## CONTENTS

# PSYCHOLOGISING ABORTION: PSYCHOLOGY AND THE CONSTRUCTION OF POST ABORTION TRAUMA

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## DECLARATION

This thesis has been prepared in accordance with the regulations specified by the University of Kent at Canterbury. It is all my own work.

Eleanor Lee
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## ABSTRACT

As I detail in Chapter 1 of this thesis, when 'lunchtime abortion' caused a furore in the British media, many objected to a service which aimed to make abortion as quick and simple as possible on the grounds of concern for women's psychological well-being. Critics of the service claimed in particular that it failed to offer women sufficient counselling, which, it was alleged, is needed to alleviate the negative feelings abortion entails. Taking this claim against 'easy abortion' as my starting point, in Chapters 1 to 5, I present a sociological approach to examination of the claim that abortion is psychologically damaging and that, as a result, women require counselling when they terminate pregnancy. As explain in Chapter 2, to do so, I draw on the work of feminist social scientists who have been influenced by the work of Michel Foucault.

In chapters 3, 4 and 5, I utilise a Foucauldian approach to interrogate the ways in which the psychological effects of abortion have been constructed in parliamentary and extra-parliamentary debates. I discuss the construction of abortion as a 'mental health' issue, I detail the argument made by opponents of abortion that abortion leads to Post-Abortion Syndrome, and I also examine the framing of the psychological effects of abortion in pro-choice discourse, which in part entails an argument for abortion counselling.

My overall resulting hypothesis is that the construction of abortion as a procedure which has significant, negative psychological effects, is likely to have influenced abortion service provision, and the experience of abortion for women who undergo it. In Chapters 6 to 9, I assess whether and how this is the case, through analysis of interviews with abortion counsellors and with women who have had an abortion. As I discuss in the final chapter, the results of this analysis suggest a more complex picture than my hypothesis allowed for. I therefore suggest how future research, particularly about women's experience of abortion, could be developed in a way that develops and improves upon that discussed in the following pages.

## Chapter 1: INTRODUCTION

Many arguments have been made against measures which have aimed to make it easier for women to have abortions. For example, during the past 10 years, arguments for liberalising abortion law have frequently been refuted on 'ethical grounds'. Some have argued that a law which would make it easy for women to have abortions would be unethical, because it would fail to offer developing human life the respect it deserves. As many feminist commentators have pointed out, in the terms of such arguments, women and fetuses are pitted against each other, in competition for respect and rights (Albury 1999; Bridgeman 1998; Himmelweit 1988; Katz-Rothman 1982; Kingdom 1991; Poovey 1992).

Another kind of argument has also been made, however, about abortion and its psychological effects. Measures which might make it easier for women to obtain abortions have been opposed on the grounds that abortion damages women psychologically. In this instance, it is not the rights of fetuses, as opposed to women, which are placed centre stage. Rather, concern is expressed ostensibly for women only, specifically for protecting their psychological well-being. It is this argument against a liberal attitude to the provision of abortion that generated the idea for this thesis.

As I detail later in this chapter, argument against this kind of attitude to abortion provision was made on precisely these grounds when the British-based abortion provider, Marie Stopes Clinics, launched a new local anaesthetic abortion service. A heated debate followed, in which the new service was criticised by many, on the grounds that abortion was traumatic for women. It was claimed that the detrimental psychological effects of abortion had been overlooked by Maries Stopes Clinics when they launched the service, and could even be made worse by easily available abortion.

Such argument was interesting because it did not contend that the problem in abortion was that it infringed the rights of an 'unborn child'. Rather, the terms of the argument seemed to be about women, and their needs. Women, it was argued, did not need services that made abortion as easy and quick as possible, but services which paid proper attention to the psychological effects of abortion. In particular, because abortion was emotionally or psychologically difficult, women needed counselling in abortion. On these grounds, quick and easy abortion provided by the new service, it was claimed, did not meet women's needs.

This aspect of the abortion debate led to the question which formed the starting point for my research: were critics of liberal abortion provision right when they contended that abortion damages women's mental health? In attempting to find an answer to this question, I looked first to psychology, and the findings of psychological studies about abortion and its effects. As I detail in the following chapter, these studies have indicated overall that the

psychological effects of abortion are not serious. According to existing psychological studies, it would be inaccurate to describe abortion as 'traumatic' for most women. Abortion, according to the research, does not lead to serious, lasting negative feelings in most women. In this case, why the debate?

In Chapters 2 to 5 of this thesis, I attempt to answer this question through providing an explanation of how abortion has come to be publicly debated in terms of its psychological effects. In doing so, I argue, it is necessary to look beyond psychology. I make the case instead for a sociological approach to abortion and women's psychology.

In particular, I argue that the insights of feminist social researchers who have analysed the abortion debate using a Foucauldian framework are valuable in explaining why abortion has been deemed psychologically problematic for women. Such researchers have utilised this framework to draw attention to the importance of medicalised discourses about abortion, and the effects of such discourses in the construction of abortion law and policy. Drawing on this approach I contend that the argument that abortion is 'traumatic' can be understood as a component of such discourses, and has played a significant and powerful role in the construction of abortion law, and of the arguments made by those involved in the abortion debate.

As part of my argument I make the case that psychology *has* played an important role in the construction of abortion in these terms. While psychological research may have found that abortion is not traumatic, nevertheless it has provided the dominant conceptual framework for debating abortion in psychological terms. Psychology's preoccupation with the measurement of women's negative feelings regarding their abortions, even if only to find that they do not affect most women significantly, has set the agenda and generated the framework and the terms for the debate.

My argument in the first half of this thesis is therefore that discourses which have construed abortion as psychologically significant are founded on the approach of psychology, if not always on its findings, and have played a powerful role in the construction of all aspects of abortion, including its legal regulation, and the public debate about it.

In the second half of my thesis, I test out this hypothesis, in relation to interviews I did with counsellors, and with women who have had an abortion. My aim in doing so was to see whether abortion was psychologised in their narratives. My analysis of the public debate about abortion indicated that abortion has been constructed as a negative experience for women psychologically. As a result, my expectation was that abortion would be described and discussed by my interviewees in similar terms. As it turned out, the way my interviewees talked about abortion was more complex and varied than I predicted, and I discuss my thoughts about this aspect of my research and its implications in the final chapter.

I hope that this thesis can thereby make a contribution to feminist analysis of abortion, and add to the body of research carried out by those who have adopted a Foucauldian approach to this subject. In particular, I hope to provide some new insights about the abortion debate in Britain, about the place of counselling in abortion services, and about women's experience of abortion today. Before beginning my discussion of the relationship between abortion and psychology, I want first to provide an account of the 'lunchtime abortion' debate, to highlight the central issue my argument addresses.

**'Lunchtime abortion'**

In June 1997 the abortion provider, Marie Stopes International (MSI), announced it was to start providing abortion in the first 12 weeks of pregnancy under local anaesthetic. This announcement was followed by a flurry of newspaper articles and broadcast news items which responded to the comment made in support of the new service by Tim Black, the chief executive of MSI, that it: '...made early abortion a minor procedure that could quite easily be completed during a working woman's lunchtime break' (Brown 1997: 2). Various commentators discussed this approach to abortion service provision, and, as I illustrate below, the debate was framed in the language of psychology.

One group of people who discussed 'lunchtime abortion' in such terms were representatives of anti-abortion groups. Jack Scarisbrick, speaking for the anti-abortion organisation Life called the service '...bad news for women because abortion violates women. Post abortion trauma is becoming a major women's disease when they try to come to terms with the guilt, grief and anger at the loss of life' (Brown 1997: 2). It was perhaps predictable that those who oppose abortion would disagree with a measure which could allow for abortion to be presented as a 'minor procedure'. While anti-abortion groups would be expected to raise criticisms of 'lunchtime abortion', the particular way they construed it as a problem was significant.

Opponents of abortion have often couched their argument in terms which have problematised abortion by deeming it a procedure which destroys a life. In this kind of argument, the fetus is construed as the main object of concern, on that grounds that its 'right to life' is overridden in abortion. In the lunchtime abortion debate, however, Scarisbrick problematised abortion in a different way, and made the alleged negative feelings of the woman who has an abortion central to his argument. He highlighted the claim that women feel negative emotions after abortion, such as guilt, grief and shame. He also contended that the psychological effects of trying to come to terms with these emotions should be considered a kind of disease suffered by women, which he called 'post-abortion trauma'. The problem of the new service was therefore construed in terms of the negative psychological effects which Scarisbrick claimed resulted from abortion.

Other commentators, not allied to groups whose stated aim was to oppose abortion, also used similar language in their discussion of 'lunchtime abortions'. In their commentary, they too emphasised the alleged negative psychological effects of abortion. Journalist Rosalind Miles wrote that she believed in a woman's right to choose an abortion, but claimed that following abortion, '...there is always a sadness and an aching sense of loss' (Miles 1997). An editorial in the newspaper *Scotland on Sunday* argued that '...the speed of the operation does not diminish its psychological dangers' and suggested that the service '...risks trivialising abortion operations if they can be carried out during a lunch break' (*Scotland on Sunday* 1998: 14). Journalist Flic Everett wrote in the *Manchester Evening News*, that the service could be detrimental for women, because of the effect abortion had on a woman's psyche: 'Although intended to help women, it's likely that presenting the procedure as so minor will inevitably add to their feelings of guilt and inadequacy when they find they need more than 'half an hour's recovery time' to get over it' (Everett 1997). The Minister for Health Tessa Jowell argued that, while she supported the development of abortion services, this particular innovation appeared to '...trivialise what for many women will almost inevitably be a difficult and distressing decision' (Borrill 1997).

Those critical of 'lunchtime abortion' thus construed abortion psychologically problematic for women. Their argument was characterised by the emphasis placed on feelings of guilt, grief, loss, sadness or inadequacy that women were said to feel after abortion. Their argument was that those who had developed the new abortion service were failing to take into account these negative psychological effects of abortion. In presenting abortion as a simple, minor, brief process, supporters of 'lunchtime abortions' were said to be 'trivialising' abortion by failing to draw attention to the significant effects of the procedure on a woman's mind.

The framing of abortion in these terms led to a specific criticism of the Marie Stopes Clinic's service. For Ros Miles, abortion should only take place where there had been '...adequate discussion and consideration' on the part of the woman of the decision to end her pregnancy, and a 'lunchtime abortion' would not provide enough time for a woman to be sure she '...knows her mind' (Miles 1997). To do so, she would need to talk to a counsellor, and discuss fully her feelings about abortion, which would not be possible where such a speedy abortion procedure was offered to a woman. The editor of *Scotland on Sunday* contended that where an abortion was carried out in a lunchtime, there would not be sufficient time for '...full, professional counselling' (*Scotland on Sunday* 1998), thus criticising the brevity of the Marie Stopes service in a similar way. A specific claim about abortion was therefore made, which centred on the construction of the need for counselling as part of abortion services: a link was made between the negative psychological effects of abortion, and the need for counselling as part of abortion services.

Commentary in the media in support of 'lunchtime abortions' was less frequent than criticism. The way supporters of the service framed their case was notable. In response to the argument against 'lunchtime abortions', Tim Black was reported to have said that the new procedure was '...very much quicker and much less traumatic' than previous abortion methods (Borrill 1997). The medical doctor Mark Porter refuted the arguments made against the service by contending that: 'This new operation is NOT about making abortion easier, it is about making it safer and less traumatic....As long as it is backed up with the proper counselling and support offered with other procedures, it should be welcomed rather than being condemned' (Porter 1997).

Those who wished to defend the service therefore also utilised the same vocabulary, in which abortion was construed as 'traumatic'. The argument put by supporters of the service was that a quicker procedure made abortion less traumatic for women. Counselling was again deemed a necessary part of abortion service provision. For Mark Porter, the provision of counselling was a prerequisite for the offer of support for the new abortion service: it should be welcomed as long as women were counselled as part of the procedure.

The 'lunchtime abortion' debate illustrates the argument in this thesis, that abortion has become 'psychologised'. In the debate around 'lunchtime abortion' a certain construction of abortion was very evident. Abortion was discussed in a way which emphasised that the procedure has important psychological effects, and that those effects are negative. As a result, the drawbacks and advantages of a particular development in the provision of abortion services were debated, agreed with or disagreed with in these terms. The merit of 'lunchtime abortion' was assessed through the prism of the effect such a service had in alleviating or accentuating the detrimental effects of abortion on a woman's mind.

This construction of the abortion debate, in terms of the effects abortion has on a woman's mind, also appeared to lead to an argument about the kind of service abortion clinics should provide. Where emphasis was placed on the negative feelings said to follow from abortion a claim followed which construed counselling as a necessary and important part of abortion services.

To suggest that abortion is psychologised involves drawing attention to the kind of language which is used to talk about abortion. The reason for doing so, however, is not simply to observe that a specific vocabulary is used when abortion is discussed. It is also to suggest that it is necessary to investigate why such language is used. As Stephen Fleck pointed out in 1970, abortion can in one sense be considered to be '...like every surgical operation', in that '...every inroad on a person's body, has psychological elements or sequelae which may leave psychological scars (Sarvis and Hyman 1973: 111). Yet in public debate about surgical operations, abortion would seem to be considered in a different way to other operations. Compared to other medical procedures, the 'psychological scars' of

abortion are frequently highlighted, but perhaps most importantly the public is invited to take these effects into consideration when formulating its opinions about abortion.

How has it come to be the case that this kind of language is used to debate abortion? How did participants in the 'lunchtime abortion' debate come to talk about abortion in this way? Two different answers could be given to these questions. The first would be that the language used to describe the experience of abortion simply reflects reality. In talking about abortion as 'traumatic', all that is happening is that a factual description is being given. As Jonathan Potter (1996) has argued, in his analysis of the ways in which the role of language can be conceptualised, this approach would suggest that the words are simply a mirror which reflect back what is real. If this approach were taken, it would suggest that there is a 'truth' to the experience of abortion, which commentators (for example in the 'lunchtime abortion' debate) simply reflected in what they wrote. Abortion is, as a matter of fact, traumatic, and leads to feelings of guilt, loss and sadness. All that words do is describe this fact.

An alternative answer would be to consider that language is active. It does not simply reflect back a reality which exists beyond language. In contrast, language acts to produce and shape what might be considered as a fact. In this conception of language, the description of abortion as 'traumatic', the presentation of a woman in grief, or experiencing loss following abortion, is not simply a description of a fact. Rather, it is part of a discourse, a framework in language through which abortion is talked about and debated, which has emerged over time. Through this discourse, a 'reality' has been constructed, brought into existence, where the psychological effects of abortion for women have come to be construed as a significant issue. It is then within the terms of this discourse that the debate about abortion takes place.

Through this thesis, I aim to provide an account of abortion which situates psychology in the latter of these two ways. My aim is to interrogate the notion that abortion simply 'is', as a matter of fact, an experience which has particular, negative psychological effects. Rather I hope, through my account, to suggest that abortion has *become* 'psychologised', constructed as an issue in these terms, over time. My contention is that discourses which construct the negative psychological effects of abortion as significant have emerged, and have acted powerfully in shaping abortion law and policy. I also contend that discourses that psychologise abortion have constructed a particular identity for women. A woman with a certain kind of subjectivity has emerged. She is the 'traumatised' or 'distressed' woman who is in need of counselling to alleviate her negative feelings about her abortion.

In the following chapters, I focus my attention on the emergence and effects of a psychologised discourse about abortion. My hypothesis is that this discourse has been highly influential, in that it has pervaded every aspect of the abortion issue: it has shaped the

way research about women's experience of abortion has been conceptualised, and the kinds of questions researchers have asked. It has affected the construction of abortion law, campaigning on abortion, services offered to women who are seeking and who have abortion, and the ways in which women themselves discuss their experience of abortion.

**Thesis structure and outline**

There are two main sections to this thesis. The first is concerned with the historical emergence of psychologised abortion discourses, and the second with the effects of these discourses in contemporary 'abortion talk'. I had not intended at the outset for this thesis to be divided equally between research about the role of psychology in the abortion debate, and empirical research. I had expected less space to be taken up by the first aspect of these two projects, and that most of this thesis would be devoted to a discussion of the role of the language of psychology in 'abortion talk' today. As it turned out, in the course of researching the development over the past 30 years of discourses which psychologise abortion, in particular in relation to the anti-abortion movement, I found myself becoming more and more interested in developing a Foucauldian analysis of this development. As a result, more time and energy than I had anticipated has gone into developing and expounding a Foucauldian approach to 'abortion trauma' and 'Post-Abortion Syndrome'. I hope in the future to be able to carry out further research into the role of psychologising discourse in contemporary speech. In this thesis however, this aspect of my research is perhaps less extensive than I had intended. The thesis is, as a result, structured as follows.

In the first section, I follow the approach of those who, using a Foucauldian approach to the analysis of the present, '...attempt to disturb the self-evident present with the past' (Bunton and Peterson 1997: 4). In this approach, categories used to describe or define subjectivity are called into question through an analysis which indicates how such categories have been brought into being (McCallum 1997: 53-73). Ways of labelling or understanding subjectivity which are accepted as the truth are shown to be historical products, which are brought into being over time. My argument, made through the first half of this thesis, is that the 'traumatised woman' can be understood in this way.

In the second section, I provide an account of three interview studies, which I have analysed using a discourse analytic approach. My aim here is to consider the ways in which psychologised discourses act 'in practice'. Through this analysis I test my hypothesis that psychologising abortion discourses act powerfully in the construction of accounts of the experience of abortion. My aim in doing so is to consider whether, in the narratives of my interviewees, abortion was psychologised, and if it was, how psychologising discourses functioned in their talk. These two sections are connected by two chapters which outline in detail the theoretical and methodological approach I have taken.

It is more usual to begin a thesis with a literature review, followed by a chapter which sets out the author's theoretical orientation. This thesis departs from this convention in that a review of relevant literature, and an argument for a theoretical approach which draws on the work of Michel Foucault, are combined in Chapters 2 and 3. This approach was taken because it allowed for a clearer case to be made about the differences between the approach of psychologists to the study of the psychology and abortion, and that of feminist social researchers. My aim was to emphasise the value and importance of feminist scholarship which adopts a Foucauldian approach to the study of abortion, in particular to abortion law, and to consider how this approach might be taken where the subject of study is psychology and the abortion debate.

In Chapter 2, I first review the findings of studies about the psychological effects of abortion. On the basis of the questions these studies raise, in relation to the debate about the psychological effects of abortion, I contend that a sociological approach to psychology and abortion is needed if a convincing explanation is to be given of how abortion has come to be debated in terms of its psychological effects. Drawing on the work of feminist scholars, Mary Boyle (1997) and Sally Sheldon (1997), I therefore put forward an argument for adopting a Foucauldian approach to psychology and abortion, which I develop further in Chapter 3.

In Chapters 4 and 5, I extend this argument in relation to the abortion debate. The legalisation of abortion through the 1967 Abortion Act generated a debate between two perspectives about abortion. One of these perspectives aimed to oppose legal abortion, and has been represented by organisations which have described themselves as 'pro-life'. It is the argument of the pro-life movement that is the subject of Chapter 4.

The usual terms in which such organisations have constructed abortion as a social problem have been that abortion is a moral wrong. This claim has been made on the basis that through aborting a pregnancy a woman is taking a life. The substantiation of the claim that abortion takes a life has been made in both religious and biological terms. The fetus has been deemed a person both on the grounds that God said it is so, and also more recently through contending that medicine has proved this is the case. Anti-abortionists have come to make extensive use of ultrasound images of a developing fetus to show that it looks like a baby. They have emphasised medical facts, such as the fact that the fetal heart starts beating at six weeks gestation, or that a fetus can respond to stimuli such as sound. On this basis pro-life organisations have claimed that the fetus has been proven to be a person by science (Franklin 1991). Whichever argument has been used however, the focus has been on the 'personhood' of the fetus. The anti-abortion movement has presented itself as a movement that exists to protect the lives of 'unborn children'.

In Chapter 4, I provide an account of the emergence and progress of an attempt to construct opposition to abortion in a different way. Abortion in this case has been construed a problem because it damages women's mental health. The specific way in which this argument has been made is that following abortion, women can suffer from Post-Abortion Syndrome (PAS), a form of Post Traumatic Stress Disorder (PTSD). In this chapter, I therefore detail the emergence of this argument, and the ways in which it constructs abortion as a problem. I suggest that the contention that abortion is a problem on these grounds is an interesting facet of the abortion debate, in that it appears to represent a departure from the more familiar moral terms of pro-life argument. Through the claim for PAS, abortion is construed as a problem not only because it is morally wrong, but also because it damages women psychologically.

The perspective on abortion which has existed in opposition to the 'pro-life' argument, which I discuss in Chapter 5, has held that women have the 'right to choose'. Organisations which have represented this perspective have developed arguments which have constructed legal abortion as a legitimate outcome of pregnancy.

The case for woman's choice in abortion has drawn on a liberal conception of individual freedom. Abortion has been defended on the basis that a woman should have 'bodily autonomy' or 'bodily integrity' . Feminist sociologist Rebecca Albury notes that those who have taken this approach draw on the approach taken by John Locke, who asserted in the 17th Century that individuals owned their bodies, each having the right to 'property of his [sic] own person' (Albury 1999: 50). This argument was used to oppose slavery, on the grounds that because of the principle of 'self-ownership' no human could be bought and sold by another.

Albury also points out that the founder of modern liberalism, J.S. Mill, made the concept of self-ownership of the body central to his argument for liberty. For Mill, liberty depended on the civilised community rejecting the exercise of power over its members for their '...own good, either physical or moral', and accepting instead that: 'Over himself, over his own body and mind, the individual is sovereign' (Albury 1999: 55).

American feminist scholar, Rosalind Petchesky, has suggested that a slightly different formulation of this same principle, the concept of 'self-possession', can be traced to the Puritan revolution of 17th Century England. Self-possession, defined as control over one's body, as well as one's mind, informed the introduction of the idea of *habeas corpus* (bodies cannot be detained without cause), and according to Petchesky, this same notion underpinned the argument for arrangements affecting women particularly, such as marriage contracts, and restrictions against wife beating. Petchesky contends:

> While the liberal origins of the "bodily integrity" principle are clear, its radical implications should not be forgotten. In its more recent juridical expressions, for

> example the so-called right to privacy, the principle has been applied to defend prisoners from physical abuse, undocumented aliens from bodily searches, and patients from involuntary treatment or medical experimentation (Petchesky 1990:3).

A radical application of this approach, with regard to abortion, has thus emphasised the centrality of individual choice, and individual freedom. As such it has not considered abortion in terms of its psychological effects. In so far as this kind of pro-choice argument has made reference to the psychological effects of pregnancy, it has been to emphasise the negative effects of unwanted childbirth on a woman's mental health. However, as I discuss in Chapter 5, a discourse which criticised the emphasis which had been placed by pro-choice opinion on individual choice, and which instead did psychologise abortion came, from the mid 1980s onwards, to influence the terms in which pro-choice argument was constructed.

In this chapter, I provide an account of the ways in which this took place. I suggest that firstly the construction of abortion in terms of PAS by anti-abortion organisations generated a response from pro-choice organisations. I discuss the ways in which the construction of abortion in terms of trauma was refuted in pro-choice argument, through utilising discourses which produced the negative psychological effects of abortion for women as minimal. Secondly, I draw attention to the construction of abortion in terms of its negative psychological effects by supporters of legal abortion themselves. I discuss the argument that was made by some pro-choice feminist writers that attention needed to be paid to the negative psychological effects of abortion. I consider the claim that emerged as a result that the pro-choice movement needed to shift its attention from 'a woman's right to choose' to 'a woman's right to feel'.

Through these chapters, I therefore show how discourses which have psychologised abortion have significantly effected the construction of anti-abortion and pro-choice argument. In Chapters 7, 8 and 9, I provide an account of the effects of these discourses today, using material gathered from my interview study.

In this study, interviews were carried out with two groups of people, counsellors who counsel women before and after abortion, and women who have had an abortion. My aim, through analysis of these interviews, was overall to investigate the hypothesis that discourses which psychologise abortion construct the accounts of my interviewees. I hypothesised that such discourses would significantly shape counsellors' accounts of the service they provide. Similarly I hypothesised that these discourses shape women's accounts of their experience of abortion. In particular, my expectation was that both counsellors and women who had had abortions, would construe abortion as traumatic, and that their narratives would be significantly shaped by discourses which have constructed abortion in this way.

The first set of interviews, those with counsellors, are discussed in Chapters 7 and 8. Some of those interviewed worked for organisations that call themselves 'pro-life', and these interviews are discussed in the second of these chapters. Other were employed by charitable organisations which provide abortion services to women, and interviews with this group of counsellors are discussed in Chapter 7.

My reason for wanting to carry out this piece of research was to shed some light on the meanings and purpose of counselling. The debate discussed earlier in this chapter about 'lunchtime abortion' indicated that the claim that counselling was an important part of abortion service provision arose where the negative psychological effects of abortion were emphasised. Though my research I wanted to investigate whether this connection held where counsellors themselves discussed their interaction with the women they counsel.

In Chapter 9, I give an account of a set of interviews with women who have had abortions. In this chapter I again consider whether abortion was psychologised in interviewees' narratives. In particular I assess whether women considered themselves 'traumatised' by abortion, and their expectations and experiences of counselling.

In the final chapter, I summarise my findings regarding the hypothesis outlined above. In doing so, I conclude that a more adequate account of abortion would consider it through a Foucauldian, social constructionist framework but would, in a way this thesis did not, also find ways to explain and account for the differences and variations in the way women experience abortion. In particular, a better piece of research would pay greater attention to the question of resistance, and focus in particular on the ways in which women who have had abortions resist the construction of abortion as traumatic.

To begin my investigation, I now turn to discuss the framework for my argument through an account of psychology's findings, and the rationale for my decision to adopt the Foucauldian concepts of discourse, biopower and disciplinary power in conceptualising the relationship between psychology and abortion.

# Chapter 2: PSYCHOLOGY, SCIENCE AND DISCOURSE

In this chapter, I outline the approach taken to the study of abortion by psychologists, and I provide a summary of their main research findings. I then make the case for an alternative approach, which conceptualises psychology in terms of the Foucauldian concepts of discourse, biopower and disciplinary power. On this basis, I argue that psychology has played an important role in the construction of the abortion debate. Finally, I expand further on the concept of discourse, in particular its relationship to subjectivity.

## Psychology as science

As feminist psychologist Mary Boyle (1997) has pointed out, psychology is commonly considered a science. Psychologists claim that their aim is to investigate and assess as objectively as possible the psychological responses human beings have to particular situations. With regard to abortion, psychologists have therefore aimed to provide an objective, scientifically based answer to the question how do women respond psychologically to abortion? Drawing on Mary Zimmerman's (1981) account of the development of the approach taken by psychologists to the study of abortion, and through detailing the approach and findings of studies of the psychological effects of abortion, I will illustrate the way in which psychologists have approached answering this question.

A large number of studies have been carried out by psychologists, the aim of which has been to investigate the psychological effects of abortion. In his report on the physical and psychological effects of abortion complied for President Reagan in 1989, the then U.S. Surgeon General Everett C. Koop commissioned a review of 250 separate studies, which were considered to be the most important (Okie, 1989). According to Michael B. Bracken, Professor of Obstetrics and Gynaecology at Yale University, since the 1960s there have been several thousand published reports on this topic, '...arguably making abortion the most widely studied of all medical procedures' (1989: letters page).

The first studies of abortion took place during the 1950s and 60s. At this time, the view was widely held by both the British and American medical professions that abortion would lead to mental ill health. According to Zimmerman (1981), investigations of the psychological effects of abortion during this time consisted almost entirely of doctors' clinical reports, and concluded almost without exception that abortion inevitably caused trauma, posing a severe threat to psychological health.

Writing in 1958, the American doctor Galdston typified this view when he said that: 'Drawing upon my experience I would summate the major psychological effects [of abortion] in three terms: frustration, hostility and guilt....I would subsume abortion as a "form of sterility

associated with profound biological and socioeconomic pathology" ' (Sarvis and Hyman 1973: 110). Another doctor Bolter argued that

> ...woman's main role here on earth is to conceive, deliver, and raise children....When this function is interfered with, we see all sorts of emotional disorders....This is not just textbook theory, as all who practice psychiatry very well know.

He went on to suggest that he '...has never seen a patient who has not had guilt feelings about a previous therapeutic abortion or illegal abortion' (Sarvis and Rodman 1973: 109). In its 1966 report *Legalised Abortion: Report of the Council of the RCOG* the highly influential British organisation the Royal College of Gyneacologists and Obstetricians argued: 'There are few women, no matter how desperate they may be to find themselves with an unwanted pregnancy, who do not have regrets at losing it' (Simms and Hindel 1971: 52). The report went on to suggest that these feelings of regret are a '...fundamental reaction, governed by maternal instinct (ibid).

It has been suggested that such views about abortion were based on the framework of Freudian psychology, dominant at the time, where a rejection of the wish for motherhood was considered to be an indicator of abnormal psychological adjustment, which led to mental disturbance (Zimmerman 1981: 66). Whatever the reasoning, it was certainly the case that at this time women who sought abortion were pathologised as abnormal, or sick, with both their reasons for requesting an abortion, and their likely psychological response to termination of pregnancy, characterised as forms of mental ill health.

During the late 1960s and early 1970s, some psychiatrists and psychologists began to question and reject such findings about women's psychological response to abortion. Following the legalisation of abortion in Britain, the U.S. and other developed countries, some research was carried out that disputed existing certainties about the inevitability of abortion having a negative psychological effect. Such research was critical of the idea that women would become mentally ill following abortion, and suggested that this account could not be sustained, given that it was based on anecdotal evidence, rather than on controlled studies (ibid: 66-8).

Existing studies were criticised on the grounds that their research method was flawed. Writing in the *British Journal of Psychiatry*, Zolese and Blacker noted that many studies done at this time were in fact conducted '...when standardised psychiatric measurement instruments were not available' (1992: 742), and that many of these studies '...employed self-devised questionnaires without proven reliability or used unstructured interviews often administered by non-psychiatrists' (ibid). These psychiatrists also commented that other problems with studies carried out at this time were the small size of the samples of women studied, indirect data gathered without actual contact with the woman following abortion and

high attrition rate, where a significant number of women originally included in the sample in the end dropped out of the study (ibid).

Existing studies were criticised also because the assessment of psychological well-being was made through clinical judgements with almost no use made of standardised procedures. This meant that psychological problems which might be evident in women after abortion were assumed to be caused by the abortion. The need to address the issue of causality between abortion, and psychological difficulties a woman might have following abortion, was emphasised, and use of control groups or comparison groups was advocated (Zimmerman 1981: 67).

