Understanding the Work of Pre-abortion Counselors

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Abstract

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Understanding the Work of Pre-abortion Counselors

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This qualitative study examined the experiences of individuals who work in abortion clinics as pre-abortion counselors. Interviewing was the primary method of inquiry. Although information regarding post-abortion distress is documented in the literature, pre-abortion counseling is rarely found in the literature. This study sought to fill a void in the literature by seeking to understand the experience of pre-abortion counselors. The documented experiences shared several themes such as a love for their job, having a non-judgmental attitude, and having a previous interest in reproductive health care.
Preface

In qualitative methodology, the researcher is the instrument (Patton, 2002). Therefore, it is important to understand the lenses through which I am examining the phenomena of pre-abortion counseling. The vantage point that I offer is influenced by my experiences as a pre-abortion counselor.

I have considered myself to be pro-choice ever since I can remember thinking about the topic of abortion. However, I did not begin to work in the field of abortion care until 2007. During my masters degree in Community Counseling, an internship was required. As I was feeling burned-out by my job at a psychiatric institution and somewhat tired of counseling in general, I tried to think about where I could do an internship that would be inspiring or at least bearable. Being adamantly pro-choice, I wondered if any of the abortion clinics in Pittsburgh would be willing to take on an intern. I called Allegheny Reproductive Health Center (ARHC) and spoke to their director. She was willing to allow me to come in and spend a day in the clinic. After spending one day observing counseling sessions, I felt inspired and excited to begin as an intern. I began working at ARHC in 2007. I have continued to work there ever since.

As I began my doctoral studies in 2008, I did not have a clear research interest. However, I knew I had an interest in abortion care and abortion counseling. I began to explore empirical studies that addressed pre-abortion counseling. I was surprised to find that there was very little literature on pre-abortion counseling. I found several articles about post-abortion psychological distress and some articles on reasons women give for choosing abortion. The primary motivation behind this study is to begin to fill a void in
the literature with empirical data on pre-abortion counseling and to encourage further research on this topic.

I chose to document the phenomenological experiences of pre-abortion counselors rather than facilitating any type of quantitative research partially because of my experience. A qualitative study allowed me to understand the lived experience of other pre-abortion counselors through meetings with them. Ely (2007) conducted a survey with regard to pre-abortion counseling that led to a best practice in pre-abortion counseling. However, the suggestions by Ely (2007) are relatively surface-level, such as the suggestion of using feminist theory and for the counselor to be non-judgmental. A qualitative study allows the researcher to understand a more in-depth understanding of the phenomenon. I have had such a profound experience working as a pre-abortion counselor that at times I find it difficult to put into words. The privilege of sitting in a counseling room with a woman who I have just met and who is trusting enough of me to tell me about what is sometimes the most private experience of her life is truly overwhelming. I feel honored to have the privilege to do this work.

In addition to my experience as a pre-abortion counselor, I have found that most individuals that I encounter do not understand what my job entails. Typically when sharing what type of work I do, I am met with individuals asking me if I try to talk women out of having abortions. They often ask me this with a pained look on their faces, which I can imagine is the perception that working in an abortion clinic must be terrible. Some simply state that “it must be such a sad job.” It is through the voices of the participants in this study, who provide abortion counseling, that I strive to rewrite and
demystify some of the perceptions that individuals have about abortion and abortion clinics.

When I began researching and writing this dissertation, I had never had the experience of pregnancy. However, during the fall of 2012, I unexpectedly became pregnant. Like almost 50% of pregnancies, this was not a planned pregnancy. Interestingly, I found out I was pregnant while working at my current job, in an abortion clinic. Similar to how I would imagine most women would react when faced with an unexpected pregnancy, I was shocked and overwhelmed. However, within minutes I felt a sense of comfort knowing I was surrounded by my colleagues. I knew that I could openly talk about my emotions and uncertainty as to whether or not I would continue this pregnancy without fear of judgment or fear of influence. I knew immediately that whatever decision I made about this pregnancy would be supported fully by my colleagues. During the two days following the positive pregnancy test, with the support of my partner, close friends, and family, I chose to continue this pregnancy. The work I have done as a counselor in an abortion clinic has always been meaningful to me. I believe the importance of supportive counseling, especially when dealing with pregnancy, has become even more salient and significant to me since I am now having the unique lived experience of being the researcher who is pregnant.
Dedication

This dissertation is dedicated to the doctors, staff, and volunteers of Allegheny Reproductive Health Center. Your efforts have allowed countless women to receive safe and caring reproductive health care. I am so grateful and proud to be a part of ARHC.
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There are so many individuals that have helped with the completion of my doctoral degree and this dissertation. For all of those individuals that have been involved in this process—this dissertation is not mine, it is ours.

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I would like to thank my family who has supported me in so many ways throughout this process. Thank you for your support, emotional and financial, your encouragement, and for listening when I’m sure what I was saying did not make sense. For my mom, Marlene Zuchelli, my dad, Louis Conte, my step-mother, Carla Conte, and my sister, Adrienne Conte—this has been a difficult road for all of us. Thank you for being beside me throughout this process. This truly was a team effort. My future husband, Tim Kramer—you met me during a difficult and stressful time, but continuously supported me. Thank you. To the life within me—I had doubts that I would ever finish this document. I thought often about giving up on it…then you came along. Your existence gave me the last little push I needed to complete this research.
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I would like to thank all my colleagues at Allegheny Reproductive Health Center for being so supportive, especially Sarah Dittoe, my co-researcher. This dissertation would literally not be finished without you. I can never thank you enough for the meticulous way you wanted to understand these interviews, for your support, and for your friendship.

I would like to acknowledge Indiana University of Pennsylvania where I received my master’s degree. Thank you to all the amazing professors at IUP for instilling enough confidence in me that I would be able to move on to a doctoral degree.

Lastly, I would like to acknowledge where my collegiate education began—the University of Pittsburgh. Hail to Pitt.
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Chapter 1: Introduction

In this chapter the researcher will discuss the rationale for research on the subject of pre-abortion counselors and their work. Presented will be the background of the study, the statement of the problem, research questions, significance of the study, limitations, definitions of terms, and legislation pertinent to the study.

Background of Study

Abortion in the United States. Abortion has been a controversial topic in the United States. Although abortion can be a very divisive topic, abortion is extremely common. According to the Merck Manual of Medical Information: Home edition (2004), abortion is the most common surgical procedure performed in the United States. According to the Guttmacher Institute (2008), approximately one-third of all women will have at least one abortion by the time they are 45 years of age. Some believe this figure is a low estimate and a higher percentage of women actually have abortions in their lifetime. Additionally, 22% of all pregnancies end in abortion (Guttmacher Institute, 2008). The Guttmacher Institute (2008) reports that almost half of all pregnancies in the United States are unintended, and it may be inferred that approximately 50% of women may have an unintended pregnancy during their lifetimes. The Guttmacher institute is reputed to collect the most accurate and comprehensive data on abortion because their data come directly from all abortion providers in each of the United States (Medoff, 2009).

A common misconception about women who have abortions is that they are typically young women without children. However, teenagers obtain only 17% of all
abortions (Guttmacher Institute, 2008). In fact, the most common age range of women who seek an abortion is 20-24 and the percentage of women that have an abortion while in this age range is 33% (Guttmacher Institute, 2008). Additionally, approximately 60% of women that seek an abortion already have at least one child (Guttmacher Institute, 2008). Henshaw (1998) analyzed data from the 1982, 1988, and 1995 cycles of the National Survey of Family Growth and found that women who were poor were more likely to have unintended pregnancies and to end in an unplanned birth and slightly more likely to have abortions than women of a higher income.

It should be noted that almost all of the research cited in this dissertation did not explore abortion due to fetal anomaly and concerns about life endangerment to the mother. Fetal anomalies are almost always determined in the second trimester of pregnancy. Almost all abortions, approximately 91%, occur during the first thirteen weeks of pregnancy, which renders them unlikely to be due to fetal anomaly (Pazol, Creanga, Zane, Burley, & Jamieson, 2009). Therefore, almost all research on abortion, specifically the research used in this dissertation, is not based on participants who have had an abortion due to fetal anomaly or life endangerment. Throughout this dissertation, if there is any research used that is specific to women choosing abortion due to fetal anomaly and life endangerment, it will be pointed out as outside of the norm of most of the research.

**Abortion and mental health.** The question plaguing both sides of the abortion debate as well as the medical and counseling communities is whether or not abortion causes psychological distress to women. Post-Abortion Syndrome is a term coined by
those individuals against abortion (Hopkins, Reicher, & Saleem, 1996). During the early 1990s, psychologists aligned with the anti-abortion movement and developed the term Post-Abortion Syndrome and then campaigned for this to be listed as a diagnostic category (Hopkins, Reicher, & Saleem). According to the criteria of this syndrome, if a woman does not acknowledge the distress she feels after an abortion, she is in denial (Hopkins, Reicher, & Saleem). This categorization would situate any woman that has had an abortion as having Post-Abortion Syndrome. One can infer that even a woman who copes well after an abortion must be in denial. Hopkins, Reicher, and Saleem contend that under the definition of Post-Abortion Syndrome, every woman must be significantly impacted by an abortion.

Anti-abortion activists often use abortion as a cause of mental health trauma as a reason to oppose abortion (Major, 2010). These activists, by asserting that abortion is a cause of mental health problems for women, demand that abortion be restricted or the right taken away all together in order to protect women. Major challenges most of the research that anti-abortion activists use to establish a causal relationship between abortion and mental health problems. A major limitation of the research cited by anti-abortion activists is that they often neglect to cite the difference between most women who carry a pregnancy to term and most women who have an abortion. Major states that women who carry a pregnancy to term are more often in committed relationships and more often are having a planned pregnancy. Women in a committed relationship who have planned their pregnancy often have more social support surrounding the pregnancy. Additionally, when anti-abortion activists cite research, they often do not account for the mental health
of the women before the abortion which can not only attribute to mental health after an abortion but also mental health after giving birth (Major).

In addition to the limitations addressed by Major (2010), Robinson, Stotland, Russo, Lang, and Occhiogrosso (2009) scrutinized the research cited by anti-abortion activists to promote the idea that abortion compromises women’s mental health, which is the same research used to support that Post-Abortion Syndrome should be a recognized diagnosis. Robinson et al. (2009) discuss a significant omission when assessing mental health after abortion is whether or not the pregnancy was a wanted pregnancy. The researchers go on to state that whether or not the pregnancy is wanted can significantly change the outcome of a study. As Robinson et al. state, “Comparing women who have unwanted pregnancies or who are forced by circumstances to terminate a pregnancy to those who are pleased to be pregnant and are able to deliver a full-term wanted pregnancy will clearly bias an outcome” (p. 270). In addition, often women who have second trimester abortions are overly represented in research, which may bias the research (Robinson et al.). In addition to second trimester abortions being statistically rare (Pazol et al., 2009), the researchers suggest that women who wait until the second trimester to have an abortion may have done so because they were ambivalent about the pregnancy, lacked social support, or had inept social skills (Robinson et al., 2009).

Dadlez and Andrews (2010) argue that Post-Abortion Syndrome is a paternalistic tactic used by anti-abortion activists. They argue that protecting women from mental health problems supposedly caused by abortion by reducing abortion options perpetuates the attitude that women are incapable of thinking for themselves. Moreover, there is no
other medical procedure in which rights are revoked from the patient in order to maintain spiritual or emotional health as is the case argued by anti-abortion activists (Dadlez & Andrews, 2010).

Another limitation in the research anti-abortion activists use to perpetuate support for Post-Abortion Syndrome is the sample of participants they choose. Robinson et al. (2009) stated that many studies overly represent women who have had a difficult time coping emotionally after the abortion. Some studies may purposefully seek out women who have had trouble coping after abortion (Robinson et al.). A specific example cited by Dadlez and Andrews (2010) is from David C. Reardon, who often writes about the effects of abortion to mental health and is a major proponent of Post-Abortion Syndrome. In this specific study, Reardon cites that 80% of women who have had an abortion experience regret about the abortion; however, the women interviewed in the study were all members of the group WEBA which stands for Women Exploited by Abortion (Dadlez & Andrews, 2010).

I have found no conclusive empirical data that supports the position that all women are negatively affected by abortion. Adler, David, Major, Roth, Russo, and Wyatt (1992) conducted an extensive review of the available research that questioned the psychological effects of abortion. The researchers concluded that abortion in a woman’s life is similar to that of any other normal life stressor and only very rarely causes long-lasting psychological distress. Although there is no empirical support that abortion causes significant psychological distress or long-lasting mental health effects (Adler et al., 1992; Major, Mueller, & Hildebrant, 1985; Major et al., 1998; 1997; Russo & Dabul,
1997, Russo & Zierk, 1992), some studies have shown that some women may have certain “risk factors” that may cause them to have more emotional trouble than the norm after an abortion. Pre-existing self-esteem (self-esteem before the abortion) may be a cause of difficult emotional healing after an abortion (Russo & Dabul, 1997; Russo & Zierk, 1992). Interestingly, Major and Gramzow (1999) found that the stigmatization of abortion may cause a woman to keep the abortion a secret which then may cause higher levels of psychological distress. Pre-existing anxiety (anxiety that existed before the abortion) may be a factor that impacts the anxiety level of a woman after an abortion (Steinberg & Russo, 2008). Violence in a woman’s life also appears to be a factor in whether or not she will have an abortion and how she will react to the abortion (Russo & Denious, 2001; Steinberg & Russo, 2008).

Protesting and clinic violence may also be a factor in the mental health of not only women having an abortion, but also the clinic workers. Cozzarelli and Major (1994) found that women harassed the most by protesters outside of a clinic were likely to be the most depressed women in comparison to those that were harassed less by protesters. Cozzarelli, Major, Karrasch, and Fuegen (2000) conducted a similar study to that of Cozzarelli and Major (1994) and found similar results.

**Abortion counseling.** Counselors may be involved in the abortion process in three ways. A woman may have an abortion and later seek counseling about the emotions she is feeling post-abortion. However, several studies note that women most often do not have long-term psychological distress after an abortion (Adler et al., 1992;
A second way counselors may be involved in the abortion process is during “options counseling.” Many abortion clinics provide free options counseling to women. Options counseling can be defined as counseling that occurs when a woman is uncertain if she should have an abortion or continue the pregnancy. This is a time when a woman can explore her options with the help of a counselor.

Although I did not find any empirical studies on options counseling as related to abortion, anecdotally many abortion clinics in Pennsylvania offer free options counseling. However, in my experience, options counseling is not often utilized. Additionally, due to the lack of literature regarding post-abortion counseling and options counseling, it appears women are most likely to have counseling before an abortion in the clinic setting. The difference between options counseling and counseling before an abortion is that most women who have scheduled an appointment for an abortion, in my experience, are already sure of their decision. Options counseling takes place, often, when a woman has recently found out about the pregnancy and wants to explore her options.

Johnston (2001) provided an overview of the levels of abortion counseling. Level one comes from the medical model and provides basic informed consent, birth control information, and answering of any questions. Level two provides interviewing and education, that may “check-in” with a patient about her feelings. Level three is psycho-educational and interactive. This level includes some emotional screening, some empathic connection with patients, and may include discussions about religious or
spiritual concerns of the patient. Level four abortion counseling includes all the prior levels and the exploration of complex issues and interventions if needed. Level four counseling may explore the association of stigma and difficulty in decision-making as well as more complex spiritual concerns. The type of counseling facilitated in clinics depends upon the amount of information required by the state as well as the clinic’s model of pre-abortion counseling.

Statement of the Problem

A number of researchers have explored whether or not abortion causes psychological distress to women (Adler et al., 1992; Major, Mueller, & Hildebrant, 1985; Major et al., 1998; 1997; Russo & Dabul, 1997, Russo & Zierk, 1992). Additionally, legislative measures have been put into place for the purpose of assuring that women have all the information about the abortion procedure they need to make an informed decision. Mandated counseling is legislated in the majority of states, although typically the type of counseling that is mandated is not regulated. Additionally, implying there is mandatory “counseling” may suggest that each woman sits with a counselor before the abortion. However, often the mandatory “counseling” is the name given to the state mandated medical information given to a woman by a doctor before her abortion, which may include the gestational age of her fetus, options a woman can choose if she becomes pregnant and a detailed description of the abortion procedure.

In addition to pre-abortion counseling being fairly unregulated, little is known about what happens during pre-abortion counseling. Within the community of abortion providers, there is information about pre-abortion counseling; however, outside of the
abortion provider community, this researcher found relatively no research on pre-abortion counseling. For example, the Abortion Care Network is a community of abortion providers and pro-choice activists who have yearly conferences and an email list used to share information.

In an attempt to research pre-abortion counseling, Ely (2007) stated that she found relatively no information on the subject of pre-abortion counseling. Ely proceeded to design a study to gain information about pre-abortion counseling. She used a Likert-type survey with some open-ended questions and left space for the participants to write in responses. The survey was administered to women that had received a first trimester abortion at an abortion clinic. Ely asked specifically about the counseling the women received. Although some participants had negative comments about aspects of the clinic, for example the long wait or the temperature of the clinic, no participants gave negative comments about the counseling. All participants in the study received pre-abortion counseling, although the level of counseling received is unknown.

Counselors working in clinic settings that facilitate pre-abortion counseling are participants in the lives of millions of women, according to the statistics from the Guttmacher Institute (2008). Although there are several accounts of the stories of women who have obtained abortions (e.g., Bender & Gramont, 2007; Gilligan, 1992; Kushner, 1997), I was unable to find any accounts of pre-abortion counselor’s stories. The stories obtained from women in the research studies previously cited that have had abortions generally revisit their emotions from the day of the abortion, their decision-making
process, their emotions during and after the abortion, and sometimes their view of the pre-abortion counseling they received at the facility where they received their abortion.

**Significance of the Study**

After the monumental case of *Roe v. Wade* (1973), women were no longer forbidden from making the decision of whether or not to continue a pregnancy. The case of *Roe v. Wade* challenged a Texas law that criminalized abortion except in the case of life endangerment of the mother. The Texas law was ruled unconstitutional. States were no longer able to halt access to abortion.

Although *Roe v. Wade* (1973) was probably the most significant legislation passed with regard to abortion, this was not the first time that abortion was legal on a state-by-state basis. In fact, by 1969 ten states had granted limited access to abortion (Cline, 2006). For example, Cline points out that Hawaii and Alaska allowed abortions by a physician, but this right was limited only to residents of each state. Before the case of *Roe v. Wade* (1973), the state of New York had the most liberal abortion laws. New York allowed elective abortions up to twenty four-weeks in pregnancy and this right was not only reserved for New York residents (Cline, 2006).

Almost immediately after the court case of *Roe v. Wade*, legislation began to pass that allowed states to restrict access to abortion. States can legally restrict abortion in three ways. The first way is with funding. In 1980, the Supreme Court stated that the federal government is not obligated to pay for the cost of abortion using public funds (Medoff, 2008). With this decision, many states forbid the use of public funds making it difficult for women with low-incomes to pay for abortion. As Henshaw (1998)...
concluded, women in poverty are more likely to continue an unintended pregnancy, which may be due to the lack of funding available to receive an abortion. A second way states can restrict abortion is to implement waiting periods before a woman can have an abortion (Medoff, 2008). These waiting periods are anywhere from 24-48 hours in length. Twenty-six states require a waiting period and nine states specifically require a woman to make two trips to the office before the abortion (Guttmacher Institute, 2008). A third way that states can restrict access to abortion is to apply mandatory counseling laws (Medoff, 2008). These laws require abortion providers to offer women certain state-mandated information regarding abortion (Medoff, 2008). Seventeen states now mandate this information be given before the abortion (Guttmacher Institute, 2008). The information that must be given varies from state to state, for example, eight states require the woman is informed of possible mental health consequences, five states require information about a possible link between abortion and breast cancer, and 12 states require information about the ability of the fetus to feel pain (Guttmacher Institute, 2008). The way this information may restrict abortion is due to the fact the information must be given by a medical doctor and proof that the woman has received the information must be made available prior to her receiving an abortion. Restrictions that are only aimed at facilities providing abortion and not other comparable medical facilities are known as TRAP laws—Targeted Regulation of Abortion Provider laws (Medoff, 2010).

Specifically, Pennsylvania, where this research takes place, has strict laws surrounding abortion. Pennsylvania law mandates that a licensed physician must perform abortions and that abortions can only be performed up to 24 weeks in pregnancy.
Pennsylvania state funding only pays for an abortion if it is a case of life endangerment, rape, or incest (Guttmacher Institute). Low-income women often will have state medical insurance and therefore may have difficulty receiving an abortion due to financial burden. Pennsylvania requires a 24-hour waiting period after receiving the mandatory information (Guttmacher Institute). A woman under 18 years of age must have parental consent for the abortion unless she completes a judicial bypass (Guttmacher Institute). One of the most recent TRAP laws in Pennsylvania is the passing of Senate Bill 732 on June 19, 2012. This senate bill requires abortion clinics to have regulations of ambulatory surgical facilities that requires very strict regulations for such as there are many rules that determine the dimensions required for hallways and each procedure room (Pennsylvanians for Choice, 2011). Additionally, in Pennsylvania from 2000-2008, the number of abortion providers decreased by 11% (Jones & Kooistra, 2008). With the passage of Senate Bill 732, more providers have closed.

