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Abortion Counselling in Britain: Understanding the Controversy

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Abortion and pregnancy counselling in Britain: explaining the controversy'



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Abstract

This article reviews literature from a number of disciplines in order to provide an explanation of the political controversy attached to the provision of abortion counselling. It will show how this is an area of health policy debate in which women's reproductive bodies have become a setting for political struggle. The issue of abortion counselling in Britain has undergone a number of discursive shifts in response to political manoeuvring and changing socio-legal framing of abortion. In particular, the article shows how much of the controversial reframing of abortion counselling was a tactical shift by political actors opposed to abortion per se, and this work is critiqued for not contextualising abortion. The article then focuses on women's abortion experiences and discusses research that shows how women's decision-making processes, and responses to an abortion, are related to gendered socio-cultural contexts; and that the extent to which women having an abortion feel they have transgressed societal norms and values, for example, is likely to affect their abortion experiences. Finally, it is suggested that providing a non-judgemental context, and challenging negative discourses on abortion, may be the most effective way of minimising the possibility of negative emotions.

Key words

Abortion counselling, provision, decision-making, discourse, experiences and emotions.

Introduction

This article examines the issue of abortion counselling as a site of policy debate, in which women's reproductive bodies have become a setting of political struggle. In seeking to understand why a seemingly straightforward subject - whether women undergoing an abortion should have access to counselling services - has become so contentious, it is necessary to consider a wide range of other issues. An over-arching requirement is to consider how the debate is socio-culturally located. This means understanding that policy debates on abortion counselling are conceptualised differently within different socio-legal frameworks; within gendered social norms; and within contentious political discourses. Even the phrase itself - abortion counselling - has been subject to a number of discursive shifts, and invested with multiple meanings which are complex and malleable. Above all, as this paper will show, different strands of academic debate around abortion counselling customarily proceed from particular political positioning, and with an eye to the political implications of research interpretations. There is an undeniable relationship between political beliefs on abortion, and intellectual framing on the issue of abortion counselling. These broader sociological issues frame this paper, which focuses on Britain¹ as a case study explicating the relationship between socio-cultural contexts, and different politics, policies and practices.

¹This focus on Britain (England, Wales and Scotland), rather than the United Kingdom (England, Wales, Scotland and Northern Ireland), is because the 1967 Abortion Act specifically excludes Northern Ireland from its jurisdiction.

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3 Britain, in recent years, has experienced repeated flurries of political debate and activity around the
4 issue of pre-abortion counselling. Between October 2006 and June 2007 two Ten Minute Rule Bills
5 that proposed mandatory counselling were rejected by the British Parliament, and in 2012 the MPs
6 Frank Field and Nadine Dorries proposed amendments to the National Health Service (NHS) and
7 Social Care Bill 2011 which would have removed counselling services from abortion providers and
8 obliged women to receive counselling from 'independent' bodies before an abortion².
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11 Abortion counselling as an issue is worthy of exploration because, as the paper also sets out,
12 developments in this area affect abortion provision, and thus have an effect upon women
13 undergoing an abortion. Although a straightforward policy question would address what provision
14 should look like in this area, such questions have always been bound up in wider political debates
15 about the morality of abortion and views on its legal status. In academia, important contributions to
16 the debate, from sociology, have come from Ellie Lee, who has consistently shown how sociological
17 constructions – of women, of abortion, of abortion providers – have informed the legal regulation of
18 abortion in Britain (Lee, 1998, 2003a, 2003b, 2012). Kristin Luker (Luker, 1984, Luker, 1996) and
19 Rosalind Petchesky (Petchesky, 1986) have pioneered sociological work in this area internationally.
20 Although fundamentally an issue of concern to political sociologists, many more disciplines are
21 involved in contributing towards literature of relevance to the issue of abortion counselling,
22 including important contributions from psychology (Boyle, 1997, MacLeod, 2011); law (Jackson,
23 2001, Sheldon, 1997); and policy research (Allen, 1985, Hoggart, 2003a, Hoggart, 2012, Rowlands,
24 2008). This paper reviews three areas of literature, all of which straddle these disciplines. Firstly it
25 considers how policy and health focused literature contributes towards understandings about what
26 is meant by counselling in the context of abortion. Secondly, it looks at literature that has sought to
27 explain, and engage with, why counselling came to feature as part of what Rickie Solinger (Solinger,
28 1998) has termed 'Abortion Wars'. Finally, it will look at a body of literature that sheds light on the
29 provision of abortion counselling, from the perspectives of women who have abortions.
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38 What is meant by counselling? 39 40