Such criticism led to the development of more rigorous studies. Zimmerman (1981) and other writers on the psychological effect of abortion have referred to one such study carried out by Ekblad in 1955 (Sarvis and Rodman 1973). This has been considered the earliest study to use improved research methods, and the approach Ekblad took is therefore worth detailing.

Firstly, the sample was larger than had previously been the case in other research. 470 Swedish women who underwent legal abortion in 1949-50 were assessed by Ekblad. They were interviewed shortly after their abortion and again two to three years later. The research made an attempt to control for causality between abortion and post-abortion psychological state. Ekblad took into account variables which might have had an effect on a woman's feelings after abortion, including personality type, age, intellectual level, new pregnancy after abortion, previous pregnancies, influence of other people on the women's request for abortion, and relationship with male partner. It was found that the majority (65 per cent of the sample of women) reported that they were satisfied with their experience of abortion and had no psychological problems at follow-up. 10 per cent had no regrets but felt the abortion itself had been unpleasant. 14 per cent had a mild degree of self reproach and 11 per cent regretted the operation and felt very guilty about it. Of this last group, only one per cent had their work ability affected. Ekblad concluded that:

> ...it is obvious that a legal abortion entails feelings of guilt and self-reproach in many women. On the other hand, it is seldom that these undesirable psychic sequelae are so serious that they may be described as morbid or that they adversely affect the woman's working capacity (Sarvis and Rodman 1973: 116).

While Ekblad's study has been referred to as an early example where improved research methodology was used, many studies carried out in the 1970s also utilised what were seen as more appropriate methods. Studies which assessed women's psychological response to abortion used larger groups of women, and attempted to separate out '...the psychological status of women seeking abortion and the psychological impact of abortion' (Zimmerman

1981: 67). The emphasis on the need for a cautious approach to causality, larger study populations, and the use of recognised tests continued.

Commentaries about a British study carried out by the Royal Colleges of Obstetricians and Gynaecologists and of General Practitioners thus emphasised that facets of its design conformed to the ideal method. In this study, conducted between 1976 and 1979, information was obtained about 13 261 women, through volunteer GPs. This included age, marital status, social status, whether the women smoked and previous psychiatric and obstetric history. As a result, four comparison groups were obtained, of 6151 women who did not request abortion, 6410 who obtained an abortion, 379 who requested the operation but were refused and 37 who requested the abortion and changed their minds. In the study, GPs were asked to record 'diagnoses' of women they saw by grouping psychological or psychiatric disorders into three categories: major mental illness (including puerperal psychosis, schizophrenia, and manic depression), minor mental illness (depression, anxiety or other emotional disorders) and deliberate self-harm (drug overdoes, self cutting) (Gilchrist 1997: 45). Key findings reported were that in women with no past psychiatric histories there was no significant difference between comparison groups in rates of psychiatric illness; that women with a previous history of psychosis were more likely to experience a psychotic illness than those with no such history; and that termination of pregnancy did not appear to increase the risk (Gilchrist 1995: 243-8).

Writing to defend the findings of the study, psychiatrist Anne Gilchrist argued that:

> A study of this size was important since it was unlikely that any rare complications of abortion, or a small increase in risk would be detected unless the number of women included was of this order (ibid: 243).

The findings of the study were said to be valid, because of the large sample of women used. Other studies have been discussed with approval for similar reasons. For example, use of a recognised test for psychological response is often mentioned as an important aspect of a study design (1).

The result of these studies overall was the emergence of a set of findings which suggested that psychological or emotional problems following abortion were not as great as had been thought previously, and that where they existed such problems were due to psychological problems existing before the abortion, rather than to abortion itself (2). However, such results did not bring an end to a perceived need to investigate and measure the psychological effects of abortion. The concern that research methods were inadequate continued, and remained a continual theme in literature about the subject.

Writing in the authoritative and subsequently widely quoted collection of articles about the psychological effect of abortion published in the *Journal of Social Issues* Wilmoth et al re-iterated this criticism:

> None of the research conducted in the U.S. ....met minimal methodological standards....the design of available research and its methodology do not provide a scientifically sound basis for reaching conclusions about the causal nature of the psychological responses studied (Wilmoth et al 1992 :62).

In addition to this preoccupation with method, another issue has held the attention of researchers. Findings of the 1970s, which suggested that the negative psychological effect of abortion was essentially of negligible significance '...brought expressions of concern that perhaps the extent of abortion-related psychological distress was being underestimated' (Zimmerman 1981: 68). Some researchers were concerned that they were not paying enough attention to the differences between women in their psychological response to abortion. Their argument was that while it may have been the case that most women did not suffer psychologically following abortion, more needed to be known about factors leading to a negative psychological response in those who did. Some research therefore became oriented to study 'risk factors' in abortion. The aim was to find out why some women had different psychological response to abortion than others.

One of the first studies to do this was carried out by Payne et al (1976). This study drew attention to differential levels of feelings of guilt at six weeks after abortion. Women who had been ambivalent about abortion and women with negative cultural or religious attitudes to abortion were more likely to feel guilty than other women. Women with a poor relationship with their mothers were found to feel more angry than other women, and women in unstable relationships were more depressed. The presence of social support systems was found in other research to have a positive effect on how a woman felt after abortion (Brown and Harris 1978). Older women and those who already had children were also found to be at risk of poor psychological response to abortion (Lask 1975), as were women who aborted a pregnancy on grounds of fetal abnormality (Donnai and Harris 1981; Dagg 1991). Women with a previous history of psychiatric disturbance were found most consistently to have psychological or psychiatric difficulties after abortion (Greer et al 1976; Lask 1975; Gilchrist et al 1995).

The result of such research was the acceptance of the idea amongst psychiatrists and psychologists that women had different psychological responses to abortion, with certain groups of women being particularly likely to respond in a negative way. These groups included women who were ambivalent about their decision to abort a pregnancy; teenage women; older women who already had children; women with little social support (for example whose male partner was unsupportive, or who did not think family and friends would approve of their decision); and women who ended pregnancy for reasons of fetal abnormality.

Sachdev provided a more extensive list of variables that he thought influenced the psychological outcome of abortion: the woman's age, marital status, religion, attitude towards abortion and motherhood, circumstances of, and reaction to her pregnancy, relationship with her sexual partner, parity, pre-existing psychiatric conditions or morbid personality, gestational age and concurrent sterilisation (Sachdev 1981: 63). In 1981, Zimmerman summarised this view as the '...growing recognition by investigators that, while the psychological consequences of abortion are not nearly as serious and painful and previously thought, they emerge from a broader and more complex psychosocial process' (Zimmerman 1981: 66). This author also noted that such studies, such as that by Handy (1982), included recommendations for counselling before and after abortion.

Thus, in addition to studying the woman and her emotional-psychological status, studies also examined the nature of her interpersonal relationships and social situation (Zimmerman 1981). The overview of research, carried out by psychiatrists Zolese and Blacker published in 1992, restated the need for this approach, concluding that the emphasis for research should be on certain groups who are '...especially at risk from adverse psychological sequelae' (Zolese and Blacker 1992: 742). These included those with previous psychiatric history, younger women, those with poor social support or pregnant previously, and those who belonged to socio-cultural groups antagonistic to abortion. They also argued that '...a better understanding of the nature or the risk factors would enable clinicians to identify vulnerable women for whom some form of psychological intervention might be beneficial' (ibid).

In summary the way women respond to abortion has been a subject of significant interest for psychiatrists and psychologists over the past 40 years. The approach taken has been to answer the question: How do women respond psychologically to abortion? The development of psychology's attempt to answer this question has been driven by a desire to make research methods more scientific. Research carried out by psychologists has been criticised from within the profession. The basis of the criticism has been that research methodology has failed to deliver objective results, which could give accurate information about how women respond psychologically to abortion. The outcome of this criticism has been a demand for the use of methods to eliminate bias, which would make research more scientific. In addition, researchers have attempted to pay more attention to particular aspects of the social situation of certain groups of women, which might make them more likely to feel bad after abortion.

**Psychology as discourse**

This account of the development of psychological research draws attention to two important aspects of that research. First, there has been the dominant concern that research

should be as scientific and objective as possible. Second, research findings to date have indicated that the majority of women do not suffer psychologically after abortion in a way that could merit the claim that abortion is 'traumatic'. Research results have not significantly correlated abortion with the development of psychological problems afterwards. Rather, certain groups of women have been defined as 'at risk' psychologically.

This second aspect of the results of abortion research raises an interesting question for those concerned with the representation of abortion, for example in the 'lunchtime abortion' debate. Psychological research has indicated that abortion is not 'traumatic' for most women. In fact, as feminist psychologist Mary Boyle has pointed out, psychological research suggests that childbirth represents a more significant psychological risk to women than abortion (1997: 30). Boyle cites research by Brewer, who found a five to six times greater risk of psychosis after childbirth than after abortion. Other research has shown that fairly serious psychological distress has been reported in around 20 per cent of women in the first year following childbirth. Yet public discussion highlights the 'trauma' women experience in abortion, rather than the psychological effects of maternity.

Taking this contradiction between the findings of research, and the public discussion of the effects of abortion as a starting point, I will now consider how we might conceptualise the persistent preoccupation with the psychological ill-effects of abortion. In doing so, I contend first that a different method of inquiry to that adopted by psychology is needed. While psychology can tell us something about how many women, at a particular point in time, are anxious, regretful, or depressed after abortion, it has illuminated little about why the effects of abortion are so frequently discussed in these terms.

In the remainder of this chapter I therefore outline an alternative approach to the investigation of psychology and abortion which might provide some answers to this problem. This approach draws on the Foucauldian concept of discourse. I suggest that this concept is useful in fostering an analysis of abortion which has as its focus an explanation of how abortion has come to be publicly discussed in the terms it has been. In this respect, the question I ask is not: Are women damaged psychologically by abortion? Rather, I ask: Why has abortion been discussed in terms of psychology? How have psychological categories which describe the effects of abortion negatively come to figure so prominently in the abortion debate?

My second contention is that psychology is not separate from the debate about abortion. Although psychology may claim to be neutral, and therefore somehow apart from the political and social abortion debates, the way in which psychology has approached abortion is in contrast of great influence in such debates. This, as I will illustrate in later chapters, is at some points overt. For example psychologists engaged publicly in the debate about abortion

in the U.S., following President Reagan's attempt to undermine the provision for legal abortion on the grounds that it was bad for women's minds.

Less obviously, and perhaps more importantly, psychology has also influenced the abortion debate because it has acted to construct a specific field of debate, frequently termed 'the psychological effects of abortion'. Psychology has generated a specific 'problem' associated with abortion, which is frequently discussed in tandem with 'The physical effects of abortion'. Women's feelings about abortion have, through psychological inquiry, become defined as an objective, measurable phenomenon, as if they are similar to abortion's physical effects. My contention is that through doing so, despite its claim to objectivity, psychology has acted powerfully in constructing the debate about abortion, and the legal and social regulation of women's access to it.

To develop these two points further, I discuss first the argument made by feminist psychologist Mary Boyle in favour of a discursive approach to the study of abortion. I then expand further on the concept of discourse, and discuss its advantages for the study of contemporary representations of abortion. In doing so, I draw in particular on the work of Nikolas Rose, and discuss his claim that psychology is profoundly implicated in the social construction of contemporary subjectivity.

## Feminism's critique of psychology

In so far as feminist writers have considered the issue of psychological research on abortion, they have sought to ask questions both about the way psychology approaches abortion, and about the effect of psychology's findings on the construction of the abortion debate. Through doing so the claim that psychology is simply a scientific and objective enterprise has been questioned, and attention has been drawn to the importance of conceptualising 'experience' as a social, rather than individual, matter.

The key text which adopts this approach is *Re-thinking Abortion: Psychology, Gender, Power and the Law* by Mary Boyle (1997), in which the author contends that psychological studies are limited in their ability to explain women's experience of abortion. She argues that an approach which draws attention to the discursive construction of abortion is more useful, and that psychological categories themselves contribute to this construction.

Boyle explains the limits of psychological research into abortion as a product firstly of psychology's attempt to use the methods of natural science to investigate human experience. The crux of her argument is that psychology cannot be objective in the same way as natural science, because its object of study is human beings, who by their very nature, are 'social' entities, rather than parts of nature. Boyle argues:

> Scientists do not apply quantification to decontextualised objects in laboratories because to do so is intrinsically scientific, but because they can make useful statements about objects by doing so. These objects have no social life, culture or language (ibid: 4).

Unlike human beings, the objects which a natural scientist studies, such as a leaf or an atom, have no 'social life, culture or language'. Hence there is no context other than the physical and chemical which makes them what they are. Human beings in contrast are 'social': they are 'made' through society, culture and language.

In making this criticism of psychology, Boyle writes in accordance with the critique of psychology and psychiatry developed by Michel Foucault in *Mental Illness and Psychology* (1962). A key point in this text is the distinction made by Foucault between medical studies of the body, and psychological investigations of the mind. In his introduction to Foucault's 1962 edition of *Mental Illness and Psychology,* Hubert Dreyfus summarises this point succinctly:

> ...whereas organic medicine is a genuine science of the body, there cannot be a similar science of human beings. 'My aim' Foucault tells us, 'is to show that mental pathology requires methods of analysis different from those of organic pathology and that it is only by an artifice of language that the same meaning can be attributed to 'illnesses of the body' and 'illnesses of the mind' (Foucault 1962: ix).

The distinction made by Foucault between 'genuine science' and studies of the mind rests on the difference between organic, or physical entities, and mental processes. This point was made even more clearly in Foucault's writings about the difference between the natural sciences (such as physics) and the human sciences (such as psychology). He contended that '...the natural sciences have been able to arrive at relative autonomy because they have found a level of analysis that authorizes valid abstractions corresponding to the causal power in the physical world' (ibid: xi).

Foucault's argument was that natural science could be 'relatively autonomous' and could legitimately operate through abstraction. Since its aim was to investigate the physical world, rather than the human one, this *modus operandi* was appropriate. In contrast, according to Dreyfus, for Foucault:

> ...such autonomy is impossible for the sciences of man. According to Foucault...the personality cannot be grasped as an organic totality of isolable functional components...each aspect of behaviour can only be understood as an expression of an individual's being-in-the world (ibid: xii).

Foucault therefore drew a clear distinction between the physical world, and in contrast, human behaviour and personality. Unlike the former, the latter could not be investigated and

explained through methods of abstraction and generalisation. As a result, Foucault criticised the use of methods of natural science to study human behaviour or personality.

He argued that techniques which put scientists in touch with a reality independent of human society could '...free themselves from the power practices in which they originate and gain autonomy and objectivity' (ibid). Where the same methods were used to investigate aspects of human society, they were however: '...dictated not by their subject matter but by the power practices under which they were developed' (ibid). For Foucault, a different methodology and approach altogether was therefore needed where the object of investigation was not clearly part of nature. Hence Foucualt emphasised the difference between investigation of physical and mental illness:

> My aim....is to show that mental pathology requires methods of analysis different from those of organic pathology and that it is only by an artifice of language that the same meaning can be attributed to 'illnesses of the body' and 'illnesses of the mind' (ibid:10).

Boyle argues, in this light, that it is therefore problematic for psychology to utilise the same methods as natural science, because in doing so it will fail to take into account the fundamentally social nature of human experience. Boyle makes clear why she thinks that reliance on such methods is problematic for psychology as follows:

> The methods adopted by psychology involve a strong reliance on experimentation, the extensive use of quantification and measurement, the separation of phenomena of interest from their contexts and their study under controlled conditions, and, finally, a commitment to the creation of general laws of behaviour. This latter commitment has led to an emphasis on the form of behaviour, or general features common across groups, rather than on its specific context or social and personal meaning (Boyle 1997:4).

For Boyle, utilising scientific methods leads to a flawed analysis of the problem under investigation. In using an approach which relies on the procedures adopted by natural scientists (such as experimentation, quantification and control groups, underpinned by the idea that there are general laws of behaviour that can be discovered through such methods) psychology treats the variables it is considering as fixed, as if they were laws of nature. This is opposed to an approach which would start with the idea that human experiences are social, that they are created, shaped and changed, and therefore have no fixed quality to them.

The problem of psychology's approach is made clear secondly through Boyle's connected criticism of its focus on the 'decontextualised' individual. The result of psychology's attempt to study the individual through the use of scientific methods has been to relegate the significance of the social:

> The individual has, of course, been psychology's traditional object of study. It is not to say that this is unreasonable in principle, the problem lies in how we conceptualise the individual and the relationship of individual behaviour and experience to its social context. It is assumed, for example, that individuals carry with them attributes and processes which can be studied independently of the social world - personality, intelligence, aptitude, depression, anxiety, dysfunctional cognitions, attitudes and so on. Psychology has taken account of social variables, such as 'class' and marital status, but these are often conceptualised as separate and discrete entities 'out there' whose impact on internal psychological attributes can be expressed numerically (ibid: 5).

The problem identified is the separation of the individual, in this case the women who has an abortion, from the 'social processes' which in fact constitute the individual and her experience. Boyle has suggested that psychology has taken this approach to maintain an impression that it has no agenda or bias. The focus on the individual has protected psychology '...from 'contamination' by the social and ideological' (ibid: 6).

In adopting this focus however, psychology has placed barriers in the way of a fuller and more nuanced explanation of women's experience of abortion. As a result of the emphasis placed on the quantification of the numbers of individuals who experience certain emotions, such emotions come to be construed as facets of individuals or groups of individuals. Interrogation of the origin and meaning of women's experience of abortion, and the relationship of this experience to the to the social world, has consequently either been frequently ignored or investigated in only a superficial manner.

In contrast to this 'scientific' approach Boyle, together with other feminist writers on abortion, such as Sally Sheldon (1997) prefer to use the concept of discourse in their explanation of the experience of abortion. As Boyle explains, this term refers to '...particular ways of talking or writing (and by implication, thinking) about certain groups of phenomena' (Boyle 1997: 8). I discuss Foucault's argument about discourse and power in more detail later, but I will introduce it briefly now, in order to summarise the difference between a discursive and a psychological approach to abortion.

Discourse and the construction of women's experience of abortion

As I discussed previously, psychology measures the effects of abortion on a woman's mind. The individual woman is the object of investigation, and psychologists determine, through use of a variety of recognised tests, what her psychological state is after an abortion. In this approach, two important assumptions are made. First, as Boyle has pointed out, this approach treats psychological states as if they were part of the natural world. The

way people feel about a particular experience becomes decontextualised. Feelings are taken out of their social and historical context, and treated as if they were objects which can be understood separately from the circumstances in which they exist. Second, the assumption is made that the negative psychological effects of abortion are a valid subject of inquiry. I make this point not to suggest that they are not a valid subject of inquiry, but to contend that the reasons why psychologists are interested in investigating this issue is not self-evident.

The negative psychological effects of most medical procedures (3) (particularly procedures which are technically relatively simple, as is the case with the vast majority of abortions) have not become subject to study and investigation, yet they have been investigated in the case of abortion. Hence categories used to measure a woman's feelings after abortion are almost inevitably negative, but no explanation is given as to why this should be the case: the notion that abortion may well have negative effects on a woman's mind is unstated, but assumed.

In contrast, an approach which conceptualises the experience of abortion as a product of discourse, rejects such assumptions. It makes no *a-priori* assumptions about the experience of abortion, but rather contends that this experience is socially or discursively constructed. Those who adopt a discursive approach will not therefore be concerned with measuring the numbers of women who experience abortion in this, or that, way. Rather, such analysis will pay attention to ways in which experience has come to be discussed, debated and conceptualised in certain ways. Mary Boyle explains this approach in the following quotation, where she draws attention to a key element of the discursive approach, the relationship between discourse and power:

> 'Discourse' provides an important link between the production of knowledge about any topic and social regulation. Given that there are potentially many different ways of talking about or construing any group or phenomena, the important question becomes not whether what is said or known about a particular phenomena is true, but for example: What conditions fostered the emergence of a particular discourse? What status is accorded to certain discourses and what status is accorded to their alternatives? Who is empowered to produce particular discourses and what devices are used to present them as valid or even factual? Which social practices and power relationships are allowed and which discouraged? (ibid: 8).

The question asked is not whether it is true that a particular number of women are anxious, depressed, or traumatised after abortion, but how and why this way of framing the experience of abortion gained such influence. Her comment therefore draws attention to the way in which discourse structures understanding. Boyle is preoccupied, because of this, with the relationship between the status given to certain discourses and social regulation.

Discourses which are more powerful act to control, and order, social practices, because they become accepted as norms or truths.

Boyle also emphasises a second important effect of discourse. This is its effect in bringing order and regulation through the internalisation of discourses by certain groups of people:

> The relationship between discourse, knowledge and social regulation is highlighted further when we consider what Foucault saw as a central feature of bio-power, and particularly of disciplinary power: that it does not so much directly oppress people (although it may do) as *produce* them. It does so by creating desires (for example the desire to be thin) and personal attributes such as locus of control, self-esteem, attitude or personality. Bio-power also creates, rather than discovers, particular groups of people (ibid: 9).

This suggests that dominant discourses do not simply act against the perceived needs, attributes and desires of groups of people. Rather discourse produces them. No-one exists outside of the discourses which create and shape their experience. Individuals do not therefore, as psychology suggests, simply have certain identifiable, measurable, traits, characteristics or responses. Rather, any 'characteristic' or 'personality trait' is a product of discourse. What we might understand such a phenomenon to be, and how it is experienced at the level of the individual, cannot therefore be understood in separation from the discursive construction of the phenomenon. This claim is important to bear in mind when considering women's experience of abortion, in particular the way in which for example women may describe themselves in such a way that 'fits' in with dominant discourses, an issue I consider further in Chapter 9.

In summary, for Boyle the experience of abortion can be fruitfully analysed through use of the concept of discourse. This approach conceptualises this experience as a social, not individual question, and demands that attention be paid to the ways in which certain discourses come to act powerfully to shape it. The focus for research should be on ways in which discourses act powerfully to bring into being certain ways of understanding phenomena which carry more weight than others, and on how individual subjects are produced through the action of discourse.

## Psychology and the social construction of abortion

I discuss further these central aspects of discourse and its effects later, but before doing so, I want to draw attention to an aspect of Boyle's argument that is key to the argument in this thesis. Boyle's claim is that psychological categories can be understood as an aspect of the discursive construction of abortion, rather than as separate from it.

In psychology, Boyle argues, certain mental states, usually negative ones, are taken as the criteria for measuring women's response to abortion. Psychologists then find out how many women 'fit' these criteria through assessing women's mental health post-abortion. Boyle has argued of this approach: 'This often takes the form of the quantitative study of women's responses to abortion, often using standard scales of assumed intrapsychic states such as depression or anxiety' (ibid: 3). While this approach can tell us something, through providing statistics, about how many women are depressed, anxious or regretful about their decision to abort a pregnancy, it can be criticised as limited in its ability to illuminate much about the experience of abortion. It tells us little about the way in which society has constructed abortion, or about why women experience it in the way that they do. Boyle explains these limitations as follows:

> Much of the research focuses on whether women 'join' a particular category, or develop certain attributes, such as anxiety or depression, after abortion. Not only does this approach take such categories as given rather than constructed, it tends to view abortion as a potentially stressful life-event whose social meanings are not central to individual women's experience. It thus creates an artificial separation between the individual and the social context, in which discrete external events impinge on the individual, leaving their mark in the form of a different psychological state but through processes which are not clearly described or analysed (ibid: 9).

Boyle again emphasises the problem of psychology 'measuring' women individually, in separation from the social context of abortion. The consequence of this approach is that in psychological studies, psychological states become a 'mark' left on women, but no indication is given of how women come to experience abortion in the way they do. The 'social meaning' and the 'social context' of abortion are ignored, where for Boyle they should be central to any study of abortion's psychological effects.

Boyle's emphasis on the importance of the 'social' is also brought to bear in her criticism of the categories used by psychologists in their studies of abortion. The categories used, Boyle contends, are taken as 'given rather than constructed'. Psychological categories such as anxiety or depression are used as if the selection of these categories is unproblematic and bears no relationship to the broader construction of abortion. It is as if the rationale for the use of such categories is obvious, and beyond debate.

In contrast, for Boyle, the terms frequently used to describe and measure the psychology of the woman who has an abortion are an important *part* of the social context. These terms are not simply objective measurements. Rather, the very inclusion of the categories 'depression' and 'anxiety' as central to the work of psychologists constitutes part of the social construction of abortion. Boyle has therefore suggested that: '...whether or not we intend it, psychological research *constructs* the phenomena on which it focuses: it tells people how to

think about themselves, about others and about particular experiences' (ibid: 6). On this basis, Boyle has connected, for example, the construction of the woman who has had an abortion as the subject of investigation by psychologists to the social regulation of abortion.

While the woman whose abortion decision is regulated through abortion law was not 'invented' by psychological theory, it is arguably the case that this theory, and psychological research has '...played an important role in maintaining and reproducing the subject and in apparently providing scientific credibility for what might otherwise be seen as a set of social beliefs and opinions' (ibid: 137). In particular, in focusing its investigation on the negative psychological consequences of abortion, psychology has constructed women and abortion in certain ways:

> ... by focusing so strongly on the negative consequences of abortion even if only to show that few women experience them, psychological research conveys the impression of 'women at risk'....In other words psychological research has reinforced the view that women cannot be trusted to make constructive decisions about their lives (ibid: 137).

This approach suggests that psychology can be considered as playing a *constructive* role in abortion. The results of research about women's feelings after abortion are not a neutral, objective measure of what is simply an object of investigation. Rather '...psychology is....embroiled in abortion, whether or not it intends or is aware of it, and....its relationship to abortion is not neutral' (ibid: 3). Psychological research constitutes part of a discourse, which acts to construct abortion, and women's experience of it.

Throughout this thesis, my argument will be informed by the approach developed by Boyle. My approach will rest on the notion that psychological categories and the vocabulary of psychology have acted powerfully to construct abortion. This approach will, I suggest, prove more fruitful than the 'scientific' approach of psychology in explaining why and how abortion has been construed in the public domain as psychologically significant for women.

In the following chapters, I therefore consider the development and effects of psychological abortion discourses. First however, I want to expand on the concept of discourse, in order to provide greater clarity about the argument it entails concerning the construction of knowledge and experience, highlighted in relation to abortion by Boyle.

**Discourse**

I will begin by discussing Foucault's concept of discourse. Foucault's argument is best understood as a critique of the way in which Enlightenment thought conceptualises knowledge formation. The result of this critique is the re-conceptualisation of the formation of knowledge as a product of the operation of 'discourse'.

Enlightenment thought works with a conception of society as a collection of rational beings, with the individual as its centre point. It assumes that knowledge originates with the individual, who in a rational manner investigates and explains the world. The truth is 'out there', waiting to be discovered through reason and investigation. Foucault's work is best understood as contesting this idea. Where the Enlightenment approach sees knowledge as an ever-accumulating process of the discovery of truth, Foucault argues that there is no such linear process at work. There is no progression from a worse to better knowledge which eventually discovers 'the truth'.

Foucault's case is that there can be no discovery of truth, because there is no unified organising principle to society that could act as the basis for truth. Society has no single, coherent dynamic which unifies social processes. Foucault therefore rejected the idea that his work dealt with a totality, or could ever aspire to the status of a global or even systematic theory. Society has no system or coherence, so there can be no 'grand narrative' which uncovers 'the truth' about 'the system'.

Hence, where previous approaches have suggested that society has a central, common dynamic which exists in a unified way across society, Foucault believed in contrast that society is better understood as a multiplicity of 'sites' which can be considered and discussed, but cannot be understood as a manifestation of a general dynamic. Commenting on this theme in Foucault's work, Barry Smart writes:

> ...his entire oeuvre can be read as a series of essays on the emergence of specific rationalities in a number of central spheres of modern society. For Foucault there is apparently no overarching process of rationalization, only a set of key 'sites' in which forms of rationalisation are manifest (Smart 1985: 7).

According to Smart, Foucault's rejection of the notion of an 'overarching process of rationalization', the idea that there is a unified social dynamic, led him to focus on specific, rather than general, 'rationalities'. His concern was to uncover and discuss how in certain specific, key 'sites' a form of 'rationalization', or coherence, may be apparent.

The concept of 'discourse' is central to Foucault's exposition on the formation of such sites of rationalization. He argues that his work aims to establish that 'discourse is not nothing or almost nothing' (Foucault 1991: 63). As feminist scholar Janet Ransom has explained, for Foucault '...discourse is not merely a concept. Discourses exist in reality: they have an objective actuality' (Ransom 1993: 131). Discourses are thus as 'real' as any social motor, such as the economy, or human reason, posited as central to social development by Enlightenment thinkers.

Foucault's concern was to consider the functioning of discourse; that is the way in which certain discursive practices become regularised and therefore are deemed to constitute the 'truth'. He attempted to identify where, between types of statements or concepts, there exists

order and correlation - what he called '...a network of interconnecting mechanisms' (Foucault 1990: 49). Where this regularity was evident, where there was a unified group of statements, then a discursive formation was identified.

In seeking the basis of the unity imputed to those groups of statements (for example associated with sex, medicine, economics or grammar), Foucault argued that the system of rules and relations that govern the formation of a discourse do not emanate from the consciousness or thoughts of a sovereign subject nor are they determinations arising from institutions or social or economic relations. The systems of formation of discourses conceptualised by Foucault constitute in contrast the conditions under which it is possible for a discourse to exist: '...what must be related, in a particular discursive practice, for such and such an enunciation to be made, for such and such a concept to be used, for such and such a strategy to be organized' (Smart 1985: 39). The formation of discourse is therefore given by the relationships within discourse itself.

'Discourse' then refers to a group of statements, that is to say statements identified as belonging to a single discursive formation. The analytic activity of describing the form of unity to which a group of statements belong is one which contradicts the precepts of the Enlightenment. For Foucault discourse is formed without people (the subject) and without 'reality' (social and economic relations).

Anti-essentialism

Such an approach, which understands any phenomenon as produced by discourse, has proved attractive for feminists because it makes possible a challenge to 'essentialism'. Where essentialist approaches rely on the idea that there is a given essence or nature to the object of investigation, a discursive approach contends that no such 'truth' exists. In relation to analysis of 'the body', feminist writer Janet Ransom therefore argues of the discursive approach:

> Foucualt brings essentialist assumptions about women's bodies into question by querying the body's status as something given in nature and existing outside the operations of power. In his view the body itself is not helpfully regarded as 'natural' but becomes thoroughly socialised. The coherence of any distinction between nature as fixed and culture as variable, sex as biological, gender as social, is undermined (Ransom 1993: 126).