Although abortion has been legal in all states in some capacity since 1973, it continues to be a controversial political and moral issue in society. In general, abortion is often stigmatized. In addition to stigmatization, women who obtain abortions and abortion clinic workers are often publicly bashed by politicians, some religious organizations, and anti-abortion crusaders. In the midst of the intense political climate, hundreds of thousands of women continue to have abortions annually and abortion clinics continue to operate (Guttmacher Institute, 2008). This research will attempt to shed light on the experience of some of these abortion clinics workers, in particular, pre-abortion counselors.
As a pre-abortion counselor, when I disclose my work, I am often asked if I attempt to “talk the women out of” having an abortion. This question is a frustrating one for several reasons. Many people asking this question are probably thinking of counseling at Crisis Pregnancy Center, which are anti-abortion centers and often attempt to convince women to continue the pregnancy instead of having an abortion. Counselors who abide by the ethical guidelines of their profession do not attempt to convince individuals to make a choice that serves the political or moral agenda of the counselor. Therefore, the conduct of counselors at Crisis Pregnancy Centers may be unethical when they attempt to convince women not to end the pregnancy. A statement by Tushnet (2003) written after volunteering at a Crisis Pregnancy Center that the goal of these centers should be “not solely focusing on discouraging abortion, but also helping men and women orient their romantic lives to marriage” (p. 111-112). This author was making the statement that Crisis Pregnancy Centers may want to expand their most imperative goal, which is discouraging abortion. In addition to counselors in Crisis Pregnancy Centers attempting to dissuade women from having abortions, individuals at these centers often give women inaccurate medical information, especially with regard to abortion (Krisberg, 2002). Workers at abortion clinics are often accused by anti-abortion activists of also giving out medically inaccurate information.

Some may believe that counselors working in an abortion clinic also carry an agenda. However, it is a common misconception that counselors in an abortion clinic have an agenda to force a woman to have an abortion. One could make the assumption that counselors working in an abortion clinic are probably pro-choice, which means they
believe the choice of abortion, continuing the pregnancy and raising the child, and adoption are all equally viable choices. This research can demystify the process of pre-abortion counseling and shed light on what pre-abortion counselors actually do during the counseling process.

Research Question

The research questions sought to be answered in this study will attempt to fill the gap in the literature with regard to the experience of pre-abortion counselors. The primary goal of the researcher is to understand the experience of pre-abortion counseling. The research question pertinent to this study is:

- What does it mean to be a pre-abortion counselor?

The research question is left broad purposefully. I wanted to understand what it means for a counselor to say she is a pre-abortion counselor. Additionally, what does the experience mean to her? While attempting to answer this question, I inquired about the primary roles of the counselor. I also attempted to learn if the counselor aids in the decision-making process, and if so, how. Additionally, I inquired how the stigma of abortion, in particular the possible presence of anti-abortion picketers, affects their experience as a pre-abortion counselor.

The time right before the abortion is often the most emotionally difficult time for a woman choosing whether or not to have an abortion (Adler, David, Major, Roth, Russo, & Wyatt, 1992). The pre-abortion counselor will often be with a woman during the most difficult time of the abortion process, which makes the role of an abortion counselor a very important one.
Delimitations

Abortions may occur in clinic settings, in a private doctor’s office, or in a hospital. The counselors chosen for interviews were all be employed or formerly employed as a counselor in an abortion clinic. Often in abortion clinics employees are trained in several different areas of the clinic. The counselors in this study had their primary job as counselor.

Additionally, all the counselors chosen for interviews were employed or formerly employed in the state of Pennsylvania. Abortion legislation varies from state to state. The legislation may influence the counseling process, for example mandatory waiting periods, judicial bypass process, and the number of weeks in which a woman can have an abortion.

Limitations

The experience of counselors in an abortion clinic was studied; however, the experience of counselors in general may be very different. The counselors may have different levels of education. Some abortion clinics may require counselors to have an advanced degree in counseling or a related field and others may not require counselors to have any specific degree or education. The differences in education level may make the experiences of the counselors different.

Another limitation of the study may be that the pre-abortion counselors interviewed had only worked in urban clinic settings, not in rural clinic settings. Counselors working in urban settings may have a different experience than those working in rural areas.
Definition of Terms

Abortion: The removal of the contents of the uterus during pregnancy through the vagina or from the use of drugs to stimulate contractions in the uterus.

Therapeutic Abortion: An abortion that occurred before the legalization of abortion, which was legal if a doctor recognized that carrying the pregnancy to term would cause greater damage psychologically to the woman than if she did not obtain an abortion (McBride, 2008).

Quickening: The time during pregnancy a woman can first feel movement of the fetus, which typically occurs during the fourth month of pregnancy (Mohr, 1978).

Vacuum Aspiration: The most common type of abortion procedure during the first trimester in which the doctor uses a dilation and suction (Runkle, 1998).

Dilation and Evacuation (D&E): The type of abortion used during the second trimester in which the doctor uses instruments together with vacuum aspiration to remove the pregnancy (Runkle, 1998).

Important Legislation

Roe v. Wade: A challenge to the constitutionality of a Texas law that prohibited abortion except for the case of life endangerment of the mother. The Texas law was found to be unconstitutional (McBride, 2008).

Doe v. Bolton: A challenge to Georgia’s criminalization of abortion except for the case of life endangerment of the mother, serious fetal abnormality, or rape. The Georgia law was determined to be unconstitutional (McBride, 2008).
Planned Parenthood of Southwestern PA v. Casey: A questioning of the wording of “liberty.” A challenge to the constitutionality of mandating spousal notification before an abortion. The court found that it is unconstitutional to require spousal notification, but upheld that it is not unconstitutional to have a 24-hour waiting period, informed consent, and parental notification or a judicial bypass to receive an abortion.

Hyde Amendment: Amendment named after Republican Congress member Henry Hyde. The amendment prohibits the use of federal funds to pay for abortions of women that receive Medicaid (McBride, 2008).

Summary

Abortion is a controversial, yet pertinent part of women’s lives. Millions of American women have abortions every year. Although the social and political climate with regard to abortion is heated, a large percentage of women continue to have abortions (Guttmacher Institute, 2008).

Due to the powerful political aspect of the abortion debate, several types of legislations have been put in place that may attempt to protect women, but also restrict abortion access. Mandated counseling is one form of this legislation. Counseling for women before their abortion is mandated in many states. However, little about this counseling is mandated.

Additionally, not much is known about pre-abortion counselors. Some researchers have attempted to give voice to women that have experienced abortion by listening to interviews in which women tell about their experience. However, there is very little, if any, research to understand the individuals that play a crucial part in the
abortion process—the pre-abortion counselors. This researcher attempted to give voice to the individuals who provide this sensitive type of counseling.
Chapter 2: Review of Literature

Introduction

**History of abortion.** The foundation of abortion law is the interpretation of the U.S. Constitution by the Supreme Court (McBride, 2008). Abortion law is not just one law (Needle & Walker, 2008). Abortion law has many sources such as constitutions, statutes, administrative regulations, and court decisions (McBride, 2008). Abortion was not always illegal (McBride, 2008; Mohr, 1978; Needle & Walker, 2008; Reagan, 1997). Abortion slowly began to be criminalized in the mid 1800s. After the criminalization of abortion, women continued to obtain abortions either illegally or they obtained “therapeutic abortions” (McBride, 2008). Therapeutic abortions were those done if the woman’s mental or physical health was in danger because of the pregnancy.

The 1970s saw a dramatic change in abortion legislation with the ruling of *Roe v. Wade* in 1973. After this ruling, as well as other legislation that forbade states to outlaw abortion access, the antiabortion backlash began. The backlash included legal, moral, and medical arguments against abortion (Medoff, 2008).

Legal arguments against abortion consist of legislation that greatly restricts access to abortion. Moral arguments are mainly based on religious reasons. Medical arguments against abortion include the concern of the mental health of women undergoing abortion. This chapter will outline a brief history of abortion in the United States beginning in the 1800s, including legal abortion in the 1800s and the criminalization of abortion. In addition to a brief history of abortion, the changing policies regarding abortion during the
1900s will be addressed. Also, mental health issues surrounding abortion will be explored.

**Legal abortion in the 1800s.** Abortion was not always a controversial issue in the United States and has been a part of medical history dating back to ancient times (Needle & Walker, 2008). Not only was abortion not considered controversial, abortion was usually readily available to women (McBride, 2008).

As Mohr (1978) and Reagan (1997) discussed, before the criminalization of abortion in the mid 1800s, it was widely recognized that abortion was the right of a woman at any time before quickening. Quickening was defined as the time during the pregnancy when a woman could first feel movement of the fetus, which usually occurs around the fourth month of pregnancy. Pregnancy tests were not available during the 1800s, so the only concrete method of procuring knowledge of pregnancy was fetal movement (Tone, 1997). A missed period was not necessarily proof of pregnancy and was sometimes thought of as another medical problem, such as a “blockage” (McBride, 2008; Tone, 1997).

In the early 1800s, abortion was not widely considered to be a moral issue (Caron, 2008). Abortion before quickening was typically not thought of as killing a human being, but as “solving a female problem” (McBride, 2008). Abortion was considered to be “women’s business” and was not a procedure regulated by the state (McBride). During the early 1800s, abortions were not typically performed by physicians (Caron, 2008). Abortion, similar to childbirth, was usually a “group” activity that took place in the home with family, close female friends, and midwives (Tone, 1997). Women sometimes took
herbal remedies that had been passed down to them by female relatives (Caron, 2008) that minimized the need for invasive medical procedures. Although abortion was regularly available to women during the early 1800s, it was not without problems. There was no regulation of abortion and women often got infections or had incomplete abortions due to faulty procedures or failing herbal remedies. Unfortunately, women sometimes died or became infertile due to unregulated abortion methods (McBride, 2008). Although abortion was readily available before its criminalization, abortion was often a dangerous procedure that left women physically scarred.

Criminalization of abortion. By 1900, all states had criminalized abortion, although some states permitted the procedure to save the life of the mother (McBride, 2008). There were three typical reasons for the enactment of criminal abortion laws. According to Tone (1997), one reason to restrict abortion was to deter illicit sexual conduct. The second reason is that the procedure was deemed to be hazardous to women (Tone). The third reason was the state’s interest in protecting the life of the fetus (Tone). The sections that follow explain the rationale behind criminalizing abortion from each of the three reasons for enactment of criminal abortion laws. Additionally, the various reasons for criminalization of abortion outside of the three typical reasons for criminal abortion laws are explained.
Deterring illicit sexual conduct. Although most women who had abortions were married, the focus of public attention was usually on unwed women (Tone, 1997). The state had an interest in deterring illicit sexual conduct because sex outside of marriage was considered morally wrong. Additionally, children produced out of wedlock were considered illegitimate. If women were able to end pregnancies, illicit sexual conduct could be hidden and possibly encouraged.

Feminists were not opposed to restrictions on abortion in the 1800s as may be the case today (Caron, 2008). Abortion, as Caron explained, was not seen as a way for women to be autonomous, but as allowing men to have sex with no repercussions. Feminists at the time wanted men to be held responsible for pregnancy similar to that which was expected of women.

Hazardous to women. After the criminalization of abortion in the United States, desperate women would go to any means necessary to end their pregnancies. This included using herbal remedies to induce a miscarriage, using homemade instruments, or seeking “back-alley” abortions from individuals with little medical knowledge (Needle & Walker, 2008). This often resulted in the inability to conceive again, serious medical problems, or even death (Needle & Walker).

Prior to the 1880s, abortion was legal, but not safe (McBride, 2008). However in the late 1880s, abortion procedures changed dramatically (Caron, 2008). The invention of the speculum and of dilation and curettage (D&C) allowed abortions to be performed with very little risk of infection (Caron). These innovations in medicine greatly reduced the risks to women during abortions.
Life of the fetus. The logic of restricting abortion is most related to the viability of the fetus, which is often understood to be around the twentieth week of gestation. The purpose of restricting abortion to this period is the idea that a fetus could be viable after the twentieth week. However, physicians do not unanimously agree on the age of viability of the fetus (McBride, 2008). In 1847, the American Medical Association was formed (McBride) and began to rally to promote the idea that abortion was the killing of a human being no matter how early in the pregnancy (McBride). One of the leaders of this promotion was Dr. Horatio Storer, an obstetrician and gynecologist who urged physicians to use their political connections to make abortion illegal (McBride).

The life of the fetus is a common moral argument against abortion and many of these moral arguments are influenced by religion. Although the Catholic Church is usually thought of as being staunchly anti-abortion, this was not always the case as the Catholic Church was typically silent about abortion before the mid 1800s (McBride, 2008) and did not oppose abortion prior to quickening up until the mid 1800s (Caron, 2008). The voice of the Catholic Church changed when Pope Pius IX declared in 1884 that abortion, even to save a mother’s life, was prohibited by the Catholic Church (McBride, 2008). In 1902, the Catholic Church prohibited abortion even in the case of a life-threatening ectopic pregnancy (Caron, 2008). It can be inferred that this prohibition made it clear that the life of the fetus is deemed more important than the life of the woman.

During the turn of the century, physicians debated about whether abortion should be performed (Caron, 2008). Despite the anti-abortion campaign and physicians
opposing abortion, the rate of abortion did not decline (Caron). The criminalization of abortion was a lucrative business for some doctors and some continued to perform abortions for women who could afford them (McBride, 2008). Doctors who performed abortions after the criminalization of abortion were able to charge large sums of money for the procedure and the ensuing price gouging by physicians marginalized women on the basis of class. Poor women in the late 1800s and the early 1900s had limited access to abortion. This class distinction is prevalent today regarding the influence of social class on access in that poor women are not able to afford the same quality of care as their affluent counterparts.

*Other arguments for criminalization of abortion.* The decade of the 1830s saw a dramatic rise in the number of abortions, especially among upper class white women (McBride, 2008). The rise in abortions was thought, by some, to be the downfall of the white race (Caron, 2008). In the mid to late 1800s the American Medical Association attempted to outlaw abortion for wealthy Anglo-Saxon women in an attempt to encourage the production of “fit” Americans (Caron). During this time, abortion was allowed for women deemed “unfit,” which were generally minority and poor women.

Additionally, Anglo-Saxon women who had abortions during the 1800s and early 1900s were thought not to be fulfilling their female role of bearing “proper” children that is, white, Protestant, and financially secure (Caron, 2008). The criminalization of abortion forced women to conform to gender norms (Tone, 1997). Women with children could not compete for jobs; however, women with no children were able to compete with men for jobs because they were able to receive an education (Caron, 2008).
During the Depression in the 1930s, although abortion was not legal, it was “covertly condoned” (Caron, 2008). The condoning of abortion was mainly due to the need for women workers in World War II (Caron). After WWII, abortion received more harsh prosecution, but the number of abortions did not decrease (Caron). Additionally, physicians continued to perform therapeutic abortions for various reasons of physical and mental health (Caron).

Criminalization of abortion took the power of reproductive choice away from women, and was put it in the hands of predominately male physicians. This was especially true in the 1800s because women were rarely allowed to receive medical training (Caron, 2008). Beginning in the mid 1800s through the early 1990s men were in control of making reproductive decisions for women as opposed to the early 1800s when women were in charge of their reproductive choices. This is similar to present day because most policies regarding abortion are made by male politicians.

Women were penalized for obtaining illegal abortions even though they were not fined or jailed (Tone, 1997). The women were often humiliated by the interrogation of male officials about their abortion (Tone). This was often done on their deathbed as illegal abortions with no complications would rarely be found out (Tone). Most women protected the individuals that performed the abortions even if they had a complication during the procedure (Caron, 2008).

A change in abortion policy. In the 1940s “psychiatric exceptions” could be given by a psychiatrist to allow a woman to terminate a pregnancy (Lee, 2003). An
abortion was more likely allowed in cases where the pregnancy was deemed a threat to the woman’s mental health than to her physical health (Lee).

A change in public opinion on outlawing abortion came about in the 1960s. Rubella, which is a form of measles that causes birth defects, reached epidemic (McBride, 2008). Women infected with rubella during their pregnancy were likely to attempt to procure an abortion. Some individuals proposed that abortion laws may be too strict and that perhaps there were instances when women should be able to choose to have an abortion (McBride).

Vacuum aspiration was developed in 1967 which made abortion much less painful and more acceptable to many physicians (Caron, 2008). Some physicians continued to provide legal “therapeutic abortions” to women (Caron). The 1967 Abortion Act made abortion legal in certain circumstances if two doctors agreed that continuing the pregnancy presented a threat to the physical or mental health of the woman (Lee, 2003).

During the 1960s approximately 1.5 million illegal abortions took place (Caron, 2008). Low-income women were much more likely to have a botched abortion that resulted in an infection afterward (Caron).

In 1967, the newly formed National Organization for Women (NOW), called for a repeal of restrictive abortion laws that allowed a woman to have an abortion only for the reasons of mental health, fetal deformity, and pregnancy by rape and incest (McBride, 2008). Several other feminist groups joined the cause of repealing abortion laws as well (McBride). The first National Conference on Abortion laws was held in 1969 in Chicago.
(McBride). From that conference, the National Association for the Repeal of Abortion Laws (NARAL), was formed (McBride).

Before *Roe v. Wade*, some states had already liberalized abortion law (Caron, 2008). By 1969, ten states had legalized abortion in restrictive manners (Cline, 2006). For example, Hawaii and Alaska allowed abortions in the first trimester, but this right was only granted to state residents (Cline, 2006). The state of New York legalized abortion in 1970 (Cline). In New York, a woman could have an abortion up to 24 weeks into pregnancy and this right was not only reserved for state residents (Cline).

*Roe v. Wade* (1973). The case of Roe v. Wade was a challenge to the constitutionality of a criminal law in Texas that prohibited any woman to have an abortion unless the life of the woman was at stake (McBride, 2008). “Jane Roe” was the name chosen to disguise Norma McCrovey who had attempted to have an abortion because she could not afford a child (McBride, 2008). In Roe v. Wade the court found that in the first three months of pregnancy, states could not interfere with a woman obtaining an abortion (Lee, 2003). However, after the third month of pregnancy, the state can restrict abortion in order to protect the health of the woman (Lee). In the last three months of pregnancy, the state can restrict or prohibit abortion by ruling that the fetus must be protected, but could not interfere if the woman’s life or health was at risk (Lee). By the time of Roe v. Wade, it was already the opinion of the psychiatric community that abortion should be seen as a medical decision (Lee).

The reasoning behind the ruling in *Roe v. Wade* (1973) is a right to privacy is implied in the first amendment of the constitution (Caron, 2008). The right to privacy, as
determined in *Roe v. Wade* (1973) constitutes that a woman has the right to decide privately with her doctor, without interference from the state, what is best for her life and health (Caron). This right includes the right to determine whether or not to continue a pregnancy.

A lesser known case is *Doe v. Bolton*, that challenged the constitutionality of Georgia’s criminalization of abortion except in the circumstances of endangered the life of the mother, serious fetal deformity, or if the pregnancy was a result of rape (McBride, 2008). In both cases, the laws were determined to be unconstitutional and violated the “right to privacy” that existed between a woman and her doctor. The constitution does not explicitly determine a right to privacy, however, through the rulings of several cases, the right to privacy has been inferred to be a constitutional right.

The case of *Roe v. Wade* set the precedent of forbidding states from criminalizing abortion during the first trimester of pregnancy. However, the Supreme Court gave permission for states to restrict access to abortion (Medoff, 2008). States have restricted abortion access in a number of ways. One way was restricting abortion on the basis of the term of pregnancy. The restrictions on the basis of the term of pregnancy varied from state to state.

Another way of restricting abortion is by instituting waiting periods before the procedure. States began enacting waiting periods along with state-mandated information a woman must have before she is able to have an abortion (Medoff, 2008). The waiting periods vary from 24 to 48 hours depending on the state (Medoff). Although officials from the Supreme Court stated that waiting periods before an abortion may cause
abortions to be more costly and difficult to obtain, states continue to enact these laws (Medoff).

Restrictive abortion laws may not appear to present an undue burden to women trying to procure an abortion; however they may restrict access in two ways. The first is by increasing costs of an abortion, either emotional or financial. Secondly, abortion laws that are very restrictive may cause abortion clinics to close which would limit the availability of abortion (Medoff, 2009).