41 The legal framework for abortion in Britain is the 1967 Abortion Act. This Act, as amended by the
42 Human Fertilisation and Embryology Act 1990, permits abortion up to 24 weeks in specific
43 circumstances (when two doctors agree that continuing with the pregnancy would be more harmful
44 to the physical or mental health of the pregnant woman or any existing children of her family than if
45 the pregnancy was aborted). After 24 weeks an abortion is permitted if it is necessary to save the
46 woman's life; or it will prevent grave, permanent injury to the physical or mental health of the
47 pregnant woman; or there is a substantial risk that if the child were born it would suffer from serious
48 physical or mental anomalies.³ In law, at no gestational point do women have the right to an
49 abortion on request. However, as Lee (2003b) has noted, a 'socio-legal gap' gradually emerged
50 between law and practice such that the wishes of women came to be prioritised. This is evident by
51 reviewing the British government's health information website, NHS Choices, which simply lists one
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56 ² <http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110907/debtext/110907-0001.htm#11090754000002>

57 ³ <http://www.legislation.gov.uk/ukpga/1967/87/section/1>

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3 of the reasons that a woman might decide to have an abortion as 'personal circumstances'.⁴ This
4 unresolved tension between law and practice, though, means that abortion practice as it has
5 developed does not have a firm legal foundation, and may be vulnerable to changing political
6 circumstances. It also legitimises the attempts by those interest groups who are opposed to abortion
7 to claim that the law is flouted (Lee, 2003b).
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10 In Britain, abortion counselling is an area of abortion practice that has been developed as part of
11 abortion services. It is not required by law, and is not legally regulated. There is, accordingly,
12 significant room for disparate and shifting definitions of abortion counselling. Nevertheless, a body
13 of research has studied these issues, and clarified both what women should expect with respect to
14 abortion counselling, and how to define and develop these services.
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17 Following the 1967 Abortion Act, a Committee on the Working of the Abortion Act (the Lane
18 Committee) was set up by the government in order to examine the workings of the Act. The
19 conclusions of the Lane Committee (Lane, 1974), as well as a paper authored by one Lane
20 commissioner (Cheetham, 1977), revealed considerable confusion around what was meant by
21 abortion counselling. The report noted uncertainties about the objectives and purposes of
22 counselling, and then offered a broad definition: counselling was described as the provision of an
23 opportunity for women to discuss their situation; and to obtain information, explanations and
24 advice. The literature has noted that the Lane Committee was particularly concerned to ensure that
25 every effort should be made to provide women equality of access to abortion within the NHS, at a
26 time when some women were being turned away arbitrarily (Wivel, 1998). As abortion services were
27 being developed in the 1970s, abortion counselling was thus primarily envisaged in the context of
28 ensuring that all women who are considering an abortion are provided with enough information
29 with which to make an informed decision, that this should be free from pressure from other people,
30 and that equality of access should be ensured (Lee, 2003b).
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35 In the 1980s, the Department of Health and Social Security commissioned a national evaluation of
36 *Counselling services for sterilisation, vasectomy, and termination of pregnancy*. To date, the only
37 study solely on these issues, it was a large multi-stranded project with a clear focus on the
38 experiences of service users on the counselling they had received, and the extent to which they felt
39 they required counselling (Allen, 1985). This focus marked a shift towards a multifaceted
40 understanding of counselling that moved beyond the Lane-based consensus of ensuring informed
41 consent and equality of access. The research found considerable variance about what was meant by
42 counselling as a specific activity, and pointed to an important distinction between the role of
43 abortion providers in ensuring that women were making an 'informed decision' to proceed, or
44 otherwise, with an abortion; and therapeutic counselling which may be necessary for women who
45 are ambivalent about their decision. The first discussion is always necessary, whilst therapeutic
46 counselling may, or may not, be needed or appreciated. Indeed, Allen also reported: '*Many women*
47 *thought that abortion should be easier and quicker to get, and that counselling should be available*
48 *for those who wanted it but not overdone*' (Allen, 1985: 342). Allen is here drawing attention to one
49 of the most notable findings in the study: that many women felt they were being over-counselled
50 about a decision they had already made. A large number of women talked about making their own
51 decision after considering their own circumstances and not needing to talk to anyone in the process.
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58 ⁴ <http://www.nhs.uk/Conditions/Abortion/Pages/Introduction.aspx>
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3 There have been no further large scale studies of abortion counselling provision in the UK, though
4 other studies and policy developments have led to further refinement of what is understood by
5 counselling. Myra Hunter presented a model of counselling for obstetrics and gynaecology (including
6 abortion) in which she distinguished between providing information and emotional support to all
7 women; and providing specific support to women who are distressed for any reason (Hunter, 1994).
8 Similarly, Jane Read (1995) considered different types of counselling in abortion: information
9 counselling, implications counselling, support counselling and therapeutic counselling; and also
10 suggested similar needs for women undergoing abortion to those seeking assisted conception.
11 Neither of these important books, written primarily for practitioners by practicing therapists, single
12 out women who have an abortion as being in particular need of counselling. What they are clear
13 about is that if some women need therapeutic counselling, this is a distinctive need that should not
14 be confused with information and general support that all women should expect from all these
15 services, and this reflected a more nuanced understanding than the Lane consensus.
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20 With respect to abortion research more generally, this has simultaneously helped shape, and
21 responded, to shifts in understandings, and practices, of abortion counselling. In a review of relevant
22 literature from 1967 onwards, Rowlands (2008) sought to identify research studies (internationally)
23 with some findings of relevance to the issue of abortion counselling. In his systematic review he
24 noted that the term 'counselling' is used widely and indiscriminately, and is frequently used to
25 describe the activity of simply providing information. He drew attention to the need to distinguish
26 between different types of counselling ranging from general support and information (as proposed
27 by Lane) through to therapeutic counselling. He also noted, however, that much of the research
28 focuses on what has been described as 'decision counselling', which has often been proposed as
29 counselling in a more therapeutic sense. Many of the papers in the review introduced the notion of
30 ambivalence to studies on abortion decision-making, a concept that will be further explored later in
31 this paper. Noting that while 'hard evidence' for the beneficial effects of such decision counselling is
32 rare, and that there was no evidence that this should be a mandatory service for all women,
33 Rowlands also observed that a general agreement emerged from the 1970s onwards that this
34 service, seeking to assist those with difficulties making decision about the outcome of a pregnancy,
35 should be provided. This is indeed the direction in which abortion policy and provision has moved, in
36 Britain, a direction which illustrates a sometimes fraught, but nonetheless significant, relationship
37 between research and policy developments.
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43 The policy approach is evident in guidelines that have been generated specifically for abortion
44 service provision. The RCOG (Royal College of Obstetricians & Gynaecologists) collates evidence and
45 sets standards for care in abortion (including counselling requirements). The RCOG's Guidelines, first
46 published in 2000, (RCOG, 2011) distinguish between three domains: the first is information needs
47 as discussed earlier (the need for clinicians to have accurate knowledge about medical complications
48 associated with abortion, to ensure that discussion with woman can allow for valid consent to be
49 given by them); the second is to state that all women should be offered the opportunity to discuss
50 their decision with a non-directive counsellor, and/or clinician; thirdly, it recommended that
51 additional counselling be made available for women who request it.
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55 The Department of Health regulates counselling provision in all abortion units through Required
56 Standard Operating Principles (RSOPs) for termination of pregnancy services (DoH., 2013). These
57 draw on the RCOG Guidelines and state (p.20) that, 'All women requesting an abortion should be
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3 offered the opportunity to discuss their options and choices with a trained counsellor and this offer
4 should be repeated at every stage of the care pathway. Post abortion counselling should also be
5 available for those women who require it'. Independent sector agencies, primarily the British
6 Pregnancy Advisory Service (bpas) and Marie Stopes International (MSI), have increasingly provided
7 the majority of NHS funded procedures (Lee, 2005, Lee and Ingham, 2010). At both these agencies,
8 two types of counselling are available: all women are offered 'decision counselling' (either by
9 telephone or in-person) as part of their advice and information session; and therapeutic counselling
10 is made available for any woman who may request it. This sector has developed a particular category
11 of staff, the 'admin counsellor' who (together with medical personnel) has responsibility for
12 information provision and 'decision counselling'. Women who need it have access to staff trained
13 and specialised in therapeutic counselling (Lee 2003b).

