to regret it but this is what I need to do," well, we could say, "No, not here, not now. We are going to send you home, here are some things you can read, here are some counseling referrals. You can come back, but we want to be able to see some kind of change in your acceptance, in your ability to cope."

Robin gave an example of a patient who raised enough red flags that her abortion was delayed (although eventually it took place). "This patient said to us, 'You have to do my abortion, because you guys are baby killers and you all are going to go to hell anyway.'"

SIGNIFICANCE OF HEAD AND HEART COUNSELING

It is not possible to say with any precision how many of the approximately 1790 abortion-providing facilities in the United States[30] employ the head and heart counseling approach, nor more generally what their counseling practices are. The many pressures facing beleaguered providers—the huge security costs, which cut into the resources available for hiring and training counselors; the necessity to devote limited counseling time to state-imposed counseling mandates, as well as to calming down rattled patients confronted by screaming picketers as they approach the clinic—have made it difficult for many to offer more than cursory counseling of any kind. The facilities most likely to incorporate aspects of the head and heart approach are affiliated with the Abortion Care Network, an association of independent clinics.[31] Seemingly, the most adopted aspect of this approach is emotional triage. The concepts and techniques of this form of counseling continue to be shared at network conferences, as well as at meetings of the National Abortion Federation, an umbrella group of abortion providers.

The development of head and heart counseling is a moving story of clinic workers whose political identities were forged in the *Roe* era, who gradually came to perceive a gap between themselves and many of their patients and to realize that these patients had quite different understandings of the abortion issue and therefore different needs as abortion recipients than had previously been the norm in abortion care. In simplest terms, these counselors came to understand that their own political commitment to the larger abortion rights movement was interfering with another deeply held political and occupational commitment—to best meet the diverse needs of their patients. Acting on this realization, they broke, not without controversy, with previous counseling conventions. ■

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Human Participant Protection

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Endnotes

1. E. Thomas, "Reality Check for 'Roe,'" *Daily Beast,* http://www.thedailybeast.com/newsweek/2006/03/05/reality-check-for-roe.html (accessed June 28, 2012).

2. *Roe v. Wade*, 410 US 113 (1973).

3. In a rigorous review conducted several years ago by the Guttmacher Institute, researchers found that 23 of the 33 states that had specific requirements for information to be imparted to patients included "information not in keeping with the fundamental tenets of informed consent." R. Gold and E. Nash, "State Abortion Counseling Policies and the Fundamental Principles of Informed Consent," *Guttmacher Policy Review* 10, no. 4 (2007): 6–13. Such counseling mandates include information that is misleading, or, in some cases, blatantly untrue, such as the alleged link between abortion and breast cancer, infertility, and suicide. Often the time allocated to counseling must be spent undoing the fright caused by such state-mandated information.

4. A. Perrucci, *Decision Assessment and Counseling in Abortion Care: Philosophy and Practice* (Boulder, CO: Rowan and Littlefield Publishers, 2012), 6.

5. A. Baker and T. Beresford, "Informed Consent, Patient Education and Counseling," in *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*, ed. M. Paul, S. Lichtenber, L. Borgatta, D. A. Grimes, P. G. Stubblefield, and M. D. Creinin (Oxford, UK: Wiley–Blackwell, 2009), 48–53.

6. I used the real and full names of interviewees who have written about abortion counseling. For other interviewees, I used only a pseudonymous first name. I selected interviewees from a pool of counselors I know to have been involved in abortion from the period around *Roe*. I obtained other interviewees via the snowball method; that is, initial interviewees suggested others who had similarly worked in the field for a very long period. All interviewees worked at (or were retired from) independent freestanding abortion clinics.

7. The therapeutic abortion committees, and their often unfair practices, such as developing informal quotas and favoring private patients over ward patients, are discussed at length in L. Reagan, *When Abortion Was a Crime: Women, Medicine and the Law, 1867–1973* (Berkeley, CA: University of California Press, 1997). See also C. Joffe, *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade* (Boston, MA: Beacon Press, 1995), 119–127.