States may also attempt to restrict the type of abortion women may have. For example, between 1997 and 2000, 13 states passed laws to ban a specific late-term abortion procedure called dilation and extraction (D&E) (Medoff, 2009). Dilation and extraction is described in the law, but not in the medical literature, as “partial birth abortion” (Medoff).

As previously mentioned, laws intended to regulate abortion providers are commonly known as targeted regulation of abortion providers, (TRAP) laws. (Medoff, 2009; 2010). Many of these regulations are extremely burdensome and not imposed on other medical facilities providing comparable medical services (Medoff, 2009; 2010).

Medoff (2009) studied certain restrictions to abortion (the variables of the study), such as those previously mentioned, to examine whether restrictive abortion laws had an impact on the number of abortion providers over the period of 1982 to 2005. Medoff found that states that do not allow public money to fund abortions, such as Medicaid, often additionally require other restrictive laws such as requiring parental involvement for teenagers seeking abortion or requiring abortion facilities to pay an annual licensing
fee. This discouraged physicians and organizations from becoming or continuing to be abortion providers, and resulted in limiting women’s access to abortion services.

Interestingly, in a later study Medoff (2010) found that in states with the most severe TRAP laws, abortion demand was not different from states with less strict or no TRAP laws.

Almost immediately after *Roe v. Wade*, antiabortion politicians began attempting to pass legislation to restrict access to abortion. The Hyde Amendment, passed in 1976 and enacted in 1977, forbade the use of federal funds to pay for abortion services unless continuing the pregnancy would lead to the endangerment of the woman’s life (Needle & Walker, 2008). As Needle and Walker (2008) pointed out, this amendment was an economic barrier for poor women wanting to have an abortion. These women were often forced to continue their pregnancies instead of having an abortion because they could not afford the procedure. After the Hyde Amendment passed, abortions funded by Medicaid dropped by 99 percent (Caron, 2008). It is interesting to note that although Medicaid does not pay for abortions unless due to result of rape, incest, or life endangerment, Medicaid covers 90 percent of the cost of sterilization (Caron).

Often individuals who oppose abortion are against it for moral reasons, such as the taking of a life. Religion often dictates attitudes surrounding abortion and the Catholic Church has been notorious for its staunch anti-abortion position (Cline, 2006). Specifically, the view of the Catholic Church is that “abortion is a violent act which harms those who choose it” (Stephens, Jordens, Kerridge, & Ankeny, 2010, p. 515). Additionally the Catholic Church has seen the act of abortion as not only wrong, but as
murder (Stephens et al., 2010). The Catholic Church has probably been the most outspoken religion with regard to abortion. Due to its powerful nature, the ideals of the Catholic Church may cause individuals to believe that all religions are as adamantly anti-abortion as the Catholic Church, however this is not true. For example, the Lutheran Church encourages women to continue pregnancies (Stephens et al., 2010). Unlike the Catholic Church, the Lutheran Church believes “arbitrary and irresponsible” abortion is a sin, but sees the necessary nature of allowing abortion in certain circumstances (Stephens et al.).

Abortion has highlighted the political arena, especially recently in the 2012 election. A question was asked to each presidential candidate and each vice presidential candidate regarding abortion. Republicans typically were either staunchly against abortion or were accepting of abortion only in grave situations such as rape or life endangerment to the mother. Often throughout the election, opponents of abortion cited their morals or religious background as a case to oppose abortion. Democrats typically were cautiously pro-choice although they often cited their religious background in order to say they would not choose abortion, but would allow the option for others. For example Joe Biden during the vice presidential debate cited his Catholic background, which opposes abortion. However, he stated he could not justify taking this right away from women. An anecdotal example of how abortion was highlighted during the 2012 election was written on billboards in western Pennsylvania. Billboards stating, “Obama supports gay marriage and abortion. Do you?” were present in the Pittsburgh area before the election.
There are not only moral and religious claims against abortion but also medical claims. “Abortion hurts women” is a common phrase used by individuals that are pro-life (Lee, 2003). The women involved in Feminists for Life, begun in 1973, believed that abortion hurts women because it causes serious emotional trauma (Lee, 2003). The argument that women are “victims” of abortion takes responsibility away from the women having the abortion. Those making this argument seem to imply women are unable to decide what is best for them. Additionally, this argument does not account for the emotional impact of continuing an unwanted pregnancy.

Overturning Roe v. Wade was a commitment made by many Republican politicians, including Ronald Reagan and restricting funding for abortion has been a successful political strategy (Lee, 2003). The effect of restricting funding for abortion is restricting abortion access, which is a platform of many Republican politicians (Lee). Often Republican politicians vow to cut funding to programs such as Planned Parenthood, which many believe will reduce abortion access.

The abortion rate fell during 1981-2005 (Medoff, 2009). While many Republican politicians equate the fall to less funding and a more “moral” society, Medoff proposes several possibilities for the decline in abortion rates:

Welfare reform, more federal government support of family planning services for the poor, a decline in the frequency of sexual activity, a growing awareness about the possible harmful effects of HIV/AIDS and other sexually transmitted diseases that result from unprotected sex, the availability and use of more efficacious methods of contraception, changing demographic factors, an increase in the
number of restrictive state abortion laws and an increase in the number of states restricting abortion access are all possible reasons for the decline in the number of abortions. (p. 225)

Recently, abortion opponents have put breast cancer risk at center stage for women who have an abortion (Lee, 2003). Breast cancer, in early studies, was found to be more prevalent in women who have an abortion as compared to women who had not (Pike, Henderson, Casagrande, Rosario, & Gray, 1981). However, the National Cancer Institute refutes the claims that abortion can lead to breast cancer (Lee, 2003). Additionally, Melbye, Wohlfahrt, Olsen, Frisch, Westergaard, Helweg-Larson, and Anderson (1997) found no increased risk of breast cancer among women who had abortions as compared to women who had not when controlling for other factors such as age.

Donahue and Levitt (2001) theorized that legal abortion would reduce the rates of crime. The authors studied states that had legalized abortion after the passing of Roe v. Wade and found a significant reduction of crime, such as violent crime and property crime, in states that had legalized abortion. Interestingly, Dagg (1991) in a series of studies conducted in Eastern Europe and Scandinavia found that children born to mothers that would have preferred an abortion but were unable to receive one for various reasons were more likely to be involved in crime. This was also true even when accounting for income level, age, education level and the health of the mother. It is controversial to suggest that legalized abortion may impact future criminal activity. The implication is not that women who would prefer to choose abortion are not fit to care for children or
that certain individuals should be aborted. This study may suggest that women who would have preferred to have an abortion but were forced into continuing an unwanted pregnancy do not have the resources available to raise a child or another child. Women likely know when they are ready and able to raise a child. Women who are not in a position to care for a child and would have preferred to have an abortion, but were denied, may not have had ample support to be able to care for a child to the best of their ability. This could lead to a child living in an environment that was not supportive.

Crisis Pregnancy Centers (CPCs) are another form of antiabortion backlash. Many crisis pregnancy centers mislead women into thinking they are making an appointment at an abortion clinic. In Pennsylvania, CPCs receive half of all public money allocated for reproductive health care for low-income and uninsured women, which is over $4 million a year (Lee, 2003). Crisis Pregnancy Centers may also give women misleading information about their pregnancy. This was evident in the documentary 12th and Delaware, which showed a CPC employee informing a woman she was four weeks earlier in her pregnancy than she actually was. In the film, a worker at the abortion clinic theorized the employee at the CPC had done this in order to lead the woman to believe she had more time to make the decision whether or not to continue the pregnancy or to abort the pregnancy. Informing a woman she is earlier than she really is in the pregnancy may cause her to wait longer than the allowed number of weeks to have an abortion.

**Reasons for choosing abortion.** Approximately half of all pregnancies in the United States are unintended (Guttmacher Institute, 2008). However, according to the
Guttmacher Institute, only half of these unintended pregnancies end in abortion. Women choose abortion for a variety of reasons. Several researchers have attempted to study a woman’s reasoning for choosing abortion. This researcher did not find evidence in the literature to suggest women have abortions simply because the pregnancy is unintended. Researchers in the literature suggest that there are additional reasons for choosing abortion, not simply due to the fact the pregnancy may have been unintended.

Violence in the lives of women may be one factor for choosing abortion. Saftlas, Wallis, Shochet, Harland, Dickey, and Peek-Asa (2010) conducted a study in an Iowa abortion clinic with women at least 18 years of age requesting an elective abortion. The women were asked to voluntarily complete an anonymous survey about intimate partner violence. The study consisted of almost 1000 women and eighty percent of the women participating in the study were White. Women participating in the survey had a high level of intimate partner violence as compared to the general population (Saftlas et al., 2010). In a study by Coleman, Maxy, Spence, and Nixon (2009), women that aborted were more likely to have been slapped or kicked by their partner than those that had delivered. Russo and Denious (2001) conducted a random household survey about the prevalence of violence in the lives of women that have abortions. The authors found that women who had multiple abortions were more likely to have violence in their lives, such as childhood physical or sexual abuse, childhood neglect, partner violence, and rape.

Violence may not be the only factor in choosing an abortion. Data from the Fragile Family and Well-being study was analyzed to identify predictors of women that chose to either have an abortion or continue a pregnancy within 18 months of having a
previous child (Coleman et al., 2009). The original study was meant to investigate the behavior of non-marital childbearing, welfare reform, and parental behavior (Coleman et al.). The researchers found a woman was more likely to have an abortion if she was a single parent, if she had considered an abortion previously, if her relationship with the man involved had not improved from the first pregnancy, and if the father was not very involved in parenting. (Coleman et al.).

Although violence and poverty seem to be correlated with women who choose abortion, they are not the only reasons women have abortions. Many factors may effect whether or not a woman chooses to continue a pregnancy or to have an abortion. Religious background is one reason why women may choose to continue a pregnancy (Wildsmith, Guzzo, & Hayford, 2010). A woman from a religious background that is opposed to abortion may continue a pregnancy due to religious beliefs. For example, in Catholicism, abortion for any reason is a sin (Stephens et al., 2010). However, this is not to say that religious women do not have abortions.

Economic status may be another reason women choose to have an abortion (Jones, Darroch, & Henshaw, 2002; Maxson & Miranda, 2011). In one study in which participants who had an abortion completed surveys regarding the reason behind their abortion, seventy three percent said financial aspects were at least one reason they chose to have an abortion (Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005).

Current relationship status may be another reason women may choose abortion (Wildsmith, Guzzo, & Hayford, 2010). Although some women may choose to have an abortion because they are not in committed relationships or because they do not find their
partner suitable, not all pregnancies of non-married women are unintended. Women who are unmarried may choose to intentionally become pregnant (Chandra et al., 2005). Additionally, 23% of pregnancies by married women are unintended (Wildsmith, Guzzo, & Hayford, 2010). In addition to relationship status, intentionality of pregnancy likely would influence whether or not a woman continues a pregnancy or has an abortion.

Pregnancies conceived unintentionally may be to women who are not ready for a child or for another child.

**Mental Health and Abortion**

**Abortion as a cause of psychological distress.** Although abortion does not cause high levels of psychological distress in most women, a very small number of women experience severe psychological distress after an abortion (Lee, 2003). Some women may be specifically “at risk” for having a severe reaction after an abortion (Lee). Violence, drug and alcohol abuse and pre-existing mental health conditions may contribute to a higher level of psychological distress after the abortion as compared to women who did not have these life conditions.

Coleman et al. (2009) studied the difference of alcohol and tobacco use between two groups—one that chose abortion and one that chose to continue the pregnancy. Using interviews, they found women who chose to abort were three times as likely to report heavy alcohol use and two times as likely to report cigarette smoking in the past 30 days (Coleman et al., 2009). This research may indicate that abortion affected women more negatively than continuing the pregnancy, however, there may be other explanations for this difference. Women who aborted may not have had an incentive to
stop using alcohol or tobacco. The women who continued the pregnancy may have viewed the pregnancy as an incentive to quit or cut down on use so as not to cause harm to the fetus.

In addition to drugs and alcohol, violence may also be a predictor of higher levels of stress after an abortion as compared to women who do not live in violent situations. Fergusson, Horwood, and Ritter (2006) studied young women in New Zealand aged 15-25 to determine the mental health outcomes of three groups of women: those that had an abortion, those that continued a pregnancy, and those that did not become pregnant. The study was longitudinal and participants were questioned at ages 16, 18, 21, and 25. The results are as follows: women who reported having a pregnancy that ended in abortion had the highest rates of mental health diagnoses, those who did not become pregnant had the lowest rates, and those that became pregnant and continued the pregnancy had intermediate rates. A limitation of this study is it did not take into account confounding factors for mental health, such as domestic violence or low SES status (Fergusson, Horwood, & Ritter, 2006). The authors suggest the possibility the study could actually be examining the effects of unwanted pregnancy, not the effects of abortion. This specific study was criticized by Robinson et al. (2009) by not assessing the wantedness of the pregnancy. Wantedness of the pregnancy does not necessarily refer to the desire to become pregnant, but rather it refers to the extend to which the woman would have preferred to continue the pregnancy after finding out she was pregnant as well as the possibility that the pregnancy was at first desired. Robinson et al. (2009) speculated that whether or not a woman wants the pregnancy can affect the outcome of the study. Often
women may want to continue a pregnancy but life circumstances such as unsuitable partner, education level or income level may cause them to abort the pregnancy.

Coleman (2005) studied the behavior of adolescent females after resolution of a pregnancy by either childbirth or abortion. The population was adolescent females in grades seven through eleven who had a pregnancy. Coleman used interviews to learn about the participants. Coleman found adolescents who choose childbirth were less likely to receive psychological services. This was found after controlling for risk-taking behavior, which is the only study to have done so (Coleman). This study also did not assess the extent to which the woman wanted the pregnancy as Robinson et al. (2009) suggested could influence the outcome of the study. Additionally, the women who chose childbirth may have done so because they had a support system.

Women who have abortions due to fetal anomaly may have more psychological distress than women who chose abortions for other reasons (Kersting et al., 2005). Women with fetal anomalies may not have found out there was a problem with the pregnancy until into the second trimester, which is when only a small percentage of abortions take place. Additionally, women who have had an abortion due to fetal anomaly may have intended the pregnancy or had wanted the pregnancy. Whether or not a woman wanted the pregnancy can significantly impact the outcome of the study (Robinson et al., 2009). Additionally, women who have had second trimester abortions should not be a significant part of studies because they take place so rarely (Robinson et al., 2009). Kersting et al., (2005) studied women who had an abortion due to fetal anomaly in order to compare the extent of trauma and grief among women several years
after with women that had a delivery of a healthy baby. The abortions were performed between 15 and 33 weeks, which is much later than the typical time of an abortion. The average time of the women completing the survey was four years after the abortion. Women who had an abortion showed significantly higher levels of traumatic experience at all times than women that had a delivery of a healthy baby (Kersting et al., 2005). The women also showed very high levels of grief after the abortion as compared to women that delivered a healthy baby. It should be noted that if a group of women who delivered a baby with a fetal anomaly had been compared, it is unknown what level of distress those women would have.

**Abortion as a typical life stressor.** Pre-abortion mental health is the best indicator of mental health post-abortion (Major, Cozzarelli, Cooper, Zubek, Richards, Wilhite, & Gramzow, 2000). This indicates abortion itself does not cause high levels of psychological distress in most women. Adler, David, Major, Roth, Russo, and Wyatt (1990) found in their review of the available studies on the psychological distress of women who receive an abortion in the first trimester, have social support, and are not ambivalent in their decision-making have little chance of psychological distress after an abortion. Additionally, another study by the same researchers found similar results. Adler et al. (1992) conducted a search on all relevant research that discussed the psychological distress of women after having an abortion. Adler et al. concluded that women who experienced high levels of distress after an abortion was rare and infrequent and add that the abortion acts as any other life-stressor (Adler et al.). Although many people focus on the reaction of women after having an abortion, Adler et al. concluded
that the most distressing time for a woman is right before having an abortion, not afterwards. Adler et al. discussed that bias by past researchers may have led people to believe that abortion is more psychologically distressing to women than it actually is.

Warren, Harvey, and Henderson (2010) measured self-esteem and depression in a nationally representative sample of adolescent females one year and five years after they had an abortion. Results suggest that adolescents who had an abortion were no more likely to have low self-esteem or depression than adolescents who were pregnant and continued the pregnancy.

Major, Mueller, and Hildebrant (1985) studied women before a first trimester abortion, thirty minutes after the abortion, and three weeks after the abortion. The researchers asked women what they blamed the pregnancy on, if they intended to become pregnant, and how well they believed they would cope after the abortion. Women who blamed the pregnancy on outside factors, such as failed method of birth control, had less psychological distress than women that blamed the pregnancy on their character (Major, Mueller, & Hildebrant). Perceived coping was highly related to actual coping of women (Major, Mueller, & Hildebrant). Major, Mueller, and Hildebrant determined that if a woman’s partner was with her, she tended to be more psychologically distressed as compared to women whose partners had not been there. This was found 30 minutes after the abortion. At three weeks post abortion procedures, there was no significant difference in the participants if their partners were present or absent during the abortion. In my experience, women who bring their partners with them on the day of the abortion
are often distressed because of empathy for their partner’s feelings. Women whose partners are not with them are often able to be more focused on their own coping.

Major, Richards, Cooper, Cozzarelli, and Zubek (1998) studied women at the one month follow-up after a first trimester abortion. Major et al. (1998) asked women about perceived coping and character traits. Perceived coping was highly related to actual coping (Major et al.). Women who had “resilient” character traits, such as perceived control and optimism, coped better than women who did not have these traits (Major et al.). Major et al. found low levels of psychological distress in women that had an abortion.

Russo and Zierk (1992) compared the well-being of women who had an abortion to women that did not. The women either had a first trimester abortion with their first pregnancy or continued their pregnancy to delivery (Russo & Zierk, 1992). The results showed that well-being, which was based on self-esteem and self-concept, did not differ significantly from women that had one abortion to women that had never had an abortion (Russo & Zierk). Russo and Zierk found that women with the highest well-being were women that had one abortion. These women were found to have the highest self-esteem, capableness, and not feeling like a failure. The women with the lowest well-being were women that had carried an unwanted pregnancy to delivery (Russo & Zierk). When pre-pregnancy well-being was controlled, women that had more than one abortion did not differ significantly with regard to well-being (Russo & Zierk).

Steinberg and Russo (2008) compared anxiety levels of women that had one abortion to those that did not have an abortion. Women that had one abortion had high
anxiety levels; however, after controlling for pre-pregnancy anxiety, no significant differences were seen (Steinberg & Russo). Women that had one abortion were no more likely to be diagnosed with anxiety, social anxiety or PTSD (Steinberg & Russo). Women who had multiple abortions, more than one abortion, were more likely to have been diagnosed with PTSD and social anxiety, but they were also more likely to have had violence in their lives (Steinberg & Russo). Steinberg and Russo stated, “Viewing abortion as a marker for anxiety is harmful because it detracts from factors that actually do cause anxiety, such as violence” (pg. 251).

Russo and Dabul (1997) studied whether well-being of women that had an abortion differs depending on race or religion. Russo and Dabul surveyed Black and White women that had one abortion and found no significant differences between well-being. Russo and Dabul found that women that were religious had less satisfaction before their abortion, but did not differ significantly in well-being after the abortion from women that were not religious. Russo and Dabul concluded that women are not significantly impacted by abortion regardless of race or religion.

Cozzarelli, Sumer, and Major (1996) conducted a study to examine mental models of attachment and their effects on coping with abortion. The participants were 615 women who had a first trimester abortion. All women that participated filled out a pre-abortion survey and a post-abortion survey on that day as well as a survey one month later. The variables assessed after the abortion were attachment styles, mental models of attachment, and post-abortion adjustment. The attachment styles examined were classified as secure, dismissing, preoccupied, and fearful. The model of self was
positively and significantly correlated with post-abortion positive well-being. Model of self and self-esteem were also negatively correlated with post-abortion distress.

**Miscarriage and abortion.** Although miscarriage and abortion are very different, especially with regard to social stigmatization of abortion, they are both pregnancy loss and women’s reaction to miscarriage may be relevant in the discussion of abortion. For example, Broen, Moum, Bodtker, and Edeberg (2006) studied two groups of women: one that had miscarriages and one that had induced abortions in the first trimester. The researchers used semi-structured open interviews. There were no significant differences found regarding anxiety and depression between the two groups when controlling for possible confounding variables. As compared to the general population, both groups had significantly higher anxiety and depression ten days after their pregnancy loss, but not at six months after the loss. Women with abortion had significantly higher levels of anxiety than the general population at five years after the pregnancy loss. A negative attitude toward abortion was a significant predictor of anxiety at six months and five years after the pregnancy termination (Broen et al., 2006). This study seems to indicate abortion may be similar in emotional response to a miscarriage.