Where existing forms of thought have naturalised women's bodies and processes such as pregnancy associated with it, the Foucauldian approach makes this social. What happens to women's bodies is understood through this analytic framework as a product of history, culture and society, rather than as a result of an inevitable, natural process. Discourses

about the body, rather than nature, produce the body, together with our understanding and experience of the body. This concept of a social, as opposed to natural, process calls into question any view of the body that sees it as having an essential, fixed aspect. Within a framework of discourse, there is no essential 'nature' which makes the body what it is.

Discussing this concept further, Ransom explains:

> For Foucault, the categories within which we think about the body do not derive from transparent necessity, but rather are seen to be fundamentally culturally embedded and imbued with the workings of power. 'Sex' or 'sexuality', for example, is not self-explanatory; rather we become eroticised within the discourses of sex and sexuality, and it is within discourse that we learn the coherence of an identity (ibid).

Through analysing the discursive construction of the body, we need to understand and indicate how this socialisation of the body is a process which includes the operation of power and control. What is meant by sex, or the way we think of sexuality, or how pregnancy and abortion are experienced, cannot be accepted at face value. Rather the meaning of such phenomena is generated by discourses which act sufficiently powerfully to bring about the creation of sexual, and other, identities.

Power

As I have indicated briefly already, in relation to Boyle's discussion of abortion, in Foucault's thought, there is an intimate relationship between discourse and power. The two are inseparably bound up together. This theme is a distinguishing mark of Foucauldian analysis. For Foucault, discourses function as sets of rules. These rules and concepts operate to specify what is or is not the case: what constitutes insanity for example. They are therefore extremely powerful.

According to Foucault, the '...condition of possibility of power....must not be sought in the primary existence of a central point' (Foucault 1990: 93). Foucault argued against theories which presented power in such a way, as originating in a single source such as capital, the state or the law:

> The analysis, made in terms of power, must not assume that the sovereignty of the state, the form of law, or the over-all unity of a domination are given at the outset; ....rather these are only the terminal forms power takes (ibid: 92).

For Foucault, there is no single, sovereign force in society which is ultimately powerful. Institutions that have been identified as such by other analyses of power are nothing more than the end-points, the surface forms, of a different process which is the profound way in which power is formed and functions. Power may therefore be exercised in the end by officials through institutions, or through many other practices, but power is in the first place

constituted in discourses. Foucault discusses this conception of the formation and functioning of power as follows:

> It seems to me that power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them; as the support which these force relations find in one another, thus forming a chain or system, or on the contrary, the disjunctions and contradictions which isolate them from one another; and lastly, as the strategies in which they take effect, whose general design or institutional crystallization is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies (ibid).

In this description of power, it is in the first place a set of multiple relations, a never-ending process. Its institutional forms, where it is expressed as law or as aspects of the state apparatus, are only forms which power takes, not power itself. Hence the significant matter for Foucault is the process of formation and transformation of power, rather that its formal appearance. The issue is not who has power but rather the patterns of the exercise of power through the interplay of discourses. As Barry Smart (1985) has explained, Foucault's analysis thus attempts to reveal interconnections between mechanisms of power and economic and political institutions. These mechanisms and institutions are the *result* not the origin of power.

Hence there is no assumption of, or place for, a general theory of power. Connections between power and power holders have to be determined in each instance through analysis. In this sense the historical nature of power is central to a Foucauldian approach. Power can only be understood specifically and contextually, in its historical form. I will now develop my discussion of this approach to power, with a brief account of biopower and disciplinary power, which are both of significance for my argument about psychological discourses about abortion.

## Biopower

'Biopower' was a term coined by Foucault to describe the form of social regulation which emerged during the late eighteenth century. He has stated:

> ...there was....the emergence, in the field of political practices and economic observation, of the problems of birthrate, longevity, public health, housing and migration. Hence there was an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations, marking the beginning of an era of 'biopower' (Foucault, 1990: 140).

There are thus two aspects of 'biopower'. One focuses on the individual body and the other focuses on the population. Many writers (Albury 1999; Jones and Porter 1994; Lupton 1997; Ransom 1993; Sheldon 1997; Thompson 1999) have pointed to centrality of medicine as an aspect of biopower. Such writers have suggested that medical knowledge has played a central role in the regulation of control of both bodies and populations. How does medicine come to be able to exert this power? Deborah Lupton, with reference to Foucault's work *The Birth of the Clinic*, has explained the operation of medical power as follows:

> ...medical power may be viewed as the underlying resource by which illnesses are identified and dealt with. This perspective fits into the broader social constructionist approach in understanding medical knowledge not simply as a given and objective set of 'facts' but as a belief system shaped through social and political relations (Lupton 1997: 8-9).

A central issue is therefore medicine's ability to define what constitutes a problem, requiring medical intervention. Part of medicine's power lies in its ability to construct medical problems, and thus make bodies subject to the 'medical gaze'. In this respect, medicine is not based on a purely objective, factual account of illness, but is shaped by its social and political context.

This point has perhaps been developed most explicitly by feminist writers, in their explorations of the role of medicine in the control and regulation women's bodies. Rebecca Albury, writing on the regulation of reproduction, has argued for example that the medical profession has:

> ...provided the language in which we speak of bodies, and the practices that interrogate and report bodily experience....experience has to be 'medicalised' in order to be recognised; that is, it must be turned into a problem that is capable of being addressed in a medical way (Albury 1999:39).

In this analysis, a central aspect of medical power lies in the ability for medicine to define how we 'speak of bodies' and how we consider what is 'wrong' with our bodies.
This approach to understanding the power of medicine can also be applied to that of psychology and psychiatry. These 'sciences' too can be understood as acting to regulate and control those subject to them, through their ability to construct and define what is mental health or, in contrast, mental ill health.

McCallum has, following this approach, discussed the emergence of the categories of 'personality' and 'personality disorder'. He contends that, rather than being natural, ahistorical contents of a person's individuality, the category of personality is constructed, and can be best understood as the result of historical contingencies, which include the '...production of knowledge concerned with the internal dimensions of individuality in all its

complexity, which is associated with the growth of the psy-disciplines during the twentieth century' (McCallum 1997:69).

This kind of knowledge, where concepts such as 'personality' come to be defined and thus are deemed 'knowable', is related to the exercise of power and control: '...through the advancement of norms of personal life, such as the forging of desire towards the shaping and presentation of a well-adjusted personality' (ibid 70).

In this analysis therefore, the 'psy-disciplines', in common with medicine and other dimensions of bio-power, are powerful and their development is inseparable from the development of control and regulation over individuals and populations. In particular however, as I will now go on to explain, central to the operation of the 'psy-discplines' is the exercise of a particular form of power, disciplinary power, which governs and disciplines subjectivity.

## Discipinary power and subjectivity

The concept of disciplinary power has been used by to explain how certain actions, lifestyles and identities become accepted as norms, while others are undermined and stigmatised (Boyle 1997: 63). Discourses act on individuals in such a way as to encourage them to act or behave in a particular manner. However it is important to grasp that within this framework of analysis, it is not that individuals are repressed or regulated against their will. Subjects are not forced by a pressure external to them into a course of action that they would rather not take. Rather they are disciplined willingly. The concept of self-regulation, used to explain how subjects are discursively produced and disciplined, is an issue which is key (and contentious) in Foucauldian analysis. The relation between discourse and individual subjectivity and agency is the issue to which I now turn.

Discourse theorist Jonathan Potter has summarised Foucault's approach to the relationship between discourse and subjectivity as follows:

> Foucault suggests that discourses can be seen to be producing subjects. What he means by this is that forms of speaking about objects closely relate to particular identities. For example, the medical discourse of examination, questioning, diagnosis, prescription and so on constitutes a range of objects....However that discourse also constitutes the doctor as a particular person. The doctor is produced as a subject with particular authority, knowledge, skills and so on (Potter 1996: 86).

Discourse does not therefore merely produce objects, for example the doctor as produced by medical and psychiatric discourse. At the same time, discourse produces subjectivities, or identities (Foucault 1972). The doctor himself is produced with a particular identity, which he takes as his own.

This approach to the mechanisms through which human beings are made into subjects is radically different to that which is to be found in traditional sociology. Its focus is on how human beings govern themselves and others by the establishment of 'regimes of truth'. Foucault discusses how a particular discursive 'regime of rationality' (Smart 1985: 72) simultaneously constitutes rules and procedures for doing things as well as 'true' discourses which legitimate activities through the provision of reasons and principles, which then produce subjectivity. These processes are called by Foucault 'technologies of the self', describing the process through which individual subjectivity is constituted (Fox 1997).

Foucault's analysis of subjectivity is not situated at the level of social institutions, which then control the individual. Rather the focus is upon the diffusion of particular 'technologies of the self' and their inter-relationship with the emergence of particular forms of knowledge, notably those sciences such as psychology, which have human beings, the individual, as their object. As such, the individual and subjectivity is not controlled, rather it is produced through these sciences. Discussing this process with reference to psychology, Potter summarises the Foucault-inspired argument of the British scholar Nikolas Rose (1989):

> ...as psychology has developed it has produced successive regimes of truth which have entered new areas of people's lives. Within these regimes, new psychological objects were fabricated: the satisfaction of workers, the aptitude of soldiers, the bonding of parents and children. These regimes brought into being 'new ways of saying plausible things about other human beings and ourselves....new ways for thinking about what might be done to them and to us' (1989: 4). Here the twin processes of producing objects and subjects are closely intertwined. As psychological discourses generate new entities, they also generate new positions from which to speak. The speaker can talk as an extrovert, as a borderline schizoid, as thoroughly repressed; in each case the discourses provide ways of speaking, particular channels and authorities (Potter 1996: 87).

I want now to discuss this concept of the 'psychologised subject' further, through reference to Rose's work.

## Psychologised subjects

Rose contends that the discourse of psychology not only produces new identifiable objects, but in doing so also produces 'new positions from which to speak', that is new identities for individuals. He draws attention to the way psychology not only categorises people in particular ways, but that those categorisations simultaneously generate psychologised subjectivities and identities. In *Governing the Soul, the Shaping of the Private Self* (1989) Rose provides a detailed account of ways in which such subjectivities are

produced, and are both distinguishable from previously existing subjectivities, and whose emergence can be explained through historical analysis. I will now provide a brief account of his argument, because of its relevance to the way in which the emergence of the 'traumatised woman' who has had an abortion might be understood. I draw attention first to Rose's conception of the 'private' self, and second, key elements of his analysis of the contemporary shaping of the 'private' self.

Rose claims that: 'We live under the beguiling illusion that our subjective lives are a personal matter' (Rose 1989: preface). However, the key issue to understand is that the conception of our 'subjective lives' as a 'private matter' is indeed an 'illusion'. While our '...thoughts, feelings and actions may appear to be the *sine qua non* of the private, intimate self', such 'personal' matters have in fact come to be the target of 'new forms of power' (ibid). What appears to be the aspect of our existence which is least connected to the public, external world is not what it seems. Our 'private' selves are in fact produced, and shaped by external power.

His analysis shows how our 'private' selves have come to be powerfully shaped and governed by new forms of power which Rose suggests are specific to the second half of the twentieth century, and in which psychological theories are key. He contends that over this time, the 'psychologising' of the self has been such that:

> Our selves are defined and constructed and governed in psychological terms, constantly subject to psychologically inspired techniques of self-inspection and self-examination. And the problems of defining and living a good life have been transposed from an ethical to a psychological register (ibid: xiii).

Rose contends that over this period of time a new kind of self, or subjectivity has emerged, which is defined by its psychologised construction and governance. In explaining how this new kind of self emerges Rose claims that the development of a new psychological language is key, but this language comes to exert its power through its relationship with a developing political order which has its focus on the management of the interior life of citizens, mediated through a new collection of experts in the management and control of emotion.

Rose thus draws attention to the '...development of a new language for speaking about subjectivity and new techniques for inscribing it, measuring it, and acting upon it' (ibid: x). Through this language '...the self became calculable and manageable in new ways. Psychological experience staked its claim to play a key role within any practice of management of individuals in institutional life' (ibid). This 'new language' of psychology, talks of the self as primarily defined by its psychological experience, which can be measured, understood and altered. However, the significance of this language is its relationship to the

management of individuals in institutions. Psychology forms a relationship with institutional and political power.

While in form psychology may appear to be concerned with the isolated individual, for Rose, its *modus operandi* and effect is quite the opposite. It makes the subjectivity of the individual public, and social. Rose explains that by

> ...stressing the significance of subjectivity as the key to our humanity, in elaborating techniques that enhance subjectivity through self-inspection and self-rectification [psychology] ....underpinned the ways in which subjectivity has become connected to networks of power (ibid: ix).

This is the distinctive aspect of contemporary subjectivity. While our emotions and feelings may always have been managed to some degree, what is novel in post-war society is the connection between subjectivity and 'networks of power'. While Rose suggests it would be 'too much' to claim that political elites construe their tasks in the management of society and its institutions entirely in terms of the interior lives of citizens, the question of subjectivity does now enter into ways in which politics and policy are formulated, in a way that was never previously the case.

Rose gives the example of child/parent relationship, and the importance placed in policy and politics on the centrality of the correct development of a child's emotional and psychological development in 'good parenting'. This approach could be extended to many other spheres, for example in the 'new emotionalism' typified by the response of the New Labour government in its communication with the British public in the wake of the death of Princess Diana.

In connecting subjectivity and power, Rose contends that the development of new forms of 'expertise of subjectivity' (ibid: 3) is of great significance. He suggests that the development of knowledge about subjectivity, new notions of personality and new theories of human psychology have '...gone hand in hand with the development of new techniques for the re-shaping of selves by systematic management under the guidance of psychological expertise' (ibid: xiii).

This new management begins in certain areas of life, for example the 'diseases' of alcoholism or anorexia. It is however generalised and extended to most areas of 'everyday life', and comes to influence '...every subject from sexual satisfaction to career promotion' where '...psychologists offer their advice and assistance' (ibid: xiii). Such 'expertise' can be seen in the psychological management now apparent in such everyday problems including giving up smoking, moving house, bereavement, problems in our sex lives and our personal relationships (Peele 1989).

This 'new expertise' is embodied in: 'A whole family of new professional groups' which each asserts '...its virtuosity in respect of the self, in classifying and measuring the psyche, in

predicting the vicissitudes, in diagnosing the causes, and prescribing remedies' (Rose 1989: 3). Included in this new collection of experts, who Rose terms 'the engineers of the human soul', are counsellors, psychotherapists, social workers, probation officers, all of whom deal in the language of psychology, and claim to have insights into human subjectivity on the basis of which they can 'cure' our psychological ills. Rose suggests a number of themes which characterise the modern therapeutic ethos, espoused by these 'new experts'. I want finally to draw attention to these insights, which I suggest are of relevance to my analysis of the process of 'psychologising abortion'. I will return to themes later, in particular in my discussion of the Lane Commission in the following chapter, and in my analysis of 'counselling talk' in Chapter 7.

The first is the notion of the 'freely choosing self'. The goal of the new therapeutic ethos is to create a self that can choose, and therefore be happy: 'The self is not merely enabled to choose, but obliged to construe life in terms of its choices' (ibid: 225). Thus the exercise of 'free choice', for the new experts, is the key to a happy, contented self. The achievement of such freedom, through individual 'empowerment' is the aim of therapeutic intervention. Rose also argues that in this theme: '...the techniques of psychotherapeutics come into accordance with the new political rationales' (ibid: 227). The post-war years of the 1950s and 60s saw the emergence of 'individual choice' in the 'private sphere' as key political theme. This was apparent in the key reforms of this time, concerning homosexuality, 'issues of conscience' and, of course, abortion. Politics came to tell us we are 'free to choose' in our 'private life'. Hence the new therapeutic discourse links powerfully with this injunction to freedom, and: 'Provide technologies of individuality for the production and regulation of the individual who is 'free to choose' ' (ibid: 227).

The second theme is what Rose terms 'the psychologization of the mundane', which involves:

> ...the translation of exigencies from debt, through house purchase, childbirth, marriage and divorce into 'life events', problems of coping and adjustment, in which each is to be addressed by recognising it as, at root, the space in which are played out forces and determinants of a subjective order (fear, denial, repressions, lack of psycho-social skills) and whose consequences are similarly subjective (neurosis, tension, stress, illness) (ibid: 244).

Day to day events become 'psychologised' through the emphasis placed on their emotional effects and subjective causes. In this context, the role of the 'new expert' comes to the fore. Such problems of life are best rectified not by the individual, the family or priests, but by psychologists and by others with similar expertise.

The third theme is 'the power of speech'. Rose contends that a key aspect of the 'new technology of the self' is the therapeutic power ascribed to the act of speaking, but never more so than in the presence of an 'expert' in human subjectivity:

> Speech, by virtue of its location in this technology, becomes a therapeutic activity. No doubt it always does us good to 'get it off our chest', but never so much as in an encounter defined as one that will make us better....The interpretive tropes of psychoanalysis, the encouraging 'm-hm' of 'non-directive therapy', the reflection back of the speaker's own words by the voice of the therapist. To speak in the therapeutic encounter is to place one's words within a whole scientific field (ibid: 246).

The notion of the 'power of speech' is a new notion, intimately connected to the emergence of the new kind of self, and through which the 'new self' is regulated. Speech in this context, in the presence of an 'expert' in human subjectivity, is thus more than simply speech, where one gets something off one's chest. To speak in this context is to become part of the 'whole new scientific field' of the psychologised society.

Rose's work constitutes a nuanced and insightful account of the relevance of the Foucauldian approach to subjectivity. He argues convincingly that powerful discourses have over time come to produce us as psychologised subjects. For Rose, to contend that subjectivity is a product of psychologising discourses is not to suggest that 'false' knowledge is produced. As he explains, his concern is '...not with truth in some philosophical sense' (ibid: 4), but with ways in which '...systems of truth are established' (ibid). His concern is to investigate '...the new regimes of truth installed by knowledge of subjectivity....new ways of saying plausible things about other human beings and ourselves' (ibid).

In the remainder of this thesis I hope to adopt the same approach. My aim is not to discuss whether the 'traumatised woman' is a true or false account of the experience of abortion, but to consider how this subjectivity is produced.

**Conclusions**

In this chapter I have outlined the differences between the approach of psychology, and a sociological approach which makes the concept of discourse central to analysis of the experience of abortion. I have summarised the main tenets of the concept of discourse as developed by Foucault, and discussed its advantages for feminist analysis, including its analysis of abortion.

Drawing on this approach, the aim of the remainder of this thesis is to add to our understanding of the effects of discourses which psychologise abortion. The questions I want to consider are: How has the language of psychology produced the experience of abortion? What happens when abortion is talked of and discussed in terms of psychology?

What effects does this have on the regulation, politics and provision of abortion? How has it come to be the case that the psychological effects of abortion are a matter of concern for those involved with the procedure? How has the way a woman feels about abortion come to be part of the public debate about abortion? What relationship does knowledge about the psychological effects of abortion have to the regulation of abortion in law, and to the provision of services to women considering abortion and afterwards? To begin, I will examine debates about the law governing abortion in Britain.

# Chapter 3: PSYCHOLOGISING ABORTION LAW

I begin my examination of the development of abortion discourses with a discussion of debates on abortion law. In doing so, I again draw on the work of Mary Boyle, and also on that of other feminist social scientists (particularly Sally Sheldon), who have analysed British legal debate about abortion from a Foucauldian perspective. Through a review of their work, I contend that this perspective can account for the kind of law that exists in Britain. It also provides a framework which can explain why participants in the abortion debate both in Parliament and outside it have framed their arguments in terms of the psychological effects of abortion.

There are four main themes running through my discussion of abortion law debates. First, abortion has been *medicalised* in legal debate. Abortion can been constructed in a number of ways in legal discourse. One construction, which has been prominent in debates in the U.S., centres on the allocation of rights, either to women or to the fetus. In Britain however, this kind of rights-based discourse has not been at the centre of legal debate. Rather, abortion has been debated primarily in medicalised terms. Arguments framed through reference to medicine or science have come to dominate the abortion debate (Franklin 1991; Hadley 1997; Sheldon 1997; Sheldon 1998). Legal scholar Sally Sheldon, on the basis of her study of the parliamentary debate about the 1967 Abortion Act and the 1990 Human Fertilisation and Embryology Act, summarises the 'medicalisation' of abortion debate as '...the pre-eminence of a medical discourse or narrative, and the marginalisation of other understandings or knowledges' (Sheldon 1997: 3). In this chapter I draw on the concept of 'medicalisation', as developed by Sheldon and others, to explain that in Britain, abortion is legally permissible not because it is deemed a woman's right, but because it can be authorised on medical grounds.

Second, I contend that the medicalisation of abortion has been highly significant in the removal of decision-making power in abortion from the pregnant woman. As Sheldon (1997) has explained, through the medicalisation of abortion, the power to make the decision about abortion has been placed firmly in the hands of the medical profession. The 1967 Act empowers two 'registered medical practitioners' to grant legal access to abortion if they 'agree in good faith' that the request for abortion meets with one of the grounds stated in the Act. There is evidence which suggests that the vigour with which medical practitioners conduct their assessments of women's abortion requests has diminished since the passing of the Abortion Act (Paintin 1998; Marie Stopes International 1999). Nevertheless the principle that medical professionals are empowered to make abortion decisions rather than women who request the procedure remains in law.

Third, the construction of abortion as *psychologically* significant for women has been, and continues to be, important in sustaining the notion that women should not make abortion decisions without professional assistance. In this chapter I argue that parity exists in British abortion law between physical and mental health. Under the terms of the Abortion Act, an abortion can be legally performed if the pregnancy is deemed a threat to the woman's physical health, but also if it is deemed threatening to her mental health. 'Health' is therefore construed to include not only the health of a woman's body, but also the state of her mind. I suggest that this broad definition of 'health' has had significant implications for the provision of abortion in Britain. On the one hand, the construction of abortion as legally permissible on grounds of mental health has played an important part in allowing a relatively liberal provision of abortion to women. At the same time, the construction of 'mental health' as significant in abortion has meant that, following the introduction of legal abortion, a woman's mind became construed as a valid site of surveillance and assessment by medical professionals. Through my discussion of the Lane Report and the argument for abortion counselling, I argue that the 'mental health' of women seeking abortion has become subject to scrutiny, and women have become considered in need of professional assistance in making, and 'coping with' abortion decisions.

Fourth, while a discourse which constructs abortion in medicalised terms has been predominantly associated with supporters of the provision of legal abortion, in more recent years it has also become associated with those who oppose abortion. As I indicate through my discussion of the 1990 reforms to the Abortion Act, one version of such medicalised anti-abortion argument had by this point become apparent in legal debate. This was an argument which centred on the claim that abortion leads to a 'post-abortion syndrome'. The history and dimensions of this argument are discussed in more detail in the following chapter.

In developing the themes outlined above, my discussion focuses on three episodes in abortion law debate. Two occurred when abortion legislation was passed in 1967 and 1990, and the third occurred when a major assessment of British abortion law was conducted by the Lane Committee which reported its findings in 1974. I have chosen to structure my discussion around these particular episodes not because they represent all the legal discourse on abortion over the last three decades (there were a further 16 abortion bills introduced into the British parliament between 1967 and 1992 (Moore 1992: 32)). However the 1967 Abortion Act, the 1990 reform to that Act and the Lane Committee enquiry into the operation of the Abortion Act constitute particularly significant components of the history of British legal discourse. These three components of abortion law and policy have all been given Government support and therefore I contend have particular status and authority in the legal regulation of abortion.

Unlike other abortion bills which were unsuccessful, the 1967 Act and the 1990 reforms were both endorsed by the governments of the day. The Labour Government gave extra parliamentary time for the discussion of abortion in 1996/7. The 1990 Human Fertilisation and Embryology Act was introduced as a Bill by the then Conservative government. Support from government for the need for discussion of these measures was important in that it meant sufficient parliamentary time was made available for debate, making it likely that new legislation would be passed. In contrast, numerous other abortion bills introduced in the past 30 years have failed to get beyond a first reading, because insufficient time was allocated for debating these Bills by government.

The Lane Committee was similarly officially endorsed. It was set up by the government of the time, and its findings were accepted by that government. Its approach to investigating the Abortion Act in practice, and its findings, can therefore be taken as representative of the official attitude at that time to abortion. Together therefore, these three aspects of debate about abortion law merit analysis because of their status and significance in the development of abortion regulation.

**The 1967 Abortion Act**

Abortion in Britain still remains formally illegal. The procedure is regulated by sections 58 and 59 of the 1861 Offences Against the Person Act (1), which set a maximum penalty of life imprisonment for attempting to procure an abortion and criminalised anyone, including the woman herself, who attempted to procure an abortion. This piece of legislation has never been repealed. Rather, from 1968 onwards (when the 1967 Abortion Act came into force), the 1861 Act had to be read in conjunction with the 1967 Act. A defence was provided against the offences defined in the prior legislation because in 1967 Act doctors were empowered to carry out legal abortion on the grounds specified in the clauses of the Abortion Act (Bridgeman 1998; Simms 1985).

Doctors or women were not however frequently prosecuted under the 1861 Act, even before 1967. Even before the Abortion Act of that year was passed, the number of prosecutions for illegal abortion was tiny. In 1919 for example, 60 people were tried for procuring abortion and 42 convicted. This stands against a pre-1967 illegal abortion rate estimated as between tens of thousands to 100 000 abortions annually (Brooks 1988). Although figures vary widely and are accepted to be inaccurate because of the absence of proper records, it seems clear that before being legalised, abortion was common, and generally accepted in the popular mind if not in the law as a method of birth control. However the fact that abortion remained illegal, with exceptions permitted, is significant because of the way this formulation of the law constructed abortion. The assumption behind the law was that abortion was *prima facie* wrong and was to be prohibited unless there were mitigating

circumstances, namely those specified in the Act, and provided two doctors agreed that one of these circumstances applied to the woman in question.

Since 1967, only one amendment has been made to abortion law, through section 37 of the 1990 Human Fertilisation and Embryology Act. The main clauses of the Abortion Act 1967 (as amended in 1990) are as follows:

> Section 1(1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion formed in good faith -
> (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
> (b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
> (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
> (d) that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
>
> 1(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph a) or b) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably forseeable environment.

According to the British philosopher Janet Radcliffe-Richards (1982), the moral basis of this law is unclear. When abortion law was reformed in 1967, reform was not predicated on principles regarding the appropriateness, or inappropriateness, of legal abortion. Legal abortion was not deemed 'right' or 'wrong'. This point can be illustrated clearly by comparing British abortion law with its equivalent in the U.S..

The 1973 Roe v. Wade ruling by the American Supreme Court deemed first trimester abortion a constitutionally protected privacy right (Dworkin 1995; Tribe 1990; Cohen 1997). In its ruling, the Court said that the right to privacy '....is broad enough to encompass a woman's decision whether or not to terminate her pregnancy' (Kissling and Shannon 1998: 145). While the court took it for granted that a doctor would be consulted, the law ultimately left decision making during the first trimester to the woman. A principle was thus established in law of a woman's right to decide on abortion. It is clearly the case that this legal principle has been undermined in the U.S., in particular by restrictions on abortion passed at the level

of individual states (2). Nonetheless, abortion in federal U.S. law remains constructed as a woman's right.

In Britain, no such principle underpinned abortion law. The woman was given no right to abortion at any stage in pregnancy, including the first trimester. It should also be noted that the fetus was not ascribed any legal protection in abortion law, until the time limit of twenty-four weeks was made the cut-off point for legal abortion in 1990. Throughout pregnancy, the right to decide whether or not a woman could legally end a pregnancy was deemed to rest in the hands of two doctors, who could agree to the request for abortion on medical grounds. It was the judgement of two doctors which was therefore primary in deciding whether a woman's request for abortion complied with the terms of the Abortion Act. Feminist scholars have therefore pointed out that British abortion law *medicalises* abortion (Fyfe 1991; Latham 1998; Sheldon 1997). Drawing primarily on the work of Sally Sheldon and Mary Boyle, I will now discuss this defining aspect of British law, and indicate how abortion law in Britain came to be formulated in these terms.

The doctor and the woman

Mary Boyle has pointed out that under the terms of the Abortion Act: 'A woman may decide that she wants an abortion, but it is doctors who decide whether she may have it' (Boyle 1997: 62). She and Sally Sheldon have discussed how this framing of the law came into being. They ask how it came to be the case that, while it is the woman who will have the abortion, it is doctors who decide whether or not she is allowed to. In order to provide some answers to this question, Sheldon and Boyle carried out thorough analyses of the debate about abortion in parliament. They analysed the talk of parliamentarians to find out how abortion law came to be framed in medicalised terms. Some key points they make are as follows.

Boyle suggests that the claim the abortion decision was a medical decision was sometimes simply asserted. Parliamentarians argued in support of the new law for instance: '*It seems to me a very big decision, and must always be a medical decision*', that '*..obviously the decision must be a medical one*', and '*...it must always be a medical decision*' (Boyle 1997: 64). In these comments, no justification for the claim that abortion decisions required the exercise of medical judgement was given. It was simply taken for granted that decision making should lie with doctors.

Others suggested that abortion should *only* be legal for 'medical reasons'. For example it was argued that '*...the main basis of the Bill is medical. Good ethics in medicine and surgery demand that an operation should not be done unless it is justifiable or indicated for medical reasons*' (Boyle 1997: 64). The effect of this argument was to draw a line between 'good' medical reasons for abortion and 'bad' social, or what were often called 'trivial' reasons. This

kind of appeal to medical justification for abortion had the clear effect of delegitimising reasons for abortion which were not 'medical'. It also means that 'abortion on demand', that is abortion where the woman is not required to specify the reason for her abortion request, was ruled out.

Sheldon also analyses the construction of medical authority in this debate. She points out that very different terminology was used where parliamentarians talked about doctors and women seeking abortion. The latter were talked about as in great state of distress, in need of pity, sympathy, and assistance from others: in sum as 'victims' (Sheldon 1997: 38-9). In thus characterising the woman involved reformers frequently made reference to the plight of those who sought back-street abortion. Sheldon quotes one MP who, talking in support of reform, described women who seek abortion as the *'distracted multi-child mother, often the wife of a drunken husband'* and the woman who '*returns to a distant town there to lie in terror and blood and without medical attention'*. Another talked of *'mothers with large families'* suffering from the *'burdens of large families'*, and another of the '*woman in total misery'* (ibid).

While the concern expressed about the effect of illegal, back-street abortion was genuine, the woman was in effect disparaged as a victim of desperate circumstances. As Greenwood and Young have pointed out, this woman was '...not only on the fringe, but literally physically inadequate' (1976: 76). The emphasis in the talk of abortion law reformers was placed on the desperation, poverty and instability of women who wanted abortion.