8. Joffe, *Doctors of Conscience*, 135–138.

9. R. Hall, ed., *Abortion in a Changing World* (New York, NY: Columbia University Press, 1970), 2:108.

10. Ibid., 109.

11. C. Joffe, T Weitz, and C. Stacey, "Uneasy Allies: Pro-Choice Physicians, Feminist Health Activists and the Struggle for Abortion Rights," in *Social Movements in Health*, ed. P. Brown and S. Zavestoski (Oxford, UK: Blackwell Publishing, 2005), 94–115.

12. C. Joffe, *The Regulation of Sexuality: Experiences of Family Planning Workers* (Philadelphia, PA: Temple University Press, 1986), 36.

13. Boston Women's Health Book Collective. *Our Bodies, Ourselves: A Book By and For Women* (New York, NY: Simon and Schuster, 1973), 147.

14. *A Guide for Training Abortion Counselors* (Newton, MA: Preterm Institute, 1976), 1.

15. T. Beresford, *Short Term Relationship Counseling* (Baltimore, MD: Planned Parenthood of Maryland, 1977); *How to Be a Trainer: A Self-Instructional Manual for Training in Sexual and Reproductive Health Care* (Baltimore, MD: Planned Parenthood of Maryland, 1980); and A. Baker and T. Beresford, "Informed Consent, Patient Education and Counseling," in Paul et al., *Management of Unintended and Abnormal Pregnancy*, 48–53.

16. To be sure, this expansive notion of what the abortion experience might be has not entirely disappeared. Amy Hagstrom Miller, who runs several clinics in Texas, Minnesota, and Maryland, has recently written about abortion in terms quite similar to those used by Beresford to describe the original Preterm model: "An unplanned pregnancy experience shines a bright light on a woman's life. The experience challenges her to look at everything—her hopes and her dreams, her relationship choices, her ideas about family and career, her plans for the future, her intentions. For many women, abortion can be a transformational experience—one where she actively chooses what she wants for her life, one where she is in charge." A. H. Miller, "*Work to End the Stigma*," (St. Paul, MN: Minnesota Women's Press) http://www.womenspress.com/main.asp?FromHome=1&TypeID=1&ArticleID=4099&SectionID=124&SubSectionID=684 (accessed July 3, 2012).

17. A. Baker, *Abortion and Options Counseling: A Comprehensive Reference* (Granite City, IL: Hope Clinic for Women, 1995); and A. Baker, *Coping Well After an Abortion* (Granite City, IL: Hope Clinic for Women, 2007).

18. *Webster v. Reproductive Health Services*, 492 US 490 (1989). The decision upheld a Missouri law that imposed restrictions on the use of state funds, facilities, and employees in performing, assisting with, or counseling on abortions. The Supreme Court in this decision allowed for states to legislate in an area that had previously been thought to be forbidden under *Roe v. Wade* and confirmed some abortion providers' fears that some of the justices were ready to overturn *Roe* altogether or, at the very least, that more regulations on abortion provision were certain to come.

19. As Hochschild argues, emotions have a social as well as a psychological component, and different groups in society struggle to assert the legitimacy of their favored frames of how one is "supposed to feel" about certain phenomena,

especially contested ones. A. Hochschild, "Emotion Work, Feeling Rules, and Social Structure," *American Journal of Sociology* 85, no. 3 (1979), 551–575.

20. The antiabortion movement had been growing in size and influence ever since the 1973 *Roe* decision; however, the election of Ronald Reagan in 1980—an effort to which the movement had contributed many resources—marked a turning point in the movement's influence in political circles, including Reagan's Cabinet picks, selection of Supreme Court nominees, and so on. This political coming of age of the antiabortion movement is well documented in M. McKeegan, *Abortion Politics: Mutiny in the Ranks of the Right* (New York, NY: Free Press, 1992).