Cosgrove (2004) reviewed the literature on women and pregnancy loss. Although her review of literature included only loss by miscarriage and not abortion, the implications may be of value with regard to pregnancy loss due to abortion. Cosgrove (2004) reported that researchers have had difficulty identifying risk factors that account for high levels of emotional distress after pregnancy loss. Cosgrove (2004) stated that the
individualized nature of pregnancy loss and its level of emotional distress were due to the
meaning women make of the loss. This finding may be similar to that of abortion which
is a personal process that may affect women differently.

**Grief and pregnancy loss.** Grief is a common emotion associated with
miscarriage. Due to the similar nature of miscarriage to abortion, grief may be a common
emotion after abortion. Isolation can be one of the most challenging aspects of dealing
with grief (Bosticco & Thompson, 2005). This may be especially true with abortion
because the stigmatizing nature of abortion may cause women to keep the abortion a
secret. Young (2008) explains that those dealing with bereavement suffer more deeply
when not given the chance to speak about their loss and pain. Talking about the loss and
receiving support may help in the lessening of grief symptoms (Muller & Thompson,
2003). Social support involving mutual sharing has been suggested as being beneficial to
those that are grieving (Whiting, Planney, & Balog, 2000).

Cosgrove (2004) reported a pregnancy loss is a “disenfranchised grief,” which is
one that is not mourned in the way the death of a person is mourned. The review of the
literature on pregnancy loss done by Cosgrove (2004) implied that most women do not
have social support for their loss because miscarriage and stillbirth is typically not talked
about. This implication may be even more powerful with regard to abortion, which is
more likely to be kept a secret than a miscarriage or stillbirth.

Keefe-Cooperman (2006) compared the grief experienced by women who had a
miscarriage to the grief experienced by women that had an elective abortion because of a
fetal abnormality. Women having an abortion due to fetal anomaly may be more likely to
have an abortion with a planned pregnancy. Attachment to a pregnancy may be more likely in modern times due to advances in medical technology (Keefe-Cooperman). Advancement in medical technology gives medical professionals the ability to confirm a pregnancy sooner than before (Keefe-Cooperman), which may increase the amount of attachment the woman feels to the pregnancy. Society does not allow much grieving for a pregnancy loss (Keefe-Cooperman). Twenty three women that had miscarriages and 62 women that had abortions participated in this study within two years of the pregnancy loss and completed a survey regarding their experiences. No significant differences were found in grieving between the two groups. Counseling after the pregnancy loss was shown in this study to be helpful with the grieving process (Keefe-Cooperman).

Layer, Roberts, Wild, and Walters (2004) conducted a spiritual grief group consisting of women having grief symptoms following an abortion. A pretest and posttest were done to examine the effects of abortion. The results of the study revealed a dramatic decrease in shame and posttraumatic stress. This suggests that pre-abortion counselors may want to consider adding spiritual counseling to their counseling repertoire and use it where relevant to meet the needs of the client.

Tentoni (2005) recalled the experience of counseling five women that were experiencing serious post-abortion guilt and grief. All of these women considered themselves extremely religious and pro-life. Tentoni (2005) encouraged the women to have a Gestalt dialogue with the fetus to say goodbye in order to facilitate closure. An example of a Gestalt dialogue may be speaking to an empty chair and imagining the
aborted fetus is there and can hear the client (Corey, 2009). This dialogue can help to gain closure (Corey, 2009). It should be noted that Tentoni is a male counselor.

**Post-abortion syndrome.** Some members of anti-abortion organizations claim that abortion puts women at risk medically for Postabortion Syndrome (PAS). Some argue PAS is a form of Posttraumatic Stress Disorder (PTSD) (Lee, 2003). Denial is a large part of the claim of PAS (Lee). Therefore, any symptoms of PTSD in a woman’s life can be traced back to the abortion, no matter how long ago because the woman was in denial of her feelings. This allows the claim that abortion traumatizes women whether they know it or not. Women can either “suppress” their emotions after abortion and be labeled abnormal or admit to psychological distress and be labeled abnormal (Lee). Essentially, a woman who has an abortion will be labeled abnormal under the PAS diagnostic criteria. PAS has been strongly contested by the majority of those in authority in medicine, psychiatry, and psychology (Lee).

Emotional symptoms after a miscarriage may be similar to Posttraumatic Stress Disorder symptoms (Engelhard, Van Den Hout, & Vlaeyen, 2003; Walker and Davidson, 2001). However, emotional symptoms after an abortion do not mimic PTSD symptoms. For example, often the most psychologically difficult time for a woman is before she has an abortion (Adler et al., 1992). In contrast, with an event that leads to PTSD—for example, rape—the most difficult time psychologically is after the event, not before (Rubin & Russo, 2004).

The Koop inquiry between 1987 and 1989 was an investigation by Surgeon General C. Everett Koop and his staff, which was pursued by Ronald Reagan (Lee,
The staff examined several studies that were conducted on the health effects of abortion. Surgeon General C. Everett Koop was known for being staunchly anti-abortion and many believed the results would show harmful effects of abortion for this reason (Lee). However, the inquiry found that abortion is a relatively safe medical procedure and the inquiry did not find evidence to support PAS (Lee). However, there has been some debate about Koop’s findings.

**Abortion Clinic Workers and Violence**

Picketers at abortion clinics may harass women entering the clinic by showing dismembered fetuses, telling women abortion causes cancer, yelling that the fetus will feel pain, calling the women names etc., all which can cause psychological distress that will later be blamed on the abortion alone (Rubin & Russo, 2004). Women may have a variety of emotions after an abortion, but an emotion does not equate to a psychological disorder (Rubin & Russo). As Rubin and Russo explain, anti-abortion advocates that contend women who have an abortion have more psychological distress than women who give birth underestimate the impact of social influence. Rubin and Russo go on to explain while women who have abortions are “stigmatized and socially ostracized,” women that give birth and become mothers are idealized in society. The authors speculated that adolescents may be more influenced by the messages by anti-abortion activists (Henshaw, 1998).

Since 1977, there have been over 80,000 acts of violence and/or disturbances by abortion opponents directed against abortion providers (Medoff, 2009). Clinic workers, especially doctors that are known to perform abortions are sometimes in danger of
physical violence and verbal assault outside of abortion clinics. Dr. George Tiller, a well-known late-term abortion provider, survived a gunshot in 1993 outside of a Wichita abortion clinic (Caron, 2008). Sadly, Dr. Tiller did not survive a second attack. He was murdered by anti-abortion activist Scott Roeder in the spring of 2009 as he served as an usher in his church. Dr. Tiller is one of several doctors and clinic workers assaulted during the 1990s.

During the 1990s, violence at abortion clinics was at an all-time high (Caron, 2008). Supporters of the American Coalition of Life Activists, founded in 1994, passed around a list of the “Deadly Dozen” (Caron), a list of physicians known to be abortion providers that were harassed by the group. Several doctors on the list were assaulted, such as Dr. George Tiller, and one killed, including Dr. David Gunn (Caron). In response, the federal government passed the Freedom of Access to Clinics Entrance Act in 1995 that ensured that threats or physical blockades to a clinic’s entrance were not allowed (Caron).

The “Army of God” website, facilitated by Reverend Donald Spitz is an example of the threat of violence against abortion clinics and abortion clinic staff in the present. A direct quote from the website, “Thank you Scott Roeder for stopping babykilling abortionist George Tiller from murdering any more innocent children” (Spitz, n.d.) exemplifies the persistence of some anti-abortion groups. Some in mainstream media have perpetrated the image of abortion providers as murders and killers. For example, Bill O’Reilly repeatedly called Dr. George Tiller “Tiller the baby-killer.”
The documentary “Unborn in the USA: Inside the War on Abortion” highlights some tactics of anti-abortion activists in a classroom setting as they prepare to protest at an abortion clinic. The teachers answer students’ questions regarding how to attempt to talk a woman out of entering the abortion clinic. For example, the teacher states the protesters should not verbally attack the women, but to listen to what they are saying for a better chance of getting through to her to reconsider her decision. Similarly, Randall Terry, leader of Operation Rescue, which is a staunchly anti-abortion group, stated in the documentary “The Assassination of Dr. Tiller” about anti-abortion picketing, “I hope to say something that will haunt them in the waiting room.”

Many in society assume that abortion is a traumatic experience. For example, Levine (2004) in his article in which he discussed the economic implications of abortion policy, stated, with regard to “costs” of abortion, “an abortion is physically uncomfortable and emotionally traumatic” (p. 80). This statement supports the myth that abortion is often traumatic for women. However, the traumatizing part of abortion is more likely the stigmatization from society rather than the abortion itself.

With regard to abortion clinic workers, Jaffe (2013) questioned, “In the face of such hostility…why does anyone keep doing this work?” The author suggests that the abortion rights advocates have created a strong movement to counter the anti-abortion movement in this country. These workers now think of this work as their mission.

**Counseling**

Counselors may be involved in the abortion process in three ways. A woman may have an abortion and later seek counseling about her decision or the distress she is feeling
post-abortion. However, several studies note that women often do not have long-term psychological distress after an abortion (Adler et al., 1992; Major, Mueller, & Hildebrant, 1985; Major et al., 1998; 1997; Russo & Dabul, 1997; Russo & Zierk, 1972).

Sometimes, women may seek “options counseling” about the abortion decision. Although this researcher has not found any empirical studies about “options counseling,” anecdotally, many abortion clinics offer free options counseling before the procedure. The counselor can answer any questions the woman has and give her information about the procedure.

A third way counselors may be involved in the abortion process is during pre-abortion counseling in a clinic setting. This researcher found no information on options counseling in the literature and very little information about post-abortion counseling. Because pre-abortion counseling is offered in many abortion clinics, women seem most likely to interact with a counselor during pre-abortion counseling.

Pre-abortion counseling. Ely, Dulmus, and Akers (2010) discussed the lack of literature and research about the pre-abortion counseling process. Contraceptive counseling has been the source of some pre-abortion counseling research. Dauber, Zalar, and Goldstein (1972) compared two groups of women having abortions in a San Francisco hospital. The first group received a ten minute lecture on contraception from a nurse before her abortion and no more contact. The second group met with a counselor and discussed contraception the day before her abortion, the day of, and the day after. Findings suggest that the group that met with the counselor on three separate occasions was much more likely to continue use of contraception and to come to the follow-up visit
(Dauber, Zalar, & Goldstein, 1972). In a similar study, Kay and Thompson (1977) found women that had contraceptive counseling at the abortion clinic after the abortion were more likely to use contraception than those that did not receive counseling after the abortion as evaluated at the time of a follow-up visit.

As Gedan (1974) explained, if the counselor provides an open discourse when doing pre-abortion counseling [with adolescents] the client may follow her example. This recommendation is in line with feminist therapy that emphasizes an egalitarian relationship in which counselor self-disclosure is encouraged. A feminist theory of counseling is often utilized in addition to other theories (Halbur & Halbur, 2007). Utilization of feminist theory may be useful in pre-abortion counseling because counselors using this theory attempt to create an egalitarian relationship with the client using techniques such as self-disclosure and discussion about power differentials within the client-counselor relationship (Corey, 2008).

Rubin and Russo (2004) suggest therapists should encourage clients to think about the positive results of their abortion. The authors also suggest therapists should avoid pathologizing the emotions women feel after an abortion.

Ely, Dulmus, and Akers (2010) studied patient’s perceptions of pre-abortion counseling in outpatient abortion clinics. The researchers conducted the study using a Likert-style satisfaction scale, which was given to patients at the clinic after they completed their counseling. Patients voluntarily filled out the questionnaire and their were 160 completed questionnaires received. Most of the women responding to the questionnaire reported being satisfied with their abortion counseling experience (Ely,
Dulmus, & Akers, 2010). However, the patients that did not fill out the questionnaire may have been dissatisfied with their counseling experience and for that reason did not fill out the questionnaire.

Dauber (1974) sought to find a profile of a typical abortion counselor. Dauber (1974) used questionnaires sent to institutions that provided abortions. The results of these surveys indicated that the demographics of the counselors were similar to that of the clients—all of the counselors were female and most counselors were of childbearing age and sexually active. Twenty percent of the respondents had an abortion in the past. There were varying education levels and none of the respondents had been trained for this specific job. Dauber (1974) attempted to find out how counselors spent their time during their job. Other than individual counseling, some did group counseling. Other duties included telephone counseling, administrative tasks, clerical work, and assisting physicians. Dauber (1974) reported there is no basic definition of the “profession” of pre-abortion counseling and there are no prescribed standards for training.

Millner and Hanks (2002) acknowledged a lack of studies about counselor value conflicts regarding abortion. Millner and Hanks (2002) discussed that pre-abortion counselors in a clinic setting generally have well-established values about abortion which are typically known to the client. Millner and Hanks (2002) defined an “abortion counselor” in a clinic as one “who provides information to one seeking an abortion” (p. 58).

Johnston (2001) provided an overview of the levels of abortion counseling. Level one comes from the medical model and provides basic informed consent, birth control
information, and answering of any questions. Level two provides interviewing and education that may include a “check-in” with a patient about her feelings. Level three is psycho-educational and interactive. This level includes some emotional screening, some empathic connection with patients, and may include discussions about religious or spiritual concerns of the patient. Level four abortion counseling includes all the prior levels and the exploration of complex issues and interventions if needed. The type of counseling facilitated in clinics depends upon the amount of information required by the state as well as the clinic’s model of pre-abortion counseling.

A number of researchers have examined whether or not abortion causes psychological distress to women. Additionally, legislative measures have been put into place for the purpose of assuring that women have all the information about the abortion procedure they need to make an informed decision. Counseling is mandated in many states, although typically the type of counseling that is mandated is not regulated. Although 27 states in the United States mandate counseling, there is limited regulation regarding the counseling that is provided.

In addition to pre-abortion counseling being fairly unregulated, little is known about what happens during pre-abortion counseling. Within the community of abortion providers, there is information about pre-abortion counseling, however this information is not often readily available in the mainstream counseling community.

In an attempt to study pre-abortion counseling, Ely (2007) stated that she found relatively no information on the subject of pre-abortion counseling and conducted a study to gain information about pre-abortion counseling. She used a Likert-type survey with
some open-ended questions and left space for the participants to write in responses. The survey was administered to women who had received a first trimester abortion at an abortion clinic. Ely specifically asked about the counseling the women had received. Although some participants had negative comments about aspects of the clinic, for example the long wait or the temperature, no participants made negative comments about the counseling.

From the survey Ely (2007) determined a “best practices” in pre-abortion counseling and suggested the following from her study: Counselors should be knowledgeable about feminist theory, be non-judgmental, maintain a friendly environment in an attempt to mimic the conversation of female friends, have answers to medical questions about the abortion procedure, and normalize the experience of having an abortion.

Although Ely (2007) provided some insight into the abortion counseling experience and made some suggestions for pre-abortion counseling, the recommendations do not provide much depth into the work of the abortion counselor and she provided relatively surface-level answers from the women that received abortion counseling.

In a study of 115 women over a five year period, Kushner (1997) attempted to understand a more intimate version of women’s stories of abortion and conducted a study with women who have had an abortion. Kushner (1997) not only documented the emotional experience of women that have had abortions, but also listened to how the time at the abortion clinic, including the pre-abortion counseling was experienced by each woman. Some women in the study discussed ways in which they felt disrespected by
clinic workers during their abortion experience. The three ways in which the women felt disrespected: when clinic workers spoke down to them or were judgmental, when workers treated them with a lack of respect, and when counseling was done insensitively.

From the study, Kushner (1997) put together a list of suggestions for counselors facilitating pre-abortion counseling. The first suggestion is that the clinic should employ “real” counselors. For example, the “counselor” should not be someone who does several jobs as the clinic, but works primarily as a counselor and is trained as a counselor. Some women experienced staff members at the clinic only asking certain questions during counseling and the experience did not feel like “real” counseling. This suggestion appears to echo Johnston’s (2001) levels of counseling. Women in the Kushner (1997) study appeared to want a higher level of counseling rather than levels one or two. Also, when counselors asked questions that elicited only one word answers, some women felt they did not have a chance to express their thoughts and feelings about the abortion (Kushner). The second suggestion was the counselor should not only deal with medical information and birth control, but also allow women space to discuss their emotions. Perrucci (2012) reflects the idea that counselors may give out medical information about the abortion and contraception, but also assess decision-making and social support of the woman. Additionally, as Johnston’s higher levels suggest, Perrucci explained that the pre-abortion counselor should reflect, reframe, validate, and normalize the woman’s experience.

The next suggestion from Kushner (1997) is the counseling should not seem rushed. The clinic should employ enough staff members for the counselor to take ample
time with each patient. Next, Kushner suggested counselors correct misinformation that women may have heard about the abortion procedure or the psychological distress they may experience after the abortion. Women may see pro-life pictures or rhetoric that may upset them and counseling should be a place where women can discuss this and the counselor can correct any misinformation (Kushner, 1997). However, counselors should not be too biased in correcting certain information. For example, one woman’s experience was the counselor insisted on saying “fetus” when the woman preferred to say “baby” (Kushner). This type of counseling is biased toward the counselor’s thoughts and feelings and perception of abortion. This type of language is “not the same as correcting misinformation” (Kushner, p. 240). Perrucci (2012) also stated that the pre-abortion counselor should not correct women’s statements such as saying the words “fetus” instead of “baby.”

Kushner (1997) suggested that women be able to talk about their conflicted feelings during counseling without fear that they will not be able to have an abortion. Some clinics will not allow a woman to have an abortion if she has conflicted emotions which can have positive and negative effects (Kushner, 1997). Women may hold back their feelings during counseling if they fear not being able to have an abortion; however, clinic personnel may be correct in not allowing a very conflicted woman to have an abortion for fear of increased post-abortion distress.

The last suggestions from Kushner (1997) involved post-abortion counseling. Kushner found that women in the study felt post-abortion counseling may be necessary. The clinic could run post-abortion support groups, which may break the taboo of having
an abortion if many women come together to talk about their experience (Kushner). The clinic could also provide written information after the abortion to help women cope, including a list of counselors that specialize in post-abortion counseling (Kushner).

**Counseling theory.** Pre-abortion counseling may take form in several different types of counseling. As Ely (2007) suggests, feminist counseling may be at the center of many pre-abortion counselor’s theory. However, other types of counseling may come into play. One may expect grief counseling to be imperative during the pre-abortion counseling process. Although grief may not be a central emotion after abortion, it may come up during counseling due to the similarities between miscarriage and abortion. Additionally, pre-abortion counselors may use person-centered and existential counseling. Similar to feminist counseling, person-centered counseling allows the client to be the expert in her own life. The counselor does not lead, but allows the client to lead the session. Existential counseling may be important as well. The ending of a potential life, for some, may be an existential question. Existential therapy dictates that individuals have freedom over choices, which means they are able to choose the different paths their lives may take (Corey, 2006), therefore abortion may be an existential choice.

In addition to the theories mentioned above, many pre-abortion counselors may employ a post-modern perspective. Therapists adhering to postmodernist thinking contend objective reality does not exist (Corey, 2009). Postmodernist thinkers assert the stories, thinking, and language of the client creates meaning through stories (Corey). This way of thinking is quite different from that of traditional counselor theory. Narrative therapy is one type of post-modernist counseling theory.
Narrative therapy is part of the social constructionist perspective that values the client’s view of reality without disputing its accuracy (Corey, 2009). Individual’s stories shape their lives. Psychological distress occurs when the dominant story of society does not match that of the individual (Corey). Like feminist therapy, narrative therapy is meant to be collaborative (Corey).

The pre-abortion counselor will be listening to the dominant story in the client’s life. For example, a dominant story in society about abortion is “abortion is bad” or “women who have abortions will go to hell.” The dominant stories in society are often oppressive. The counselor may point out this societal story may not fit with the client’s reality. Together, the client and counselor may discuss the client’s story, which is different from the dominant story in society. New stories do not gain power unless there is an “audience to appreciate and support them” (Corey, 2009, p. 395) which exemplifies the importance of the pre-abortion counselor working with the client to find people and areas of support for her post-abortion.
**Feminist counseling theory.** The institution of motherhood implies that the existence of the unborn child is more important than the possible negative impact on a woman who continues an unwanted pregnancy (Timpson, 1996). Society idealizes woman as a nurturer and this is considered an appropriate role for a woman (Timpson). Any woman who does not give birth and look after babies is not considered a “complete” woman (Timpson). Motherhood is not only considered normal, but as wanted and unavoidable (Timpson). Feminism challenges the “institution of motherhood, not mothers or motherhood” (Timpson, 1996, p. 780).

“The personal is political” is a well known principle of feminist theory that emphasizes psychological distress often originates from oppression (Corey, 2009). Feminist therapy can be used as a theory on its own or it can be integrated into other counseling theories (Halbur & Halbur, 2011). One could infer that many abortion clinics would operate under the feminist model, as suggested by Ely (2008), so feminist theory is central to the pre-abortion counselor. One of the most important parts of feminist theory is the egalitarian relationship between counselor and client.