In contrast with the image of the desperate woman the doctor was depicted as a '*calm, responsible, rational and reassuring figure'*; as *'highly skilled and dedicated'*; as *'sensitive, sympathetic'*; as a member of a *'high and proud profession'*; and as displaying '*skill, judgement and knowledge'* (Sheldon 1997: 40). Unlike the worn down, distraught woman, the doctor was depicted as in a position to make rational, considered decisions, and as thus clearly the best candidate for the law to empower with the authority to make abortion decisions.

It should be noted that the contrast made between doctors and women was characteristic of the arguments put forward by supporters of reform. Indeed, it could be argued the success of abortion law reform was predicated on the granting of decision making power in abortion to those considered responsible and trustworthy - doctors - and the assurance that it would not be granted to those considered not so - their female patients (Francome 1984; Latham 1998; Paintin 1998: Simms 1998).

The second, related aspect of the medicalisation of abortion was the construction of the negative effect of continuing pregnancy on the health of the woman involved, or on her existing family, as legal grounds for terminating a pregnancy. I now briefly highlight the terms of the debate between opponents, and reformers to illustrate this point.

Motherhood, morality and health

The way that reformers and opponents of abortion law reform talked about women requesting abortion displayed both similarities and significant differences. Sheldon contends that these two 'camps' of opinion were united in a fundamental way, in that whether parliamentarians were for or against making abortion legal, they saw maternity as a state that women normally desired. Sheldon argues that: 'The image of the woman as mother is appropriated for the cause of both reformists and conservatives alike. It is not until the 1990 debates that (some) MPs feel able to challenge the inevitability of maternity for all women' (Sheldon 1997: 40). The difference between opponents and supporters of reform lay in the way in which they constructed women who wanted abortion in relation to this norm.

For opponents, abortion was constructed as an abomination, which was antithetical to the desire any normal woman should have to be a mother. Abortion was construed as both immoral and unnatural. For reformers abortion was a 'necessary evil' which could help ensure that when children were born, they were born to women who were deemed to be capable of mothering them effectively. Women on this basis could be justifiably exempted from maternity, and should be able legally to abort a pregnancy if they were temporarily incapable of being 'good' mothers. By contending that their health would be placed 'at risk' through childbirth, abortion could then be justified on the grounds that women with poor health would make poor mothers. Hence for reformers, access to abortion could help facilitate successful and effective motherhood by ensuring that women only had children only in circumstances where they were healthy enough to mother them. The following brief extracts from the 1967 debate illustrate these differing positions.

Opponents of the Abortion Act saw the woman who sought abortion as '...a selfish, irrational child' (ibid). Women who wanted abortion were said to be feckless, irresponsible and immature. Having become pregnant, and then requesting abortion, such women were said to demonstrate moral weakness by refusing to face up to their responsibility to the future child. This narrative constructed abortion-seeking women as outlandish and as even despicable. Comments made in Parliament by the well-known opponent of legal abortion, Dame Jill Knight, illustrate this view:

> *People must be helped to be responsible, not encouraged to be irresponsible....Does anyone think that the problem of the 15-year old mother can be solved by taking the easy way out?....here is the case of a perfectly healthy baby being sacrificed for the mother's convenience* (ibid: 36).

Women who sought to end pregnancy by abortion were characterised as whimsical and unthinking. Their motivation for abortion was construed as a desire to avoid responsibility by taking the easiest option available, rather than doing what was 'right'. It is striking that Knight used the example of a 15-year old girl. This is a case where even those opposed to 'easy

abortion' might accept that there are good grounds for ending the pregnancy. The idea of a child bearing a child is something few would actively support. However this commentator saw that even in this situation there was no 'good reason' for abortion. This implied that older women who sought abortion must be remarkably feckless and irresponsible to even consider such a course of action. Where Knight was contemptuous of women who sought abortion, other anti-abortionists, such as the Labour MP Kevin McNamara indicated incomprehension that a woman could even consider abortion in the event of pregnancy:

> *How can a woman's capacity to be a mother be measured before she has a child? Fecklessness, a bad background, being a bad manager, these are nothing to do with the love, that unidentifiable bond, no matter how strange or difficult the circumstances, which links a mother to her child and makes her cherish it* (ibid: 40).

A long-standing argument in psychology and medicine, which has claimed that women have an 'unidentifiable bond' with their child or potential child, has been discussed in feminist writings (see for example Sayers 1982; Stanworth 1994). Those who argued against abortion in 1967 used this construction of women to delegitimise abortion as wrong for any woman, on the grounds that it went against women's instinct, which was to have babies. Opponents of the Act considered women to be fundamentally maternal, and women who sought abortion were therefore regarded as feckless and irresponsible in their violation of this basic instinct.

Reformers, whilst agreeing that motherhood was the ideal and desirable end to pregnancy, '...represented the woman who would seek to terminate a pregnancy as a vulnerable, unstable (even suicidal) victim of her desperate social circumstances' (Sheldon 1997: 35). According to David Owen, the then Labour MP for Plymouth, abortion was for the woman 'in total misery' who:

> *....could be precipitated into a depression deep and lasting. What happens to that woman when she gets depressed? She is incapable of looking after those children, so she retires into a shell of herself and loses all feeling, all drive and affection* (ibid: 21).

In this comment abortion was constructed as an adjunct to motherhood, not in opposition to it. The woman concerned was already a mother and so had fulfilled her destiny to show care and affection to her offspring. However bearing another child would diminish her ability to continue doing so, and hence abortion would be the best solution because it would enable her to continue being a good mother. Her grounds for abortion were therefore the 'depression' that would result from further child-bearing. This approach is shown more clearly still in the following comment, from Dr John Dunwoody (Labour MP for Falmouth and Camborne):

> *My belief is that in many cases today where we have over-large families the mother is so broken down physically and emotionally with the continual bearing of children that it becomes quite impossible for her to fulfil her real function, her worthwhile function as a mother* (ibid).

Abortion was construed an option for a certain type of woman. She was already a mother and so had fulfilled her 'real function'. She was also 'worn down' physically and emotionally and so could not cope with another child. Sheldon suggests therefore that: 'Whilst the reformers believed that women seeking abortion had been wrongly stigmatised as criminals, they represented them as victims who needed help and guidance' (ibid: 20).

In summary, the law that emerged from this discussion had motherhood at its centre. Women were constructed as fundamentally maternal, and it was assumed that normally pregnancy should be carried to term. The woman who could legally terminate pregnancy was discussed as unable to bring up more children than she had already, and hence abortion was the best outcome for her. In 1967 a key theme for supporters of reform was whether the woman's health was good enough to allow her to bear and mother a child.

In the event the reformers' arguments were successful, and through the 1967 Act, doctors were empowered through the law to take into account women's health in deciding whether or not a request for abortion was legal. Under the law, a doctor could allow an abortion if carrying the pregnancy to term constituted a greater threat to the woman's physical or mental health than if the pregnancy were terminated. This construction suggested that abortion might represent some threat to health, but pregnancy carried to term might constitute a greater risk. To put it another way, women were construed in this debate as warranting legal abortion provided they were physically or mentally unable to cope with bearing a child. Abortion was legalised only for those women deemed too physically or mentally weak to cope with continuing pregnancy to term.

**Mental health and abortion law**

As I have argued, the 1967 Act medicalised abortion. However, the construction of abortion as justifiable on 'medical grounds' is more complex than it might appear at first sight. Following Kennedy, Boyle has argued that in general, not just in abortion, what constitutes a 'medical decision', taken for 'medical reasons' is not self-evident (Boyle 1997: 66). It is difficult to find a consistent and convincing definition of what such a decision constitutes. A decision taken by doctors is not adequate, since doctors make many decisions which are not medical. Perhaps the definition of a decision made by a doctor about health would be more convincing? Again this is problematic, since what constitutes a decision about health is not at all straight-forward. How, for example, is the line to be drawn between interventions which are 'medical' and those which are 'non-medical'. For example the

prescription of the contraceptive pill to a teenager to prevent acne and the payment of money to a body-piercing salon could both be described as activities which aim to improve the appearance of the individual concerned. Yet in the first case, the decision to prescribe the pill would be deemed 'medical'. The pill is a 'treatment', paid for by the NHS. In the second case, the decision to purchase body-piercing would be deemed 'cosmetic'. Body-piercing is a 'service' paid for by the individual. As Boyle suggests, what constitutes a 'medical decision' is not objective and descriptive, but is profoundly influenced by norms and values, and is subject to change and redefinition.

In considering the definition of the abortion decision as a 'medical issue' in 1967, the exercise of value judgements, and the re-working of what is meant by 'health' was very apparent. If 'medical judgement' had been narrowly defined, it would have meant that the doctor was in a position to pass judgement about the likely effect of abortion on a narrow range of bodily processes, for example the risk of perforating the uterus during abortion. However, in making an abortion decision, this is not what the doctor was said to be judging. Mary Boyle suggests that medical involvement in abortion decisions instead came to imply that the doctor should make value judgements, rather than strictly medical judgements, about the fetus, the woman's wishes and her social and personal circumstances.

Sheldon also points out that the law rested on a broad definition of what the doctor was in a position to judge. Through the 1967 Act (s.1 (2) as set out previously) the doctor was empowered to take into account the 'woman's actual or reasonably foreseeable environment' in assessing her abortion request. As a result, as Sheldon puts it:

> The woman's whole lifestyle, her home, finances and relationships are opened up to the doctors' scrutiny....The power given to doctors far exceeds that which would accrue merely on the basis of a technical expertise (Sheldon 1997: 25).

The Act thus relied on the construction of doctor as in a position to make judgements that do not primarily rely on technical expertise. This broad conception of 'medical' expertise was in fact overtly argued for by the initiator of the 1967 Act, David Steel MP. He argued that:

> ...social conditions cannot and ought not to be separated from medical conditions. I hope that the Abortion Act by its very drafting has encouraged the concept of socio-medical care (ibid).

A further component in broadening the definition of what constituted a 'medical matter' was the inclusion of the effect of pregnancy on a woman's psychological state, or 'mental health', as a legal ground for abortion. As I indicated earlier, the justification of abortion on this ground (that continuation of pregnancy would bring about depression, or other negative psychological states) was made by reformers in the debate about the 1967 Act. However, the inclusion of the assessment and treatment of mental states as a medical matter involved redefining health and illness.

Boyle suggests that by the time of the 1967 debates, the inclusion of 'mental health' as 'medical reason' for abortion was relatively unproblematic (Boyle 1997). The construction of the problem of 'mental health' as a legitimate issue, deserving of medical attention, had already been established through a process which preceded the 1967 reforms. Boyle draws attention to two moments in legal history, which she contends are significant in this respect.

The first was the Bourne ruling. This ruling, made in 1938, acquitted a Doctor Bourne, who had been charged with committing a criminal offence, after performing an abortion on a 14 year old girl who had become pregnant after being raped by soldiers. The significance of this ruling is discussed by Boyle as follows:

> The acquittal of Dr Aleck Bourne, who was prosecuted in 1938 for carrying out an abortion on a 14-tear -old 'decent' girl who had been raped, suggested to some that a woman's mental state was as important as her physical state in abortion decisions. The nineteenth and early twentieth centuries, however, lacked an accepted system of thought which allowed the incorporation of a wide range of behaviour and psychological experiences into the notion of health (ibid: 17).

While the Bourne ruling gave an indication of the way in which physical and mental health would emerge as having equal status as grounds for medical intervention, Boyle contends however that this conflation only became systematic later, with the 1959 Mental Health Act.

She writes that this Act: ' ...sought to blur or abolish any distinction between physical ailments and psychological distress or disturbing behaviour.' Further she argues that:

> The second assumption was that doctors have the knowledge and skills to make impartial judgements about these matters and that they should be allowed to do so free from public or judicial interference. Finally it was assumed that the intervention of psychiatry was always therapeutic and in the best interests of the patient' (ibid: 18).

Thus, by the time the 1967 Abortion Act was passed, there was therefore already a legal framework in place through which doctors were established as the best placed to make judgements about what interventions should be made on the grounds of 'mental health'. As a result, a situation existed where: '...physical and mental health held identical status as medical reasons for abortion; it was simply that different factors needed to be taken into account in judging whether these reasons were present in a particular case' (ibid: 65).

The blurring of the distinction between physical and mental health was therefore central to the formation of the 1967 Abortion Act. This process is worthy of comment for two reasons. First, it can shed further light on the particular way in which the terms of the Abortion Act were framed. Physical and mental health were given equal status in this legislation, which resulted from a historical process through which the meaning of 'health' was broadened and redefined. Second, the construction of legal grounds for abortion in

terms of 'mental health' has been important in the development of the practice of abortion since 1967.

Under the Act, a woman can terminate pregnancy if continuing the pregnancy represents a threat to her physical or mental health, or to that of her existing family. In the years since the passing of the Act, this has turned out to be by far the most commonly used criterion given by doctors to give women access to abortion: over 98 per cent of the abortions currently carried out in England and Wales are for this reason (RCOG 2000: 10). The relatively greater threat to physical health posed by childbirth, as compared to early abortion, has allowed liberally minded doctors to judge just about any first trimester abortion legal (3). The mental health effects of abortion, as compared to childbearing, have however also been important in allowing legal abortion. The case made by doctors where they believe a woman should be able to have an abortion has often been that continuing pregnancy to term will be psychologically damaging for the woman, and that therefore abortion should be allowed. In this way, assessment of the mental health of the woman has become a significant feature of the operation of abortion law.

The implications of this practice can be read in two ways. On the one hand, the very broad definition of health, in particular the elasticity of the concept of 'mental health', has created a situation where liberally-minded doctors can judge almost any abortion, carried out relatively early in pregnancy, to be legal. As David Paintin, a gynaecologist active in providing abortion both before and after the passing of the 1967 legislation has argued. '...the Act can be interpreted so that abortion can be provided virtually on request' (Paintin 1998: 17). He suggests that even when the Act came into force in 1968, there proved to be a significant minority of doctors who were willing to interpret the Act as '...allowing them to provide abortion to women stressed by unwanted pregnancies' (ibid: 18).

Since that time, Paintin contends, doctors have come to use the WHO definition of health more and more, that health is '...a state of complete physical and social wellbeing and not merely the absence of disease or infirmity' and as a result, doctors can certify '...that there is a risk of injury to mental health if they can identify factors in the woman's life that would stress her mental well-being if the pregnancy were to continue' (ibid: 17). Since '...such factors are present in the lives of all women who are motivated enough to consult a doctor about abortion' any woman can qualify for an abortion on this ground (ibid). Boyle has pointed out on the other hand what this means about the construction of women when British abortion law is applied in practice:

> ...the vast majority of abortions - over 90 per cent - are performed because the woman herself is said to be suffering from or vulnerable to mental disorder, usually neurotic or depressive disorder (ONS). Thus abortion legislation which relies on health grounds produces weak and vulnerable women (Boyle 1997: 72).

The psychologising of abortion has thus generated what appears to be a contradictory, and complex situation. The request for abortion can be, and is currently, deemed legal in the vast majority of cases. In practice, it is therefore relatively easy for women to gain permission for legal abortion, although accessing the service on the NHS, without having to resort to paying privately is another matter (ALRA 1997; ALRA 2000; Stanworth 1994; Sheldon 1997). At the same time, abortion discourse and legislation produce 'weak and vulnerable women', through citing their risk of mental ill health from continuing a pregnancy as grounds for legal abortion. The balance between these dynamics is an issue I will return to in the conclusion to this thesis.

I will now continue my account of the development of legal discourse regarding abortion following the introduction of the 1967 Abortion Act. I will first consider the Lane Committee findings, published as the Lane Report in 1974, and then the reforms to the Abortion Act, passed in Parliament in 1990.

**The Lane Report**

The Abortion Act was enacted in April 1968, and in 1969, the first full year after the Act came into force, 50 000 legal abortions were notified in England and Wales. This number doubled over the next two years, to reach a total of between 100 000 and 130 000 abortions for the next 12 years (Simms 1985: 84-5). From the point of view of supporters of abortion law reform, the enactment of the 1967 Act was a great step forward. It led to a huge increase in the numbers of safe, legal abortions being performed. However significant problems still existed, notably the great disparities between access to NHS abortion in different parts of the country, due to the barrier to access created by doctors with a moral or religious objection to abortion. The problem was particularly apparent in Birmingham, and this led to the initiation of a non-profit referral agency by members of the Abortion Law Reform Association (ALRA). The agency later established abortion clinics of its own, and was named the Birmingham Pregnancy Advisory Service, a name later changed to the British Pregnancy Advisory Service (BPAS) (ibid).

While significant difficulties existed for women seeking abortion following the implementation of the Act, opponents of abortion, angered by the provision for legal abortion *per se*, believed the terms of the Act were being flouted in practice, and that a larger number of women were being granted access to legal abortion than the Act should have made possible. In response to complaints about legalised abortion, and on the initiative of opponents of law reform, the government of the time set up a committee of to investigate the working of the Abortion Act in 1971. The Government appointed the Honorable Mrs. Justice Elizabeth Lane, the only woman High Court Judge, as chair. Doctors, psychiatrists, lawyers,

social workers, health administrators and teachers sat on the committee and spent three years investigating all aspects of abortion services.

Despite the fact that the committee had been established in response to opponents of reform, Madeline Simms argues it '..came to very positive conclusions about the effects of the Abortion Act' (ibid: 89). The report argued that:

> By facilitating a greatly increased number of abortions the Act has relieved a vast amount of individual suffering....We are unanimous in supporting the Act and its provisions. We have no doubt that the gains facilitated by the Act have much outweighed any disadvantages for which it has been criticised (cited in Simms 1985: 89).

This endorsement of the Abortion Act is significant since it can be taken as a measure of the official attitude taken by government towards abortion. The provision of legal abortion had been established, and accepted by the (Conservative) administration as a 'significant gain'. The Lane Report can therefore be taken on the one hand as a 'great blow' to the opponents of the Abortion Act (ibid: 90). On the other, as Simms has argued, the conclusions of the Lane Committee were 'carefully moderate' (ibid). The Report ensured that the emphasis of supporters of reform, who construed abortion as a procedure justified for 'victims' of unfortunate circumstances presided over by medical professionals, was continued.

In this respect, the way in which the Lane Report framed the 'gain' of legal abortion is significant. Abortion is justified where it alleviates 'individual suffering'. As Mary Boyle points out, abortion was construed by the Lane Committee as '...a form of therapy...necessary in the face of women's psychological and physical suffering..' rather than as a social and political issue connected to women's rights and equality (Boyle 1997: 25). The Lane Report therefore reinforced the medicalisation of abortion, established through the 1967 Act.

I contend however that as well as continuing the medicalisation of abortion, the Lane Report also psychologised abortion. In the Lane Report, as I detail later, the decision whether to have an abortion was presented as psychologically difficult. Justification for continuing control of doctors over abortion decision making was maintained, but was also re-cast through the Report's claims regarding 'abortion counselling'. In order to illustrate this point, I discuss first the consideration given in the Lane Report to the case for 'abortion on demand'. In rejecting this, the Lane Report further psychologised abortion, through construing the decision whether to have an abortion as too psychologically difficult for a woman to make without professional assistance. I discuss the extension of this construction of abortion, particularly as regards the case made in the Report for providing 'abortion counselling'.

Abortion on demand?

One particularly interesting section in the Lane Report was titled 'Who Should Decide?' It was divided into sub-sections, 'The patient or the doctor?', 'Individual Doctors or Panels or Referees?' and 'Which Doctors?' (Lane Commitee 1974: 64). It is significant that it posed the question of who should have decision making power in abortion. In the debates around the 1967 Abortion Act no such question was posed. The idea that the medical profession would have total control over decision making in abortion was assumed. In contrast the Lane Report indicated that there was an issue to be debated in relation to abortion decision making. The report conceded that there was a valid perspective, which contended that the most appropriate approach would be to make the woman the sole decision maker in abortion. The report stated:

> In principle there are two possible ways of reaching a decision as to whether an abortion should be performed: either it remains as at present a matter for medical discretion or it could be made a matter for the woman herself to decide....The latter case is often described as abortion on demand but there is also a situation which could be described as abortion on request. By abortion on demand we mean a situation where the woman asserts a right to abortion regardless of the doctor's professional opinion; on the other hand abortion on request would involve a right thereto without regard to any statutory criteria but subject to a doctors' professional approval and willingness to perform the operation (ibid).

The Lane Committee therefore recognised that abortion 'as a matter for the woman herself to decide' was a principle which should be taken into account as an approach to abortion decision making. The report noted that this viewpoint was contrary to the conditions of the Act and therefore strictly speaking outside of the remit of the Committee's enquiry. However the Committee decided it still wanted to comment on this question since, as the Report pointed out, the exercise of medical discretion is a 'frequent cause of complaint that the Act is working unfairly'. It also argued that '...every woman requesting abortion should have her case carefully considered' (ibid).

The notion that 'every woman should have her case considered' and the recognition that the exercise of medical power can be discriminatory and inequitable indicated a significant shift from the terms of the discussion in 1967. The total control of doctors in abortion decision making was called into question, and the need for abortion as a solution to unwanted pregnancy was recognised as valid. However the Commission's recommendations were striking in their ultimate denial of the case for women's autonomy in decision making: 'Nevertheless we should have recommended against abortion solely at the request of the woman even if the matter had been fully open to us' (ibid). The justification for this denial of autonomy in decision making on the part of women was as follows:

> The concept of medical care is, or is becoming that a patient should be treated as a whole person viewed in the light of personal physical and mental health and social conditions, and not merely as one suffering from a particular disease or condition requiring amelioration or cure. Given this wider view, in our opinion, it is in the interests of the patient as an individual that the abortion decision should be taken by doctors....some women would find the burden of making their own decision, unsupported, a heavy one and in such cases the operation might well be followed by emotional turmoil and feelings of guilt (ibid: 64-5).

It was therefore maintained that it was the doctor's role to ensure the psychological well-being of women who wanted an abortion. The best way doctors could do this would be by their holding a position of power in abortion decision making, which would mean the woman had to discuss her decision with her doctor. The logic is that in the same way that a patient could not mend a broken leg unaided, so a woman could not decide to abort a fetus without the intervention of her doctor. To do so would put her mental health at risk, because of the problem of dealing with the turmoil and guilt that it was said may result from abortion. In the Lane Committee findings, this approach was described as 'holistic medicine'. The mind, as well as the body, was seen as a site for the exercise of medical judgement, and the role of the medical profession was defined as including that of ensuring the woman's psychological well-being. This psychologising construction thus justified the continuing role of doctors in abortion decision making.

Counselling

The Lane Report was also significant in suggesting that ways should be found to develop this 'holistic care' in particular through counselling. The role of the counsellor in the abortion process was seen by the Lane Commission as an extension of what doctors should be doing in their consultations with women in authorising their request for abortion. A section of the Lane Report, Section K, was dedicated specifically to counselling. In this section, there was a statement of the importance of this intervention: 'In our view....every woman seeking abortion should have the opportunity to obtain adequate counselling before an abortion decision is taken' (ibid: 288).

The argument made was that the woman needed to be counselled before she made the decision to abort a pregnancy. This recommendation is significant, in that it construed that the decision to end a pregnancy required counselling, unlike the decision to continue with the pregnancy. The Report detailed the purpose of counselling as follows:

> What is meant by counselling?....We see counselling as providing opportunities for discussion, information, explanation and advice. A woman considering abortion

> should be able to discuss and explore her difficulties and anxieties in an informal and unhurried manner....She should become more fully aware of the implications of the continuation, or alternatively the termination, of her pregnancy and helped to arrive at a wise and independent decision as to what her real wishes are. Further, when her personal and social circumstances are discussed, it may be possible to identify problems which would be appropriately dealt with by others, e.g. a psychiatrist or a social work agency (ibid: 292).

First, abortion was assumed to bring about 'difficulties and anxieties', which the woman should discuss with the counsellor. Second, she was seen as needing to be helped to become fully aware of the implications of having a baby or ending the pregnancy. It was suggested that she must be 'helped' to find out what her real wishes were. This produced the woman seeking abortion as in need of a counsellor if she were to be able to think through her decision properly. Third, the possibility of further intervention by helpful professionals was suggested on the grounds that, in the course of discussing the woman's thoughts about abortion, more problems in her life might emerge.

It is important to note that the approach to abortion outlined by the Lane Commission, formed the basis for guidelines for the provision of abortion services in Britain from 1974 onwards (guidelines that are still in place today). These included the Guideline for Health Authorities published July 1977, which used the Lane Commission recommendations as the basis for directions given to NHS Hospitals providing abortions. This Guideline says: 'The Department [DHSS] fully accepts the need for counselling and also recognises that it is already undertaken in the majority of cases where abortion is under consideration' (DHSS 1977).

The Lane Report was therefore significant for two reasons. First it offered strong support for the provision of legal abortion. The increasing number of women who accessed legal abortion, following the implementation of the Act, was therefore rendered acceptable. Second, as I have illustrated through my discussion of the Lane Commission findings on the role of medical professionals in abortion decision making, the medicalisation of abortion as established through the 1967 Act was endorsed. It was however also extended through the claim that abortion decision making was psychologically difficult.

**The 1990 Human Fertilisation and Embryology Act**

I now turn to the legal debate about abortion that took place in 1990. I argue that, in general, this debate illustrates the continuing medicalisation of abortion. I also contend that in this debate, it was evident that opponents of abortion, as well as supporters of legal abortion, had come to construct their arguments in medical terms. Whereas in 1967, anti-

abortion parliamentarians opposed abortion on moral grounds, by 1990 they opposed it on medicalised grounds.

The 1990 debate about abortion took place as part of a debate about the Human Fertilisation and Embryology Act (HFEA). This piece of legislation dealt primarily with the regulation of infertility treatment and experimentation on the human embryo. However, the HFEA also amended the 1967 Abortion Act. While various amendments to the Act were suggested, it was the upper time limit for legal abortion which in the end became the focus for debate. The Act was amended to include a fixed time limit in the law.

Prior to the HFEA, there was no specific statutory upper time limit for abortion. Rather by 1990 a limit of 24 weeks applied in practice. This limit was inferred from the 1929 Infant Life Preservation Act, on the grounds that this Act said protection should be given to a 'child capable of being born alive'. For the purpose of abortion, this was taken as 24 weeks, since at this point in gestation the survival of the fetus outside the womb had become possible through use of sophisticated technology which aided the survival of premature babies.

It was argued in the 1990 debate that a new point of viability should be explicitly recognised in law. Anti-abortion MPs contended that this limit should be set at 18 weeks, but in the end the case made by supporters of legal abortion for a 24 week limit was accepted, and the 1967 Act was amended accordingly. Exemptions to this limit were accepted in the final amendment, in the case of threat to the mother's life, and in the event that substantial risk of serious abnormality was detected in the fetus. In these cases the amended Act applies no time limit.

In one sense the 1990 reform was of little significance. In terms of the practice of abortion, the fact that a new limit was made explicit in the law, made little difference to abortion provision. Before 1990, fewer than 100 abortions were carried out after the 24th week of pregnancy (of a total of around 180 000 in England and Wales), and even following the reform most of these would have been allowed in any case, because they were performed on account of fetal anomaly. In another sense, the debate about the reform was highly significant. It made explicit the overriding predominance of the medicalisation of abortion, and the almost total absence of other ways of construing abortion. In the debate, the need for reform was discussed almost exclusively with reference to medical knowledge.

For example, in justifying the need for reform, the then Minister for Health Virginia Bottomley, argued that '*...recent development in medical and scientific practices*' had to be taken into account (Sheldon 1997: 109). The nature of abortion law, it was therefore suggested, should be determined by medical and scientific expertise. The significance of the claim is that other ways of constructing what might be central to abortion law - for example women's needs and wants - were left out of the picture. As Sheldon has explained:

> A most significant feature of the parliamentary debates surrounding the reform is the pre-eminence of medical discourse and the marginalisation of other knowledges or ways of structuring dispute....The agenda is unmistakably set within a medical framework and the issue of what is at stake in the abortion debates centres essentially around the medical development of the foetus to the exclusion of broader social issues (ibid: 6).

The centrality of claims which referred to medicine and medical knowledge in shaping the debate between supporters and opponents of legal abortion, as well as the justification for reform in the first place, has also been noted by Sheldon. In making the case for a 24 week time limit, reference was frequently made to support amongst doctors for this limit. In addition, the argument that the selection of this limit was not arbitrary, but rather was based on sound medical and scientific evidence about fetal viability, was central to claims made supporters of the 24 week limit (ibid: 109-14).

Opponents of abortion similarly made their arguments through reference to medical knowledge. Their case regarding lowering the time limit (for example to 18 weeks) rested on the contention that 'medical bodies' supported such a limit, and that as technology for pre-term babies improved, the time limit would need to be progressively reduced. In addition their arguments made great play on the amount ultrasound and other 'window on the womb' techniques could enable the medical profession, and society in general, to learn about fetal development. This claim had become a significant aspect of anti-abortion argument since before 1990 (Franklin 1990; Petchesky 1987), and was reiterated again in the contention that such technology had proven the fetus to be a 'person' in its own right (Sheldon 1997).

**Post-Abortion Syndrome**

I want now to discuss a further dimension of medicalised anti-abortion argument evident in the 1990 debate. This argument constructed the abortion 'problem' in terms of its detrimental effects on women's mental health. In the 1990 debate, anti-abortion MPs made their case against abortion in part on this ground. Veteran anti-abortion campaigner David Alton MP argued:

> *I agree with the Minister who said that every abortion - I extend that to whether it is legal or illegal - is a personal tragedy for all involved....People in this country are recognising that abortion is a destructive act; that it destroys a child and that it destroys women psychologically and physically* (Hansard 1990 (a)).

Similarly, Baroness Ryder of Warsaw said: *'No words can express the horror and later the sorrow of the mothers who grieve for their babies who have been destroyed'* (ibid).

The impact of abortion on the mind of the woman involved was presented as harmful and damaging. Baroness Ryder's comments implied this would be the case because the

pregnant woman thought of herself as a mother, and the fetus as her baby. Hence the act of destroying the fetus through abortion would be experienced by her as the death of her child, for whom she would therefore grieve. This post-abortion reaction was presented as commonplace by another anti-abortion MP, Dame Elaine Kellett-Bowman: *'Is the hon. Gentleman aware that research carried out in the United States shows that 82 per cent of women who have had their pregnancy terminated suffer from post-abortion syndrome?'* (Hansard 1990 (a)).

Viscount Buckmaster argued that the negative psychological effects of abortion on women was a key reason for supporting a reduction in the time limit for performing abortions: *'It is the appalling, traumatic effects on so many women who suffer abortions. I have heard of some from my friends, and indeed I have seen one or two personally. I feel it is a very powerful argument against the late abortions which are made possible by the Bill'* (Hansard 1990 (b)). Restricting women's access to abortion was defended on the grounds that it would prevent its psychological ill effects. Reducing the time limit on abortion was therefore construed as beneficial for women seeking abortion.