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17 This overview has shown that (apart from those opposed to abortion) a policy consensus has
18 emerged, and that this consensus does inform abortion providers: therapeutic counselling for
19 women considering an abortion should be available for those women who may need it, but this
20 should not to be confused with discussions that facilitate informed consent, or with discussions
21 designed to establish women's comfort with their decision (sometimes called options-, or decision-,
22 counselling). Although these latter discussions may be facilitated by a trained counsellor, this is not
23 essential, and they do not constitute therapeutic counselling. Decision-counselling is potentially
24 confusing, as for the most part it will not involve therapeutic counselling; but, if women are
25 experiencing difficulties with abortion decision-making, for any of a number of what could be
26 complex reasons, then therapeutic counselling should be available. As will be shown later, the
27 research on women's abortion decision making suggests that such counselling would almost
28 certainly not be needed by the majority of women.

32 33 34 35 **Why did abortion counselling emerge as a controversial issue?**

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38 Given that the purpose and scope of abortion counselling has been both expanded and clarified
39 since the Lane Committee, and detailed guidance exists, why does it regularly emerge in Britain as a
40 controversial issue? An exploration of the literature on the politics of abortion, and on debates
41 around 'Post-Abortion Syndrome' (PAS) can shed light on this conundrum. Although these are
42 international issues, and this literature is not confined to Britain, this paper will continue to apply
43 the research to the British case study.