Feminist therapists strive for an egalitarian relationship with the client; however, the therapist must acknowledge that power is almost never truly equal (Brown, 1994). The therapist must acknowledge her power position for the therapeutic relationship to be a truly feminist one (Brown). To deny the existence of the difference in power, even in a client/counselor relationship that strives to be equal, maintains oppression by contradicting feminist theory’s claim of attempting to provide an egalitarian relationship.
Often, there is a practice during counseling to have a “power-over” paradigm (Walker, 2008). The counselor is the dominant one in the counselor/client relationship. However, feminist counselors attempt to eradicate this power relationship. Open discussion of the power differential and roles of counseling can help to diminish the power paradigm of the client/counselor relationship (Corey, 2008).

The feminist counselor does not want the relationship during counseling to mimic any oppressive relationships the client may endure outside of the counseling relationship. “Though not in equal measure and not at all times, the relationship is a place where client and therapist share in shifting vulnerabilities as they move toward deeper connection” (Walker, 2008, p. 92).

The counselor should recognize the therapy relationship may “replicate the systems and arrangements we see in the larger world” with regard to power differential (Walker, 2008, p. 91). The feminist therapist attempts to break through the dominant discourse (Brown, 1994), which is often patriarchal.

Feminist theorists reject diagnosing, contending psychological distress is almost always a product of an oppressive society and not diagnosable as a disease (Corey, 2009). Additionally, diagnosing is a part of a system developed by mainly White male psychiatrists, who may “represent an instrument of oppression” (Corey, 2009, p. 352). Reframing is a technique used in feminist theory to deflect the cause of psychological distress from internal causes to social factors (Corey). Traditional counselor theories place blame of the problem on something wrong with the client. Feminist theory puts societal factors as the center of the problem, not the client.
Feminist therapy is more about how the therapist thinks about what she does, and less about who the clients are (Brown, 1994). Feminist therapy does not attempt to calm or ease experience—feminist therapy will often lead to an enhancement of knowledge of social realities that oppress (Brown). The counselor should not only offer a “therapeutic bandage” for the pain the client currently feels, but encourage thoughts about the future (Halbur & Halbur, 2011).

Feminist therapists should understand details of the client’s unique experience and be able to relate the client’s experience to the experience of others that are molded by social and political forces (Brown, 1994). During pre-abortion counseling, the counselor could emphasize other instances when women may feel pressured to conform to social forces, especially with regard to pregnancy.

**Person-centered counseling.** Society does not seem to encourage grieving after a miscarriage or to attach much value to pregnancy loss (Keefe-Cooperman, 2006). This may be especially true with abortion due to the stigmatizing nature of the procedure. During the grief counseling process, person-centered counseling can be known as companioning (Whiting, Planney, & Balog, 2000). A therapist’s main function, according to the tenets of person-centered approach, is to be present with the client during their immediate experience (Corey, 2009). The counselor must be present during the grief of the client in order to serve her best.

The intimate experience of being with the client in her grief may help to allow the client and counselor to have contact. Psychological contact, as defined by Carl Rogers, refers to the “difference that one person makes in interaction with another person” (1992,
p. 175). “When the deepest self of the therapist meets the deepest part of the client, the counseling process is at its best” (Corey, 2009, p. 178).

The intimate nature of the client/counselor relationship during the pre-abortion process is one that may warrant the counselor to disclose to the client. Self-disclosure is a technique used during person-centered therapy to emphasize the genuine nature of the counselor (Cottone, 1992). In person-centered therapy, the genuine nature of the therapist is a necessity to facilitate change (Corey, 2009). Self-disclosure is also used as a technique in feminist counseling to lessen the power relationship (Corey, 2009).

Unconditional positive regard is a completely nonjudgmental attitude conveyed by the therapist in which the counselor fully respects the client no matter what the client says (Cottone, 1992). As Ely (2007) suggests in her best practices in pre-abortion counseling, the counselor should convey a nonjudgmental attitude during the counseling session. Any judgment by the counselor may cause the client to feel judged as she does in society about abortion.
**Existential counseling.** The choice whether or not to continue a pregnancy may be not only a difficult choice, but one that also evokes an existential question. The question, to some, during abortion may be the morality of whether or not to take a life or a potential life, depending on the view of the client. A main concept of existential therapy is individuals have freedom over choices, which means they are free to choose the direction their lives take (Corey, 2009) and the responsibility of this choice may be an overwhelming one.

Another main idea of existential therapy is awareness of our own mortality (Corey, 2009). The choice of having an abortion may or may not cause a woman to examine her mortality, but it may provoke thoughts about what it means to choose life or death. This may be an existential problem for women and may need examining during counseling.

**Summary**

Before its criminalization, abortion was widely accepted as a women’s issue. Although abortion was legal, it was not safe and not regulated. The criminalization of abortion led to more unsafe abortion practices with women seeking out unsafe, illegal abortions. Many women were left with permanent problems from unsafe abortion practices.

The ruling of *Roe v. Wade* in 1973 brought about a change in abortion policy in that states could no longer prohibit abortion. However, this change in policy incited several initiatives to minimize or end access to abortion. The Hyde Amendment, which prohibits the use of federal funds for abortion, is one of these policies.
A modern argument against abortion is the so-called traumatic aftermath of abortion on women’s mental health. Although many studies have concluded that abortion is similar to any life-stressor, many anti-abortion advocates promote the belief that abortion causes severe psychological effects for women. Some states have enacted policies, such as mandatory counseling before an abortion, in an effort to reduce the psychological affect of abortion.

Most abortions today take place in an abortion clinic setting. Often, women procuring an abortion will meet with a pre-abortion counselor. The counselor may use several different counseling theories. Feminist theory as well as existential theory and person-centered counseling may be most useful during pre-abortion counseling.
Chapter 3: Methodology

Introduction

The process of having an abortion often involves counseling before the procedure. Some state laws, including the laws in Pennsylvania, require a woman to have mandatory counseling before an abortion. However, mandatory counseling, as is the case in Pennsylvania, only requires medical information to be given to the patient by a doctor.

In addition to the mandatory medical counseling, many clinics providing abortions also provide additional counseling before the procedure. Although I have found considerable literature discussing post-abortion distress, I found only one study regarding the counselor during the pre-abortion counseling process. With this research, I hoped to gain knowledge about the experience of working as a pre-abortion counselor. Specifically, I was most interested in understanding how counselors in the abortion clinic view their role as a counselor and whether or not they aid in the decision-making process.

The research question explored was, what does it mean to be a pre-abortion counselor. I attempted to understand the work of pre-abortion counselors by using one-on-one interviews. All interviews were conducted in Pennsylvania and all of the counselors interviewed were currently or previously employed as counselors in abortion clinics. Each interview lasted approximately 45 minutes to one hour.

After conducting interviews, all of which were tape-recorded and transcribed, content analysis was conducted. A co-researcher was used in order to gain more validity and present the information in a more unbiased manner. During content analysis, recurring themes consistent throughout interviews were examined.
Method

Phenomenological inquiry. Phenomenology is a method of attempting to understand and convey to others an individual’s experience of some phenomenon—“how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk with others about it” (Patton, 2002, p. 104). In general, qualitative research is a description of an individual’s experience and not just general beliefs or opinions (King & Horrocks, 2010). In my inquiry, the phenomenon studied was the experience of working as a pre-abortion counselor. During the course of this research, I strove to understand the “lived experience” of a specific group: pre-abortion counselors (Patton, 2002).

According to Patton (2002), there are three implications of the phenomenological perspective:

1. What is important to know is the lived experience of people and how they interpret the world.

2. The only way for one to understand the lived experience of an individual is to experience the phenomenon as directly as possible.

3. There is an assumption that there is a common meaning of the shared experience. The meanings are understood through the sharing of a specific phenomenon.

The goal of this research is to gain an understanding of the experience of pre-abortion counselors. Post-abortion distress has been studied in both qualitative and quantitative studies, including the lived experience of women that have had abortions. However, I was unable to find any empirical studies of the lived experience of pre-abortion counselors. To gather this type of phenomenological data I paid heed to the
recommendations of Patton (2002) and I carried out in-depth interviews with individuals who directly experienced the phenomena in question rather than gathering secondhand experience.

Throughout phenomenological inquiry exists an assumption that there is an “essence” of the phenomenon (Patton, 2002). Patton describes an “essence” as being a sort of culture that exists among the group of individual’s being interviewed. I endeavored to find the “essence” of being a pre-abortion counselor. Additionally, I hoped to find the essence of the shared experience of the individuals in this study.

**Research question.** This study explored one key question while observing the lived experience of pre-abortion counselors. The research question was:

- What does it mean to be a pre-abortion counselor?

**Participants.** The participants in the study were individuals who had either provided pre-abortion counseling in the past or are presently providing pre-abortion counseling. The participants were limited to those who had provided or are providing pre-abortion counseling in the state of Pennsylvania. Abortion laws vary from state to state. Limiting the interviews to those individuals that have worked in Pennsylvania was an effort to ensure that differing state laws would not influence the interview process or results.

The participants were invited to participate by using different recruitment techniques, including help from my coworkers at Allegheny Reproductive Health Center (ARHC), which is a clinic that primarily provides abortion services to women in Pittsburgh, Pennsylvania. In my experience, the providers of abortion in Pennsylvania are a small group who are often in contact with one another. My coworker put my need
for research participants on the Abortion Care Network list server. She identified the characteristics of participants needed for the study. Six of the participants were found through this process. A clinic in an eastern Pennsylvania city offered to help with this research. The director of this clinic contacted me by email. We corresponded and set up a time where I could conduct interviews with some of the participants who worked at the clinic and had volunteered to be interviewed.

The strategy used to recruit other participants included email contact and the snowball technique as advocated by Patton (2002). One of the participants I had known personally gave me the name and contact of an abortion counselor she believed might be interested in being a participant. I was given the name of one possible participant from a coworker at Allegheny Reproductive Health Center. I contacted this participant by email and she agreed to partake in the study.

My intention was to find participants from different regions of Pennsylvania. My position is that abortion counselors working in rural areas would be subject to different experiences than those working in urban areas. Initially, the director of counseling at an abortion clinic in a rural area contacted me stating that she had three counselors, including herself, who were willing to participate in this study. We arranged a meeting in order to complete these interviews, however, before the meeting she contacted me saying the clinic was too busy to allow the staff members time away from their work to participate in the interview on the day we had arranged. I sent two emails asking to change the day and time of the interviews in order to accommodate their schedules, but I
did not receive any response. Therefore, all of the participants in this study worked in abortion clinics located in urban areas.

Patton (2002) states that the sample size for interviews should be large enough to have information to the “point of redundancy,” however this is typically not realistic in a qualitative study. Instead, Patton (2002) suggests having a minimum sample instead of having a sample size to the “point of redundancy.” The number of participants interviewed in this study was ten. I believe that the point of redundancy was met in this study. There were several themes that emerged throughout the data, however, each participant had a unique individuality and it is impossible to know what else would have surfaced if many more participants were utilized.

As Patton (2002) explains, in qualitative research small sample size and non-random sampling is one of its strengths and a generalization of research is not the focus. Instead, the focus is on gathering a wealth of knowledge about a small number of participants that share some certain quality. The small sample size can be a strength because it allows the researcher to gather knowledge that lacks breadth, but makes up for it in depth (Patton, 2002).

**Procedures**

**Researcher bias.** The purpose of qualitative inquiry is not to test a hypothesis or to have the ability to generalize the phenomenon studied to other situations. Additionally, because I am a pre-abortion counselor, I needed to be aware that counselors in any type of setting have different styles and that many different styles can be effective. Personal bias can be an issue in any type of research. However, those critical of
qualitative methods of research, such as interviewing, critique the approach as being too subjective mainly because the researcher is an “instrument” in the data collection (Patton, 2002). However, Denzin (1989) states that regardless of research methods used, the researcher carries preconceptions and interpretations of the research being studied. I have worked in the field of pre-abortion counseling for over five years. Additionally, I have strong beliefs about issues surrounding abortion. Becoming aware of personal bias is the first step in any phenomenological inquiry (Patton, 2002). All personal bias may not be eliminated; however, gaining transparency about biases is important for conducting firm qualitative research (Patton, 2002).

In gaining self-awareness about my biases that may have influenced this research, I thought about my strong feelings towards pre-abortion counseling. In alignment with phenomenological research, I became aware that my experience in pre-abortion counseling is only MY experience and not anyone else’s experience. I had to listen in as unbiased manner as possible, to fully understand the experience of others in the same field. There is no standard for pre-abortion counseling, which implied there would be a difference among clinics and among pre-abortion counselors. Additionally, I had to understand that pre-abortion counselors most certainly would have different styles. These styles can be just as effective just as counselors in any field may differ in their styles.

Although I attempted to shed any bias that could be evident to the interviewee during the interview, not all bias can ever be eliminated. This research was looked at through the critical lens of feminist theory which is geared toward social change. Researchers who use qualitative inquiry as a method of social change take more of an
activist approach rather than an open-minded approach (Patton, 2002). Throughout the process of data collection and analysis, I listened with feminist ears and I processed the data I heard with a feminist perception.

In an effort to gain self-awareness, I kept a journal during the interview process. The journal noted my thoughts and feelings about the interviews. Additionally, I noted my thoughts and feelings about what each participant said, including ways in which I felt differently about pre-abortion counseling based on my experiences relative to that shared by the participants.

In addition to personal awareness, I utilized some of my colleagues during the analysis process to reduce bias. Although my colleagues also have investment in abortion counseling and share my politics, each have different views of abortion and the counseling process. I anticipated that my colleagues would analyze the data differently than I would. After the interviews were conducted, I often collaborated with my colleagues and asked their opinions about the interviews. They often gave me their interpretation of the data. See the data analysis section for further information.

**Interview procedures.** I have been employed at Allegheny Reproductive Health Center for over five years on a part-time basis. Therefore, I am acquainted with all the staff at Allegheny Reproductive Health Center. Although a number of staff members have come and gone during the last five years, a small core of staff, including counselors, are still employed at the center. The counselors at Allegheny Reproductive Health Center were not participants in the interviews used for research to avoid what Glesne (2006) calls “backyard” research.
The participants were given a consent form to be signed for their participation prior to the beginning of the interview. The consent form explained the purpose of the study and the process of the interview. The interviews were audio-recorded with the consent of the participants. Note-taking during the interview helped with the analysis process by drawing attention to important parts of the tape (Patton, 2002). During most of the interviews, I took some notes. The notes were mostly about themes I thought were emerging even as the interviews were taking place. However, the notes were not in-depth. They were often a few words or a short phrase to help me as I reflected during the content analysis.

Questions in qualitative interviewing can be based on the researcher’s experience with the phenomenon and anecdotes and stories the researcher has heard (King & Horrocks, 2010). This interview guide was made up of questions based on the small amount of prior research on pre-abortion counseling as well as the interviewer’s experience as a pre-abortion counselor. An interview guide was used for the interviews (Appendix B) which according to King and Horrocks allows the interviewee to guide the interview. The interview guide lists several open-ended questions in order to keep the interview on topic and maintain a similar line of questioning for each interview (Patton, 2002). Although the interview guide was used, the participants discussed topics that were not part of the interview guide. During the interview, other topics began to materialize. Additionally, the guide helped to keep the interviews comprehensive by strategically determining the topics beforehand (Patton, 2002). I did not stray from the interview guide unless the participant wanted to talk about another aspect that I was not
covering. As stated previously, there is relatively no literature on the topic of pre-abortion counseling (Ely, 2007; Ely, 2008), therefore, the interview guide was based mostly on my interest about the topic and anecdotal information.

The interviews took place in several different locations. Six of the interviews took place in a private office within an abortion clinic. The other four interviews were conducted in the home of the participant. The interviews averaged approximately 45 minutes in length, however, some were as short as 35 minutes and others were as long as one hour and 15 minutes.

Data collection. The analysis process for the study began at the beginning of each interview and continued after the interviews are conducted. I tape-recorded each interview, after consent was given by each interviewee, which allowed me to make additional notes and observations during the interview. Note-taking during the interview helped with the analysis process by drawing attention to especially important parts of the tape (Patton, 2002). After each interview was conducted, the interview was transcribed and further analysis was conducted.

Analysis of data. Patton (2002) states “developing some manageable classification or coding scheme is the first step of analysis” (p. 463). Coding is defined by Strauss and Corbin (1990) as the “process of analyzing data” (p. 61). My co-researcher and I continued to reflect back to the research questions during the coding process. As Patton (2002) states, “content analysis involves identifying, coding, categorizing, classifying, and labeling the primary patterns in the data” (p. 463).
Patton (2002) articulates a system for coding which includes transcribing the material yourself in an effort to be truly immersed in the data and using field notes to see themes as they emerged throughout the interview process. I followed the method for coding advocated by Patton. I made fields notes, as Patton suggests, during the interview process. These notes mostly consisted of further questioning I wanted to do during the interview. Some of the notes described themes that I thought might emerge in the data.

I transcribed the interviews myself instead of using a transcriptionist. I believe that transcribing the interviews myself helped me to become even more familiar with the data than I would have been if someone else was responsible for the transcribing. Furthermore, while transcribing the interviews, I noticed more common themes.

After transcription, I read through each of the interviews. During the second reading of the transcribed interviews, I went through the written pages by hand and made comments in the margins, as Patton suggests. Some of the first comments were simply emphasizing common words that many of the participants used. Although I had intended on using shorthand codes, this did not seem necessary to me during the coding process. Instead, I typically made one or two word comments in the margins as well as underlined and highlighted specific words or passages. As Patton states, several readings of each interview transcription will often be needed in order to formalize the coding process. I read through each of the interviews numerous times.

The type of coding process was an inductive analysis. Inductive analysis allows for patterns to emerge in the data (Patton, 2002). As expected, certain patterns did emerge from the data that followed the interview guide. For example, I expected effects
of protesters to be a theme that may emerge in the responses. Indeed, the thoughts and feelings about the protesters did end up being a theme. However, I expected themes to emerge that I had not considered.

In order to improve the validity of my coding, I employed a form of triangulation with a co-researcher. Although I had planned on using a team of researchers for this purpose, busy schedules prevented this from occurring. Only one researcher was ultimately used for triangulation. The co-researcher was given the transcribed interviews after all identifiers were removed.

The co-researcher, Sarah Dittoe, is a colleague at Allegheny Reproductive Health Center who volunteered to help me with this project. Sarah has worked in reproductive health care for approximately ten years. She states that she got her first job at an abortion clinic by answering a want ad that stated “feminist wanted.” Sarah states that the job was a good fit right away. She described increasing her understanding of abortion throughout her work. Specifically, she stated that she had no idea there were so many barriers to abortion before working at the clinic such as political challenges, stigma, and the challenge of finding a provider. She has held almost every position in the clinic such as reception, counselor, lab technician, medical assistant, administrative, and even security guard. She states that she hopes this research will help to dispel some of the myths of abortion, especially since abortion is such a common part of women’s lives.

Patton (2002) suggests that when more than one person is working on analysis, each person may develop a coding scheme independently and then compare and share these ideas. Following Patton’s suggestion, I independently formed a coding scheme.
The coding scheme outlined themes that I thought emerged in the data. However, this was only an outline. The co-researcher read over each of the transcribed interviews several times. After the first reading, she began to make notes in the margins of the transcribed interviews. The notes identified themes she felt were emerging in the data as well as particularly interesting quotations.

After the co-researcher had coded her transcription, we collaborated on the material often over a period of several weeks. We spoke mostly in person, but also by email. As different ideas emerged, we discussed the coding schemes that made the most sense to us. Although the co-researcher and I had similar ideas of the themes that were emerging, she brought a unique perspective. Often, although, there were themes that seemed to be emerging, we were unsure as to what we should label the themes. For example, in terms of the theme of non-judgmental attitude as well as respect, I had originally coded them as separate themes. However, as the co-researcher and I collaborated, we came to the conclusion that the themes were far too similar to be separate. We decided this was not two themes, but one theme.

**Summary**

The method of qualitative interviewing was used in this study to gain a greater understanding of the experience of a pre-abortion counselor in a clinic setting. The participants were current or former counselors employed in abortion clinics in Pennsylvania. The knowledge gained, I hope, will aid in understanding of the pre-abortion counseling process from the counselor’s perspective. I have found relatively no research from the perspective of the pre-abortion counselor. The data obtained through
this research could be useful to those working in an abortion clinic and those who work in other counseling settings.

The interviews were conducted face-to-face and were tape-recorded. An interview guide was used in order to keep the interviews consistent. After transcription was completed, an inductive analysis was performed to understand the emergent themes. After I completed coding, a co-researched conducted coding as well in order to increase the validity of the research. The next chapter explores the themes that emerged during the interviews.
Chapter 4: Results

Introduction

As indicated previously, there is a paucity of studies on pre-abortion counseling in the counseling literature. Therefore, pre-abortion counseling and the experience of pre-abortion counselors is virtually unknown outside of the small group of individuals who are involved in abortion care work.