21. Of course, as a perceptive anonymous reviewer for this journal pointed out, the feeling rules surrounding abortion may well have changed for the counselors as well as for their patients. This is an intriguing question for which my interviews do not contain a direct answer. In the most general terms, it is fair to say that the abortion-providing community—counselors as well as clinicians—has always had a diversity of views about abortion (e.g., some see abortion as sad but necessary and others reject that formulation, viewing the abortion decision as often the first decision a woman has made for herself and the first step in taking control of her life). However, I speculate that the counselors I interviewed had less change in their own views about abortion than did the general public, including patients, because so much of their professional and political identity revolved around the protection of legal abortion. The various admissions made by interviewees of their regrets about not "hearing" their patients sooner suggest this.

22. C. Taft, "Abortion Counseling—the Full Head and Heart Process" (unpublished paper), 2010. This paper was circulated by Taft to fellow members of the Abortion Care Network, to help them make best use of the *Pregnancy Options* Workbook (see note 23). One of the earliest compilations of head and heart counseling principles was *Abortion Resolution Workbook: Ways to Connect the Head and Heart*, a 1991 booklet prepared by the staff of the Routh Street Women's Clinic, in Dallas, where Taft then served as clinic director. Eventually, portions of this approach were incorporated into a two-page precounseling needs assessment form written by Anne Baker for use in her Illinois clinic and reprinted in the leading textbook on abortion provision in the United States: Paul et al., *Management of Unintended and Abnormal Pregnancy*, 52–53.

23. Johnston M, ed., *Pregnancy Options Workbook: A Resource for Women Making a Difficult Decision* (Binghamton, NY: Ferre Institute, 2006); and Johnston M, ed., *A Guide to Emotional and Spiritual Resolution After an Abortion* (Binghampton, NY: Ferre Institute, 2008). These publications are also available at http://www.pregnancyoptions.info (accessed June 28, 2012).

24. The counselors I interviewed estimated that the number of patients whose initial screening led to their being sent home or, if they lived too far from the clinic, their abortions being delayed for a few hours of further reflection and work with clinic-provided materials such as the *Pregnancy Options Workbook*, was 1% to 5% of the total patient load. A somewhat larger group, approximately 10% according to some interviewees, proceeded with their abortions as scheduled, but only after more extensive counseling than was received by other patients. These figures are consistent with a large study recently completed by researchers at the University of California, San Francisco, which examined data from the precounseling needs assessment forms and clinic intake forms of more than 5000 patients at one US clinic and concluded that 87% of women seeking abortions had "high confidence in their decision" before receiving counseling. D. Foster, H. Gould, J. Taylor, and T. Weitz, "Attitudes and Decision Making among Women Seeking Abortion at One U.S. Clinic," *Perspectives on Sexual and Reproductive Health* 44, no. 2 (2012): 117–124.

25. Joffe, *Regulation of Sexuality*, 94.

26. Alissa Perrucci offers an extended and sensitive discussion of how to counsel patients who believe abortion is murder, yet wish to have an abortion: *Decision Assessment and Counseling in Abortion Care*, 87–115.

27. It is impossible to answer the question of whether the practices of those using the head and heart approach—that is, acknowledging the emotional difficulties some women have with abortion, and incorporating into the counseling session such previously taboo language as "killing" and "baby"—have hurt either the larger abortion rights movement or others in the abortion-providing community who do not use these practices. However, the fears earlier expressed by some have not come to pass. In 2003, *Glamour* magazine published an article on the November Gang, and this generated predictably negative attention from several antiabortion groups: "Are you ready to understand abortion?" *Glamour*, September 2003, 264–267, 294–295, 299. Since then, however, the denunciations of abortion and its alleged harm to women by abortion opponents have ignored both the November Gang and its counseling approach. It is possible that abortions that are denied or delayed for the most conflicted women, as urged by head and heart adherents, in fact have reduced the number of women who come to regret their abortion, but no evidence exists to verify this.