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47 Following the 1967 Abortion Act, anti-abortion organisations began campaigning against abortion
48 provision in Britain, at first concentrating on campaigns supporting legislation drafted to restrict
49 existing provision. A series of Private Members Bills, all of which would have seriously curtailed
50 women's right to an abortion in one way or another, were introduced in the 1970s and 1980s. All
51 prompted vociferous and confrontational political campaigns for and against the legislation; all were
52 defeated (Hoggart, 2000). During this period, organisations opposed to abortion, such as SPUC
53 (Society for the Protection for the Unborn Child) and then LIFE, very much focused on the right to life
54 of what they conceptualised as the 'innocent baby'; and abortion politics was dominated by a
55 discourse of competing rights, with campaigners in favour of retaining abortion rights campaigning
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3 in favour of 'a woman's right to choose' (Hoggart, 2003b, Himmelweit, 1988, Hoggart, 2003a). The
4 oppositional viewpoints in this conflict are generally referred to in academic literature on abortion as
5 pro-choice, and anti-choice (Cannold, 2002).
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8 A number of academics have analysed how anti-choice activists were obliged to rethink their
9 strategy when it became clear that the ('innocent baby') foetal discourse was not effective (Cannold,
10 2002, Lee, 2003a, Lee, 2003b, Lee, 2001). Throughout the 1970s and into the 1980s, opinion polls
11 had indicated that a majority of the population supported liberal abortion law, and it became
12 increasingly clear that large numbers of people were not going to be persuaded by appeals based on
13 positioning women seeking an abortion as immoral murderers. So from the mid-1980s a new anti-
14 choice strategy, characterised by Leslie Cannold as a 'women-centred strategy', was developed: 'a
15 key task of the anti-choice women-centred strategy is to replace the fetus with the guilt-ridden, self-
16 hating, grief-stricken, victimised and finger-pointing "woman hurt by abortion" as the summarising
17 image of what is wrong with abortion' (Cannold, 2002, p173). This strategy not only constructed
18 abortion as an innately traumatic event that may cause psychological damage (PAS), but portrayed
19 women seeking an abortion as inherently vulnerable and susceptible to duress. This was a conscious
20 and significant tactical and discursive shift amongst activists campaigning to restrict abortion. Recent
21 debates on abortion counselling need to be understood in the light of these political developments.
22 The research evidence on these issues will now be examined in a little more detail.
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28 The argument for PAS, and its diagnostic criteria, has been traced by Ellie Lee (2001) to the work of
29 an American, Vincent Rue, who proposed it as a form of post-traumatic stress disorder (PTSD) (Rue,
30 1995). More recently the mantle has been taken up by Priscilla Coleman. Coleman's claims that
31 quantitative research has shown an increased risk of mental health problems after abortion were
32 published in *The British Journal of Psychiatry* (Coleman, 2011), but have since been widely
33 discredited.⁵ These discussions are relevant to the pre-abortion counselling debate because, as
34 noted earlier, some anti-choice activists made a discursive shift to focus on the possibility of post-
35 abortion psychological distress and this incorporated the argument that women will suffer if they
36 have been insufficiently 'counselled' about the negative impact of abortion. Indeed, Coleman's
37 paper was explicitly referred to by Nadine Dorries in the House of Commons when she was seeking
38 to introduce additional abortion counselling requirements.⁶ This conceptualisation of counselling is
39 quite different from the decision-counselling proposed in the health service research discussed
40 earlier, in which there is a strong emphasis on the need for the counselling to be non-judgemental.
41 An extra stimulus for anti-choice activists in Britain to adopt this strategy is that suggesting that
42 abortion causes psychological damage also challenges one of the main criteria for abortion:
43 continuing with the pregnancy would involve a greater risk to the woman's physical or mental health
44 than ending the pregnancy.
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50 There is now a large amount of international literature discussing the possible negative psychological
51 consequences of abortion in which pro-choice academics have devoted a significant amount of
52 energy to critically analysing the claims that abortion causes mental health problems (Steinberg and
53 Finer, 2011). There are two main issues to note about this discussion. First, there is a lack of *robust*
54 research evidence supporting the concept of PAS. As noted by a panel commissioned by the
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56 ⁵ <http://www.legislation.gov.uk/ukpga/1967/87/section/1>

57 ⁶ <http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110907/debtext/110907-0001.htm#11090754001604>