The purpose of this study was to answer the research question, *What does it mean to be a pre-abortion counselor?* In order to answer this question, interviews were conducted with individuals who work as pre-abortion counselors. Because most abortions in the United States take place in an abortion clinic setting, the counselors interviewed were limited to those who work in abortion clinics rather than in hospitals.

Participants

The interview participants are identified by pseudonyms to maintain anonymity. Ten participants, all females, were interviewed for this study. All the participants with the exception of Kate, Christine, and Adrienne, are currently employed as a counselor in an abortion clinic in Pennsylvania. Kate, Christine, and Adrienne were all previously employed in an abortion clinic in Pennsylvania.

**Participant profiles.** The following participant profiles highlight a brief background of each of the participants. Included is previous experience in counseling as well as previous reproductive experience. Additionally, the length of time working in an abortion clinic is described. The profiles of each participant are not equal in length as was the case with the interviews themselves. Although the average length of time for an
interview was approximately 45 minutes, some interviews were a bit shorter while other extended past one hour. Some interviews were easier to conduct than others. For example, Christine is what I would consider an icon in the abortion care community. She has been interviewed many times and the interview process with her was very easy. There was so much rich material in her interview that it was difficult to limit even her participant profile. Other participants had never been interviewed and had much less to say during the interview. It was for these reasons that the participant profiles differ in length.

**Kate.** Kate worked in an abortion clinic for approximately one and a half years. Although she does not work on a full-time basis any longer, she sometimes counsels when needed. She did not have any previous counseling experience when she was hired, but had a masters degree in Medical Anthropology. During her studies, she focused on reproduction in international communities. She also had experience as a volunteer at another abortion clinic.

**Christine.** Christine had the most extensive experience in abortion clinic work. She began her work as a volunteer in 1971 before the legalization of abortion in Pennsylvania. Her volunteer work included referring women who needed abortions to safe abortion providers. Christine described her first experiences in abortion care at the clinic after the legalization of abortion in 1973. She worked as a counselor and then ultimately as the director of an abortion clinic until her retirement in 2009. She explained the most significant difference she has seen throughout the years is the increase of the anti-abortion movement.
Christine had a unique view of abortion counseling. She described that in the first years of providing abortions to women, there was no counseling. She stated many feminists had the view that if a woman wanted an abortion she should be able to come in and have one with no questions asked. After a few years of work, she began to realize that abortion was a different type of medical decision for women. Some abortion providers began to provide pre-abortion counseling in order to make sure women knew all of the medical risks of abortion. In addition, counselors began to explore the emotions of women as they relate to engaging in the process of abortion.

Christine described the need for abortion care workers, including herself, to continuously evaluate their feelings relative to abortion. She gave an example of accompanying a woman to the hospital to have an abortion because she was beyond the point of being able to have an abortion in the clinic. Christine stated she did not feel comfortable with this woman having an abortion at 20 weeks into her pregnancy and therefore felt uncomfortable being present for the abortion. Christine stated that she stayed in touch with the woman for years after her abortion. She stated that the woman often stated that the abortion had saved her life. Christine described the experience of being with that woman as a profound one. She described working in an abortion care as being her passion.

**Diane.** Diane began her experience in abortion care as an escort at another clinic. As an escort, she would accompany women into the clinic to prevent them from being harassed by anti-abortion protesters. She described her urge to work in a clinic after becoming repeatedly angered by the protesters while she was an escort. She states that
she called the current clinic in which she is employed and basically “begged” them for a job. She began as a counselor and is currently the director of counseling.

Although the protesters often angered her as a clinic escort, she feels somewhat different now. She describes that the protesters still anger her, but she used what they say to women during counseling. She states that when women are upset about the protesters, it gives them a place to begin in counseling. She says that although the protesters often say hurtful and horrible things to women, they are often just verbalizing the stigma that is already in place for the woman. Stigma surrounding abortion is prevalent in society. However, the protesters are actively engaging women and reminding them of the stigma of abortion.

Diane explained that she often brings up adoption during her counseling sessions. She states that she believes women should have a clear understanding of adoption in order to make a totally informed decision. She described an experience she had with a client who decided to choose adoption instead of abortion while she was at the clinic. Diane says that she kept in touch with her throughout her pregnancy. She stated that the young woman, after giving birth, changed her mind and decided to raise the baby instead of giving it up for adoption. Diane says that she was happy she and the woman had so many conversations about her choices and that she repeatedly told the woman if she chooses to keep the baby, she is not disappointing anyone, including Diane.

**Stephanie.** Stephanie’s title is that of a phone counselor in a clinic. She describes that she is often the first person to interact with the woman. She says she did not have any counseling experience before the clinic, but wanted a job where she was
able to help others. She described her family and friends as being pro-choice and supportive of her decision to work at the clinic, however she states they often make “jokes” about her work. She described the joking as her friends and family calling her names like “baby-killer.”

Stephanie stated that she is not personally bothered by the protesters, however it is upsetting to her that they are judging the women. She states the clinic workers do not judge whether a woman has an abortion or continues the pregnancy.

Stephanie says that although she is a phone counselor, she is not just there to make appointments. She says patients would often call to speak with her about concerns or emotional issues that come up before and after their appointment.

Stephanie also disclosed that she had an abortion herself. She stated she felt as though she had control over her life. She stated the abortion was the best thing she could have done for herself.

**Elizabeth.** Elizabeth holds the title of a phone counselor. She states she answered an online ad about her current position. She feels her job is especially important because, being Hispanic and bilingual, she can assist Latina women who she believes are underserved. She also provides individual counseling on a frequent basis with Spanish-speaking women when they come into the clinic.

Elizabeth disclosed that she had always been pro-choice, but never thought abortion would be for her. She described that those feelings changed when she had an abortion. She says that working at the clinic has been a healing process for her. She says she kept her abortion extremely private and not even her husband knows about it. She
shared that it was not too long ago that she told her coworkers about the abortion. She also described that most of her family is against abortion and very vocal about it.

She described that the experience of working at the clinic has made her open-minded and also judgmental. She stated that the only time she feels judgmental is when a woman refuses birth control. She states that she is also more open-minded because she never knew much about abortion or women who had abortions before her job.

After I thanked this participant and turned off the tape-recorder, she began to cry. She stated that nobody had ever asked her what it was like to be an abortion counselor. She stated that most people believe that the job would be a very negative experience. She states that it isn’t a bad experience at all.

**Kim.** Kim stated that she took the job as a pre-abortion counselor to gain some health care exposure because she is intending to go to nursing school. She explained that she had done abortion access work before in another state. During that job she worked mostly with legislation and funding. She stated she wanted to work in a different capacity that was more patient-centered.

Kim talked about the morality of abortion. She stated that she believes abortion is killing and that it is perfectly fine. She states that she believes a pregnancy is a form of life and that having an abortion is ending that life. She states she believes this idea is in line with the way many patients think about abortion and pregnancy.

She spoke about several difficulties of working as a counselor in the clinic, such as a lack of support from supervisors in the clinic. She went on to say that the work can be very draining and very emotional. However, counselors are not compensated very well
and do not have much vacation time which is needed to be able to take care of oneself. She stated she also has difficulty working with minors whose parents are trying to coerce them into having an abortion against their will. She described that she finds it satisfying to be in the unique position to hear such personal stories from women.

Dina. Dina had a unique perspective. She is employed as a counselor not only in Pennsylvania, but also in New Jersey where the laws regarding abortion are much more liberal. She stated that she believes the TRAP laws enforced in Pennsylvania, such as the 24 hour waiting period, are completely unnecessary. She states that in New Jersey, they are able to perform abortion just as safely as in Pennsylvania, so the laws have no effect except to stifle access to abortion.

Dina is completing a masters degree in counseling and quit her job teaching at a Catholic school in order to be a pre-abortion counselor. She explained that many of her family and friends are against abortion and often encourage her to find a new job. She states that one comment that was bothersome to her was one of her friends telling her she is “playing God” by being an abortion provider. Dina went on to say that she was formerly against abortion. She states when she was a child, she and her mother would protest at abortion clinics. She states her opinions changed when she began learning more about Catholicism. She states that most religions are dictated by men who are often using the Bible to control women’s actions.

Shelbi. Shelbi did not have any counseling experience prior to her job at the abortion clinic. She explained that she does not hide her work from anyone, including the pastor at the church she attends. She states that the workers at her clinic had shirts
made stating that they are abortion providers which she wore outside of work, including to her daughter’s school. She stated she is proud of the work that she does.

Shelbi also described her experience of working at the clinic while she was pregnant. She stated that she worked at the clinic until her eighth month of pregnancy. She described that some patients would ask her how she felt about being pregnant while working at an abortion clinic. She stated believes there was no judgment about her working while pregnant. She stated she was just making a different choice. She said believed women who choose to have an abortion or choose to continue the pregnancy are just making different choices at different times in their life.

Adrienne. Adrienne described her first experience in reproductive health care as volunteering as a clinic escort at two different clinics. While she was in college, Adrienne also attended seminary school. She states she ultimately decided she is a spiritual person, but not a Christian person. She states she believes pregnancy and sexuality are very spiritual issues. She then began as a counselor at another abortion clinic. She described some experiences she had as a teenager with her family in Nicaragua. She stated she would volunteer with her family at a health center for malnourished children. She stated that when she got a little older she understood that the health center was providing safe, but illegal abortions to women.

In addition to her work as a pre-abortion counselor, she had also worked as a doula, which is a birthing assistant, and is currently in nursing school. She stated that many people believe her birthing work is usually happy while her abortion work is usually sad. She stated that this is untrue. She states she has seen some very tragic births
and some very happy abortions. She stated that she did not mean tragic as in something medically wrong. She stated that birth can be tragic if a woman does not want to have a baby, but is forced into giving birth.

She stated that as a gay woman she has the luxury of not having to deal with the “bullshit” that many women go through. She stated she believes she would not remember to take a pill every day, she would not be able to put up with men who refuse to use condoms, and she would not want to be blamed for not getting an IUD like she believes many women are. She described that it is often disenfranchised women who end up being forced into pregnancy, who cannot afford birth control, and are often treated like “idiots” if they get pregnant.

Anna. Anna began her work in abortion care because her partner was an active worker in an abortion clinic. She described that she has always been pro-choice. She stated that she had known about abortion since she was a child. She said she would not be here if it was not for abortion. Her mother had an abortion when she was very young and she does not believe her mother would have had her or her sisters if she had been forced to continue that pregnancy. She also stated that her grandmother had a lot of unwanted pregnancies by various men, but never sought out abortion. She believes this is because the resources were not there for her to do so. She said she believes her grandmother’s life was changed for the worse because of all the unwanted pregnancies she had to endure.

She also described being pro-choice because she sees it as comparable to being gay. She states that being a lesbian, she has a lot of moral agendas pushed upon her. She
states that these moral agendas are the same as women having anti-abortion stigma pushed upon them.

Anna described that she believes she is more liberal with abortion than some others in the abortion care community. She says she has no problem with women having multiple abortions. She states she does not believe women should have to take birth control. She also says she has no problem with later-term abortions.

**Themes**

Understanding the lived experience of individuals working in the field of pre-abortion counseling was the focus of this study. During the interview process, I followed an interview guide. The interview guide allows for some structure in the interview process but also permits the participant to talk about topics not in the interview guide (Patton, 2002).

Although many of the themes were somewhat obvious to the researcher and co-researcher, other themes seemed to be more unspoken and less specific. For example, being non-judgmental as well as being respectful seemed to be overall themes throughout the interviews. However, the word “respect” was not always used outright. Some participants seemed to imply the importance of respecting women, respecting the “space” in the counseling room, and feeling distress if others did not seem to be respectful.

Additionally, being non-judgmental was an important theme throughout the interviews. However, the participants spoke about being non-judgmental in different ways. Many participants discussed the importance of not judging patients. Other
participants talked about becoming less judgmental during their work at the clinic. The following sections outline the themes that emerged from the data.

**Non-judgmental/respectful attitude.** A common thread that ran through all the interviews was the participants’ non-judgmental and respectful attitude. The participants were adamant that counselors in an abortion clinic should be non-judgmental during counseling. Several of the participants expressed that a woman who is pregnant will likely not be able to find anyone to talk to that will be non-judgmental about her pregnancy. For example, Christine stated that, “I think people are really good at telling a woman with an unintended pregnancy what they ought to do, but there are very few people in their lives who will really help them to explore the issues…I mean unless all your friends are therapists.” Most often a friend or family member will have some opinion about what the woman should do with her pregnancy. It is likely that the counselor at the abortion clinic will be the only person who does not have a personal investment in what she does with this pregnancy. Additionally, Kate, when asked what it means to be a pre-abortion counselor, stated, “My first thought when you asked what does it mean to be a pre-abortion counselor, my first thought was basically being somebody, some non-judgmental entity for women to talk to…”

The idea of not having an investment in what the woman does with her pregnancy is one that may be contrary to what an outsider may think about workers in an abortion clinic. Unlike counselors at crisis pregnancy centers, who are likely to have an investment in the woman continuing her pregnancy because they are against abortion, the participants expressed that counselors at an abortion clinic are supportive and non-
judgmental of any choice the woman makes. For example, Stephanie stated, “…when we bring patients here and they don’t like, somehow they are like, oh well I want to carry to term [instead of have an abortion], we don’t judge them.” This participant, as well as others, was suggesting that abortion is not the only acceptable option to the pre-abortion counselor. Another participant, Adrienne, discussed this issue by stating:

Over the years, I worked at three different abortion clinics and I did primarily birth work for a while, which a lot influenced my feelings about abortion and only strengthened my idea that people really know what’s best for them and I can’t possibly know…What does it mean to be a pre-abortion counselor…I think that it means that you really are just supportive of whatever [abortion, adoption, carrying to term]… certainly not to give advice, but just to kind of hold a space that she probably hasn’t had.

Similarly, some of the participants expressed this non-judgmental attitude by suggesting that only the client would be able to know what is best for her. “We trust women” is a common feminist phrase used to convey the message that women know what is best for them regarding their reproductive health. Some of the participants echoed this sentiment. Stephanie stated, “…we trust women here to make decisions that are best for them.”

Some participants expressed respect and a non-judgmental attitude in a different way. For example, Christine stated the following:

One was a patient calling up and wanting to make sure she had the right place because she said, ‘I know there is another clinic not far from where you are, um,
but they don’t respect the babies. I want to come to your clinic because you respect the babies.’ And I thought, wow, that’s what we do here. That is what we consciously do…it is respecting the life within her and yet honoring her decision…”

This participant seemed to be talking about respecting each woman’s body, the life inside her, and the decision she makes about the pregnancy simultaneously. Some may find the idea of those working at an abortion clinic “respecting” the life inside of a woman to be contradictory. On the contrary, many working in abortion care consider the abortion clinic to be a “sacred” place. For example, some clinics offer the opportunity to have the fetus blessed with holy water after the abortion. Others have places where patients and their friends or family may take time to pray, meditate, or just be alone with their thoughts.

In my experience working at ARHC, offer a small room called a sanctuary. This room is only large enough to hold a small wooden bench, a table that holds water that has been blessed, pamphlets for spiritual healing after abortion, and a dim lighting that shines on colorful stones. During the opening of this sanctuary, ARHC held a small ceremony with several different clergy who read blessings for the sanctuary. This remains a place where women or any support person may take time to sit in silence.

Additionally, at ARHC we offer the opportunity to have the fetus blessed with holy water after the abortion. In my experience, this is something that is not widely done at the clinic. However, I have been a part of two blessings. If a patient wishes to have
her fetus blessed after the abortion, we either ask her if she would like to write something for us to read during the blessing or if there is something special she would like us to say.

**Previous interest in reproductive health.** Another theme that emerged was having a previous interest in reproductive health. Half of the participants had an interest in reproductive health prior to their employment at the clinic. All of the participants that had an interest in reproductive health were volunteers in some capacity relating to reproductive health. Many of the participants that were volunteers were clinic escorts. Typically, clinic escorts stand outside of the abortion clinic in an attempt to shield patients and their guests from anti-abortion protesters.

In addition to being clinic escorts, some participants had previous experience in reproductive health in other capacities. Kate stated that she had a research interest in reproductive health in other countries. Adrienne also had international experience with reproductive health. She stated:

*Well, I started escorting at a clinic when I was 18…and I had traveled to see family abroad in [country removed] and when I was there, um, I mostly like would help my cousins at a, like nutrition center for mal, undernourished kids and it was connected to another health project and, um, when I was younger I wouldn’t ask a lot of questions about it. They were like, oh it’s a health center, but then as I got older [I understood] it was an illegal abortion clinic.*

Both participants with international reproductive health care experience expressed that they were concerned about access to abortion care in the United States.
Two of the participants described doing “abortion access” work. Although one participant did not go into detail about her previous work, Christine had a unique perspective with her previous abortion care experience. She described her experience that took place before Roe v. Wade of helping women find access to doctors that would perform illegal abortions.

Although interest in reproductive health was a theme, the training of the counselors as well as the education level of the counselors was not clear. Some participants talked about previous work experience; however, there was not a theme that became evident about what types of training the participants received within the clinic setting or training they received as counselors before they became counselors in the clinic.

**Role of the counselor.** The participants echoed many similar thoughts as to what their role as a counselor was. The role of the counselor seemed to not always be clear-cut. Additionally, the role of the counselor seemed to vary depending on the client and the client’s needs. The following are themes that emerged regarding the role of a counselor.

**Helper.** Every participant stated in some way that she believed she was a helper or helping women while working in the abortion clinic. Several participants described their work at the abortion clinic as a health care provider helping women obtain reproductive health care. For some participants, being a helper or helping the patient seemed to be helping the client obtain an abortion if that was the outcome she desired.
However, helping was not only with obtaining an abortion. Other participants talked about helping clients during the counseling process. Ways the participants described helping was to reframe information, clarify, and to reflect what the client was saying. For example, Christine describes counseling a woman whose father was a preacher. She talked about the conflict the woman experienced with her faith and wanting to have the abortion. Christine describes taking the time to help the woman clarify what her faith meant to her. Additionally, Diane described listening and reflecting as “holding up a mirror to a patient and saying…is that what it feels like on the inside because this is what I hear you saying?”

Being present with a client through the abortion constituted being helpful for some participants. Several participants described what it was like to be beside a client during the abortion procedure. As Christine described, being next to the client during the abortion was like “literally walking the path side by side with them, which is the goal of any counseling.”

To Give Information. All of the participants spoke about giving information to patients in some capacity. However, the type of information given varied in some ways. All of the participants discussed giving medical information to the patients. Some of the participants discussed answering questions from clients regarding how they would feel physically during and after the abortion. This seemed to constitute giving medical information.

In addition to giving medical information about the abortion procedure, some of the participants discussed dispelling “myths” about abortion, which mostly seemed to be
in the form of giving correct medical information. Some participants stated that clients often ask about fertility in the future after an abortion, which is fueled by the misperception that having an abortion can largely affect fertility.

Some of the participants discussed giving information in the form of birth control. In fact, Kim stated that one of her most memorable experiences while working in the clinic was having an honest discussion with a woman about birth control. After their lengthy discussion, the woman decided to get an intrauterine device (IUD) as her form of birth control after many other methods had failed her.

Another type of information many of the participants discussed was referrals. Referrals, according to the participants could be placed in one of three categories. The first type of referral is adoption referrals. Diane stated, “And so I feel like a lot of the women I speak to about adoption are the younger women, um, being like 15, 16, teenagers that either are here because they think that this is the right decision or they really don’t know that much about adoption.” Other participants discussed giving adoption information to some, but not all women. The issue of adoption and giving information about adoption seemed to only come up, according to the participants, when a woman was unsure of her decision about abortion.

The last type of referrals the participants discussed was given for emotional reasons. For example, a few of the participants talked about women that were having trouble coping with how they interpreted their religion’s view of abortion. One of the specific referrals was for a group called Faith Aloud. This group is a religious coalition made up of individuals from several different religions that are affirming of abortion. In
addition to Faith Aloud, the participants talked about giving hotline numbers as well as other resources for coping emotionally after abortion.

**Challenges.** Throughout the interview process the participants spoke of a number of challenges they experienced while working as a pre-abortion counselor. These challenges could come into one of two categories, namely, (i) challenges during the counseling process, and (ii) personal challenges.

**In counseling.** Several participants discussed the internal struggle of sending patients home without having an abortion that day. The participants who discussed this struggle seemed to have conflicting emotions about sending patients home. Often, they spoke about having to send patients home for medical reasons. Each abortion clinic had a policy regarding the cutoff number of weeks into the pregnancy in which they were able to perform abortion. In some circumstances, a woman who happened to be further into the pregnancy than she originally thought, would not be able to have an abortion that day. In other cases, some women have to be informed that the abortion procedure could not be performed because they were too far into the pregnancy and termination is prohibited by state or national regulations.