The intervention by counsellors in the abortion decision making process was presented as essential and as currently insufficient. Counselling was seen as necessary to safeguard the woman's mental health. Further it was seen as a way of discouraging women from making the 'wrong choice' in opting for abortion. Sir Bernard Braine commented:

> *In most civilised countries, there is a requirement before an abortion is permitted that the woman - who in such circumstances, will obviously be in a state of distress - is counselled by a doctor. There is a pause during which she is given the opportunity to consider the situation. There is at least one organisation in Britain which not only gives counselling but which, if necessary, would help a woman in that situation bear her child* (Hansard 1990 (c)).

In this construction of the psychology of the woman who requested abortion, her distress may have led her to opt for what might have turned out to be the wrong choice. As a result doctors needed to counsel her, and then give her time to think through what she wanted to do. She may then, after consideration, decide to have the child. Braine, through arguing for this intervention, construed women as in need of a doctor's assistance to help them make their abortion decision. The counselling intervention was necessary to bring clarity to the woman's thinking, and could lead to the woman changing her mind and choosing to have a baby.

In the 1990 debate, the arguments of those opposed to abortion were framed in the language of medicine. This was the case both with regard to their claims about the setting of an upper time-limit for abortion at 18 weeks, and with regard to their focus on the health

effects of abortion. The dimensions of this latter claim are discussed in more detail in the following chapter.

**Conclusions**

In this chapter I have examined ways in which women's bodies and minds have been constructed in legal discourse about abortion. I have argued that, through a broad definition of the concept of health, debate about abortion has construed its psychological effects as significant in the regulation of abortion. This has taken place in two main ways. First, through formulating the provision for legal abortion on the grounds that continued pregnancy could constitute a threat to mental health; second, as exemplified by the Lane Report, through construing abortion itself as a threat to mental health because of the psychological difficulties it was said result from deciding to have an abortion.

I have also argued that while in 1967, abortion opponents framed their case mainly in terms of the alleged immorality of abortion, by 1990 their arguments were couched in medical terms. Anti-abortion argument was medicalised in different ways, including in the claim that abortion led to a medical condition, Post-Abortion Syndrome (PAS).

I want now to consider ways in which the construction of abortion in psychological terms has emerged in debates outside Parliament in arguments made by opponents of legal abortion, and by those who define themselves as pro-choice on abortion. I begin with the anti-abortion case, specifically with its claims regarding PAS.

# Chapter 4: INVENTING POST-ABORTION SYNDROME

In the following two chapters I detail the context for and content of claims about women's psychology in anti-abortion and pro-choice discourse. In this chapter, I discuss the case made by opponents of abortion that abortion can lead to a psychological 'condition' or 'illness' termed Post-Abortion Syndrome (PAS).

I begin by situating the claim that women suffer from PAS in the context of the development of the psychiatric category PTSD. The emergence of this categorisation of psychiatric illness has been explained by the American sociologists Allan Young and Wilbur Scott in Foucauldian terms. I draw on their work at the start of this chapter to present an analysis which conceptualises PTSD as an 'invented' or 'constructed' condition, rather than as an objective medical 'fact'.

I then discuss the extension of PTSD to include a wide range of experiences as traumatic (from women who have been raped, to policemen at the scene of the Hillsborough football stadium disaster, to soldiers returning from the Gulf War). I argue that two processes can explain this development. The first is the 'politicisation' of PTSD, that is the instrumental use of the category by lobby-groups to gain resources and recognition for those they claim to represent, and the second is a process which could be termed the 'reconstruction' of PTSD. This entails a reworking of the diagnostic criteria for assessing the condition. I argue that, on this basis, the PTSD diagnosis has been extended to an ever-widening range of experiences, including putatively abortion, through the PAS claim.

Finally I discuss ways in which claims regarding PAS construe reactions to abortion in terms of 'denial'. I consider the resultant case made by opponents of abortion that they oppose abortion because they are concerned with the psychological well-being of the woman involved, not just with the 'right to life' of the fetus.

## PTSD

PTSD was first defined as a psychological disorder in the third edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA 1980). Prior to 1980, the effects of traumatic events on psychological health had been discussed using a variety of different terms. The term PTSD has been said to '...provide a common language' (Joseph et al 1997: 5) which succeeded in bringing together research in a wide range of fields under one, unifying, theoretical umbrella. As a result, a single diagnostic category, rather than a variety of them, emerged.

In the first place, the APA defined PTSD in response to symptoms apparent in Vietnam War veterans. The inclusion of PTSD in the DSM at this time was seen as significant given the status of the Manual as the official 'handbook' used by psychiatrists in diagnosing mental

disorders (Hacking 1995). Inclusion in the DSM makes a disorder 'official', and a diagnosis based on DSM criteria is taken as 'the truth'.

In DSM III, the symptoms of PTSD are grouped into three sections: (1) re-experiencing of the traumatic event; (2) numbing of responsiveness to or reduced involvement in the external world; and (3) a miscellaneous section which includes memory impairment, difficulty concentrating, hyperalertness or an exaggerated startle response. In addition, in line with clinical experience, the DSM named three forms of PTSD: acute (symptoms emerging within six months of the event and lasting for less than six months); chronic (symptoms lasting six months or more); and delayed (symptoms emerging at least six months after the event) (1). The DSM III also states:

> The essential feature of this disorder is the development of characteristic symptoms following a psychologically distressing event that is *outside the range of usual human experience* (i.e., outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict). The stressor producing this syndrome would be markedly distressing to almost anyone....The trauma may be experienced alone (e.g., rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (e.g., floods, earthquakes), accidental man-made disasters (e.g., car accidents with serious physical injury, airplane crashes, large fires), or deliberately caused disasters (e.g., bombing, torture, death camps)' [my emphasis] (APA 1980: 247-8).

This definition has been revised twice subsequently, in 1987, with the publication of DSM-III-R, and in 1994 in DSM IV. The second of these revisions involved a change in the definition of what constitutes a traumatic event. As I discuss later, this shift in definition has proved significant in the formulation of the psychological effects of abortion in terms of PTSD. First however, how, in Foucauldian terms, was PTSD 'invented'?

## Inventing PTSD

Allan Young, in his book *The Harmony of Illusions, Inventing Post-Traumatic Stress Disorder*, has taken a very critical, questioning approach towards the PTSD diagnosis. For Young, PTSD is not a condition that is simply 'there' as a 'fact' that has been proven to exist as a result of undeniable, objective evidence. He argues instead that the symptoms that are put forward in DSM III as characteristic of PTSD have no 'intrinsic unity' (Young 1995: 5). There is no definitive reason why the existence of these symptoms should have led to a diagnosis of PTSD. Rather: 'In practice the ideational content of these symptoms is often open to multiple interpretations and consistent with alternative diagnosis' (ibid: 120). For

Young, it is not the case that PTSD has clear, easily recognisable symptoms, which lead to an unproblematic diagnosis.

Young contends instead that what is now called PTSD is rather a 'cluster of symptoms', which could be interpreted in a number of ways. His argument is therefore that the particular interpretation of symptoms that emerged in 1970s America, and which led those symptoms to be labelled PTSD, is better understood not as objectively determined fact, but rather as a social or political process. The cluster of symptoms now known as PTSD are, according to Young:

> ...glued together by the practices, technologies and narratives with which it is diagnosed, studied, treated and represented and by the various interests, institutions and moral arguments that mobilised these effects and resources (ibid: 5).

The argument Young makes is that PTSD is not a neutral category, but one which is created by the intersection of various diverse forces, which include already existing 'practices and technologies' which are then interpreted and shaped by social 'interests and institutions'. Wilbur J. Scott has provided a similar analysis. In his work he:

> ...aims to show how diverse champions of this new diagnosis brought it to light as an always-already-there object in the world, relevant to medical work. This process has been shown in reverse for the diagnosis of homosexuality where we saw how a psychiatric disorder ceased to exist as an official diagnosis and as a relevant medical object in the world. Like the disappearance of the disorder of homosexuality from DSM-II, the story of how PTSD appeared in DSMIII is one that belies the cool language in which the manual's diagnoses and syndromes are described (Scott 1990: 295).

Scott contrasts the end result of the appearance of PTSD in DSM III as an always existing condition, that was diagnosed scientifically and objectively, with the process through which this came about. Through doing so he is suggesting that what is accepted as a medical fact at a particular moment is best understood as an 'invention' which comes about through argument that utilises the language of medicine and science. The fact that diagnoses of 'psychological disorders' such as homosexuality have appeared and disappeared is testament to the analysis which understands such disorders as constructions rather than facts. Of PTSD, he argues: 'In the story of PTSD we see again how the orderliness of the natural world is to be found in its very accounts of orderliness (ibid: 308). The 'order' is not to be found in nature: PTSD is not a 'natural' condition which is discovered by science. Rather the order is to be found in the accounts of PTSD, the discursive process that leads to its diagnosis.

In analysing the process which produces PTSD as a category of psychiatric disorder, Scott and Young both emphasise the political activities of those who lobbied on behalf of

men who had fought in the Vietnam War. As Eric Dean (1997) has argued, many psychiatrists acted as 'unbridled advocates', arguing strongly with others in the APA for PTSD to be diagnosed in veterans. Together with social workers working for the Veterans Administration (VA), and psychologists and other professionals opposed to the Vietnam War, an active lobby group emerged. Scott argues, of activity to advocate the PTSD diagnosis, that '...the struggle for *recognition* of PTSD by its champions was profoundly political, and displays the full range of negotiation, coalition formation, strategizing, solidarity affirmation, and struggle - both inside various professions and "in the streets" - that define the term' (ibid: 295).

In this analysis, it is the extensive, effective campaigning of the champions of PTSD that led to the official 'naming' of the disorder. Ways were found to generate the case for the recognition of PTSD that corresponded with the views of other groups and individuals, and therefore won their support for the diagnosis. Scott highlights especially the importance of winning the support of the APA for the PTSD diagnosis: 'To move war neurosis down the path from disputed condition to accepted diagnosis, its champions worked primarily with key psychiatrists and with the Vietnam veteran community'. Activity within the APA was of '...critical importance because the APA owned psychiatric diagnosis in the United States' (ibid: 309).

The PTSD diagnosis was thus legitimated as the 'truth', to explain the symptoms exhibited by Vietnam vets, at the point at which members of this official body of American psychiatry came to endorse it. Their 'ownership' of psychiatric diagnoses meant their use of PTSD as a category of psychiatric disorder gave it a power and influence it otherwise lacked.

Young also highlights the importance of the 'invention' of PTSD for the YA. In his analysis, this lobby group eventually promoted the notion of PTSD in relation to the Vets, in order to lubricate their compensation claims from the Government: 'It was clear to everyone that the proposed diagnosis would have important fiscal and manpower implication for the VA....the VA could anticipate substantial compensation claims from large numbers of veterans for chronic impairments plausibly attributed to PTSD' (Young 1995: 113).

The aim of the VA was to find a way of giving credibility to its claims for compensation placed on behalf of war veterans. A diagnosis of PTSD would allow for such a claim to be made. The central point about how PTSD makes such claims possible is highlighted by Scott in his identification of a shift, brought about by the PTSD diagnosis, from a focus on the individual soldier's psychological make-up to the psychological effects of war. Scott suggests that the key point about the PTSD diagnosis was how:

> This orientation shifted the focus of the disorder's cause from the particular details of the individual soldier's background and psyche to the nature of war itself. Its advocates claimed: soldiers disturbed by their combat experiences are not, in an

> important sense, abnormal: on the contrary, it is normal to be traumatized by the abnormal events of war (Scott 1990: 308).

Such an approach produces ex-soldiers who are experiencing psychological problems as victims of war rather than as psychologically weak individuals. PTSD constructs the experience of war as 'the problem', with those who have taken part as normally traumatised by this experience. This is in contrast with the previous constructions of soldiers who exhibited psychological problems following combat as cowardly or weak individuals. Scott suggests that the impact of this process is profound. It:

> ...raises....substantive questions about what constitutes the normal experience and response of soldiers to warfare. We see that what psychiatrists once regarded as abnormal behavior is now thought by many to represent a "normal" response to situations of combat. With the PTSD diagnosis, psychiatrists now say it is "normal" to be traumatized by the horrors of war....PTSD occurs when this trauma is not recognized and is left untreated (ibid: 295).

Through PTSD, the expectation of how a soldier will respond to war changes substantially. The expectation becomes that the soldier will experience war as trauma, and that treatment will be required as a result. The result is a reversal of the situation that existed pre-PTSD: now those soldiers who are not traumatised by war are produced as abnormal.

The way in which this reversal has taken place in constructions of normal and abnormal psychological responses to war indicates the need to emphasise the *social* nature of the PTSD diagnosis. Thus Scott argues, in placing emphasis on the invention of PTSD, his aim is:

> ...not to suggest that this diagnosis - and diagnoses in general - are "merely" a social construction, or simply the result of disinterested psychiatric hegemony. Rather, in telling the story of PTSD I contribute another case to those that help us understand in detail how objective knowledge - and medical scientific knowledge in particular - is produced, secured, and subsequently used to create other objective realities, such as, in this case, acknowledgements of war's horrors, populations of treatable clinical cases of PTSD, patients entitled to insurance coverage, and the like. Each new clinical diagnosis of PTSD, each new warrantable medical insurance claim, each new narrative about the disorder reaffirms its reality, its objectivity, its "just thereness" (ibid: 295).

PTSD is now accepted as a 'real' disorder that is objective and 'there' for all to see. Scott and Young's analyses show how that 'reality' is brought into being in the first place through a social process, central to which is political activity and the creation of alliances and agreement about the 'rightness' of the PTSD diagnosis.

Politics and the extension of PTSD

Since 1980, the PTSD diagnosis has been applied to more and more experiences and groups of people. How did this extension of PTSD come about? I argue first that the model of political activity supplied by the VA discussed above has been adopted by other groups of claims-makers, to allow them to make their case for the groups they claim to represent. The precedent setting nature of diagnosing the Vietnam Veterans is noted by Young:

> The therapeutic act of bringing the secret into full awareness is now inextricably linked to a political act. Vietnam veterans are the first traumatic victims to demand collective recognition, and they are followed by victims of other suppressed traumas such as childhood incest and domestic rape (Young 1995: 142).

Groups other than Vietnam Vets, such as women subject to domestic violence or those who were abused as children, have a ready-made case for making their claim as victims of suppressed trauma (Raitt and Zeedyk 2000). The claims of these groups are seen as morally legitimate: the Vietnam veterans' experience has made the notion of PTSD socially valid, and hence others can mobilise the same argument to gain recognition of the trauma they have suffered.

As a result, the definition of groups of people as 'victims' of past trauma, who need recognition of what they have suffered, has become a pattern. More and more groups of 'victims' have come to make their case that their trauma must be recognised and in many cases compensated. The construction of women as victims through the recognition of the trauma they have suffered as a result of male violence is one important example, and can be considered a deeply political process.

Judith Lewis Herman, author of *Trauma and Recovery* (1992), a work which has become central in the construction of women's psychological response to domestic violence in terms of PTSD, has drawn attention to the political origin of her argument. She explains the origin of her work, and its emphasis on the extent of trauma suffered by women, in the following way: 'Its intellectual mainspring is a collective feminist project of re-inventing the basic concepts of normal development and abnormal psychology, in both men and women' (Herman 1992: ix).

Herman discusses in her work how the feminist movement allowed her to recognise the particular experience of women, and understand trauma in this light. According to Herman, before this movement existed, the trauma of domestic violence experienced by women was ignored, or not seen for what it was. For Herman, the conceptualisation of women's experience with violent or abusive men as traumatic arises as a result of political action by the women's movement. In this analysis, certain groups, both those men who are sent to war, and women who according to Herman suffer routine abuse at the hands of men, have a

particular experience, which is brought to light by movements that act on their behalf. Herman explains:

> To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and that joins victim and witness in a common alliance. For the individual victim, this social context is created by relationships with friends, lovers and family. For the larger society, the social context is created by political movements that give voice to the disempowered (ibid: 9).

The key issue raised by Herman is therefore the importance of 'political movements that give voice to the disempowered' if trauma is to be recognised. As a result of feminists drawing attention to the psychological responses demonstrated by women subject to men's sexual violence, psychological disturbance has been directly connected to their victimisation by men. Herman argues that this perception of women as victims is to be encouraged by elevating women's experience as the most significant and widespread example of trauma. In its intensity she argues, it is on a par with the experience of war, but in its prevalence it is more significant than war:

> For most of the twentieth century, it was the study of combat veterans that led to the development of a body of knowledge about traumatic disorders. Not until the women's liberation movement of the 1970s was it recognised that the most common post-traumatic disorders are those not of men in war but of women in civilian life (ibid: 28).

Feminism can thus be seen as impelling the use of an already existing PTSD diagnosis in constructing women as victims of trauma in the everyday lives of their sex. For feminists such as Herman, this project is viewed as a positive one. Other commentators, for example Young (1995) and feminist writer Elaine Showalter (1997), argue that constructing women (or men), in terms of PTSD, as victims of trauma is disempowering. Rather than seeing this development as a victory for feminism (or for the Vietnam veterans lobby, or whichever lobby makes claims on behalf of others) they suggest that far from empowering people, the PTSD diagnosis disempowers them by producing them as victims.

Whatever the assessment that might be made of the value of the extension of PTSD, it is indisputable that this diagnosis does now act powerfully. It has also been extended to abortion, as I will explain later in this chapter. Before doing so, I want to discuss a second factor of significance in the extension of PTSD, that is the change in the criteria for diagnosing the 'condition'.

## Re-constructing the PTSD diagnosis

I now discuss what I contend is a critical factor in the process through which PTSD comes to be applied to a widening range of experiences. This concerns the re-definition of the

'diagnostic criteria' for PTSD, which was revised in 1994. The re-definition of the diagnostic criteria entails a change in thinking which developed during the late 1980s regarding Criterion A (the criterion for assessing whether or not the person has been exposed to a traumatic event).

I have already noted above that according to DSM III, an event capable of leading to PTSD would have to be: '...outside the range of ....common experiences'. Similarly in DSM-III-R (1987), Criterion A for the diagnosis of PTSD states:

> The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g. serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has been, or is being, seriously injured or killed as the result of an accident or physical violence (Joseph et al 1997:10).

However, by 1994 (in DSM IV) Criterion A had been amended, to the following:

> The person has been exposed to a traumatic event in which both the following were present:
>
> (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
>
> (2) The person's response involved fear, helplessness, or horror. *Note:* In children this may be expressed instead by disorganised or agitated behavior (ibid: 13).

This shift in definition, and in particular the removal of the criterion that the event has to be 'outside the range of usual experience' and 'markedly distressing to almost anyone', is greatly significant. It reflects an important and on-going debate about what constitutes a traumatic experience. Criterion A has traditionally served as a 'gatekeeper' to the diagnosis of PTSD. As two commentators on the definition of PTSD have put it:

> If a person does not meet the required definition of a stressful event, it matters little whether all the other criteria are met because the person cannot be diagnosed with PTSD. If criterion A is loosely defined and over inclusive, then the prevalence of PTSD is likely to increase, whereas a restrictive definition will reduce its prevalence (Davidson and Foa 1991: 346).

As these writers indicate, the way in which Criterion A is defined will affect the prevalence of PTSD. A looser definition means that more people can be defined as sufferers of the condition. As the revision of Criterion A in DSM IV indicated, a looser definition has been accepted. It is therefore perhaps unsurprising that the prevalence of PTSD has increased.

I want now to review some arguments that have been made in favour of abandoning a strict definition of a PTSD stressor, in particular, those made by the British authorities on

PTSD, Scott, Stradling and Parkinson. I do so in order to indicate that an argument about 'stress', which contends that stress should be considered a normal, not unusual, aspect of life, has attracted significant support. A wide (potentially very wide) range of 'life events' have, as a result, come to be considered 'stressful' and hence as potential instigators of PTSD.

Scott and Stradling question the validity of a single, objective definition of trauma. They argue:

> In DSM III-R, PTSD is defined as a response to a major trauma. Indeed according to DSM III-R a diagnosis of PTSD cannot be made if such an event has not occurred. But this raises....important questions....what makes an event traumatic as opposed to simply being stressful? (Scott and Stradling 1992: 18).

These writers ask whether there can be a clear definition of a traumatic event. How is the distinction to be made between an event which is labelled as traumatic, rather than stressful? Is it possible to have an objective, scientific definition of a trauma inducing event, as distinct from a stressful one? In posing the question 'what makes an event traumatic or stressful' we are invited to consider whether it is the case that some events simply are traumatic, and will always generate severe psychological symptoms, whilst others, while unpleasant and difficult, will not.

Scott and Stradling contend that: 'Different people react to objectively similar situations differently. For example one person may react to a divorce with disappointment and sadness whilst another becomes suicidal' (ibid: 19). If this is true, then, for example, the case made in DSM III-R that 'usual marital conflict' does not constitute a traumatic event is called into question. Given that divorce is very common, it cannot be defined as 'outside the range of usual human experience', but according to Scott and Stradling it can generate PTSD like symptoms.

Frank Parkinson has also criticised the DSM III-R definition of a traumatic event. In *Post-Trauma Stress* he argues:

> Post-Traumatic Stress Disorder is defined in the American Psychiatric Association publication *Diagnostic and Statistical Manual of Mental Disorders* (revised 1987), as 'The development of certain characteristic symptoms following a psychologically distressing event which is outside the range of normal human experience'....the problem is with what is and what is not 'normal' (Parkinson 1995: 95).

Parkinson contends there is a problem with the assumption made in the DSM III-R that some events can be defined as a 'normal' part of life, and others outside of what we might expect will happen to us. Parkinson gives his own answer to the question 'what is and what is not normal?' when he argues: 'Post-trauma stress can result from any experience which, for me is not normal; because it is not normal it can cause traumatic reactions' (ibid: 36).

This approach represents a significant departure from the definition of PTSD in DSM III-R. According to Parkinson, the basis on which an event is defined as traumatic rests with the perception of the individual who claims subsequently to be suffering from PTSD. This suggests that there can be no objective or universal definition of what is a traumatic event. Rather any event can be defined as traumatic on the grounds that the person who experienced it believed it was unexpected or not normal for them. As a result almost any experience in life can be said to produce PTSD including, for Parkinson, bereavement, divorce, moving house and marriage break-down (ibid: 31).

In the DSM III-R, the events named by Parkinson as traumatic are deliberately excluded as capable of leading to PTSD. Moving house is seen as a normal aspect of life, as are bereavement (unless it takes place in unusual or violent circumstances) and divorce. In contrast, in Parkinson's terminology, they are included as traumatic events. To emphasise this point, where the DSM III-R makes distinctions between events, Parkinson conflates them:

> Post-trauma stress is the development of certain symptoms or reactions following an abnormal event. The event is abnormal in that it can be life-threatening or extremely disturbing, and can be anything from a minor accident to a major disaster. This includes other incidents such as divorce, riots, war, bereavement or any other event which causes trauma and shock. This trauma is the disturbance of our normal life beliefs and turns our world upside down causing confusion, disbelief, feelings of vulnerability, a loss of meaning and purpose in life, and changes in self-image or self-esteem (ibid: 36).

The notion that there is any real difference in the psychological impact that a minor accident or major disaster might have is challenged. Divorce and riots are named next to each other as being as traumatic as war and bereavement. The deliberate aim of Parkinson's definition is to break down differences between experiences. Rather, a commonality is created between events once understood as quite distinct in their ability to generate psychological harm. In order to make this connection between events, Parkinson construes any event that involves change or loss as traumatic:

> There are many situations in life where the stress generated becomes 'dis-stress' and we may find it very difficult to cope. This can be the result of a bereavement, divorce, moving home, being made redundant or some other incident involving change and loss (ibid: ix).

In this approach, events are deemed traumatic on the grounds that they involve 'change and loss'. This indicates the way in which any aspect of life can be, in Parkinson's terms, construed as traumatic since inevitably most things that happen to us involve change of some description, and it is in the nature of change that there will be loss.

As a result, Parkinson describes the transition from birth to death in the following way:

> ...losses are due to the changes we go through as we grow and develop from conception and birth to death: in childhood separation anxiety, going to school, puberty, making and breaking relationships, leaving school and home, starting work, unemployment and redundancy, falling in love, marriage, pregnancy, miscarriage and abortion, having new children in a relationship, separation and divorce, moving home, a hysterectomy, the menopause, retirement and adjusting to old age, the death of a spouse and the inevitability of one's own death. All of these, including natural and man-made disasters, entail loss, and therefore involve reactions of grief and post-trauma stress (ibid: 45).

Parkinson therefore construes traumatic events and the psychological consequences which result as nothing out of the ordinary.

The result of this type of construction of trauma is pointed out by Ian Hacking. He suggests, with regard to the broadened definition of trauma:

> Trauma is psychic hurt. The word has become a metaphor for almost anything unpleasant: "That was really traumatic!" Previously "trauma" had been a surgeon's word. It referred to a wound on the body, most often the result of battle. It still has that old meaning....But few of us, in everyday conversation, even think of trauma in that sense (Hacking 1995:183).

In this context, where a discourse is prevalent which constructs trauma as subjectively defined, and where trauma has become used as a description of almost anything that happens to us which is unpleasant, it becomes possible for abortion to be produced as an experience capable of producing PTSD at least for some women, if not all. As I discuss later in this chapter, it is this kind of elastic definition of a 'traumatic experience' which is central to the PAS claim.

**Post Abortion Syndrome**

I have discussed the development of a discourse that construes an ever-widening range of events as traumatic. I now want to return to discuss abortion, and consider the claim that abortion leads to 'Post-Abortion Trauma' or 'Post-Abortion Syndrome' (PAS).

As I discussed in the previous chapter, this claim was made by those opposing abortion in British parliamentary debates in the late 1980s. The claim for PAS first emerges in the U.S. abortion debate however, before its 'diffusion' to Britain via links between American and British opponents of abortion (Lee: in press). I will discuss features of the PAS 'diagnosis', as developed by its American proponents, and then consider, through a discussion of arguments made in both British and American anti-abortion literature, how women's psychology is constructed in the PAS claim.

Features of the PAS 'diagnostic criteria'

American opponents of abortion Vincent Rue and Anne Speckhard have been credited with first developing the PAS 'diagnosis' (Doherty 1995: 12). Rue's first public presentation in America about PAS was in 1981. During the 1980s he gave papers at anti-abortion conferences and published a number of articles about PAS (2).

In their writings on abortion, Rue and Speckhard have stressed that the psychological effects of terminating pregnancy should not be underestimated; rather, they claim, it is: '...possible that the decision to elect abortion can generate significant resulting psychosocial distress' (Speckhard and Rue 1992: 96). In 'Post-abortion Syndrome: A Variant of Post-Traumatic Stress Disorder', a contribution to a collection of essays about PAS, Rue has argued that:

> ...while abortion may indeed function as a 'stress reliever' by eliminating an unwanted pregnancy, other evidence suggests that it may also simultaneously or subsequently be experienced by some individuals as a psychosocial stressor, capable of causing posttraumatic stress disorder (PTSD)....We suggest that this constellation of dysfunctional behaviors and emotional reactions should be termed "Postabortion syndrome (PAS)" (Rue 1995: 20).

As I discussed previously, according to DSM III-R, for a PTSD diagnosis to be made, the trauma has to be 'outside the range of usual human experience'. On this basis, the U.S. expert on medical aspects of abortion, Henry David, has contended that the PAS 'diagnosis' makes no sense (David 1997). He has argued that, given the numbers of women who have had abortions (it is estimated that around one third of American women and one quarter of British women will have an abortion at some point in their life), it is difficult to see how abortion could be defined as an event that is 'outside the range of usual human experience'. For David, abortion is part of everyday experience for so many women that it simply cannot be defined as a potentially traumatic experience.

In claiming that abortion can lead to a form of PTSD, Rue and Speckhard have responded to this criticism by attempting to construe abortion as an 'unusual' experience. In addition, they have drawn on the wider definition of a 'stressful event' discussed previously in this chapter.

In order to define abortion in line with the DSM III-R criteria, as an 'unusual' event, Rue has construed abortion as a 'death experience'. He has stated:

> If elective abortion is nothing more than the removal of nondescript cells or tissue, then it would be highly unlikely that such a procedure could cause any significant psychological harm, much less resemble the symptom picture of post-traumatic stress disorder (PTSD). On the other hand, if elective abortion is an intentionally caused human death experience, then it is likely that some women, men and

> significant others could manifest profound symptoms of intrusion/re-experience, avoidance/denial, associated symptoms, depression, grief and loss. It is also true that stress and trauma begin with one's perception of it (Rue 1995:19).

In this comment, Rue presents two possible perceptions of abortion - the 'removal of nondescript cells' and in contrast a 'human death experience'. If abortion is perceived as the removal of 'nondescript cells' there would be no reason to believe that the psychological response to abortion would be negative, certainly not to the extent that the woman could suffer from PTSD. If abortion is perceived, in contrast, as a 'human death experience' then severe psychological problems could be predicted post-abortion on the grounds that the woman, and those who were associated with her when she had an abortion, have participated in killing a human being. Rue thus construes abortion as 'outside the range of usual human experience'.

In addition however, Rue and Speckard have, in line with the reconstruction of PTSD criteria, stated that: 'Stress begins with one's perception of it' (Speckhard and Rue 1992: 106). According to Rue, a subjective definition of stress is most appropriate. Following this line of argument, while some women may not perceive abortion as a stressor, others will. Thus, where abortion is perceived as stressful by the woman, according to Rue, symptoms characteristic of PTSD are likely to emerge, and in this circumstance, the women can legitimately be 'diagnosed' as suffering from PAS.

A further noteworthy feature of the PAS claim, in line with a looser definition of a PTSD diagnosis, are claims about the 'symptoms' of PAS. Rue explicitly compares the 'symptoms' of PAS and those which are said to be characteristic of PTSD as diagnosed in Vietnam veterans. He argues '...the symptoms are the same: flashbacks, denial, lost memory of the event, avoidance of the subject' (Rourke 1995). He has also developed 'diagnostic criteria' for PAS, along the lines of the criteria for PTSD given in the DSM. According to these criteria, the abortion experience can be defined as a stressor, sufficiently traumatic so as to cause the symptoms of re-experience, avoidance and impacted grieving. To be diagnosed as having PAS, the woman has to re-experience the abortion trauma in one of four listed ways (for example recurrent, distressing dreams of the 'unborn child'); she has to show three manifestations of a possible seven listed examples of avoidance (such as avoiding thoughts about abortion or feeling detached from others are included); and she has to have two of a possible eleven 'associated features' (such as difficulty in falling asleep or eating disorders) (Rue 1995). The PAS claim is therefore formally modelled on the existing, accepted psychiatric criteria for PTSD.