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3 American Psychological Association to investigate the psychological consequences of abortion, the
4 majority of studies suffer from methodological problems (Major et al., 2009). This is because it is
5 virtually impossible to compare a cohort of women who have an abortion, to a valid comparison
6 group (Steinberg and Russo, 2008a)⁷. Second, the research that purportedly demonstrates PAS has
7 been widely discredited for not taking into consideration the social, cultural and health care contexts
8 within which an abortion takes place, as well as events confounded with abortion (sexual abuse, for
9 example) that may themselves be associated with negative mental health outcomes (Lee, 2003a,
10 Steinberg and Russo, 2008b, Dagg, 1991). In 2008 a review of the literature (Charles et al, 2008)
11 concluded that the claim that abortion leads to mental health problems had been discredited by
12 high quality research. More recently, the research on abortion and mental health has also been
13 systematically reviewed for the Academy of Medical Royal Colleges, which concluded that there was
14 no difference in mental health problems between women with unwanted pregnancies who gave
15 birth and those who had an abortion (AMRC, 2011).
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20 Although this may appear to be a purely academic debate, critiques of PAS have demonstrated how
21 anti-abortion bias has affected the way in which data are interpreted. Dervious and Russo (2000)
22 show how in research that claims to identify PAS, any negative mental health outcomes that may be
23 identified in women following an abortion are: firstly, mis-labelled as psychological sequelae when
24 they are correlates; secondly, attributed to the abortion, rather than an unwanted pregnancy; and,
25 thirdly, taken out of context. In addition, the anti-choice call for abortion counselling, drawing on the
26 concepts 'post abortion syndrome' and 'abortion trauma', not only elides pre- and post-abortion
27 counselling, but also blurs the distinction between information provision and obtaining informed
28 consent, and counselling.
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32 This particular focus of much pro-choice research and scholarship has thus been reactive, making it
33 difficult for researchers to focus on what women actually want. Further, there is a notable absence
34 of a clear consensus on the most appropriate framework to deploy when researching women's
35 abortion experiences. As Mary Boyle (2000) has pointed out, the heated debates that take place
36 about abortion, often from polarised positions, make it politically difficult for researchers to explore
37 the complexity of women's abortion emotions, behaviour and needs. Indeed, she cautions against
38 research that is focused upon whether women do, or do not, experience negative outcomes
39 following an abortion; or whether or not women seeking an abortion could be described as
40 vulnerable, on the grounds that this keeps research within an agenda which focuses on abortion's
41 intrinsic potential to harm women (Boyle, 2002). In Britain, this is an especially pertinent point: as
42 Lee (2003b) has pointed out, the justification of legal abortion enshrined in the 1967 Act is very
43 much based on the construction of women as psychologically vulnerable victims. So there are a
44 number of factors that discourage pro-choice researchers from dwelling on abortion and emotions.
45 Others, however, have pointed out that the polarisation can cause pro-choice researchers to deny
46 any possibility of negative or ambivalent emotions following an abortion, suggesting that such a
47 denial of some women's feelings may not be welcomed by women themselves Cannold (2002).
48 More recently, there has been greater willingness to tackle such issues, often within the context of
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54 ⁷ The closest semi-experimental research possible on this topic is currently being undertaken by a team of
55 researchers at the University of California, San Francisco. The Turnaway Study is comparing outcomes of
56 women who have been denied an abortion because they are beyond the legal time limit, to women who have
57 obtained an abortion 'just in time', before reaching the limit. <http://www.ansirh.org/research/turnaway.php>
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3 theorising abortion-related stigma, and with an underlying assumption that an exploration of the full
4 range of post-abortion emotions does not, of necessity, lead to an anti-choice interpretation of the
5 research (Quinn and Chaudoir 2009, Hoggart 2012, Cockrill and Nack 2013).
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8 Although such considerations have made research challenging, there has been interest amongst pro-
9 choice researchers and abortion providers in examining women's abortion experiences. From this
10 research it is possible to analyse the issue of abortion counselling from the perspectives of women
11 who have abortions.
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13 **Women's abortion experiences: who needs counselling?** 14