28. Liberal clergy from a variety of denominations were active in abortion referrals in the pre-*Roe* era. For an account by its founders of the Clergy Consultation Service, see A. Carmen and H. Moody, *Abortion Counseling and Social Change: From Illegal Act to Medical Practice* (New York, NY: Judson Press, 1973). After legalization, direct clergy participation dropped off, although a notable exception, besides Baker, was the late George Tiller, who was assassinated by an anti-abortion extremist in May 2009. Tiller, who provided post–24-week abortions to women who were carrying fetuses with anomalies or who had serious health conditions of their own, hired a chaplain to minister to these grieving patients and devoted a special space in his clinic to meditation and prayer. See C. Joffe, "Working with Dr. Tiller: Staff Recollections of Women's Health Services of Wichita," *Perspectives on Sexual and Reproductive Health* 43, no. 3 (2011): 199–204. More recently, there has been an upsurge of interest in bringing spiritual elements into the clinic for those patients who wish this, and two groups in particular, the Religious Coalition for Reproductive Choice and Faith Aloud, have been prominent in these efforts.

29. Reardon, who holds a BA degree in electrical engineering, subsequently received a PhD degree in biomedical ethics from Pacific Western University, an unaccredited correspondence school offering no classroom instruction. His claim, made in numerous books and articles, that abortion causes mental illness, has been repeatedly challenged by leading psychologists, such as Brenda Majors of the University of California, Santa Barbara; Nancy Russo of the University of Arizona; and Julia Steinberg of the University of California, San Francisco. A task force of the American Psychological Association has on several occasions challenged the existence of "postabortion syndrome." B. Major, M. Appelbaum, L. Beckman, M. A. Dutton, N. F. Russo, and C. West, "Abortion and Mental Health: Evaluating the Evidence," *American Psychologist* 64, no. 9 (2009): 863–890. Nevertheless, to the dismay of many in the abortion-providing community, the notion of postabortion syndrome received a substantial boost in legitimacy in 2007, when Justice Anthony Kennedy, writing for the majority in the Supreme Court's decision in *Gonzales v. Carhart*, stated, "While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow." *Gonzales v. Carhart*, 127 S.CT. (2007), 1610.

30. The figure of 1790 abortion-providing facilities in the United States comes from the Guttmacher Institute, http://www.guttmacher.org/media/nr/2011/01/11/index.html (accessed June 28, 2012). In one of the few studies of clinic counseling practices, a research team from the University of California, San Francisco surveyed 27 clinics and found that 96% of them reported providing information about the abortion procedure; nearly as many stated that they checked on the "certainty of patients' decisions." Some 74% reported that they "assess the patients' feelings and provide emotional support." H. Gould, A. Perrucci, R. Barar, D. Sinkford, and D. G. Foster, "Patient Education and Emotional Support Practices in Abortion Care Facilities in the United States," *Women's Health Issues* 22, no. 4 (2012): e359–e364. No reliable studies of counseling effectiveness nor of the superiority of one model of counseling over another have been published.

31. Planned Parenthood clinics that provide abortions have taken a more standardized approach to abortion counseling, have not used the head and heart model, and, in general, have done less in-depth counseling. However, the Planned Parenthood Federation announced a new approach to meeting the emotional needs of its abortion patients and developed a training program for all staff who interact with abortion patients. Its new training manual states, "Addressing emotional issues is similar to addressing physical ones. So, just as we provide antibiotic prophylaxis to prevent infection, this training supports giving clients 'emotional prophylaxis.'" Not unlike head and heart efforts, this manual also stipulates that patients should be screened for potential risk of poor coping after an abortion, such as "stigma and social disapproval of others," "coercion or history of abuse," and so on. *Talking About Abortion* (New York, NY: Planned Parenthood Federation of America, 2008), 1,2.