In addition to being too far into the pregnancy to have an abortion, some patients had to be sent home was if they were physically ill on the day of the abortion. Another reason one participant stated was due to body mass index (BMI) being too high for their medical protocol. These medical reasons for sending a patient home seemed to pose difficulty for the participants. The participants often had to deliver the news to the patient which then caused the patient to be upset. However, the participants seemed to
have much more difficulty sending patients home when the reason was not medical, but due to their own opinion that a woman was not resolved enough to have an abortion on that day. Sending a patient home for medical reasons or for being too far into the pregnancy are objective reasons. However, sending a patient home because she seemed unresolved is a more subjective reason. The subjectivity seemed to cause participants to have more distress.

As the participants described sending a patient home for emotional reasons rather than medical reasons, they seemed emotionally torn. For example, if the counselor thought the patient was too unresolved in the decision-making process or if she did not have adequate coping skills, she may be sent home for being too emotionally torn. In one aspect, they were sending the patient home because they seemed to think that it was in the patient’s best interest; however, they seemed uneasy being a barrier to a woman having an abortion. Or as Kim described, “…being part of a system telling a woman she is not able to have an abortion.” This decision was more difficult because it was not objective, but more of a subjective decision. The objective reasons, such as medical reasons, to send a woman home were imposed by the clinic, not by the individual counselor. However, sending a woman home for emotional reasons, such as the counselor believing the woman was too unresolved in her decision to have an abortion, made the counselor seem like a barrier to abortion for the woman. Barriers to abortion are imposed by legislation, such as mandatory waiting periods and restricting access to abortion, yet the participants seemed to feel uneasiness or sometimes guilt being yet another barrier to a woman trying to have an abortion.
Sending a woman home due to ambivalence can be difficult, in my experience. I have had this experience several times while working at ARHC. Although each case was different, some key phrases that were said by women that were sent home for emotional reasons were them stating they were unsure if this was the right decision, stating they might as well have the abortion since they are already here, and stating they know they will regret having this abortion. The reason for sending a woman home if she is too ambivalent is not to cause emotional harm. The goal is not to perform abortions that knowingly will be harmful. Women who are being sent home for this reason may be angry at the counselor for sending her home, which can be difficult.

Another challenge the participants discussed was patients believing that abortion was wrong for others, but okay for their situation. This was both a theme in the section of challenges in counseling as well as a theme in non-judgmental attitude. Participants saw this as a challenge for different reasons. For example, some participants disliked the “disrespect” in some patients thinking her situation was exceptional, but other patients were being bad people by having an abortion. As Christine explained, “…there was a time that without a doubt, that would push my button…the patient or the patient’s mother who would say, ‘we’re not like the other people here. We’re [implied] better than they are.’” Other participants reflected this sentiment as well. They seemed to be protective of the other patients in the clinic as well as disliking the judgmental attitude of some patients.

Another participant echoed the idea of disliking the judgmental attitude of some patients who thought that their abortion is unique. Adrienne stated when speaking about
other patients, “those were women were not legitimately choosing abortion…how is that coping. How is that not just self-hate later?” The participant described that these women condemned other women for having an abortion, but legitimize their own abortion. The participant stated she believed this was actually a form of coping because a woman who says she is staunchly against abortion but has an abortion needs to figure out a way for the abortion to be okay for her.

Another challenge some participants stated experiencing in counseling was with women who have had multiple abortions. However, these participants did not specify how many abortions a woman had that would cause them to feel uneasy or cause them to think of this patient as a challenge. Additionally, the participants had difficulty with these patients in different ways. Elizabeth stated that she only had difficulty with women who have had multiple abortions. She did not go into specific detail as to what was bothersome about the abortions but commented that, “a patient who has refused birth control or who never came back for her follow-up and is now pregnant two months after.” Refusing birth control was a challenge to this participant. Additionally, Dina discussed her discomfort when women refuse birth control and have had multiple abortions.

However, Kim seemed to have a different type of challenge with multiple abortions. The abortions themselves were not the challenge. The challenge was a patient who was not having an honest conversation about the multiple abortions. This participant stated that if a patient could openly discuss being comfortable with not using birth control and being okay with the outcome being multiple abortions, that she had no challenge.
Kim explained that the multiple abortions were not the challenge for her, but the lack of a genuine discussion about the multiple abortions was a challenge. The participant stated, “…it feels really hard to like meet each other and talk about what’s going on, especially because I think there’s a lot of shame involved with those patients…” The challenge with this participant seemed more about being genuine than it did about having multiple abortions.

*Personal challenges.* The one personal challenge the participants discussed was mainly dealing with such intensely emotional content every day during their sessions. Bringing their work home with them due to the strong emotional nature was part of this challenge for some participants. The participants seemed deeply invested in each patient and were unable to forget about the women’s stories when they left the clinic for the day. As Elizabeth explained, “I didn’t think it was going to be, or that I was going to feel or get that attached to each and every patient that called. That was really hard.”

The participants embraced the deep personal, and often strongly emotional, experience of each of their clients. The participants seemed to have the ability to empathize strongly with most of their clients. Most counselors listen to very personal stories of their clients. However, the stigma of abortion causes many women who have had an abortion to keep the experience private. The participants interviewed may often be hearing a story that will be only told to her. In essence, the participants understood they may be the privileged one to hear her client’s story.

One participant stated clearly that the clinic itself was a difficulty. Kim stated:
I think that our clinic doesn’t support us well as counselors, specifically though like the emotional toll that doing this kind of work can have on us. We’re not encouraged to take time to talk with each other, debrief with each other, process with each other. We are given very little paid time off, things like that, that I think make it in the end really exhausting, more than anything…

This participant seemed to be saying that more support in the form of a debriefing could lessen the very emotional task of doing this type of counseling. She also stated later that she often took her work home with her in the way of not being able to be emotionally available to her friends and family. Although this participant stated that the clinic was more of the problem, it also seems that it is the intense nature of the job that poses the challenge.

**Support system of counselor.** The support system of the counselor was defined as the friends, family, and significant others of the participants. The majority of the participants stated that their friends and family were supportive of them working in an abortion clinic. Interestingly, even though all participants described their friends and family as supportive, the word supportive did not seem to be an accurate description. Stephanie stated that her friends would make comments such as, “So…oh you’re a baby killer and when we have a holiday party, they are like, are you going to the baby killer ball?” Although these remarks do not seem supportive, she described her friends as being “really supportive.”

Similarly, a few participants said that their family and friends are supportive but, mentioned comments their friends and family would make that did not seem supportive.
Elizabeth stated that her family often asks her when she will be getting a new job and her friends had stated that she was “playing God.” Although these participants described their friends and families as supportive, their comments seem to contradict the perception of support.

However, many participants stated that they have kept their job a secret from at least one person in their life. Also, most participants stated that their families were at least somewhat supportive of their job, almost all participants discussed some comments that their friends and family made toward them regarding their job that were not supportive. For example, Diane described her relationship with her partner’s mother:

The church she works in is anti-abortion and is very vocal about it, so we just leave it as I work in a women’s health care facility. She doesn’t question. I don’t bring it up. Politics are not on the table for us in order to have a working relationship.

Christine described a similar situation. She stated that the only person that did not know about her job was her uncle who was a Catholic priest. She seemed to imply that she was aware he would not be supportive. Only one participant, Ann, stated that her family was not supportive. Anna stated:

Yeah, my grandfather definitely is not supportive. He only, uh, believes in abortion in the case of rape or incest. We’re actually very close, um, but my other family is Catholic and they just don’t ask me any questions. It’s like [me] being gay really, so there’s no questions about it and that’s it.
Although she stated that her grandfather was not supportive of her working in an abortion clinic, she did not imply that they argued about this. Anna was the only one stating non-support; however, her experience seems to be quite similar to other participants that stated their family and friends were supportive.

Another similarity that occurred with the support system was the majority of participants stated at least one friend or family member did not know that they work in an abortion clinic. Some participants kept the fact that they worked at an abortion clinic private from their family, but revealed that they worked in women’s health care. The participants seemed satisfied to keep their job a secret from some members of their family and some friends due to the fact it was easier kept a secret than shared.

**View of PA legislation surrounding abortion.** Almost all participants at some time discussed the laws in Pennsylvania surrounding abortion. The common theme regarding the abortion legislation in Pennsylvania was that the laws were too restrictive, impede access to abortion, and made women jump through hoops for no apparent reasons. The laws the participants talked about most were the Abortion Control Act and Senate Bill 732. The Abortion Control Act requires that a woman in Pennsylvania must receive the reading of a script containing medical information from a doctor before her abortion. Additionally, after this script is read, the woman must complete a 24 hour waiting period before having an abortion.

These laws, which are common in many states, are often passed because legislators state that they help abortion to be “safer.” Several participants described these laws as making women “jump through hoops” in order to have an abortion. More than
one participant described these laws as often causing abortions to be pushed into the second trimester which is more costly. As Elizabeth stated, “I just believe it’s [the mandated information session and waiting period] completely unnecessary.”

An unusual experience was documented by Dina. The participant works both in an abortion clinic in Pennsylvania and in an abortion clinic in New Jersey. The laws in New Jersey are less strict. For example, there is no waiting period to have an abortion, there are no parental consent laws, and there is no mandated script to be read from a doctor before the abortion as there are in Pennsylvania. Dina described her experience as follows:

Women call and schedule appointments on that day [in New Jersey]…It’s just a lot, like women are jumping through hoops in PA…at [abortion clinic in New Jersey] we’re able to help more women, um, in an effective manner and I feel it’s as safe there as it is here [in Pennsylvania]. So it kind of makes those laws that we do have here in PA irrelevant because if we can do the same type of work in New Jersey and have women have successful procedures that they want to have I feel that there should be no differences here in Pennsylvania.

Dina’s experience implies that although the other participants do not work in abortion clinics in other states, their assessment of the need for the mandated script as well as the waiting period seems valid. The participants working only in Pennsylvania abortion clinics mainly believed the mandated script and waiting period is unnecessary. Dina’s experience seems to show that these restrictions do appear to be unnecessary.
**Feelings about their work.** Perhaps the theme that stuck out most during the interviews was the participants’ feelings about working as a counselor in an abortion clinic. This was indicated not only in my perception as the researcher, but also within the data analysis. This theme was pervasive throughout the interviews. All the participants explained how they felt about their work as a pre-abortion counselor with words like “privilege,” “amazing,” and “love.” Diane stated, “…it overwhelms me that I get to do this every single day.”

As participants had stated previously, the intense nature of this work could be a challenge at times. In other aspects, participants stated that it was the intense emotional element of the job that caused them to love the work so much. As Christine stated, “Abortion work just grabbed my soul. And that didn’t take too long until I realized that, that was all I wanted to do…You know, it just felt real. It was real.” What this participant seemed to mean by “real” was genuine, emotional, and raw.

The connection with the client as well as working in a political job seemed to provide a sense of importance to many of the participants. As Anna described, “…I don’t know. It’s important. It’s just important.” Diane also described the importance of working in a political job by saying “…I still get to keep the political side of having the individual stories but at the same time understanding that this is not a political decision for the patients that are coming in here. So I get to fight for them…” Christine also explained how she came to understand the politics of abortion were important to her, especially with regard to women having access to legal, safe abortion, but that often patients did not feel the same way. She explained “…I think it was more, um, coming to
realize that not all women were thrilled to have abortions just because they could. Just because it was legal didn’t make it a marker in their lives…”

**Experiences with protesters.** All of the participants stated they had the experience of anti-abortion protesters being outside of the clinic where they work or worked. All of the participants stated that they felt some sadness, anger, or fear due to the protesters. However, an overarching theme regarding the protesters was that the protesters became less of an issue for them the longer they worked at the clinic. They used terms to describe them such as a “non-issue” and a “distraction.”

Typically, the participants stated that they were warned about protesters before they began their job. They often felt some fear because they did not know what to expect. None of the participants described being fearful of the protesters. None of the participants described the protesters as being extremely aggressive or threatening towards them.

All the participants described the protesters as being more of a bother than anything else. As Kate stated, “I think it [the protesters] became almost a non-issue.” Several of the participants simply stated that the protesters “don’t affect” them. Although the participants denied feeling any very strong emotions towards the protesters after working at the clinic for a while, they were unhappy with the way patients often felt after contact with the protesters. The emotions of the participants regarding the protesters seemed to deal more with the impact on the patients rather than on themselves.
Summary

The main themes that emerged were surrounding social support, their thoughts about restrictive abortion laws, strong emotional reactions to their job, and having prior abortion experience. The themes that emerged regarding what happens during their counseling sessions were having a nonjudgmental attitude, being a helper to patients, and to give information to the patient. Many of the participants had prior experience volunteering at an abortion clinic before they became pre-abortion counselors. Another theme was surrounding social support. Although all the participants stated that, in general, they do not keep their job a secret, often there is at least one person in their life who does not know that they work in an abortion clinic. All of the participants felt that the restrictive abortion laws in Pennsylvania were unnecessary and often had detrimental effects on patients, such as later-term abortions and increased cost. The participants overwhelmingly stated that had strong emotional reactions to their job as pre-abortion counselors. These feelings were mostly described as love and gratitude. All ten participants had experience with anti-abortion protestors, which they overwhelmingly described as somewhat of an annoyance, but mostly a non-issue.

Participants seemed to agree that the main roles of pre-abortion counselors were to be non-judgmental, to give information, and to be a helper to the patient. A non-judgmental attitude was a strong theme in many instances during the interviews and suggested by all participants. Additionally, the participants stated they had a challenge with patients or the support system of patients who were judgmental of other patients or who thought their reason for choosing abortion was the only legitimate reason. Another
challenge pertained to the emotional nature of the work. Several participants stated the emotional nature of the job, at least at first, had a detrimental effect on them.

In the following chapter the themes will be discussed with regard to the literature. Additionally, my reflections as well as limitations and future research implications will be outlined.
Chapter Five: Discussion

Introduction

This study has focused on understanding the lived experience of pre-abortion counselors working in an abortion clinic setting. During the course of this study, ten face-to-face interviews were conducted. This study was guided by a phenomenological method and as asserted by Patton (2002) the purpose of phenomenological inquiry is not to develop a theory about the phenomenon studied, but to understand the lived experience of the individuals. My intent is to fill a void in the literature with regard to pre-abortion counseling as well as provide insight into the experience of the participants. In this chapter the participants’ experience of providing pre-abortion counseling as well as particular themes that emerged during the coding process will be highlighted. Additionally, suggestions for future research as well as limitations to the study will be discussed.

The researcher is the instrument in qualitative inquiry (Patton, 2002). Although the researcher must gain understanding into her own biases or assumptions about the phenomenon studied, the researcher cannot be void of all bias (Denzin, 1989). Because the researcher is so intricately involved in the research process, the researcher is no doubt changed by the process. My reflections on the experience as a researcher as well as my thoughts and feelings about the experiences of the participants will be presented in this chapter as well.

Discussion of primary themes. Each of the themes that follow was evident in at least nine of the participant’s interviews. After the discussion of themes, there is a short
discussion of secondary themes. The secondary themes were prevalent in some participants and worth mentioning, but not strong enough to be characterized as primary themes of the study.

**Being non-judgmental.** In general, the participants described an overwhelmingly nonjudgmental attitude towards clients as well as within their counseling sessions. For example, participants made statements such as not being shaming of a woman in any way, validating the client’s experience and listening without influencing. Additionally, several participants stated they provided unconditional support for the client even if the client chose not to have an abortion. The participants’ experiences of working as pre-abortion counselors echoed the best practices in pre-abortion counseling that Ely (2007) suggested. For example, Ely stated that counselors should answer questions regarding the abortion procedure, be non-judgmental, attempt to normalize abortion, and be knowledgeable about feminist counseling theory. According to the participants’ narratives in this study their actions were similar to the recommendations made by Ely.

Although the participants seem to be following the recommendations articulated by Ely (2007) none of the participants stated that they use any specific theories during pre-abortion counseling. However, some of the participants seem to be using elements of feminist theory. Almost all the participants spoke about being nonjudgmental, which is part of feminist theory. Additionally, some of the participants talked about being an advocate for the client in different ways, thereby acknowledging the power differential within the counseling relationship (Brown, 1994). Many of the participants spoke about reframing which is a tenet of feminist theory (Corey, 2009). Most of the participants also
acknowledged the stigma and oppressive nature of society in terms of abortion which is central to feminist theory (Corey).

Feminist counseling theory was not the only theoretical paradigm articulated by the participants, and the interventions by some suggest a person-centered orientation. For example, some participants described being with a client during the abortion and helping her through the procedure. The description by one participant as literally walking side-by-side with the client is central to the premise of person-centered counseling in that the therapist is present with the client during their immediate experience (Corey, 2009).

Additionally, unconditional positive regard, which is a primary theme of person-centered therapy, seemed to be conveyed by the participants in their description of being nonjudgmental (Corey). Other tenets of person-centered counseling, genuineness and empathic understanding of the client’s experience Corey were both expressed by the participants.

Feelings about their job/Previous experience in reproductive health. All of the participants discussed feelings of love they had for their job as a pre-abortion counselor. Although I attempted to portray the feelings the participants expressed about their job using their own words in quotations, it was a difficult task to accomplish. While the client-counselor relationship tends to be one of an intimate nature, the participants expressed the relationships formed during pre-abortion counseling as some of the most intense they have experienced. In addition to the special intimate relationship shared between the client and counselor, many of the participants seemed to be expressing the
feeling of gratitude. Some participants stated that they felt “lucky” to have this as their job.

In addition to feelings of love and gratitude toward their job, two of the counselors stated that one of the myths they believe people have about working in an abortion clinic is that the workers are sad. The participants stated that they are not sad about working in an abortion clinic. Also, one participant stated that some abortions can be sad, but others can be very happy. She went on to say that the happiness often has to do with a woman taking charge of her life. The participants show genuine empathy toward the clients, such as feeling sad when they are sad about their abortion and happy when they feel happy, which is in line with feminist theory as well as person-centered theory (Corey, 2009).

Most of the participants had previous experience working in reproductive health. Many had been volunteers either at the clinic where they currently worked or at another abortion clinic. Some worked in reproductive health care in other capacities. The previous experience seems to coincide with the feelings about their job. As the participants explain, doing work in abortion seems to have grabbed them and they often felt compelled to continue to help provide women with abortion access.

Although most of the participants had a previous interest in reproductive health, there was little discussion regarding the training the participants received at the clinic as a counselor. Additionally, there was little discussion about the training the participants had received as counselors in general before becoming counselors in the clinic. This leaves the question as to whether or not there are training manuals about counseling and what
standards are training are used. Additionally, most of the participants did not mention having an educational background as a counselor. This fact may make the setting of ARHC an anomaly due to the fact all counselors employed at the facility hold at least a master’s degree. Additionally, all counselors currently employed at ARHC have degrees in either counselor or social work. The training at ARHC, in my experience, consisted of weeks of shadowing counselors, collaborating with counselors, reading counseling materials provided by the clinic, and finally being supervised during counseling sessions.

**Role of the counselor.** According to Johnston (2001) there are three levels within pre-abortion counseling. All of the counselors interviewed for this study appeared to be facilitating counseling at either level three or four. According to Johnston (2001) at levels one and two the counselor may or may not “check-in” about feelings, but the counseling is mostly focused on answering medical questions and ensuring the client understands the consent forms. Although the counselors in this study all identified one of their roles as discussing consent forms, answering questions about the procedure, and talking about complications and risks, they also identified more of a personal relationship with the client, which is in line with person-centered theory and feminist theory (Corey, 2009). Both of these theories emphasize the client/counselor relationship (Corey).

Many of the participants described being a listener for the client. Usually when the participants were talking about being a listener, it was accompanied by stating they would also give emotional support to the client when needed. Some of the participants spoke about using some basic counseling skills during the sessions such as active listening, reframing, and reflection. According to the tenets of person-centered theory,
the counselor should listen, without judgment, and attempt to empathize, not to give advice (Corey, 2009).

In addition to the counseling skills the participants described, some of them spoke about discussing religious or spiritual issues with the client. A few of the participants went into detail about handling religious and spiritual issues with clients. For example, a few participants stated they ask the client to describe what their God is like, if their God is a forgiving God and if they believed God would forgive them if abortion is a sin. Also, one participant described talking about what Jesus is like in the Bible with a client. Two participants spoke about praying with clients and reading Bible verses with clients.

The more in-depth counseling that all of the participants described seems to coincide with Johnston’s (2001) level three and four of pre-abortion counseling. Johnston describes level three as psycho-educational and interactive. She describes level four as being a combination of all three prior levels as well as exploration of complex issues and using interventions when needed.