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16 Although few research studies have focused specifically on counselling, there is a body of research
17 that has considered women's abortion decision-making, abortion experiences and their expressed
18 needs. The socio-legal context outlined above, in which understandings of abortion counselling have
19 become more nuanced over the years and yet are still not legally defined or regulated, forms the
20 backdrop to the research in Britain.
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24 A particularly important theme in research on women's abortion experiences is the value women
25 place on providers being clearly non-judgemental. In particular, information provision and staff
26 attitudes (kindliness and acting in a manner that reduces women's feelings of anxiety and isolation)
27 feature in women's reports (Harden and Ogden, 1999; Lee et al., 2004). Rowlands (2008) also points
28 out that the research indicates that women value being given clear information about abortion
29 procedures at the pre-abortion consultation, and a recent study has shown that women value an
30 uncomplicated referral process (Brown, 2013).
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34 Research on abortion decision-making has shown that women take a range of issues into
35 consideration and generally make their decision based on their own individual circumstances at a
36 particular moment in time (Rowlands, 2008; Purcell et al., 2014). It has been noted also that the
37 most usual experience is where women discuss their situation with friends, parents and family
38 members, and have already made their decision, before they approach a medical professional, or
39 abortion provider (Kumar et al., 2004; Brown 2013). It has been argued that the research evidence
40 indicates that while women may be distressed when faced with an unwanted pregnancy, more are
41 comfortable with their decision that is often assumed in public debate (Hadley, 1996, Boyle, 2000),
42 thus echoing findings of Allen's (1985) counselling study.
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46 Another area where there is some agreement is in the recognition that it is women who may be
47 ambivalent about their decision who are most likely to express a need for therapeutic counselling.
48 Research has shown that ambivalent women are at higher risk of poor psychological outcomes than
49 non-ambivalent women (Ashton, 1980, Cameron, 2010, Hare and Heywood, 1981). And Rowlands'
50 (2008) international review points out that most studies have shown that ambivalence has been
51 shown to be a predictor of poor outcomes, but he is careful to point out that 'feelings of
52 ambivalence are an indication that abortion has a price, which implies that it is a more or less painful
53 solution to an unwanted pregnancy' (Rowlands, 2008: 176). As we have seen, this does not mean
54 that the abortion itself has caused poor psychological outcomes: abortion needs to be compared
55 with continuation of pregnancy for this case to be made. (Kirkman et al., 2009) also conducted a
56 review of the literature on reasons women give for an abortion and concluded that ambivalence was
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3 evident, and abortion was chosen because continuing with the pregnancy was assessed by the
4 women as having adverse effects on their own lives and the lives of significant others. Purcell et al
5 (2014) have characterised the ambivalence they found in their study as women struggling with a
6 dual candidacy: they are candidates for abortion and they are also candidates for motherhood, and
7 sometimes this is a difficult decision; in this study, despite ambivalence, the women were
8 comfortable that they had made the right decision for themselves. The literature on ambivalence
9 indicates that women who are unsure of their decision may need extra time and help, and maybe
10 sometimes counselling. The previous section has shown that official guidance and abortion
11 providers have taken this into consideration.
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15 There is another body of work, however, with a pro-choice perspective, which suggests that the
16 extent of women's need for therapeutic counselling may have been underestimated (Dana, 1987,
17 Ashurst and Hall, 1989, Walker, 1990). This work can be traced back to feminist approaches to
18 counselling offered by the Women's Therapy Centre during the 1980s and 1990s. The Centre viewed
19 therapeutic counselling to be a necessary intervention that enabled feelings surround abortion to be
20 addressed (Dana 1987). It was also argued that abortion can be experienced as part of a process of
21 psychological maturation, and counselling can help in this respect. Some more recent contributions
22 from the counselling profession have echoed the position developed by feminists regarding the role
23 that therapeutic counselling could play in pushing abortion towards being a positive, rather than a
24 negative, experience (Hodson, 2002, Brien and Fairbairn, 1996).⁸ As there have been no recent
25 studies on the provision and content of abortion counselling, it is not possible to judge whether this
26 particular focus has influenced the content, and affect, of therapeutic counselling. There is,
27 however, research evidence to support the claim that abortion can be a positive experience,
28 showing how making such an important decision, and exercising autonomy, can - in and of itself -
29 empower women (Harden and Ogden, 1999). This research suggests that positive experiences
30 associated with abortion, such as non-judgemental treatment, or feeling empowered, can contribute
31 towards positive feelings. Conversely, an association can be seen between negative abortion
32 experiences, whatever may cause the negativity, and negative emotions (Boyle and McEvoy, 1998).
33 Negative emotions clearly can make the need for therapeutic counselling more likely. The socio-
34 cultural context within which abortion takes place is therefore of central importance to the debate
35 on abortion counselling. With this in mind, it is worth pointing out that although abortion services
36 have improved considerably in Britain since the 1970s, the political discourse has lagged behind.
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43 National statistics show that over the years there has been an increase in NHS funded abortions
44 provided by the independent sector; and that an increasing proportion of these abortions are carried
45 out earlier in pregnancy⁹. Such improvements have been facilitated by sexual health policy
46 developments going back to the formulation of a *National Strategy for Sexual Health and HIV* (DoH,
47 2001), a strategy that sought to improve access to abortion services, and has recently been updated
48 (DoH 2013a). However, as has been pointed out, these developments can be characterised as
49 'abortion pragmatism' (Lee, 2013): that is they are based on an understanding that abortion needs
50 to be tolerated in order to prevent 'undesirable' childbearing - particularly amongst teenagers.
51 Within this agenda it is still possible to frame abortion as morally undesirable: by proposing that
52 contraceptive services might be improved on the basis of reducing the abortion rate, for example
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57 ⁸See also recent papers available on the pro-choice forum website: [Everett; Paterson and Ross.](#)