However, the writings of proponents of PAS reveal a shift from a definition of the 'symptoms' of PAS where the proposed comparison with PTSD is made clear, to a much broader collection of 'symptoms' that could perhaps more accurately be described as

negative feelings. In the same chapter where the above 'diagnostic criteria' for PAS are given, Rue has listed a wide range of feelings, and forms of behavior that he argued might be evident in women who have had an abortion. These included feelings of helplessness, hopelessness, sadness, sorrow, lowered self-esteem, distrust, regret, relationship disruption, communication impairment and/or restriction and self-condemnation (Rue 1995).

Other American PAS claimants have taken a similar approach. The U.S.-based Elliott Institute has included as symptoms of PAS sexual dysfunction (comprising loss of pleasure from intercourse, an aversion to males in general, or promiscuity), increased cigarette smoking, child neglect or abuse (including 'replacement pregnancies' i.e. becoming pregnant after an abortion), reduced maternal bonding with children born after the abortion, divorce, and repeat abortions (having another abortion in the future) (3).

In her discussion of the PAS claim, American feminist theorist Valerie Hartouni lists the syndrome's '...vast range of indications' as '...guilt, remorse, despair, unfulfillment, withdrawal, helplessness, decreased work capacity, diminished powers of reason, anger and rage, seizures, loss of interest in sex, intense interest in babies, thwarted maternal instincts, residual "motherliness", self-destructive behavior, suicidal impulses, hostility and child abuse' (Hartouni 1997:43).

Associating this broad range of 'symptoms' with a diagnosis of PAS lets claimants argue that large numbers of women may suffer from the syndrome. As the 'diagnostic criteria' for PAS become broader, it is easier to claim that many women may suffer from it.

In their contribution to the *Journal of Social Issues'* special edition on the psychological effects of abortion, Rue and Speckhard have formalised this elastic definition of PAS 'symptoms' when they suggest that '...as a psychosocial stressor, abortion may lead some women to experience reactions ranging from mild distress to severe trauma, creating a continuum that we conceptualize as progressing in severity from postabortion distress (PAD) to PAS to Post abortion psychosis' (Speckhard and Rue 1992:104-5). Positing reactions to abortion as a continuum in this way is significant, in that it creates a link between mild and severe responses: all become versions of the same response. Feelings a woman might have after abortion, such as sadness or regret, become less severe versions of PAS.

PAS and denial

The PAS claim thus construes women's psychological response to abortion as a form of PTSD. I want now to discuss in more detail the construction of women's psychological response to abortion in the PAS claim. Using literature produced by anti-abortion organisations in Britain and the U.S. as my source, I discuss the representation of women's psychology central to PAS, that of 'denial' after abortion.

According to proponents of PAS, if the truth of what the woman has done in having an abortion is too unpleasant to cope with, it is denied or repressed in the unconscious. A briefing paper from the British anti-abortion organisation Life thus contends:

> Doctors have told her that they will remove a 'blob of tissue', a 'product of conception' and that 'her problem will be solved' so that she will be able 'to get on with her life' as if nothing had happened. Yet deep down the women knows from the physical changes that are taking place in her body, that she is expecting not a 'blob of tissue' but a baby. To cope with this contradiction the woman has to employ the full force of psychological defence mechanisms (Jarmulowicz 1992: 9).

The key feature of this argument about women's psychology is that abortion is construed as a significant threat to psychological health, regardless of whether the woman herself perceives this to be the case. Through the concept of denial, the PAS claim allows a woman's belief or even declaration that her psychological health will be, or is, unaffected by abortion to be downplayed or dismissed. In contrast, this discourse allows its proponents to assert that many if not all women can be adversely affected by abortion, even if they do not recognise this themselves.

The same briefing paper from Life continues:

> One of the problems of post Abortion Syndrome is that it can be difficult to recognise, because one of the defence mechanisms against the pain is one of denial. Post Abortion Syndrome is a variant of "Post Traumatic Stress Disorder", first described in Vietnam war veterans. The wives of the men suffering described how they had changed: - they might be violent or abuse alcohol....So it is with abortion:- The feelings about the abortion are suppressed, but the subconscious must have some mechanism of release and other apparently unrelated symptoms emerge (ibid).

On these grounds, when a woman has had an abortion, any negative psychological reaction after the procedure can be related back to the abortion, even if the woman does not make this connection herself. Through this construction of women's psychology, as long as the woman has had an abortion at some point in the past, she can be diagnosed as suffering from PAS.

PAS can of course be diagnosed where the woman says she is psychologically distressed as a result of abortion, but also if she believes that the abortion has had no negative psychological consequences. In this case she is said to be in denial, and can still be diagnosed as suffering from PAS. Further, in the terms of the PAS claim, acknowledging negative psychological response to a previous abortion is the precondition for re-establishing mental health, since the woman:

> ...must admit that the child is dead so she can grieve. To reach this point the woman must break through the denial to allow for recognition of the guilt. Guilt can then be used in a therapeutic way to help the woman accept that she has done wrong, seek forgiveness and be healed (Franz undated).

Through constructing women's psychological response to abortion in this way, those who believe in the existence of PAS make the claim that they are the best advocates of women's health needs in abortion. They contend that those who truly understand the suffering abortion brings to women, in contrast to supporters of legal abortion, are, as I discuss in more detail next, the true 'woman-centred' feminists.

The 'woman-centredness' of PAS

The key issue for opponents of abortion over the past 30 years has been to gain support for opposition to laws which make abortion legally permissible. As I discussed in Chapter 3, part of the argument made by opponents of abortion in parliament in the debate about the 1967 Act, was that legal abortion was morally wrong. Women who sought abortion were construed as feckless and immoral in seeking to avoid the responsibility of motherhood. After 1967, it has also been the case that anti-abortionists have framed the immorality of abortion through reference to the 'personhood' of the fetus. As Hadley (1997) has pointed out, the fetus has become central to anti-abortion argument. In particular, the fetus has been portrayed as an 'innocent victim' of abortion, whose rights abortion opponents seek to defend.

In their interesting and informative study of anti-abortion argument, Hopkins et al (1997) situate the emergence of the PAS claim in relation to such arguments for fetal rights, which they contend have generated difficulties for abortion opponents. These writers argue that, through the PAS claim, opponents of abortion are responding to the criticism that they ignore the experience and needs of women. Hopkins et al argue that this criticism represents the 'rhetorical Achilles heel' of anti-abortion argument.

In the abortion debate, it has been those who agree with legal abortion, the pro-choice lobby, who have been recognised as the advocates of women's needs. Their argument that women need and want access to legal abortion, and that legalised abortion represents a way of improving women's lives, has been accepted as the perspective sympathetic to women's experience. In contrast:

> ...the anti-abortionists' focus upon the foetus means that they remain vulnerable to the charge of ignoring the woman and her experience. Indeed whilst the image of the foetus as a free-floating independent individual able to claim 'rights' is actually dependent upon what Rothman (1986) describes as the reduction of the woman to

> invisible 'empty space'. This treatment of women constitutes something of a rhetorical Achilles heel. Put simply, it gives pro-abortion activists the opportunity to castigate anti-abortionists for ignoring the woman (ibid: 542).

The PAS claim is significant, in that: 'Whilst until now anti-abortionists have portrayed the foetus as the victim of abortion, there has recently been a move towards constructing the woman as similarly victimised' (ibid: 541).

Following Hopkins et al, I therefore assess how the claim for PAS attempts to repair this 'Achilles heel'. Through a consideration of the case made about legal abortion in literature supportive of the PAS claim, I discuss how those who construct women's psychology in terms of PAS define themselves as the interest group who are truly concerned with women's health and well-being.

Many pro-choice social scientists and doctors have argued that women's quality of life and mental health has been improved by the provision of legal abortion (David 1998; Paintin 1998; Simms 1985; Tietze 1984). The greater social acceptance of abortion, brought about through its legalisation, has been construed as positive for women.

Supporters of the PAS claim invert this argument. They suggest, in contrast, that the legalisation of abortion, and its increased social acceptance, has in fact been detrimental for women. Rue and Speckhard claim that social acceptance of abortion: '...may discourage women from revealing their postabortion feelings and may result in labelling women with emotional difficulties after their abortion as deviant and in need of psychotherapy' (Speckhard and Rue 1992: 95). Their argument is that through making abortion legal, the real trauma women feel becomes suppressed. Additionally, as a result of legal abortion, those women who do admit to trauma are labelled abnormal. Rue and Speckhard thus see the normalisation of abortion through its legalisation as negative for women.

Jack Scarisbrick, chairman of Life has also criticised legal abortion on the grounds that it is psychologically bad for women:

> The Abortion Act was also a grievous setback for true feminism, because every time a pregnancy is deliberately destroyed a woman is abused. From our nationwide care service for women facing an unintended pregnancy or suffering from the effects of abortion, we know that the true human cost of twenty five years of abortionism has been thousands of women deeply wounded in mind (Scarisbrick 1992: foreword).

This construction of legal abortion, as bad for women's mental health, has led to a claim about the motivations of anti-abortion campaigners. In challenging those who support legal abortion, opponents of abortion have contended they speak on behalf of women and their interests. For example, in one of their leaflets, the organisation British Victims of Abortion (BVA) have promoted their campaign for the recognition of PAS by claiming: 'Society and

the medical profession have largely ignored this syndrome, denied its reality, or minimised its impact on the lives of countless women and men' (BVA undated).

BVA thus present themselves as acting on women's behalf in battle with 'society' and the medical 'establishment' who have refused to believe in, or recognise, the trauma of abortion. Where the latter are purposefully blind and insensitive to women, those who recognise PAS are construed in contrast as sensitive to women's experience and as seeking to care for the 'victims' of abortion.

The theme of victimisation of women, through abortion, is a recurring feature of literature about PAS. Women are presented as victims of others, who have forced them to have abortions against their will, with little regard for the psychological consequences. One American leaflet, distributed in Britain by BVA, contends: '...we know that the majority of women who have had abortions would have preferred another solution to the problem. They are clearly victims of someone else's decision making' (Franz, undated).

PAS discourse thus overtly challenges the contention that anti-abortionists fail to concern themselves with women's rights. Some who believe in the existence of PAS have argued that they do so because they are feminists and want to make society aware of the damage abortion does to women. They counterpose their desire to do this with what they construct as the 'phoney' argument that pro-choice feminists make in connecting abortion with women's liberation. An internet bulletin put out by a 'Pro-Life feminist' therefore claims:

> Abortion doesn't "liberate" women - it "liberates" the people around them. For instance, employers do not have to make concessions to pregnant women and mothers. Schools do not have to accommodate to the needs of parents, and irresponsible men do not have to commit themselves to their partners or their children (Gargaro undated).

Similarly the British anti-abortion organisation Life, in its leaflet *A Woman's Right to Choose? Women and the problem pregnancy*, disputes the claims of pro-choice feminists in the section titled 'Freedom to choose?':

> When pregnancy is unwanted what real choice is there?
>
> The choice is between abortion, with its physical and emotional after-effects, or continuing the pregnancy. Those people closely involved with the pregnant woman know that if the pregnancy continues they will be expected to do something to help her and the baby. If she has an abortion they need do nothing. She has the abortion alone. She has to live with it afterwards - alone. For selfish partners, parents, friends, the choice is simple. They do the choosing, not her. Sometimes the pressure is gentle. Often it isn't. There is little freedom of choice when those who should give love and support walk away leaving her to cope alone. Readily available abortion has made women more vulnerable (Life: undated).

Through aping the language of feminism, the PAS claim constructs those who recognise the existence of PAS as more concerned with women's well being than supporters of legal abortion. Their role has been defined as speaking on behalf of women who are victimised by others, and as bringing their experience to the attention of society. Through PAS, anti-abortion campaigners have claimed to be a voice for women who have had abortion, whether such women believe they are suffering from PAS or not.

**Conclusions**

In this chapter I have situated the PAS claim as a response not only to the medicalisation of abortion in Britain, but also to the development of the psychiatric category PTSD. I have argued that the PAS claim emerged after PTSD had already been diagnosed in a wide range of situations, and when looser and more inclusive criteria for diagnosing PTSD had been developed. I have also detailed the features of the PAS claim, including the construction of women's psychological response to abortion as denial of negative emotions, and of abortion opponents as women's rights advocates.

The PAS claim has generated a response by pro-choice organisations. Those in favour of legal abortion have been concerned to dispute the idea that abortion leads to psychological damage. It is to their claims about the psychological effects of abortion that I now turn.

# Chapter 5: WOMEN'S PSYCHOLOGY IN PRO-CHOICE DISCOURSE

The PAS claim has generated a heated and high profile debate in the U.S., and a less publicised contest in Britain about the psychological effects of abortion. In this chapter, I discuss the response from representatives of pro-choice organisations in the U.S. and Britain during the 1980s and 1990s to the claim that women suffer from PAS. Next I consider feminist claims made from the mid-1980s onwards that abortion does have important psychological effects. Finally I provide an account of representations of women's psychological responses to abortion in pro-choice commentaries about the provision of counselling in abortion services.

## Contesting PAS

Those who have publicly disputed the PAS claim have in the main adopted the style of argument characteristic of mainstream psychology. Their arguments have relied primarily on research about women's psychological response to abortion, which has been used to put forward statistically based objections to the PAS claim.

In this section, I will therefore argue that the dominant case in pro-choice discourse has been that the majority of women are not ill-affected psychologically by abortion. Additionally, some arguments have been made about 'risk factors', where certain groups of women have been construed as more likely to suffer psychologically following abortion, where others have been construed as benefiting positively psychologically from abortion.

### Quantifying negative psychological responses

The PAS claim had its greatest visibility between 1987 and 1989 in the U.S.. It was during this time that the then Surgeon General, Everett C. Koop, undertook, at the behest of President Ronald Reagan, an enquiry into the health effects of abortion (both physical and psychological). There were two main components of the Koop investigation. The first was an investigation by the Surgeon General and his staff, that took a year and a half to complete. This involved staff in several agencies of the Public Health Service evaluating 250 pieces of research, as well as meetings and discussion '...with a variety of groups representing pro-life, pro-choice, and professional perspectives' (Wilmoth 1992: 2). Second, following this inquiry, Koop and a range of experts on the psychological effects of abortion presented written and verbal statements at a 1989 hearing before a subcommittee of the House Committee on Government Operations (1).

The Koop Report was completed in January 1989, but it was not made public. The report was finally released at the Hearing of the Human Resources and Intergovernmental Relations Committee of the House Committee on Government Operations, held on 16 March 1989. The hearing itself did not draw any conclusions, or make suggestions with regard to abortion law or policy. However, it did generate significant comment in the media, and the views of opponents of the PAS claim achieved a high degree of prominence.

It was in fact the official organisations of American psychology and psychiatry, rather than those dedicated to lobbying for abortion rights or on women's health issues specifically, who commented most publicly about PAS. These organisations have stated their support for legal abortion however, and have thus defined themselves as pro-choice. Their main case against PAS drew on the lack of evidence for the claim found in what such organisations considered methodologically sound research.

The American Psychological Association (APA) was the most prominent opponent of the PAS claim. Brian Wilcox of the APA, who contributed a literature review to the Koop study, was quoted in the prestigious journal *Science* in February 1989. He argued: '...although we searched and searched and searched, there was no evidence at all for the existence of the "postabortion syndrome" claimed by some right-to-life groups' (Holden 1989). In line with Wilcox's argument against PAS, the article was titled 'Right-to-lifers fail to get hoped-for evidence to reverse Roe v. Wade'. The press covered APA spokespeople in a similar manner: the *Chicago Tribune* titled an article on the Koop Report 'Study shoots down 'abortion syndrome', on the basis of comment from an APA spokesman that '...there is no evidence' for PAS (Kotulak and Van 1989); and Nancy Adler from the APA was quoted in *Time* magazine as claiming that '...abortion inflicts no particular psychological damage on women' (Thompson 1989).

Following the hearing, publicity for the argument against PAS continued. In April 1990, it was reported that a study carried out by the APA countered the contention by anti-abortion groups that large numbers of women suffer severe trauma that surfaces years after an abortion. The study had found that '...severe negative reactions after abortions are rare and can best be understood in the framework of coping with a normal life stress' (Brotman 1990). In an often quoted article, psychologists associated with the American Psychological Association and other influential scientific bodies argued in *Science* that: 'A review of methodologically sound studies of the psychological responses of U.S. women after they obtained legal, nonrestrictive abortions indicates that distress is generally greatest before abortion and that the incidence of severe negative responses is low'. The article also noted that Koop did in fact testify at the congressional hearing that the development of significant psychological problems after abortion was '...miniscule from a public health perspective' (Adler et al 1990).

The American Medical Association did not give evidence to the Koop enquiry, but published a 1992 article on the subject in its house journal. This article by Nada Stotland of the American Psychiatric Association was titled 'The Myth of the Abortion Trauma Syndrome', and has been a reference point in subsequent reporting about PAS (Vogt 1992; Boodman 1992). It began: 'This is an article about a medical syndrome that does not exist'. In this article, Stotland argued that the only evidence in support of the claim that there is such a syndrome is to be found in a '...small number of papers and books based on anecdotal evidence' and that such publications '...have been presented and published under religious auspices and in the nonspeciality literature'. Stotland claimed that while women may experience abortion as a loss, and thus feel sad afterwards, a feeling is 'not equivalent to a disease', and that negative feelings should always be distinguished from psychiatric illness (Stotland 1992). The journal carried a further article in 1992, submitted by the AMA's Council on Scientific Affairs, that reported:

> Until the 1960s, many assumed that serious emotional problems following induced abortion were common. In 1989, after reviewing more than 250 studies of the emotional aftermath of abortion, Surgeon General C. Everett Koop concluded that the data were "insufficient....to support the premise that abortion does or does not produce a post-abortion syndrome." He noted, however, that emotional problems resulting from abortion are "miniscule from a public health perspective" (Council on Scientific Affairs, American Medical Association 1992).

American pro-choice organisations have, subsequent to the Koop Report debate, disputed the PAS claim in their literature and leaflets. Where they have done so, they have framed their case in a similar way to that discussed above. The lack of scientific evidence for PAS has been the main argument made. America's largest pro-choice organisation, Planned Parenthood, has argued:

> Anti-family planning extremists....are circulating unfounded claims that a majority of the 25 per cent of pregnant American women who choose to terminate their pregnancies suffer severe and long-lasting emotional trauma as a result. They call this largely nonexistent phenomenon "post-abortion trauma" or "post-abortion syndrome." They hope that terms like these will gain wide currency and credibility despite the fact that most studies have found abortion to be a relatively benign procedure in terms of emotional effect except when pre-abortion emotional problems exist (Planned Parenthood undated).

The idea that most women suffer from PAS after abortion has thus been challenged through the contention that anti-abortionists are 'hoping' that the terms post-abortion trauma and post-abortion syndrome will gain credibility. This construction of the anti-abortion lobby's views implies that there is no real evidence to sustain the PAS argument. Underlying this

construction of PAS as a myth circulated by abortion opponents is a reliance on research evidence from mainstream psychology and psychiatry.

In Britain, the debate about PAS has been much less visible, and it has been pro-choice organisations which have responded publicly to the PAS claim, rather than medical or scientific bodies. The most significant attempt to promote the PAS claim in Britain took place in 1994, with the publication of the report of the Rawlinson Commission on the 'Physical and Psycho-social Effects of Abortion on Women' (Rawlinson 1994).

The Rawlinson Commission was headed by Lord Rawlinson of Ewell, and administered by Christian Action Research and Education (CARE). Its stated aim was to carry out an investigation into the physical and psycho-social effects of abortion, rather than to discuss the ethics of abortion. Its brief was therefore confined to an investigation of the effects of abortion on women's health (Rawlinson 1994). The Commission recommended that '...further good quality research with a fully representative sample' should be carried out '...to determine the extent of physical, and especially psychological consequences of abortion' (Rawlinson 1994: 17). In addition it urged that the Department of Health investigate how its guideline on counselling was being applied in practice, '...because it seems that many of the clinics fail to offer pre-abortion counselling', and that clinics be required to make available information about '...*independent* counsellors....who offer post-abortion counselling' (emphasis in the original document) (Rawlinson 1994: 180).

In comparison with the Koop enquiry, the debate following the publication of the Rawlinson Commission was low-key. Other than one response from the Royal College of Psychiatrists (RCPsych), no major scientific organisations responded to the report. The RCPsych responded to dispute a statement made in the Commission report about the College's position on abortion. In its press release about its findings, the Rawlinson Commission claimed that the Royal College of Psychiatrists had given written evidence to the Commission that there are 'no psychiatric indications for abortion'. The press release claimed that this '...raises serious questions given that 91 per cent of abortions are carried out on the grounds of the mental health of the mother'. The RCPsych subsequently issued a statement to say that this was '...an inaccurate portrayal of the College's views on abortion' and asked for a public retraction of the statement. The College also chose to restate its opinion that: 'There is no evidence of an increased risk of major psychiatric disorder or of long lasting psychological distress [following abortion]. For the minority who do develop psychiatric disorders, there are predictable risk factors and such women should be offered a psychiatric assessment before the termination, and psychological help afterwards' (RCP 1994).

Britain's main pro-choice organisations did issue statements and press releases. Birth Control Trust highlighted the RCPsych's statement, and repeated the extract above from it

(Birth Control Trust 1994). The National Abortion Campaign press release disputed the neutrality of the Rawlinson Commission, pointing out that most of its members were '...the country's best known anti-abortionists' and that most were 'Roman Catholics'. In addition it disputed the claim that more research was needed about the health effects of abortion, and argued: '...there is a huge body of evidence that legal abortion is physically and even psychologically less harmful than full-term pregnancy and childbirth' (National Abortion Campaign 1994).

British pro-choice organisations have also commented on PAS other than in response to the Rawlinson Commission. Ann Furedi, of the British Birth Control Trust, has argued: '...where abortion is legal and relatively freely available there is no evidence of significant psychiatric after-effects' (Birth Control Trust 1995). A similar approach has been taken by the veteran British pro-choice gynaecologist, David Paintin, who has claimed:

> All women regret having to have an abortion but the vast majority find that they can live with the experience without any emotional problems. A small number (about 3 per cent) have long-term feelings of guilt and some of these feel that the abortion was a mistake. For such women, the unwanted pregnancy was often only one problem in a life that was not going well and which continued to be unsatisfactory after the abortion. There is some evidence that for most such women not having the abortion would have made matters worse. Post-abortion problems have been grossly exaggerated by those who oppose abortion on principle (Paintin 1997: 10).

Those women who have severe emotional problems post abortion are in this case said to be a small group, and their problems are construed as resulting from a 'life that was not going well.' In comparison the majority of women are described as able to live after abortion 'without any emotional problems'. This emphasis on the findings of research evidence which proves that the majority of women do not experience negative emotions post-abortion is the most consistent feature of pro-choice discourse.

Risk factors

As I discussed in Chapter 2, discussion of 'risk factors' for negative psychological response to abortion has been an important aspect of psychological research. A concern with 'risk factors' has also been reflected in the discourse of pro-choice organisations in part in response to anti-abortion claims.

Literature from the Planned Parenthood Federation of America has suggested that women who are 'at risk' for '...enduring, severe psychiatric disturbances following abortion' are '...those with previous psychiatric or abnormal obstetric histories as well as those expressing ambivalence toward abortion' (Planned Parenthood undated). Henry P. David, director of the U.S. based pro-choice organisation The Transnational Family Institute, has summarised the

findings of research that has the aim of identifying 'risk factors' for post-abortion psychological problems in a paper which criticised the PAS claim:

> Women identified in the research literature as being at some risk for negative psychological reactions - and in potential need of special counseling - are those who terminate a very much wanted pregnancy for medical reasons; lack of support from partners or parents for their decision; were coerced into making a decision they subsequently regretted; are conflicted about deeply held religious values; are uncertain of their coping abilities beforehand; blame themselves for the pregnancy; delay into the second trimester; or had a previous psychiatric episode (David 1996: 8).

Mary Boyle has listed the 'risk factors' often mentioned by pro-choice commentators as allegiance to religious or cultural groups which do not support abortion; length of pregnancy; difficulty in making the abortion decision; lack of social support for the decision; regarding the decision as being externally imposed; and where the abortion is of a wanted pregnancy where abnormality has been detected in the fetus (Boyle 1998: 115).

In drawing a distinction between the majority and a minority of women as outlined above, pro-choice discourse has framed abortion as in most cases psychologically harmless. Abortion has been construed as a benign procedure for most women. For the minority of women, who are emotionally disturbed after abortion, abortion itself has been portrayed as blameless in relation to these emotional problems. In all of the examples mentioned previously, where 'risk factors' for negative abortion psychological sequelae are discussed, pro-choice discourse has constructed 'other factors' than abortion as responsible for negative feelings. Pro-choice argument has therefore disputed PAS by contending that it is not possible to prove a direct link between abortion and post abortion psychological problems.

Psychological benefits of abortion

Some pro-choice commentators have gone a step further, and have argued abortion can lead to positive psychological reactions. Henry David, referring to the research findings of American pro-choice psychologist Nancy Russo, has argued:

> While there may be temporary sensations of regret, sadness, or guilt, the weight of the evidence indicates that legal abortion of an unwanted pregnancy in the first trimester does not pose a severe psychological hazard for the vast majority of women. Indeed, most women report experiencing a feeling of relief - of anxiety lifted (David 1996: 8).

Planned Parenthood Federation of America has described abortion as a 'positive coping mechanism'. The experience of coping, and successfully dealing with a 'crisis situation' has been construed as a positive experience:

> For most women who have had abortions, the procedure represents a maturing experience, a successful coping with a personal crisis situation. The event provides them with an opportunity to reconsider their attitudes and relationships and thus achieve more rewarding emotional lives (Planned Parenthood, undated).

Underlying this construction of abortion is a different model of women's psychology and abortion to that traditionally used by psychologists in their investigations of the subject. The previous model, sometimes termed the 'medical model', has assessed women's psychological response to abortion by measuring the outcome of abortion using (usually negative) psychological categories, such as depression or regret. In contrast, what Boyle has termed a 'framework of stress and coping' (Boyle 1997: 115) has more recently been employed. American psychologist, Nancy Adler, speaking on behalf of the American Psychological Association, described this approach as follows:

> Unwanted pregnancy and abortion are....potentially difficult stressful life events, events that pose challenges and difficulties to the individual but do not necessarily lead to psychopathological outcomes. Rather, a range of possible responses, including growth and maturation as well as negative affect and psychopathology can occur (Adler et al 1992: 1202).

This approach has attempted to introduce an alternative concept of women's emotional response to abortion into the research framework to that traditionally used. Rather than relying on the convention of negative, or pathological constructions of women's psychology post-abortion, and seeing how many women 'fit' into these categories, it has introduced into the analysis an alternative approach, where, from the start, the possibility of the experience of abortion being a positive one for women is considered.

According to Boyle such research, while novel in its departure from the conventional emphasis on negative psychological responses to abortion, can be thought of as still prone to the same flaws as mainstream psychological method discussed in Chapter 2. Boyle has argued such research '...retains a view of women's response to abortion which is extremely narrow and individualistic', since it fails to '...draw attention to the ways in which structural conditions shape women's response to abortion'. Nevertheless, Boyle suggests: 'This research....has been useful in counteracting assertions that the majority of women are psychologically harmed by abortion' (Boyle 1997: 116).

The overall direction of pro-choice discourse on abortion has therefore been to dispute the PAS claim, by utilising the research findings and approach of mainstream psychology. However, the argument that, on this basis, abortion can be considered psychologically

unproblematic for women, has been disputed by some individuals and organisations of a pro-choice outlook.

**Taking the negative psychological effects of abortion seriously**

Attempts on the part of pro-choice opinion to minimise the extent to which women suffer psychologically from abortion has attracted criticism from some feminists. Some British and American feminists have argued that, as a result, insufficient attention has been paid to explaining why some women suffer psychologically after abortion. American feminist psychologist Mary Roth Walsh has summarised this concern as follows:

> ...research since the liberalization of the abortion laws....has consistently reported that the psychological after effects are negligible. Nevertheless, there is some concern that minimizing the negative effects of abortion overlooks the needs of the small number of women who do experience difficulties. The issue is obviously fraught with political implications. Pro-choice social scientists....fear that by raising this issue they may provide anti-abortion forces with additional ammunition in the battle (Roth Walsh 1987: 11).

Two significant points are made here. The first is that emphasis on the lack of negative effects of abortion has led to ignorance about the experience of those women who are distressed following abortion. The experience of such women has been overlooked, suggesting that those who are part of the pro-choice 'camp', and therefore supposed to be sympathetic to the needs of women who have abortion, are failing to meet those needs. The second is that the reason for the lack of attention paid to the negative effects of abortion is political in origin. Pro-choice researchers have been concerned that opponents of legal abortion will benefit if attention is drawn to the negative effects of abortion.

Other feminist commentators have also suggested that fear of an anti-abortion backlash has led to a refusal on the part of pro-choice opinion to acknowledge distress following abortion. Feminists have suggested in their writings that while legalised abortion has been beneficial to women, emotional responses to the procedure have been unduly underestimated, and attention needs to be redirected towards this question. The proposition made by feminists is that the concern with the need to defend legal abortion has tended to obscure the real impact of abortion on women's psychological health.

From 'Abortion on Demand' to 'The Right to Feel'

In Britain, concern about presenting abortion as emotionally unproblematic for women was expressed in an influential statement made by abortion rights campaigner Eileen Fairweather. Her article titled 'The feelings behind the slogans' was published in *Spare Rib*

magazine in 1979 and prompted considerable debate in women's groups around Britain (Fairweather 1979). The starting point for the article was the observation that, for many women, abortion was not a pleasant experience associated with liberation. Women did not actively want abortions, and therefore the presentation of abortion as a right, associated with women's liberation, did not match with women's feelings about it. Her conclusion was that abortion rights campaigners should tone down their slogan 'Free Abortion on Demand' to the less aggressive 'For a Woman's Right to Choose', and in doing so shift the emphasis for feminists onto the problems women face in choosing and living with abortion. British feminist Miri Dana similarly criticised the focus in pro-choice campaigning on fighting for abortion rights. Her view, as summarised by Ernst and Maguire, was that:

> ...some of the political slogans used in the feminist campaigns to defend abortion may have actually lost supporters by simplifying or evading women's psychic realities....shifts in social attitudes towards abortion leading to and following on from its partial legalisation have enabled women to examine more closely their conscious and unconscious beliefs and feelings about abortion (Ernst and Maguire 1987:25).