**Challenges.** One of the challenges the participants spoke about was clients being judgmental of abortion. This seems counterintuitive. One would think that if a woman was there to have an abortion, she would consider herself pro-choice. However, in my experience as well as the experience the participants spoke about, many clients presenting for an abortion openly state that they are against abortion or pro-life. Similarly, some clients will imply or state outright that their circumstances constitute a reason to have an abortion, but other women should not be having abortions. For example, some women will say that they were using birth control so it is okay for them to have an abortion, but if
a woman was not using birth control she was not being responsible and therefore somehow deserves to carry an unwanted or mistimed pregnancy. As Christine said during her interview, “…there was a time that without a doubt that would push my button…” I relate to Christine’s feeling.

However, the biggest challenge with a client who believes her abortion, or the circumstances surrounding her abortion, is the only legitimate reason to have an abortion, is not the fact that it is irritating to the counselor. The challenge is how to address this in counseling. Merely empathizing, as person-centered counseling dictates, does not seem to also address the stigma of abortion, which the client is using as a way to make illegitimate the reasons surrounding other women’s abortions. Feminist counseling tenets make clear that addressing stigma brought on by society should be addressed (Corey, 2009). Additionally, in this circumstance, confronting the client about her incongruent views of abortion may be helpful, but is more in line with the teachings of Gestalt theory, which suggests using challenging and confrontation of the client in order to bring forward the genuine emotions of the client (Corey, 2009).

**Support system of counselor.** Unlike most careers, the career of an abortion care worker is often left unknown to at least some of the workers family or friends. The participants mostly stated that they found their family and friends to be mostly supportive, but usually had a few people in their life with whom they are unable to share their work as a pre-abortion counseling due to conflicting views about abortion.

In my experience, I have found it difficult to talk about my work with most people. Generalizations and stigma overwhelm most people’s thoughts about abortion
making it difficult to share experiences about work. Collaboration with colleagues has been helpful when needing to discuss challenges about work. Collaborating with colleagues coincides with practices used by all counselors (Corey, 2009).

**Protesters.** All of the participants stated that they have been involved with anti-abortion protesters during their time as a pre-abortion counselor. In their study Fitzpatrick and Wilson (1999) examined the relationship between time worked at an abortion clinic and the number of symptoms of Post-Traumatic Stress Disorder. The authors found the longer an individual worked at an abortion clinic, the more symptoms they had. However, most of the participants described being concerned about the anti-abortion protesters at the beginning of their career when they were unfamiliar with them, but that the protesters became more of a “non-issue” or a distraction as they kept working at the clinic. Some of the participants described feeling sadness due to the impact the protesters have on the clients. However, none of the participants explained feeling fearful of the protesters on a regular basis.

**View of PA legislation.** Overwhelmingly, the participants stated that they believed the legislation surrounding abortion in Pennsylvania was completely unnecessary. These laws are supposed to be enacted to “protect” women. However, the participants stated that they did not believe that the laws made abortion safer.

A few of the participants mentioned the difficult financial burden of abortion due to the fact that abortion is not covered by any health insurance provided by the state except in the cases of rape, incest, or life endangerment. Some of the participants mentioned that the mandatory waiting period often pushes women further into their
pregnancy resulting in later-term abortion which are not only more difficult medically, but also more costly than an abortion in the first trimester. This echoes the ideas by Medoff (2008) who discussed that legislators have acknowledged the fact that mandatory waiting periods make abortion more difficult to access and more costly.

The legislative climate in Pennsylvania surrounding abortion has been difficult for abortion providers especially in the past year. Pennsylvania legislators recently passed Senate Bill 732 which put extreme restriction on abortion clinics. As of now, none of the abortion clinics in Pennsylvania have facilities that fit the restrictive guidelines of the new law. Unless court appeals are filed, all the abortion clinics in Pennsylvania will close their doors beginning June 19, 2012 due to the restrictive nature of this Senate bill. This fact may have caused the participants to feel even more strongly with regard to their feelings about Pennsylvania legislation.

**Discussion of secondary themes.** Prior to the discussion of the main themes that were evident in the narratives of all participants, two perspectives emerged that, although not strong enough to be considered primary themes, were shared by at least three of the participants and are worth discussing. The first perspective is that although abortion is very political, the decision being made by the patients is not a political decision. The participants sharing this idea, Christine, Diane, and Adrienne, were saying that abortion seems, and is, very political. It is talked about during presidential races and abortion access is constantly being challenged. However, to the patient coming to the abortion clinic on the day of her abortion, she does not see her abortion as a political decision.
She sees her abortion as a deeply personal and sometimes spiritual decision, which is most often void of politics.

A second perspective mentioned by three participants was that of the role of the counselor being an advocate. Kim, Dina, and Adrienne all mentioned that at least part of their role as a counselor was to be an advocate for the patient. When they spoke about being an advocate, it is the interpretation of the researcher that they wanted to advocate for the wishes of this patient, whatever that may be. For example, Kim stated she felt she often needed to be an advocate for minors whose parents were attempting to force them to have an abortion against their wishes.

Although these two perspectives were mentioned more than once by three participants, they did not emerge as strongly as the other themes to be considered stand alone themes.

**Limitations**

The original intention in this study was to have participants from different parts of Pennsylvania. However, the abortion clinic located in a more rural area of Pennsylvania was not able to accommodate the researcher to conduct the interviews. All of the participants in the study had worked in urban areas of Pennsylvania, four of the participants in the western part of the state and six of the participants in the eastern part of the state, but none in rural areas. Participants from a rural areas of the state may have had a much different experience than those located in the urban areas, since rural areas tend to have individuals with more conservative views (Halpin & Agne, 2009). As a result, the counselors may have had different feelings about their work as well as more
intense experiences with protesters because protesters tend to be ideologically against abortion (Rubin & Russo, 2004).

Many of the participants worked at the same abortion clinics which may be a limitation because their experiences as shaped by the location of the clinic and its policies may be relatively similar. All of the participants seemed to be counseling from Johnston’s levels three and four, however, some abortion clinics have a less in-depth counseling process and mostly rely on levels one and two in Johnston’s (2001) pre-abortion counseling levels.

**Implications**

The participants discussed a strong desire to be nonjudgmental and to trust the clients with which they worked. As Millner and Hanks (2002) suggested, the counselors working in an abortion clinic often have clear views about abortion that are well known to their clients. However, counselors working outside of an abortion clinic may or may not have value conflicts with abortion, which may make it difficult for them to stay entirely nonjudgmental. In an unpublished study by Kegarise (2009), she showed that counselor trainees held many incorrect assumptions about abortion that may lead to unknowingly presenting biased information. Millner and Hanks (2002) acknowledged a lack of empirical studies that address value conflicts with regard to abortion.

As the lack of research implies, little is known about what actually goes on in abortion clinics, including what type of counseling, if any, is facilitated. Although millions of American women have entered the doors of an abortion clinic either to receive an abortion themselves or to act as support for a woman having the procedure,
their experience seems to be lost among the anti-abortion rhetoric that paints the picture of an abortion clinic as being a place where women are harmed in some way, given incorrect medical information, or forced into having an abortion. The interviews within this research imply that this anti-abortion rhetoric is untrue. These counselors seek to be nonjudgmental and unbiased, not forceful with abortion. With this research I sought to understand the experience of one small group of abortion clinic workers, particularly the counselors, to understand just one part of the experience of working in an abortion clinic. Although the purpose of this research was to understand the counseling process, the implications of the harm done by anti-abortion legislation, some anti-abortion activists, and extensive anti-abortion legislation became more evident during the interviews as well.

One of the generalizations about abortion clinics is that they give out inaccurate medical information. As the participants in this study revealed, they do tend to give medical information about abortion and birth control to participants. However, none of them revealed giving information that they know to be inaccurate for any reason. In fact, they discussed just the opposite. They overwhelmingly talked about discussing informed consent with their patients in order to ensure the patients understood possible risks and complications, although rare. Interestingly, Crisis Pregnancy Centers, not abortion clinics, are documented to give out inaccurate medical information in an effort to create an obstacle for women interested in having abortions.

The assumption that abortion clinics give out inaccurate medical information could be related to the fact that many people see abortion clinics and Crisis Pregnancy
Centers as having conflicting agendas. Crisis Pregnancy Centers are often staffed by individuals that label themselves as being pro-life and anti-abortion. Therefore, individuals working or volunteering at Crisis Pregnancy Centers have the agenda of convincing women not to have abortions. Because the individuals working at abortion clinics are providing abortions, they are often thought to have the agenda of convincing women to have abortions rather than to continue the pregnancy. However, as this research has highlighted, none of the counselors had any investment in what decision the client makes. In fact, all of the counselors interviewed described just the opposite. They described having no investment in the decision that the client makes. They described being supportive of any decision whether it is abortion, adoption, or continuing the pregnancy and raising the child. This implies that counselors working in these abortion clinics provided unbiased, ethical counseling which is counter to information given at Crisis Pregnancy Centers.

Another implication of this research surrounds the anti-abortion protesting that often occurs outside of abortion clinics. All of the participants had the experience of interacting with anti-abortion protestors standing outside of their place of work. Several of the participants stated that they felt scared or anxious of the protesters during their first days of working at the clinic, but surprisingly almost all of the participants now labeled the anti-abortion protesters as more of a distraction than anything else. The participants described the protesting in varying ways. Some explanations of the protesting included praying outside of the clinic and handing out religious material that condemns abortion, being called names such as murderer, baby-killer, lesbian, and racist, and holding signs
with pictures of dismembered fetuses. The fact that the participants find this type of behavior to be a common distraction outside of their workplace implies that shaming women and attacks on women’s health care have become expected and common place. In most settings, an employee walking into a place of work would be appalled to find someone standing outside of their building hurling threatening or disrespectful language at them and holding signs that are intended to try and coerce individuals from not entering. However, working at an abortion clinic, this type of behavior is expected and tolerated, not only by the clinic workers, but also by the women attempting to receive services. The implication with this finding is that harassment is not only tolerated when it comes to abortion, but expected. Additionally, many abortion clinics, due to the harsh political nature of abortion and the history of abortion extremists violently targeting abortion clinics, are forced to use metal detectors as well as having a guard at their door in order to monitor who comes and goes from the clinic as well as protecting against any weapons that could enter. Not only the counselors and staff working at the clinic, but also the patients and their guests must walk through protesters as well as be subject to being within a place that must use metal detectors due to threats of violence. This is in direct opposition to the type of environment, safe and non-judgmental, that the counselors hope to portray.

Implications also surround the legislation discussed by the participants. None of the participants stated that they believed the legislation targeting abortion clinics aided women in any way. Most of the participants discussed the ways in which strict legislation surrounding abortion restricts access to abortion. Approximately six months
after the interviews were completed, Senate Bill 732 was passed in the state of Pennsylvania. This legislation was passed quietly and with most of the general public unaware of the consequences. These laws closed two of the four abortion clinics in western Pennsylvania as well as other throughout the state by implementing strict policies specifically targeted for abortion clinics. Particularly, this legislation has demanded that abortion clinics follow the regulations for ambulatory surgical centers. These regulations include many changes in construction, such as having extremely large operating rooms that are unnecessary for abortion. My experience with this legislation has been that the number of patients at Allegheny Reproductive Health Center for abortions has nearly doubled since the closure of the other abortion clinics. Additionally, many women are being forced to wait longer in order to have an abortion, which has ultimately caused women to have later-term abortions. This example of limiting access to abortion is precisely one point the participants were making during the interviews. Senate Bill 732 is a perfect example of a TRAP law, which is a law that applies only to abortion providers, not other comparable medical facilities, that increases costs and demand on the staff and facility (Medoff, 2010). The counselors who work first hand with these women who must be subject to these demands see no reasoning behind them. The participants all stated they did not believe that these demands made abortion safer, and only provided barriers to abortion which likely make the procedure more costly.

**Future research**

**Pre-abortion counselors.** The primary focus of this study was to provide an understanding the experience of pre-abortion counselors—a topic which was has been
relatively limited empirical research. This research has begun to address the gap in the counseling and related literature and realizes this study has merely touched the surface in terms of the scope of the experience of pre-abortion counselors. Future researchers could further expand the knowledge base regarding of pre-abortion counseling by focusing on counseling theories used during the pre-abortion counseling process. An analysis of the data suggest that there were elements of person-centered as well as feminist counseling theories used by the counselors, but it was unclear whether the counselors were purposely using these theories and the type of training they received relative to these theories. The training process for counseling in general could also be a source of future research since no themes of that nature emerged.

Moreover, some of the participants spoke about their religious and spiritual beliefs regarding abortion. However, more specific interview with religion and spiritual beliefs as the primary objective could be done to better understand the values of the pre-abortion counselors. Although all of the participants in this study were pro-choice, they had very different ways of thinking about abortion. For example, two of the participants stated that abortion was “killing” and that they “were okay with it” or “felt completely fine about it.” However, two other participants stated that they did not believe abortion was killing. It is likely that the counselors working in abortion clinics will have more resolved views about abortion than most mainstream counselors.

It is suggested that future research could explore what types of issues the pre-abortion counselors typically deal with during counseling. All of the participants described some of the issues a woman may be dealing with during pre-abortion
counseling. However, there was not much detail in some of the descriptions. Most of the research studies done about reasons to have an abortion as well as psychological issues surrounding abortions have been documented from women before or after having an abortion. However, the viewpoint of the counselor has not been well-documented in the literature.

**Mainstream counselors.** Counselors outside of an abortion clinic will no doubt come into contact with clients before or after their abortion. Based on the assertion by Millner and Hanks (2002) regarding a lack of studies examining value conflicts with counselors regarding abortion, it is recommended that future counselors as well as counselors currently in practice explore the role that value conflicts may play in the experiences of abortion counselors.

Additionally, research by Kegarise (2011) showed that counselors in training hold many unfounded generalizations and biases about abortion and women’s mental health. Because abortion is a part of many women’s lives, it is imperative that counselors are educated on this matter of women’s health. Women’s health issues, such as abortion, should be a part of counselor education as well as topics in continuing education for counselors. The stereotypes about abortion and distress of abortion perpetuate a stigma about abortion. As other researchers have found, stigma of abortion appears to be more psychologically harmful to women than the abortion itself (Rubin & Russo, 2004). If the stigma of abortion is lessened, the psychological distress will be lessened as well. According to feminist theory, counselors should act as advocates and not be another oppressive entity for the client (Cottone, 2008).
In addition, the counseling used within these abortion clinics could be used as a model for mainstream counselors. The counseling that was described during these interviews mimicked some mainstream counseling, such as using client-centered, feminist, and existential theories. However, in other ways the counseling described was much different than used in mainstream counseling as well as in counselor training programs. This counseling, although not typically long term, can be very intense. Also, the counselor holds, what seems like, less strict boundaries than would be used during mainstream counseling. For example, it is not uncommon for counselors to accompany a woman into the procedure room, if the woman wishes, during her abortion. In that aspect, the counselor is literally, not just figuratively as in client-centered counseling, side-by-side with the client. To these counselors, being by a client’s side while she goes through a pelvic exam as well as an abortion would not be inappropriate or crossing boundaries as it might be during mainstream counseling.

**My Reflections**

Having worked as a pre-abortion counselor for over four years, I have many thoughts and feelings about the work of pre-abortion counselors as well as the topic of abortion itself. Understanding my biases was imperative in order to collect and code this information to the best of my ability. After each interview session, I took time to reflect on the interview, how I felt, and what I thought about the session.

I was excited to do this research for several reasons. First, I feel passionately about women’s reproductive rights and I have been greatly distressed about the stereotypes and generalizations many in society have about abortion, abortion clinic
workers, and the women that have had abortions. I was excited to do research that I was so interested in.

The second reason I wanted to do this research was because I wanted others to understand the work of pre-abortion counselors. I love the work I do as a pre-abortion counselor. I began as a pre-abortion counselor during a time in my life when I questioned whether counseling was the right field for me. There is no doubt in my mind that if I had not became a counselor at Allegheny Reproductive Health Center during this time I would not be in the counseling field. This work is close to my heart. It is also work that can be difficult for others not in the field to understand. I understood the challenge that a few of the participants stated which was that most people believe that their job is a very sad one. In my opinion, the job of a pre-abortion counselor is only sad sometimes, but more often it is satisfying and happy.

The third reason I wanted to conduct a study with pre-abortion counselors as participants is to attempt to share this work with other types of counselors. Abortion is such a common occurrence, however, abortion is kept secretive by most people therefore it does not seem common. Abortion is often thought of as damaging psychologically, which is typically not true, however, the stigma of abortion can be psychologically damaging (Rubin & Russo, 2004). I wanted counselors outside of abortion clinics to understand pre-abortion counseling as well as the impact it may have on the clients.

Facilitating, transcribing, and coding these interviews was, at times, an emotional experience for me. As I said, I love being a pre-abortion counselor. The words some of the participants used to describe their experience were so touching to me. For example,
Christine stated that a client many years ago had shared with her that she was coming to her clinic because she knows they “respect the babies there.” The participant went on to describe her feelings about what this client said. She talked about honoring women, their bodies, and the life within them during her work at the clinic. This description brought about an emotional reaction when I was transcribing and reading it. I thought to myself, that is what I do during my work, but I did not have the words to describe it. I shared many, but not all of their feelings about their work and their experience.

I empathize greatly with the sentiments of the participants when discussing their difficulty, at times, dealing with such highly emotional information on a daily basis. I share being overwhelmed and appreciative of the ability to hear the clients’ personal stories. I felt inspired while listening to the emotional reaction of the participants when talking about their feelings toward their job. I too share feelings of gratitude each time I listen to a woman’s story as I know that I may be the only one hearing it.

**Summary**

This study has provided a glimpse into the experience of pre-abortion counselors. The results show several themes that emerged during this research. The themes include a love for their job, often keeping the job a secret from one or more of the people in their lives, the experience of dealing with protesters, what they see as the role of the counselor, and having a nonjudgmental attitude. Additionally, some participants saw themselves as an advocate for clients.

The results of this study may influence some generalizations people have about the experience of working in an abortion clinic as a pre-abortion counselor. Also, this
study could influence some ideas other counselors have about abortion and abortion counseling. Hopefully, counselors will take some of the experiences of these counselors, such as having a nonjudgmental attitude, as a guide to use while counseling women who disclose either having an abortion or the intent to have an abortion.
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Appendix A: Participant Consent Form

Title of Research: Understanding the Work of Pre-abortion Counselors
Researchers: Jennifer Conte

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You will receive a copy of this document to take with you.

Explanation of Study
This study is being done to understand the work of pre-abortion counselors. Although there is quite a bit of research on post-abortion outcomes, such as distress, there is almost no research outside of the abortion provider community on pre-abortion counseling. My hope with this research is to understand more clearly the work of pre-abortion counselors in a clinic setting.

If you agree to participate in this study, you will be asked to share your experience as a pre-abortion counselor during an audio-recorded interview. This interview will last approximately one hour. However, I ask for your consent to be contacted either by email or phone after your interview if a further explanation of any content is needed.

Risks and Discomforts
No risks or discomforts are anticipated.

Benefits
You may not benefit, personally, by participating in this study. However, this study is important because it will allow for the understanding of pre-abortion counseling from a counselor perspective, which has only been minimally studied.

Confidentiality and Records
Your information will be kept confidential by keeping your audio-recording and any paperwork with identifying information either in my possession or locked in a file cabinet in my home. Although your words during the interview will be transcribed in my dissertation, your name and specific place of employment will be omitted along with any identifying information that may allow for your identity to be known.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:
• Representatives of Ohio University, including the Institutional Review Board, a committee that oversees the research at OU

**Contact Information**
If you have any questions regarding this study, please contact:
Jennifer Conte
jcconte@ccac.edu
724-244-1887

Yegan Pillay (Advisor)
pillay@ohio.edu

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.

By signing below, you are agreeing that:
• you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered
• you have been informed of potential risks and they have been explained to your satisfaction
• you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study
• you are 18 years of age or older
• your participation in this research is completely voluntary
• you may leave this study at any time. If you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

Signature_____________________________________________ Date_________________

Printed Name__________________________________________
Appendix B: Interview Guide

- Research Question: What does it mean to be a pre-abortion counselor?
  - How did you become a pre-abortion counselor?
    - Were political beliefs a factor?
  - What challenges have you faced while working as a pre-abortion counselor?
    - Protesters?
    - Unsupportive family or friends?
    - Legislation in Pennsylvania?
  - What is the most rewarding part of being a pre-abortion counselor?
  - How has the experience of being a pre-abortion counselor transformed you?
  - What do you believe your role is?
    - Giving medical information?
    - Helping with decision-making?
The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below. This review was conducted through an expedited review procedure as defined in the federal regulations as Category(ies):

Project Title: Understanding the Work of Pre-Abortion Counselors

Primary Investigator: Jennifer Marie Conte
Co-Investigator(s):

Faculty Advisor: Yegan Pillay
Department: Counselor Education and Supervision

Rebecca Cale, AAB, CIP
Office of Research Compliance

10/18/11 Approval Date

Expiration Date

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.