58 ⁹ www.parliament.uk/briefing-papers/sn04418.pdf
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3 (Hoggart, 2012). Such framing does not challenge what has been termed the 'awfulisation' of
4 abortion (Hadley, 1996), and 'abortion negativity' (Lee et al., 2004), and can have an impact on
5 services. It has recently been claimed by a leading abortion provider that the political environment
6 in Britain makes it difficult to press for significant improvements in abortion care (Furedi 2014). In
7 addition, some research has suggested that 'abortion negativity' can contribute towards abortion-
8 seeking women experiencing ambivalence pre- and post- abortion (Rowlands 2008). Such negativity
9 is also an important part of a cultural context which can engender post-abortion regret for some
10 women (Hoggart 2012). Some studies have shown how abortion providers may play a role in
11 differentially constructing the legitimacy of abortions for different 'types' of women (Benyon-Jones,
12 2013), whilst others have argued that providers themselves are subject to stigma and that the public
13 discourse on abortion prevents them from challenging this stigma (Harris et al., 2013).
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18 Comparative analysis has also shown how women's cultural affiliations and beliefs have an impact
19 on their emotional experiences and post-termination feelings (Bennett, 2001, Kero et al., 2004,
20 Lafaurie et al., 2005). When abortions take place within a context of moral disapproval this is likely
21 to impact negatively upon women's decision-making and experiences (Boyle and McEvoy, 1998,
22 Kumar et al., 2009). Relatively recently, researchers have begun to theorise one aspect of this
23 negativity through an exploration of how abortion stigma is generated in different contexts, what
24 forms it takes, and what the consequences are for women seeking an abortion. Stigma has been
25 defined as 'a negative attribute ascribed to women who seek to terminate a pregnancy that marks
26 them, internally or externally, as inferior to ideals of womanhood' (Kumar et al 2009: 628). As such,
27 the theorisation of abortion stigma draws on work that has pointed to gender-specific meanings of
28 abortion in relation to motherhood (Luker 1984), and other constructs of the 'feminine'. As Cockrill
29 and Nack (2013: 975) put it: 'Abortion can signal multiple transgressions, including participating in
30 sex without a desire for procreation, an unwillingness to become a mother, and/or a lack of
31 maternal-fetal bonding'. These meanings vary according to different contexts.
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36 The stigma associated with women challenging particular gendered norms of sexuality and
37 motherhood through undergoing an abortion has been linked to the decision-making process as well
38 as subsequent reproductive behaviour (Tsui, 2011). Similarly a recent UK study has shown non-
39 disclosure of abortion is related to women's perceptions of abortion as potentially stigmatising
40 (Astbury-Ward et al., 2012). Norris et al. (2011) have stressed the importance of legal restrictions as
41 an additional cause of abortion stigma, and this, of course, would vary according to different
42 jurisdictions. In the UK this is particularly relevant to Northern Ireland where legal restrictions result
43 in thousands of women travelling, mainly to England and Wales, to obtain abortions or purchasing
44 the 'abortion pill' illegally.¹⁰ The moral conservatism, gendered social norms and religious
45 legitimisation associated with these restrictions has undoubtedly contributed towards especially
46 negative experiences for women undergoing an abortion (Boyle, 1997, Bloomer and Fegan, 2014,
47 Bloomer and O'Dowd, 2014).
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52 Internationally, studies have found that abortion-related stigma can generate fear and guilt, and
53 contribute to feelings of shame, in moralistic societies. Although the stigma of abortion was
54 perceived similarly in both legally liberal and restrictive settings, it was more evident in settings
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58 ¹⁰ <http://www.theguardian.com/world/2013/mar/10/northern-irish-women-risk-jail-over-abortion-drug-use>
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3 where abortion is highly restricted and this affected disclosure (Major and Gramzow, 1999, Quinn
4 and Chaudior, 2009, Schellenberg et al., 2011, Cockrill and Nack, 2013).

6 Discussion

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10 This overview of the literature has shown how abortion counselling debates and controversies are
11 fundamentally political, thus reflecting political divisions over abortion itself; and subject to change.
12 This is evidently true on a number of different levels.

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14 In the first instance, the debate itself has its roots in the attempted construction of abortion as
15 inherently psychologically damaging; and is most strongly articulated in the creative development of
16 the notion of Post-Abortion Syndrome (PAS). This discourse positions women as vulnerable, at risk of
17 abortion-induced trauma, and therefore in need of therapeutic counselling. Legislative attempts to
18 enforce pre-abortion counselling in which women can reflect upon their decision are not value-free
19 but are linked to this anti-abortion agenda.

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22 However, as has also been shown, some pro-choice feminist practitioners and scholars have
23 suggested that counselling, both pre- and post-abortion, may be beneficial for women. This
24 confluence of extremely dichotomous positions around the perceived need for abortion counselling
25 calls for further exploration. Understanding that this is not a shared – but rather a contested –
26 position is the starting point: those who support abortion and call for counselling do so from a
27 perspective of helping abortion-seeking women (who may be experiencing emotional difficulties)
28 make a decision that it right for them. Within this framing of counselling, some feminists have
29 proposed therapeutic counselling in order that women can become empowered in their abortion
30 process. By way of contrast, those who oppose abortion and call for counselling are anticipating
31 that this may discourage women from having an abortion, or, at the very least, make it more difficult
32 for them to do so. These are very different policy positions.