During the 1970s, Dana contended, it was very difficult for pro-choice lobbyists to talk about the problems of abortion:

> At that time it was still too 'dangerous' to talk about the painful emotions surrounding abortion, because the anti-abortion pressure groups had monopolised the emotional and moral ground. It was they who spelt out the emotionally painful aspects of having an abortion, they who argued that abortion was killing....Because of these threats it was almost impossible for feminists to engage with the emotionally difficult aspects of abortion or the complex moral issues involved (Dana 1987: 155).

She emphasised the need for feminists, who were no longer faced with such a threat, to talk openly about the negative emotions associated with abortion.

Her argument was endorsed, and publicised during the 1980s, by feminist journalist, Angela Neustatter. In 1986, Neustatter published a book titled *Mixed Feelings, the Experience of Abortion* (1986), which resulted from a documentary, of the same name, made for Channel 4 television in 1982. According to Neustatter '...the film touched a nerve. After the programme ended, more than 1000 women 'phoned in to the Broadcasting Support Services to ask for information in setting up abortion self-help groups' (ibid: 1). She therefore decided to write a book, based mainly around interviews with women who had had an abortion, about their experiences, which drew on the work of Dana.

In her book, Neustatter argued that whilst she had always campaigned for a woman's right to choose abortion, she was '...shocked by the distress and confusion' she felt, when she came to chose an abortion herself. Through comments made by her interviewees (which comprised abortion counsellors, including Miri Dana, as well as women who had had an

abortion), she concluded that: 'Over and over again, women talk of the isolation and loneliness they feel after an abortion....particularly daunting and frightening is the feeling many have that their sorrow and grief will be endless' (ibid: 92).

For Neustatter therefore, negative feelings after abortion were construed as the normal, common experience of women. Her aim was to bring this to light, and, through doing so, encourage the pro-choice movement to change their approach to campaigning on abortion, and in particular alter what Miri Dana called a: '...flippant attitude....almost as dangerous as that which seeks to claim that abortion is murder', where those in the pro-choice movement '...think of it [abortion] as a minor event in a woman's life' (ibid: 108).

Neustatter's argument about the almost uniformly negative emotional consequences of abortion for women, and her claim that discussing such feelings should be central to the work of the pro-choice movement, was re-stated in a 2000 newspaper article. Titled 'Women's Cruel Choices', she wrote that 'We must keep the right to choose, but we should not pretend that abortion is ever pain free'. She contended that abortion is '...in fact a momentous decision, even if the result is not clinical psychological damage, in that we face a choice between life and death....that is neither a painless nor a value free thing to do' (Neustatter 2000: 16).

For Neustatter, abortion thus inevitably involves some degree of psychological 'pain', even if it severity of the 'pain' is not sufficient for it to qualify clinically as 'damage'. In her view, the pro-choice movement should make it clear that it recognises and accepts that abortion is experienced this way by women, rather than downplay the negative psychological effects of abortion.

Other feminist writers have also pointed to what they consider to be the enduring problem of the reluctance of the pro-choice movement to take the negative psychological effects of abortion seriously. Leslie Cannold (1998) claimed in this vein that the notion that the abortion debate turned on the question of rights was a myth. She suggested instead, that if women's accounts of their abortion experience were taken seriously, the '...all too familiar and all too predictable' (ibid: 5) discussion of rights would be replaced by one which emphasised the moral and emotional difficulties associated for women with choosing abortion. She argued the results of her research: '...provided absolutely no support for feminists arguing the 'abortion is straightforward' line' (ibid: xiv).

## Feminist accounts of women's psychological response to abortion

I now want to consider in more detail the ways in which women's psychological response to abortion has represented in such feminist accounts, in their response to the alleged underplaying of the effects of abortion in pro-choice argument.

There is a distinctive construction of women's psychology within some feminist accounts of abortion which has emphasised the importance of the unconscious, and the relationship of gender to it. This psychoanalytic approach assumes first that every event has an unconscious meaning, second that meaning is inevitably influenced in a fundamental way by gender, and third that in practice, women can be helped, through therapy, to understand that meaning.

In her book *Experiences with Abortion* (1988), Denise Winn, on this basis, discussed the benefits of hypnotherapy for women who were unable to conceive. This problem was explained as a result of: '...unexpressed grief about an abortion....working as a psychological block, preventing conception' which indicated that: 'The power of the subconscious can be strong indeed' (ibid: 7). On the basis of interviews with 12 women who had had an abortion, and with psychotherapists Miri Dana and Gillian Isaacs Hemmings (who worked in private practice, but who had also worked for the abortion provider Marie Stopes Clinics), Winn drew the following conclusion about abortion:

> It carries emotional connotations, to do with life and death, with fertility and womanhood, sexuality and identity. For some, unconscious conflicts in these and other areas, may have led to pregnancy in the first place. For many more, they cause unconscious conflict afterwards (ibid: 75).

Moira Walker took a similarly psychoanalytic approach in *Women in Therapy and Counselling* (1990), where she argued:

> Abortion is not an easy option for women. It causes pain and agony that can reverberate for years.....It is a decision taken for a variety of rationally correct reasons, and yet rarely feels right. Reasoning and rational thought do not coincide with feeling where abortion is concerned (ibid: 94).

Other writers have also emphasised the difference between the rational thoughts a woman has about abortion and her feelings. While the first exist in the conscious mind, and lead to a view on the part of the woman that opting for abortion was the correct decision to take, her feelings, generated by her unconscious, do not coincide with this perception. The authors of *Understanding Women in Distress* highlighted the conflict regarding abortion, between the conscious and unconscious:

> Hidden behind seemingly inexplicable symptoms in women patients lie painful traumatic experiences in the recent or distant past, which related to the patient's image of herself as a woman or as a mother. Once these experiences are brought to light, she can perhaps for the first time express her sadness, rage, humiliation, or despair, understand the meaning of her symptoms and begin to overcome them. These traumatic experiences are not divulged, or the emotions are not expressed,

> because the patient does not realize, or does not expect others to realize their importance (Ashurst and Hall 1989: 2).

The psychological 'symptoms' of experiences such as abortion apparently had no explanation because they were based in feelings which lay hidden in the unconscious, and which related to the woman's self-image as wife and mother. Abortion was traumatic because of this.

Miri Dana has perhaps been the most influential British proponent of this approach, which she developed through her work at the Women's Therapy Centre (2). Dana contended that there were three levels to the experience of abortion. The first was the experience itself: what actually happened and the feelings surrounding it. However, for Dana it was not possible to separate this first, conscious level of experience from the second, unconscious experience. For Dana, without an appreciation of unconscious motivation, it would not be possible to fully understand the reasons for actions taken and their meaning. The third level was the social level, which affected both conscious and unconscious behaviour. Applying this approach to abortion, Dana argued:

> It may take an unpleasant or painful experience such as an unwanted pregnancy and its termination to force a person to face the fact that there may be other forces at work besides the apparently straightforward and obvious ones (Dana 1987:153).

According to Dana, abortion is unpleasant and painful, but the experience of such pain could lead to a recognition that feelings about abortion were based on unconscious processes. Therefore to understand the experience of abortion, it was necessary to investigate these unconscious forces. Dana thus emphasised that her approach was based on the '...language of the unconscious which involves unconscious motives and meanings as well as patterns that we carry with us from our childhood' (ibid), motives and meanings that she described in terms of motherhood and women's relationship to it.

Dana discussed the 'myth of motherhood' as: '...the portrayal of women as essentially mothers'. This myth was created socially, since society had in various ways placed emphasis on women's role as carers and mothers within the nuclear family unit. It was also created through the traditional identity given to women as wife and mother, as the identity through which she would best find her sense of self. This myth included the '...picture of the unconditional, all-giving, all-good, never-harming mother, and of an eternal, incomparable, inseparable bond between mother and child' (ibid: 157-9).

Such 'social conditioning', for Dana, impacted on a woman's unconscious, and as a result

> ...it thus becomes clearer why abortion is such a painful and difficult experience for so many women. If motherhood means womanhood, what does abortion - which is its opposite, its 'negation' mean? (ibid: 159).

She answered this question by suggesting that the conflict in women between ideas about womanhood, deeply ingrained in the unconscious, and abortion as the negation of these ideas, was the source of psychological difficulty for women.

In 'killing' a 'baby', women may consciously know it was 'the right thing to do', but their unconscious is ridden with conflict. As a result, emotions that a woman felt and needed to express after abortion included anger, guilt, fear of sexuality, envy and sense of loss. In understanding the source of these emotions as a result of unconscious conflicts, a woman could, through therapy after abortion, come to integrate the experience into her conscious mind. The 'right to feel' was therefore crucial for women, because only through the recognition of that right, enacted through support for therapy, could women come to accept abortion, and experience it in a less psychologically damaging way.

Abortion could not therefore be a straightforward choice without repercussions. For Dana it would inevitably be a traumatic experience, requiring therapy afterwards. If trauma was not recognised, denial of it would take place, which would be damaging to the woman. For Dana, this approach did not contradict supporting women's right to choose abortion, but aimed to foster recognition that the choice women made when they chose abortion was problematic for them, because of their unconscious reaction to it.

Other feminist accounts of the 1980s did not explicitly emphasise the importance of the unconscious. They nevertheless stressed the psychologically negative effects of abortion. American feminists Lodl, McGettigan and Bucy (1987) contended that abortion could be traumatic, but used the term 'post-abortion stress' rather than 'post-abortion trauma' to describe its effects. In their contribution to the influential American publication *The Psychology of Women: Ongoing Debates*, they replied to the question 'Does Abortion Cause Psychological Harm to Women?'. In answering 'yes' to this question, they wrote about the origins of women's emotional response to abortion by defining two types of emotion:

> ...socially based emotions that reflect the social stigma and norm violation associated with unwanted pregnancy and abortion; and internally based emotions associated with the abortion experienced as personal loss (ibid: 399).

'Socially based emotions' resulted where abortion was perceived by society as wrong because it went against established norms. Lodl et al argued that '...often the guilt experienced by these women is due more to the circumstances surrounding their pregnancies and sexual activity than to the abortion itself' (ibid). In this presentation of negative feelings about abortion, such feelings were a product of negative attitudes surrounding abortion, external to the woman. In a society that disapproved of abortion, women could feel guilty and shameful about ending pregnancy not because of anything intrinsic to the act of abortion, but because of the views others held about it.

'Feelings of loss', unlike socially based emotions, were 'internally generated'. Women experienced abortion as loss because of what the abortion meant to them as individuals. Lodl at al suggested that women:

> ...may be dealing with loss of several types: loss of the fetus, loss of self-concept based on their perceptions of abortion and of themselves as a certain kind of person, or the loss of a lifestyle or value they has thought was important before the pregnancy or abortion. These issues may be dealt with through repression or denial, or through grief and confusion; or a woman may enter a period of introspection whereby she is engaged in a process or reexamining her life and values and beginning to take control for the first time (ibid: 401).

Feelings which were 'internally based' existed regardless of society's views on abortion. Regardless of the society around them, women had perceptions of themselves, their values and their relationships with others, which might lead abortion to be experienced as loss. Lodl et al suggested that a range of psychological responses, including denial, grief and introspection could result from such loss.

As the above discussion indicates, some feminists have contended that abortion is a traumatic experience for many women, and that a greater degree of attention should be paid to the emotional costs of the procedure by those are pro-choice. I now turn to consider the issue of counselling in abortion, and the debate within pro-choice opinion as to whether or not women need counselling because of abortion's psychological ill-effects.

**The counselling debate**

In some countries, such as Germany, it is compulsory for a woman to receive counselling before she can obtain an abortion (Murphy 1996). In Britain, the need to counsel a woman seeking an abortion was not stipulated in law, but as I discussed in Chapter 3, following the Lane Commission, abortion counselling came to be seen as good practice. Juliet Cheetham, a member of the Lane Committee, and author of *Unwanted Pregnancy and Counselling* (1977) argued in this light: 'There is general agreement that counselling should be offered, not imposed, and that it should never become an obligatory process to be endured as a condition of obtaining other kinds of help' (Cheetham 1977: 195). She suggested however, that whilst counselling should not be obligatory:

> ...helpful decisions cannot usually be taken without some counselling, by which is meant the opportunity for reflection with an empathetic person who tries to understand the parents' predicament (ibid).

and that:

> Nor is it possible, with some of the help available when pregnancies are unwanted, to imagine counselling as an optional extra....In many cases, mere information about

> services available, although essential, is not enough. Before making a realistic choice people frequently need to discuss their reactions to the options before them. This too can involve counselling, although it may not be recognised as such (ibid).

In this approach, it was seen as vital that women seeking abortion were offered counselling before abortion. In addition, whilst it was not discussed extensively in the Lane Report, it has also come to be seen as good practice for women to be offered post-abortion counselling, although it has latterly been emphasised that this needs to be available only for a small number of women (RCOG Clinical Effectiveness Support Unit 2000). Yet, as I discuss next, the rationale and objective of counselling in abortion is not self-evident, and has at times generated significant debate amongst those of a pro-choice outlook.

Investigations into the purpose of abortion counselling, carried out in the 1980s, suggested that the mandate for counselling was unclear. In her widely cited study of counselling services in termination of pregnancy, published in 1985, Isobel Allen justified the need for such a study on the grounds that:

> Existing evidence suggested that counselling services had developed in a piecemeal fashion, that there was considerable variety in both quality and quantity, no generally accepted standards of practice and no agreement on aims or objectives of counselling of this kind (Allen 1985: 333).

Marie-Anne Doggett (1981), in her unpublished review of the available literature about abortion counselling, also noted that there was apparently no consensus about the aims of abortion counselling. She argued that, to the contrary, there were a number of varying definitions of what abortion counselling should involve. She noted, referring to studies by Quillam and Grove (1990) and Gallen et al (1987), that some had used a 'broad sweep approach', offering such definitions as 'caring support of all kinds - practical, emotional, psychological' or 'any face-to-face communication between providers and clients that helps clients make a free and informed choice'. As a result of this lack of definition of its purpose, Doggett noted, Landy (1986) claimed abortion counselling had been regarded as an '...odd mixture of education, advice, caretaking and therapy', and Simms (1973) claimed it was '...somewhat uneasily suspended between psychotherapy and contraceptive instruction' (Simms 1973: 4).

Doggett did however identify six objectives of abortion counselling from the available literature. These were clarification and acceptance of decisions; attenuating emotional trauma; practical support; encouraging future contraceptive use; screening for physical or emotional risk factors; and deriving benefit from the abortion as a positive growth experience. This suggested that there was no single, identifiable benefit claimed for abortion counselling, but that the construction of abortion as a potentially psychologically damaging

experience had led to claims in favour of counselling in abortion. Counselling was therefore in part construed as an activity which aimed to 'attenuate emotional trauma'.

Doggett referred to a number of accounts which discussed the purpose of counselling in this way. For Bracken (1977), writing in the *Journal of Reproductive Medicine*, counselling before abortion could provide reassurance, thus reducing anxiety, stress, and regret. After abortion, patients who were normally well-balanced but who reacted to their situation by becoming depressed or anxious should have their 'mental health' restored after abortion through counselling (Hawkins and Elder 1979).

Different opinions about the desirability of constructing the benefits of counselling in these terms have been put forward. Views expressed in the literature from the 1980s and 90s which discussed abortion counselling differed. There were disagreements expressed as to whether it was appropriate or helpful for women for counselling to be offered on the basis that deciding to have an abortion, and living with it afterwards, was potentially psychologically damaging. I summarise first the case made in support of the provision of counselling on this basis, and then criticisms of this case.

For abortion counselling

One of the few books published in Britain after Juliet Cheetham's 1977 work, entirely dedicated to a discussion of abortion counselling, is *Pregnancy and Abortion Counselling,* by Brien and Fairbairn (1996). In introducing the book, the authors noted that there is:

> ...little written material directed at those undertaking this work' and that 'there are as yet no detailed written guidelines as to what pregnancy counselling is or how it should be carried out (Brien and Fairbairn 1996: vii).

The stated aim of the book was therefore to provide some '...guidelines to good practice' in pregnancy and abortion counselling. In Brien and Fairbairn's discussion of what they saw as good practice in abortion counselling, the psychological difficulties surrounding abortion were however emphasised where the need for abortion counselling was explained.

They argued that for women '...making the decision to terminate a pregnancy is both difficult and painful' (ibid: 1) and that counselling could '...provide people with the time to look at the pregnancy and situation, explore all possible options and make an informed choice when they feel ready to do so' (ibid: 57). On the basis of research by Hare and Heywood (1981), they stated that 32 per cent of women had been found to be ambivalent about their decision, and 20 per cent were unprepared and needed time to consider their decision, which meant '...an estimated 52 per cent of women could benefit from counselling' (ibid: 57). A connection was therefore made between ambivalence about deciding to abort a pregnancy, or needing more time to consider this decision, and counselling, where 'benefit' would result from counselling for a woman who found herself in that kind of situation.

While the reasons for this connection between ambivalence and the benefit of counselling were not made explicit, Brien and Fairbarin suggested that a goal of counselling that could be achieved with reliability was '...reducing negative feelings related to abortion' (ibid: 55). It would therefore seem to be the case that the 'benefit' Brien and Fairbarin perceived as most likely to accrue from counselling was the attenuation of negative feelings, where making the decision to end a pregnancy was difficult.

These writers also argued that '...48 per cent of women who have made a decision [to have an abortion] often benefit from counselling' and that: 'Paradoxically, it may be those women who 'know what they want, and don't want to talk about it' who will in fact benefit most from counselling'. The benefits for women who were not ambivalent or undecided therefore lay in the opportunity counselling offered to 'explore relevant issues' (ibid).

The benefit of counselling in reducing negative feelings was also made more explicit where Brien and Fairbairn argued that after abortion, some women:

> ...for a variety of reasons, find the experience so unsettling that they ask for the opportunity to talk with a counsellor in an attempt to gain some understanding of the gamut of feelings they are experiencing (ibid: 139).

They stated that ' ....the aim of this appointment is not to dig up and unearth hidden wounds but to validate a woman's experience and give her 'permission' to talk about her feelings if she so wishes' (ibid). The particular feelings named as the 'emotional legacy' of abortion were sadness and grief, regret, envy, guilt and anger. Panic attacks and dreams and nightmares were also discussed as possible effects of abortion.

Brien and Fairbairn also argued that it was '...important to try to ascertain how many women may be distressed enough to value the opportunity to talk to a counsellor'. They suggested that '...research into post-abortion sequelae gives contradictory results, but there is consistent agreement that abortion is beneficial to the mental health of women, releasing them from the emotional trauma of unwanted pregnancy' (ibid: 141). They also contended however that:

> We believe from our own and colleagues' clinical experience that many women, at some relevant time in their life, value the opportunity through counselling of integrating this experience and understanding what abortion meant to them (ibid: 142).

While abortion could act to release women from the 'trauma of unwanted pregnancy', counselling after abortion was therefore regarded by them as nevertheless helpful for many women.

The need for counselling to attenuate emotional trauma was supported most explicitly in Brien and Fairbairn's discussion of 'hidden feelings':

> Some women will realise they need counselling soon after the termination. Many others will lock their pain away and to all outward appearances have dealt with the abortion, getting back to 'normal' quickly afterwards. Some time later several of these women may be affected by an event such as a friend having a baby, a miscarriage, or a TV programme about abortion. These events can act as a catalyst which may expose their hidden feelings. Other women will put up with years of confused symptomology before they ask for help (ibid: 140).

This presentation of the need for counselling construed the effects of abortion in terms of PTSD. Feelings were repressed, and emerged later, but as 'symptoms' which might not appear to be clearly related to abortion. Hence '...the request for counselling may be precipitated by a wide variety of symptoms, at any time from a few days to many years after the abortion' (ibid: 142).

Other writers have also justified the need for counselling in terms of PTSD. Vanessa Davies, author of *Abortion and Afterwards* argued that: 'Abortion is an extremely stressful event which falls outside the normal range of women's experiences and as such leaves us open to many profound feelings' (Davies 1991: 120). Davies suggested there could be 'themes' common to women who have experienced abortion, which she named as depression, anxiety, guilt, anger, sadness, euphoria, relief, resentment, anxiety and grief (ibid: 121). As a result, women needed

> ...to be able to express our feelings if we are to heal naturally and completely. Our feelings need to be understood by others for what they are and not interpreted as weak and hysterical (ibid: 137).

Ashurst and Hall have similarly emphasised the possibility of negative feelings after abortion, which needed be acknowledged:

> It may be a lesser evil than continuing with the pregnancy, but the decision is never a simple one. The loss of the child-that-might-have-been may be re-experienced repeatedly and needs to be grieved. Choosing termination means taking responsibility for killing part of oneself, and the anguish can be such that grieving is avoided....Acknowledgement of the powerful emotions that accompany such an episode will help facilitate the normal mourning process, so that depression is less likely to follow (Ashurst and Hall 1989: 117).

In these accounts, counselling has been presented as a helpful response to the negative feelings generated in women before and after abortion. The activity of counselling has been constructed as a response to such feelings, which could help to minimise them, and as such has been regarded as beneficial for women.

Critiques of abortion counselling

Other commentators have taken a critical approach to this construction of the need for abortion counselling. They have contended that where counselling was advocated on this basis, it relied on an exaggeration of the intensity and duration of psychological difficulties women experienced regarding abortion. It was argued that advocates of counselling sometimes presented the negative feelings associated with abortion as more problematic for women than was really the case.

Critics of counselling have also suggested that the provision of counselling on this basis could be understood as part of a possibly damaging set of assumptions about what abortion represents psychologically for women. In presenting counselling as a response to the trauma of abortion, it was claimed that counselling advocates risked reinforcing a particular expectation of how women normally respond psychologically to abortion. In this approach, the argument for counselling tended to present psychological difficulties as a likely outcome of abortion. In doing so it helped maintain an expectation about how women would, or should, feel following abortion. This was construed as problematic for women who did not feel this way, since they experienced their lack of negative feelings following abortion as a departure from what had been constructed as the norm.

The first of these arguments about the problem of counselling was made fairly soon after the Lane Commission findings were published, by veteran campaigner for abortion law reform, Madeleine Simms (1973/7). Simms pointed out that the assumption behind the provision of counselling rested on an exaggeration of the extent to which women are traumatised by abortion. She suggested that at the point at which the Abortion Act was passed, there were many women who felt guilty and unsure about their decision to abort a pregnancy. For Simms, such feelings were unsurprising, and constituted a response to prevailing negative social attitudes to abortion at the time. Counselling was at this point an 'antidote' to such feelings, and therefore, according to Simms, could be legitimately conceptualised as a response to the psychological difficulties women experienced when they aborted a pregnancy. Simms argued:

> This was the main reason why the concept of counselling 'caught on' and proved so attractive to abortion law reformers, to the Lane Committee and to the Department of Health and Social Security who later developed this as guidance to health authorities' (Simms 1977: 2).

However, writing in 1977, Simms also suggested that while abortion counselling may therefore have made sense as a part of abortion service provision at an earlier point, this was no longer the case. Simms described abortion counselling as an idea whose 'time has almost passed'. In her discussion of the way women responded psychologically to abortion,

she argued that a minority of women '...will still be uncertain, guilt-ridden and confused' and 'welcome the opportunity of discussing their problems in depth' (ibid: 2). Most though did not have these feelings about abortion, and were in any case likely to have discussed their decision with boyfriends, relatives and friends. Her conclusion was that counselling was therefore a less essential service than it had previously been, although it might still be important for a small number of women.

Reports of the results of Isobel Allen's extensive study of counselling in abortion services, which was published in 1985, pointed out a similar disparity between the provision of counselling, and the extent of psychological difficulties faced by women who had abortions. According to medical journalist Jeremy Laurance, the study found, as its principle conclusion, that there 'is *too much* counselling. We need less of it, but better directed to patients who need it' (Laurance 1985). The study also found that many of the patients interviewed resented the extent to which they were counselled. Their discussion with friends and relatives was found to be more important than formal counselling from professionals. Two thirds of the women interviewed said they had seen no need to discuss their decision with a doctor at all. According to Laurance, this response to counselling 'reflects social change' where 'both men and women knew their own minds, and took a very robust attitude to their decisions' (ibid). This approach therefore construed the psychological effects of abortion for women as relatively insignificant, in so far as women are confident about being able to make the decision to end a pregnancy without counselling. The existence of the provision of counselling in excess of what women wanted was problematised, in that it assumed women's ability to make decisions about the outcome of pregnancy as less 'robust' than was in fact the case.

Some of those who have called into question the provision of counselling in abortion have therefore based their argument on the construction of abortion as less problematic psychologically than advocates of counselling suggested. Again drawing on the statistical approach to women's psychological response to abortion constructed by psychological research, abortion counselling has been construed as an unnecessary response to the effects of abortion on a woman's psychological state.

Other critics have contended that the provision of counselling may *itself* act to make abortion traumatic. The provision of counselling was not simply unnecessary, but may be actively psychologically problematic. This criticism challenged the argument that counselling was simply a response to the experience of women, and instead contended that the argument for counselling itself contributed to making abortion psychologically damaging.

Writing in *The Guardian*, columnist Suzanne Moore, well know for her pro-choice stance on abortion, has suggested that the expectation that women needed abortion counselling could itself make abortion traumatic. She pointed out that women opting for abortion have

been assumed to be in need of counselling: 'A woman undergoing the trauma of mastectomy may receive no counselling, while a woman who is certain of her decision to have a termination will be expected to jump through the correct emotional hoops for a counsellor' (Moore 1992). She also suggested that: 'Somehow the emotions we are expected to get in touch with are always fairly negative. What about the woman who gets in touch with her feelings and feels not so bad at all, whose only guilt is about not feeling guilty' (ibid). For Moore, the demand that counselling made for women to 'get in touch' with their feelings could lead to a situation where some women felt more guilty than they otherwise would have done. The absence of guilt they experienced could be re-evaluated by women as a negative experience, which itself induces guilt.

More recently, Mary Boyle has also pointed to the possibly problematic effect of the provision of counselling in abortion through her discussion of a comment made by an abortion counsellor. The counsellor, quoted in Angela Neustatter's book *Mixed Feelings* (1986) said: 'I always say to a client, however old or young, or whatever the circumstances, that she will grieve for what has had to happen....In a sense we are all involved in bereavement counselling'. Boyle has suggested that counsellors were in a difficult position, because while they would understandably want to normalise what some women may feel, they risked '...presenting the abortion decision as naturally and inevitably associated with suffering and grief and of encouraging women who do not react in this way to see themselves as deviant' (Boyle 1997: 111).

Like Moore, Boyle therefore argued that such women may have seen themselves as deviant because they did not feel bad following abortion, and as a result experienced feelings of guilt. The provision of abortion counselling was therefore constructed as actively damaging at least for some women.

**Conclusions**

There are a number of discourses about abortion and its psychological effects that have been associated with a stance on abortion that supports its legal provision. A discourse can be identified that emerged in response to anti-abortion arguments, which has construed abortion as psychologically harmless, or even as therapeutic for women. However, in contrast feminist discourses have, like PAS discourse, construed abortion as traumatic. Feminist discourse has differed from the PAS claim in supporting the legal provision of abortion to women. However, it has similarly produced trauma as a frequently occurring response to abortion.

Difference of opinion about the psychological effects of abortion has also been reflected in the debate about the need for counselling in abortion. Some have suggested that the extent of emotional trauma associated with abortion means many, if not most, women considering

undergoing abortion need counselling. Others have argued in contrast that a tendency to over-estimate the emotional costs of abortion has led to the provision of too much counselling. This line of argument has also problematised the provision of abortion counselling as not simply unnecessary, but as possibly harmful for women.

In chapters which follow, I consider the current influence of the psychologising discourses I have so far discussed, in constructing the narratives of abortion counsellors, and of accounts by women who have had an abortion, of their experience of abortion. First I will detail the methods I used to gather and analyse my data.

# Chapter 6: RESEARCH METHODS

In Chapter 2, I discussed my rationale for adopting a Foucauldian approach in this thesis. I explained that my concern is to provide an account of the operation of psychological discourses about abortion. In subsequent chapters I have given an historical account of the development of such discourses in three sites - legal debate, anti-abortion argument and pro-choice argument. From this point on, I consider the current effects of these discourses. My aim is to test the hypothesis, outlined in Chapter 1. I argued in this chapter that discourses which emphasise the psychological ill-effects of abortion, and which in particular construe it as traumatic, are evident in public debate about abortion. I contended that it was likely that such discourses influence the practice of counselling women before and after abortion, and influence the ways women who have had abortions describe and discuss their experience of abortion. In the chapters which follow, I present an assessment of whether this is the case. I base this assessment on analysis of detailed interviews with abortion counsellors, and with women who have had an abortion.

My reason for choosing counselling as an area for further investigation arises from the debate outlined in previous chapters. As I explained, the claim that women need counselling in abortion because of its negative psychological effects has been a component part of the abortion debate from the Lane Commission onwards. Argument for counselling has been made extensively by government officials, representatives of anti-abortion organisations and by some advocates of a pro-choice position on abortion. These opinion formers have claimed that counselling is needed in part because of the deleterious psychological effects of abortion. Some of those of a pro-choice outlook have criticised its provision, and sought to question the validity of abortion counselling, but it is still a requirement of abortion providers that they provide counselling. My aim is to investigate how those who currently counsel women in Britain construe the need for their work. I ask the question put by David Silverman (1997) in his investigation of counselling in HIV testing: what is the 'mandate' for counselling? My expectation was that those who counsel women before and after abortion would justify the need to do so on psychological grounds.

The rationale for investigating whether women who have had an abortion construe their experience in terms of its psychological ill-effects in one sense requires no justification. Given that it is women who have abortions, their experience should clearly be central to any study of the contemporary construction of abortion. Specifically however, my aim is to consider whether, as my hypothesis suggests, women discuss their experience of abortion in psychological terms.

I will now discuss the research method I chose to use, how I selected participants for interview, the ethical and practical issues which emerged in the course of conducting my research, and the procedure I adopted for the analysis of my findings.

**Discourse analysis**

The research method I chose was discourse analysis. My reason for selecting this method related in the first place to the theoretical framework adopted in this thesis. Given my interest in developing a Foucauldian analysis of abortion, my emphasis was inevitably to be placed on the importance of discourses, particularly those which psychologise abortion, in the construction of abortion and women's experience of it. This must therefore have led to a research method which had analysis of such discourses as its central focus.