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37 Nevertheless, the confluence is striking. The two groupings are unlikely bedfellows, and this only be
38 understood by analysing political contexts and positionings. A further indication of the contentious
39 political nature of these debates has been tensions within pro-choice research around the value of
40 therapeutic counselling, and also concerning abortion-related emotions. Much of the research in this
41 area is either concerned to dispute any connection between abortion and adverse psychological
42 outcomes; or reluctant to engage in the issue of emotions, particularly post-abortion emotions. This
43 reluctance is largely due to an unwillingness to unwittingly contribute towards the 'awfulisation' of
44 abortion. It is only comparatively recently, in a body of work emanating from the US on abortion-
45 related stigma, that women's emotions are being fore-fronted in abortion research.

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49 There is less disagreement amongst those who support abortion about decision-counselling; in all
50 probability because such counselling is a central aspect of facilitating women's reproductive choice.
51 Taken as a whole, the research indicates that women considering abortion have a wide range of
52 emotional responses to their situation. Many – possibly most – make their decision rapidly and are
53 comfortable with their decision (Rowlands, 2008). Some women may experience ambivalence and
54 decision counselling may be helpful to them.

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3 This review has also shown how women's decision-making processes, and responses to an abortion,
4 are related to gendered socio-cultural contexts. In particular, the work on abortion-related stigma
5 has shown how general shared features across different contexts – such as gendered norms of
6 sexuality and motherhood – form a backdrop to abortion decision-making and experiences. Moving
7 to another level, the research has shown how different contexts – taking into account, for example,
8 socio-legal jurisdictions, the extent of moral conservatism, and different manifestations of abortion
9 stigma - are likely to impact differentially on women considering an abortion.
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12 A final way in which politics intrudes is to hamper an evidence-based development of abortion
13 services, through creating a political environment in which abortion policy and provision is contested
14 terrain. Those opposed to abortion portray it as a moral wrong to be prevented, either by
15 introducing a more restrictive legislative framework; or making the process of obtaining an abortion
16 more difficult, through imposing pre-abortion counselling, for example. Politicians and policy-makers
17 who have embraced a pragmatic acceptance of abortion invariably find it difficult to avoid a
18 moralistic framing of abortion, such that whilst necessary it is nevertheless undesirable. It has been
19 argued that medical advances in the abortion field, and a significant body of research on women's
20 abortion experiences, could lead to continual improvements in provision; yet political tensions
21 create a policy climate which is not conducive for the further development of evidence-based
22 abortion services (Furedi, 2014).
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27 Conclusion

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30 This paper has shown how debate around abortion counselling customarily proceeds from particular
31 political positioning. In Britain, following legalisation of abortion in limited circumstances in 1967,
32 early 'abortion wars' were concentrated on legislative attempts to amend the 1967 Abortion Act in a
33 restrictive manner. In parallel, those who were concerned to implement the Act focused on equality
34 of access, and abortion counselling was viewed as a way of enabling women to access abortion.
35 Moving into the 1980s and beyond, understandings of abortion counselling, however, changed, and
36 became a primary battleground. In the British Parliament, attempts to change current provision are
37 consistently fronted by well-known anti-abortionists. Within the pro-choice, and also abortion
38 provider, community there is no overall consensus on the extent to which abortion counselling may
39 be called for though there is an acknowledgement of the importance of decision counselling to
40 facilitate informed choice. Only those writing from an anti-choice perspective have disagreed with
41 the general consensus that therapeutic counselling should be a voluntary activity openly available to
42 all women.
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47 There currently is a pragmatic acceptance of the need for abortion in Britain, and the attempts to
48 generate causal theories about abortion engendering psychological damage have been thoroughly
49 discredited. It is probably no accident that recently research has begun to focus more systematically
50 on women's experiences and needs, rather than simply responding to anti-choice discourses. In the
51 US, research on abortion-related stigma is leading to the development of creative interventions to
52 combat stigma (Cockrill et al., 2013, Martin et al., 2014, Hessini, 2014, Shellenberg et al., 2014).
53 Although Britain is very different to the US in terms of the pragmatic acceptance of abortion, the
54 research still indicates that a societal level acceptance of the viewpoint that abortion is morally
55 undesirable can adversely affect women. The research evidence leads logically to the suggestion that
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women’s abortion experiences might be improved by a determined effort to normalise, or de-stigmatise, abortion. Such developments would have the potential to make abortion decision-making less stressful, and also decrease the likelihood of post-abortion distress, thus lessening the need for decision counselling or therapeutic counselling.

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