Difficulties arose however when I sought a more precise definition of discourse analysis as a research method. As Wendy Hollway has indicated, this is a difficult issue when the researcher wants to use a method which is based in Foucauldian theory. Hollway has argued that, while the primacy of written or spoken language and text is the starting point for all discourse analysis, this principle

> ...is practically the only thing which the many variants of discourse analysis have in common, for the term has come to cover virtually any approach which analyses text, from cognitive linguistics to deconstruction. My own use of the term 'discourse' is indebted to Foucault, for whom the term is integrated in analysis of the production of knowledges (or discourses) within power relations. To complicate matters, however, the term 'discourse analysis' is not often used in connection with Foucault's work! (Hollway 1989: 33).

The theoretical approach developed by Foucault does not therefore lead neatly to discourse analysis as a research method. Potter and Wetherell have also drawn attention to this potentially confusing aspect of discourse analysis:

> ...the label 'discourse analysis' has been used as a generic term for virtually any research concerned with language in its social and cognitive context....It is a field in which it is perfectly possible to have two books on discourse analysis with no overlap in content at all....the term 'discourse' itself has been used in many varying ways. Some researchers take 'discourse' to mean all forms of talk and writing, others take the term to apply only to the way talk is meshed together. While at the other extreme, some continental discourse analysts such as Foucault take 'discourse' to refer to much broader, historically developing, linguistic practices....All in all there is a great deal of potential for confusion (Potter and Wetherell 1987: 6-7).

Deciding how exactly to conduct a piece of research, given the broadness of discourse analysis as a method, and given the lack of clarity about the relationship between the

Foucauldian concept of discourse and such methods, is therefore difficult. Potter and Wetherell have however helpfully clarified that, while discourse analysis can be a confusing term, there is a central, defining feature of all discourse analysis, and as long as the researcher takes this seriously, there is no need to worry unduly about methodology. They have suggested:

> ...the message we wish to get across in this work is that developing an adequate theoretical understanding or interpretation is at least as important as perfecting a cast iron methodology, and theories can be assessed using a set of techniques (ibid:159).

'Proving' theories through 'watertight' research methods is therefore not necessarily the aim of research. Rather, developing theoretical insights and paying attention to the interpretation of results is as important. They have also argued:

> It is important to re-emphasize that there is no *method* to discourse analysis in the way we traditionally think of an experimental method or content analysis method. What we have is a broad theoretical framework concerning the nature of discourse and its role in social life, along with a set of suggestions about how discourse can best be studied and how others can be convinced its findings are genuine (ibid: 175).

Potter and Wetherell have therefore made it clear that there is no single method called discourse analysis, which attempts to imitate other methods, which have roots in claims to scientific objectivity. Rather, the key issue for discourse analysts lies with the emphasis they place on the importance of discourse, and its central role in constructing reality. Beyond this, there are only 'suggestions' about how to study discourse, rather than definitive rules. As long as the analysis carried out draws attentions to the importance of discourse, and analyses carefully the ways in which discourse acts constructively, the particular method used is relatively unimportant.

Potter and Wetherell argue therefore that in their work, they:

> ...use 'discourse' in its most open sense....to cover all forms of spoken interaction, formal and informal, and written texts of all kinds. So when we talk of 'discourse analysis' we mean analysis of any of these forms of discourse....our concern is not purely with discourse per se; that is, we are not linguists attempting to add social awareness to linguistics through the addition of the study of pragmatics. We are social psychologists expecting to gain a better understanding of social life and social interaction from our study of social texts (ibid: 7).

In this approach therefore, broad definitions are given of the term 'discourse', and the aim of the analysis of discourse is also broad: to add to knowledge about social life and the way it is constructed, rather than to study discourse in itself. To put it another way, for Potter and

Wetherell, it is not discourse itself that it interesting, rather what it tells us about how social life and social interaction are constructed. Such an approach, following Potter and Wetherell, is also taken by Hunter and O'Dea in their study of discourses of the menopause. They explain: 'Our aim was to map out the broad themes within women's accounts which relate to social and historical discourses, rather than attempt a detailed linguistic account' (Hunter and O'Dea 1998: 205).

I have therefore followed Potter and Wetherell's approach, outlined in *Discourse and Social Psychology: Beyond Attitudes and Behaviour* (1987). My analysis of the talk of my interviewees, like that of Hunter and O'Dea, is concerned with broad themes, rather than detailed linguistic formulations. I will now describe and discuss the interview study carried out in more detail. To start with, I want to explain why I chose interviews as the way to collect the data.

**Unstructured interviewing**

Stephen Ackroyd and John Hughes have described unstructured interviewing, and explained its advantages, as follows:

> In this type of interview, interviewers work from a list indicating, often in some detail, the kinds of topics to be covered in the interview. Interviewers are free to ask questions in whatever way they think appropriate and natural, and in whatever order is felt to be most effective in the circumstances. Both interviewer and respondent are allowed much greater leeway in asking and answering questions than is the case with the structured interview (Ackroyd and Hughes 1992: 103).

As these authors indicate, the aim of this kind of interview is to allow for leeway in asking and answering questions. It allows the interviewer to pick up on points made by the interviewee, encouraging the interviewee to talk in more detail about these points and to develop what they have to say in greater depth. Having the space for this kind of interaction, which can allow for detailed accounts by interviewees to be given about the terms and concepts they use, is important where the researcher aims to provide a detailed account of the meaning of a range of discursive constructions. As Lee has suggested: 'Such interviews provide a means of getting beyond surface appearances and permit greater sensitivity to the meaning contexts surrounding informant utterances' (Lee 1993: 104).

Lee also draws attention to the advantages of unstructured interviewing as follows:

> ...defining the boundaries of the research topic too tightly may inhibit respondents from defining it in their own way....defining the interview in one way may preclude the raising of other topics (ibid: 103).

Ensuring that the issues deemed relevant to the research are not defined narrowly allows interviewees to talk about the way they perceive the topic under investigation. This is

important if the interviews are to lead to insights about the multiple ways in which meanings are constructed.

In the interviews I carried out, I was concerned to ensure that the boundaries of the interviews were left as open as possible. The aim was to encourage the interviewee to talk as much as possible about issues they thought were relevant. As the interviewer, I was sensitive to the use of certain constructions of abortion on the part of those interviewed, and where these constructions were used, I encouraged the interviewee to develop them. However, at the outset the interviewee was free to give their account of their views and thoughts in the way that seemed appropriate for them.

Therefore while, as Ackroyd and Hughes indicate, I did have detailed questions relevant to the broad areas I thought I would cover in interviews (see Appendix 1), these questions did not always determine what was discussed in the interviews. In the end, they acted mainly as an aid for me, to help with preparation for the interviews, in thinking through what issues it would be useful to discuss with interviewees.

For the interviewer, this open-ended approach also allows certain themes and issues to be revisited in the course of the interview. In structured interviews, the design of the interview is such that the interviewer needs to constantly move on to the next subject area. In a study where the aim is to investigate the operation of discourses, however, it is important to be able to be able to return to certain themes at various points in the interview if it appears that a particular discourse is acting is a way that seems to merit further development.

The importance of doing so is discussed by Potter and Wetherell:

> ...the researcher should try to generate interpretative contexts in the interview in such a way that the connections between the interviewee's accounting practices and variations in functional context become clear. One of the ways this can be done is to tackle the same issue more than once in an interview, in the course of a number of different general topics (Potter and Wetherell 1987: 164).

In order to allow for connections and variations in the ways interviewees' narratives functioned, I therefore frequently returned to themes discussed at the start of interviews, where they appeared to re-emerge in different contexts at a later point.

**Feminist rationale**

Feminist researchers in particular have advocated and developed unstructured interviewing as a research method. Some feminists have suggested that unstructured interviewing allows power differentials between the interviewer and interviewee to be overcome, by focussing on the importance of the account given by the latter. For example Reinharz, in her book about feminist research methods, refers approvingly to sociologists

Pauline Bart and Patricia O'Brien, who '...explain that careful listening allows the interviewer to introduce new questions as the interview proceeds. Thus the interviewer, the interview and the study become interviewee oriented' (Reinharz 1992: 2). According to this argument, since the interview is not structured by a pre-ordained set of questions, and in contrast, aims to develop points raised by the interviewee, the study becomes 'interviewee oriented'.

Reinharz also gives further reasons why feminists have found this research method attractive, which relate to the subordinate social position of women. She argues that having access to people's ideas, thoughts, and memories in their own words rather than in the words of the researcher is important '...because in this way learning from women is an antidote to centuries of ignoring women's ideas altogether or having men speak for women' (ibid: 21). This applies where women are being interviewed about their opinions and experiences. In this instance, a feminist approach to research aims to maximise the ability for women to put forward what they have to say 'in their own words' rather than in those of the researcher. Reinharz also makes a further point about the relationship between feminist views and the interview method. She explains:

> Other feminist thinkers focus on the importance of interviewing to the interviewer, arguing that open-ended interviewing is particularly suited to female researchers. Asking people what they think and feel is an activity females are socialised to perform, at least in contemporary Western society....Interviewing is also consistent with many women's interest in avoiding control over others and developing a sense of connectedness with people (ibid: 20).

Here Reinharz again makes reference to the relationship between interviewing as a research method, and the feminist emphasis on the value of non-heirarchical relationships between interviewer and interviewee. She also suggests that female researchers may find interviewing attractive as a way of gathering data because they find it easy to carry out.

In my interviews, I tried to adopt this approach, and ensured throughout that my interviews were 'interviewee centred'. The degree to which I found it easy to develop a sense of connectedness with people varied however. All of those I interviewed were women, but it was easier to interview and connect with some than others.

The relationship generated in the interviews with women who had had abortions seemed to be the most connected and reciprocal. I found it easy to listen to what they had to say, and they seemed to find it easy to talk. There also seemed to be some desire on the part of these women to use me as a conduit for information about the abortion experiences of others. This created a situation where in some cases they wanted to 'interview' me about what I thought and knew, which made the interaction very relaxed and non-hierarchical.

In my contact with counsellors, who were without exception women, the ease with which I could interview my interviewees in contrast varied considerably. I found it particularly difficult

when interviewing 'pro-life' counsellors to develop a sense of interconnectedness with them. I frequently found myself wanting to contradict and disagree with opinions these counsellors expressed about the practices of abortion service providers, their views about the psychological effects of abortion, and their opinions on what constitutes 'good' abortion counselling. Although I did so, it was sometimes difficult to hold back from disputing their constructions of abortion and women's psychological response to it. This raises the issue of the problem of the differences between women, and the difficulties raised by the suggestion made by some feminists that all women's voices should be listened to and accepted.

**Selecting interview participants**

I have already discussed my reasons for wanting to include accounts given by counsellors of their work, and accounts given by women of their experience of abortion as data for this study. I now describe how I selected specific interviewees from these two groups.

As Potter and Wetherell indicate, issues that are of relevance where other research methods are used do not apply with discourse analysis. They argue that the issue of sample size is a point of divergence between discourse analysis and traditional research methodology:

> If one is interested in discursive forms, ten interviews might provide as much valid information as several hundred responses to a structured opinion poll. Because one is interested in language use rather than the people generating the language and because a large number of linguistic patterns are likely to emerge from a few people, small samples of a few interviews are generally quite adequate for investigating an interesting and practically important range of phenomena (Potter and Wetherell 1987: 161).

My aim in subject selection was not therefore to attempt to gather a 'representative sample' and carry out any kind of quantitative assessment. Rather it was to provide data which could be used for an in-depth analysis of discursive formations. In selecting participants to interview for my study, there was, however, a sense in which 'the people generating the language' was an issue. It was of relevance in approaching organisations that counsel women before and after abortion, where the approach taken to abortion on the part of those organisations differs widely.

Counselling is provided by a range of organisations, including the National Health Service, charitable organisations that provide private abortion services for women, and 'independent' organisations. Counselling provided in the NHS and by private abortion service organisations takes place in the context of organisations that provide abortion for women. Counsellors working for these organisations therefore believe that abortion should be legally

available to women, as a means for dealing with unwanted pregnancy. Counselling is also provided by 'independent' organisations, which, in contrast, are often opposed in principle to legal abortion.

In selecting interviewees therefore, I was concerned as far as possible to interview counsellors working for a range of organisations, and in this sense 'the people generating the language' was very relevant. It would not have made sense to ignore the differences between organisations which provide abortion and those which oppose its provision. I therefore decided to select participants taking this difference into account. Rather than simply interview 'abortion counsellors' I opted to attempt to carry out 10 interviews in settings where counselling was provided as part of an abortion service, and 10 where it was not.

I also aimed to interview 15 women who had had abortions. In this latter case the issue of 'the people generating the language' was relevant in so far as I needed to ensure a certain degree of uniformity in the sample. For reasons I discuss later, I restricted my sample to women who had undergone abortion at clinics in the South East of England. In addition, I did not include any women who had had aborted wanted pregnancies following the discovery that fetus was abnormal. The issues surrounding this type of abortion are very specific (Birth Control Trust 1997; Boyle 1997) and have not been discussed previously in this thesis. Hence it would have been inappropriate to introduce discussion of the experience of abortion on grounds of fetal abnormality at this stage in my research.

Potter and Wetherell have also indicated that there may be limits to the possibilities available for gathering data:

> In many cases, practice will be governed by what is available....Generally there is no 'natural' boundary line to be drawn in these cases, or no point at which sampling can be said to be complete. It is simply a case of giving a clear and detailed description of the nature of the material one is analysing and its origins' (Potter and Wetherell 1987: 162).

In my case there were limits to what was available. Issues of access and the extent to which organisations would co-operate with my request to interview staff created some difficulties where I wanted to interview counsellors. Difficulties in finding participants for interview were, in the end, the biggest problem however, and limited the size of my sample of women who had had an abortion, as I now discuss in more detail.

At the start of the process of obtaining interviewees, I decided to restrict the sample geographically to South East England to minimise variations resulting from particular local idiosyncrasies. For example, North East England and Birmingham have at certain points in the past been areas where anti-abortion opinion has been influential, and abortion provision as a result restricted. Liverpool is a city with a significant Catholic population, where people are to some degree influenced by the religious and social divisions in Irish society. It is also

a city to which large numbers of Irish women seeking abortion come to, because abortion is still illegal in Ireland. I therefore decided to restrict my sample geographically, so as to avoid some of the issues which might arise from a geographically diverse sample. For practical reasons, I would have like to have interviewed a sample drawn entirely from my local area, but it proved impossible to find sufficient interviewees in this locality. I therefore extended the sample to include interviewees working in the South East, if they were counsellors, or living in the South East at the time of the abortion, if they were women who had had an abortion.

Selecting counsellors

A number of organisations advertise in the telephone book under 'pregnancy advice'. In total, when I was soliciting for interviews, ten such organisations advertised in London and three did so in my local area. The wording of the adverts varied, in some cases making it explicit that abortion services were provided. These said: 'Abortion treatment' and 'Day care early abortion service', without specifying that they also offer counselling. Other adverts offered counselling only, rather than abortion services: 'Pregnant? Worried? Confused? Free tests and counselling'; 'Free abortion advice. Counselling on all options'; and 'Pregnant? Thinking of abortion? Before deciding call....'

Through my contact with these organisations, it became clear that those which advertised offering counselling services only, rather than abortion services, were against abortion, or, in their terms, 'pro-life'. In fact eight of the ten organisations which advertised their services in the telephone book were pro-life, and I contacted all these organisations to ask if I could interview counsellors. I first called the numbers advertised to obtain the name of the manager of the organisation. I then wrote to request an interview with a counsellor at the organisation, explaining that the interview was part of research being carried out for a PhD. In the other two cases (both organisations which provided abortion services), I had personal contacts at the organisations, through whom I sought counsellors to interview.

(i) Accessing counsellors in service provision organisations

Gaining access to counsellors who work for abortion providers appeared easiest at the outset since I had personal contacts at the relevant organisations. In one case, a senior staff member at the organisation concerned assisted by asking, on my behalf, if counsellors in the employ of the organisation would be prepared to be interviewed, leading eventually to more offers than I needed. However, this degree of access was based on my submitting an outline of the ideas in this thesis, and the aims and methods of the proposed interviews, to the ethics committee of the organisation (see Appendix 2). Access was only granted following this process.

Since the organisation in question provides abortion services, it was undoubtedly important for the ethics committee to be reassured that I was sympathetic to the views of the organisation, and that my research would not be used to attempt to discredit abortion provision. In the end therefore, it was a rather lengthy process to gain the number of interviewees required. However, I gained the majority (eight) of my 10 interviewees this way. The final two interviews took place through my other personal contact, and in this case I had to send a thesis outline and summary of what I wanted to achieve through the interview to prospective interviewees themselves.

(ii) Accessing pro-life counsellors

I was concerned that where I approached pro-life organisations, my own pro-choice views would act as a barrier to access. In the end however, this proved not to be the case. In most cases, I was not asked what my own views on abortion were. Of the eight organisations I wrote to, five agreed to allow me to interview their counsellors. In the end, I secured interviews with senior representatives of two of these organisations, both London based, who I had encountered previously in other contexts. Both knew I was pro-choice, but nevertheless agreed to be interviewed, and then went on to set up further interviews for me. I therefore had no difficulty in gaining the required number of interviews with pro-life counsellors.

Selecting women who had undergone abortion

My aim was to interview 15 women who had had an abortion. In accessing these participants, my original intention was to do so through the organisations I contacted to request interviews with counsellors. In particular, I was hoping that the organisations which provide abortion services to women would be a route through which I could access women who might be interviewed. I therefore asked the managers at the places where I conducted interviews with counsellors for permission to leave leaflets in the waiting room, which would display my telephone number, and would ask for help with research about women's experiences of abortion.

However my request was turned down by both abortion provision organisations asked. Reasons given were that it would be 'disruptive' for the clients; clients might be offended; and that it might lead to women offering to be interviewed soon after the abortion, when they could be in a particularly 'emotional' state. This would lead to an unbalanced view of women's response to abortion. The only other possible way of accessing women via abortion service organisations would be through client notes, and this was not an option because of client confidentiality. At one clinic however, I was given permission to sit in on

pre-abortion counselling sessions. This was useful because it allowed me to observe the interaction between counsellor and client.

My next approach was to ask all the counsellors and staff members at the organisations I visited for help. Inevitably, in the course of my contact with them, some discussion of progress with my research and the tasks that were left for me to complete emerged. This provided an opportunity to raise the difficulties I was having in accessing women for interview and a request to all those I talked to for help. Some staff members were more willing to help than others, but as a result, I was contacted by two women, who were prepared to be interviewed.

These difficulties in accessing women to interview through abortion organisations are worthy of brief comment. In part they related to a desire on the part of organisations to deliver a professional, high standard service to clients. Particularly in contexts where women were paying for their abortion, it was likely that service providers wanted to ensure a high degree of 'client satisfaction'. Therefore anything that might appear problematic to a client or cause the client discomfort was to be minimised. This clearly applied in relation to access to client records, since primacy was placed on client confidentiality, and thus no-one other than the client herself (including her doctor) could gain access to records without her permission.

It also applied to my request to distribute leaflets however, which, while not actually in conflict with any guidelines for client care in place at the organisations visited, was viewed as possibly problematic. The perception that requests to clients for interview could be potentially 'offensive' or 'disruptive' may have indicated that staff at the clinics assumed that abortion is psychologically difficult for women. It may have been that that they held the view that following abortion women might prefer not to re-visit the experience by talking about it in an interview with a researcher.

I also attempted to use 'word of mouth' as a way of accessing women for interview. As well as asking counsellors for help, I asked fellow students and other personal contacts for assistance. In the course of discussing my research with others, it frequently emerged that they knew women who had had abortions. I therefore asked if they would prepared to discuss the possibility of an interview with these women. This led to six further interviews, but it took a long period of time for these interviewees to emerge.

Again, this experience merits comment. Many of those I asked for help expressed discomfort with the idea of raising the subject of a past abortion with their friends, and also indicated that they thought it unlikely that their friends would be prepared to be interviewed. They indicated that they thought their friends might find it 'difficult' to talk about abortion, and that it was an experience they wanted to put behind them. As a result, I ended up with fewer interviews than I had hoped for, but could not carry on indefinitely trying to obtain interviewees before beginning the analysis of interview data.

**Confidentiality and rapport**

Issues surrounding the conduct of interviews have been discussed extensively in literature concerning research methods. I now want to discuss how such issues, most importantly concerning ethics, affected the interviews I carried out.

Ensuring interviews take place in an ethical manner is of crucial importance where the interview subject is deemed 'difficult' or 'sensitive'. In his book *Doing Research on Sensitive Topics,* Raymond Lee noted that in this case, '...the researcher has responsibilities to the respondent' (Lee 1993: 102) which require that special attention be given to the need to protect confidences disclosed and emotions expressed. Potentially, this would apply where a woman is talking about her abortion, an experience which she may not have discussed with close friends and relatives. Making sure that she feels secure that measures are being taken to ensure confidentiality would, in this circumstance, be vital. As Lee suggests, the interviewee will feel more comfortable and confident '...when privacy and anonymity are guaranteed and when disclosure takes place in a non-censorious atmosphere....privacy, confidentiality and a non-condemnatory attitude are important because they provide a framework of trust' (ibid: 98).

Ensuring the interviewee feels confident that the interview is confidential is also important where the professional work of the individual is under discussion. In the case of abortion counsellors, this was the case because of the social context of the work they do. As I have discussed previously, abortion counselling is not an activity that takes place in separation from the broader debates and campaigns surrounding abortion. Those who counsel women seeking and following abortion seemed in my contact with them to be aware of this, and conscious of the controversial nature of their work. As a result, the possibility of difficulties in the interaction between me and my interviewees existed. As Lee has indicated:

> Where research is threatening, the relationship between the researcher and the researched is likely to become hedged about with mistrust, concealment and dissimulation. This affects the availability and quality of data with usually adverse consequences for levels of reliability and validity (ibid: 2).

It was possible that counsellors could have perceived the interview as possibly threatening. In interviews I conducted, this problem could have emerged for example where a counsellor I interviewed disagreed with the definition given of counselling by the organisation she worked for. It could also have been an issue where pro-life counsellors understood that their stance against abortion had led some to be cynical about their claim that their counselling was 'pro-woman', and they were concerned that interview material would be used to discredit them. Establishing trust about the confidential nature of the interviews was therefore crucial in creating a situation where interviewees felt they could talk openly about their work.

I therefore took measures to reassure interviewees that confidentiality was guaranteed. These included a written assurance about confidentiality where the first request for interview was made and a discussion at the start of the interview about how the interview would be approached with an opportunity for as much discussion as necessary of any questions or difficulties the interviewee wanted to raise. I also made it clear that all identifying details would be changed; that, in the case of counsellors, the name of the organisation they worked for would not be mentioned; and that the interview would be taped, and transcribed verbatim, and a copy sent to the interviewee. I explained that it would then be entirely acceptable for changes to the document to be made. Any comments that the person would prefer not to have made could be removed, and clarifications or additions made. Finally I stated that, at any point, the interviewee could terminate the interview and that any questions the interviewee preferred not to discuss would not be pursued. A further written assurance of confidentiality was included with the transcript of the interview. I also made sure I asked specifically for the address to which to send the document. This was important, for both women and counsellors interviewed, since they might be in situations where other people open their mail.

The final ethical issue I considered was the offer of access to research results. I decided to state to interviewees that, on completion of my thesis, they could have a copy of the chapter which included analysis of their interview if they wanted it. I also made it clear however, that the analysis and conclusions drawn could not be changed at this stage.

A further issue in conducting interviews is ensuring that an atmosphere conducive to disclosure of information, where the interviewee feels free to talk, is established. Ackroyd and Hughes refer to Benney Hughes, who suggested that there should be a norm of 'equality' governing the interviewer-respondent relationship: ' 'Equality' assumes that information is more likely to be valid if freely given. Therefore, from the outset, the interview should be a relationship freely entered into by both parties, but especially by the respondent' (Ackroyd and Hughes 1992: 109). A relationship of equality is likely to ensure that information is freely given, but in addition, as discussed previously, in feminist research, establishing this relationship is also ethically important.

In discussing how such a norm of equality can be established, Ackroyd and Hughes explain that the interviewer is required:

> ...to establish a suitably relaxed and encouraging relationship with the respondent: one normally described as a relationship of rapport. The interviewer must communicate trust, reassurance and, even, likeableness to the respondent so that the latter's interest and motivation are sustained. Interviewers should never threaten respondents or destroy their confidence in the relationship (ibid: 108).

In part, I attempted to generate this kind of relationship through the means described already. Making it clear that issues of confidentiality were taken seriously hopefully allowed trust to be encouraged. In addition, I attempted to establish rapport with interviewees by answering as fully and engagingly as possible any questions asked of me about my research, and by attempting to encourage the idea that common interest in discussing issues surrounding abortion existed between us. This was considerably harder to achieve where pro-life counsellors were interviewed.

Appropriate conduct in establishing the boundaries at the start and the end of the interview was also important. Ackroyd and Hughes comment:

> If the interview is non-standardised....interviewers should aim to relax respondents as soon as possible so that they feel free enough to talk at some length. It is also a good idea to ask relatively innocuous questions early so that both parties can become used to each other more quickly (ibid: 109).

I therefore asked a very general question at the start. I asked counsellors 'Could you tell me about what you do?' and I asked women who had had an abortion: 'Could you tell me about your abortion?'. The aim was to ensure the interviewee could talk about what they felt was important to begin with. I asked more specific questions during the interview only on the basis of points raised by the interviewee.

I also aimed to ensure the interview was not shut down too quickly. At the point at which I felt we had discussed all the main issues I could think of, I asked if there was anything more the interviewee would like to add that they felt was important. On several occasions this led to the interview 'restarting' and a re-visting of themes already discussed, but which the interviewee must have felt warranted further comment.

The issue of boundaries also emerged in the interviews in another respect. As I have discussed already, establishing a relationship of trust, in which interviewees could talk openly about their views and experiences was important. However, this also created some demand for reciprocity, where interviewees felt able to ask me about my own views and experiences, and what I had 'found out' in interviews with others. This was particularly the case where I interviewed women who had had an abortion.

In his discussion about researching sensitive topics, Lee suggests that such a response is likely to occur in interviews where private information is disclosed. For Lee, such disclosure '...is likely to be problematic because privacy itself produces pluralistic ignorance. That is, because individuals only know about their own behaviour, it is difficult for them to judge how 'normal' that behaviour is compared to other people' (Lee 1993: 6).

The experience of women wondering whether they are 'normal' in seeking abortion and responding to it in the way they have, and wanting to find ways of comparing and judging their experience against that of other women, has been noted by other researchers. Linda

Bird-Franke for example commented on both the large number of women who wrote to her to describe their experience of abortion after she published a newspaper article about hers, and how the similarities and differences between her and other women's experience impelled her to research this issue (Bird-Franke 1980). It did seem to be the case that women I interviewed also wanted to be able to 'judge' their behaviour in having an abortion, and their response to it, in relation to others' experiences. Their 'ignorance' about the experience of other women led to a feeling that they may not be 'normal' in the way they had experienced their abortion, and a desire to measure that experience in some way.

This led to a situation where I was asked, usually after the interview had finished, about what other women had said to me, and whether it was similar to the account given by the interviewee. Given the commitment to confidentiality made in all interviews, this request clearly raised an issue of boundaries and questions about the degree I was required to reciprocate the type of disclosure demanded of the interviewee. Since I had expected the interviewee to 'tell me everything', and the ethical assumption of the interview was based on 'equality' did this mean I should discuss what other interviewees had told me? My response was firstly to indicate that the numbers of interviews I had carried out were small, and so what I had found out could not constitute an 'overview' of women's experiences. I did then recommend books that were based on larger scale surveys of women's experiences and opinions. I also commented on what I had noticed myself, on the basis of not only other interviews I had carried out, but also on discussions I had had in other contexts with women after abortion. However, I was very careful to talk in terms that upheld the anonymity of my interviewees. In particular I tried to emphasise that I had spoken to, and read about women who had similar experiences to those of my interviewees (which was inevitably the case) in order to provide some reassurance that their experience was like that of other women, and therefore 'normal'.

**Analysing discourse**

In this final section, I discuss the analysis of the material acquired from the interviews. The approach I took is based on the 'ten stages in discourse analysis' detailed by Potter and Wetherell (1987). For these discourse theorists, there is one important principle that underpins the approach to analysing discourse, regardless of whether conversations between individuals, speeches made by world leaders or in-depth interviews are the source of data for analysis:

> Participants' discourse or social texts are approached *in their own right* and not as a secondary route to things 'beyond' the text, like attitudes, events or cognitive processes. Discourse is treated as a potent, action-oriented medium, not a transparent information channel (Potter and Wetherell 1987: 160).

The aim of the analysis therefore is not to comment for example on the attitudes expressed by interviewees, or whether accounts of events are 'true' or 'right'. Questions the discourse analyst asks are therefore restricted: 'The concern is exclusively with talk and writing itself and how it can be read, not with descriptive acuity' (ibid: 160). Potter and Wetherell summarise the questions that are of concern as:

> ...broadly related....to construction and function: how is discourse put together and what is gained by this construction....our research questions give priority to discourse, in any form, and ask about its construction in relation to its function (ibid: 161).

In the chapters which follow, I do not therefore aim to critique or comment on the validity of accounts of abortion given by my interviewees. I do not support or oppose the various constructions of abortion which I detail. Rather, I assess whether abortion was discussed in terms of its psychological effects in my interviewees' narratives, and in particular whether interviewees construed abortion as traumatic. In addition, there are specific issues I raised in relation to the two groups of interviewees.

In relation to the narratives of counsellors, my aim was to ask about the 'mandate' for counselling. How did counsellors justify the need for counselling? Did they construe the need for counselling in terms of the psychological effects of abortion? If they did, what were the effects of these constructions? In particular, where the need for counselling was discussed in terms of the psychological effects of abortion, how did this produce the subjectivity of women who have abortion, and how did it produce the subjectivity of counsellors themselves? Where I analysed the narratives of women who had had an abortion, my aim was similarly to assess whether they discussed their experience in psychological terms. Did they talk about abortion in terms of trauma, and did they identify themselves as traumatised by the experience as my hypothesis would suggest? If they did not talk about their experience in this way, what discourses could be identified, and how did they produce my interviewees' experience? In the final chapter of this thesis, I draw some conclusions about the ways in which psychologising discourses operate, and I evaluate what my research has uncovered. In doing so, I am aware that I depart from the relativistic approach adopted by discourse analysts.

As I discussed previously, according to proponents of discourse analysis such as Potter and Wetherell, the aim of discourse analysis is not to judge whether a particular piece of discourse represents a 'true' or 'false' account of the subject discussed. The aim of the researcher using this methodology is not, as a result, to pass judgement about the validity of or truth status of different accounts. The aim is only to identify and discuss the different kinds of discursive constructions present, but not to measure their value, and, on this basis endorse or criticise them. As a result, even if this is not necessarily intentional, all discursive

constructions gain the status of equal validity, since this methodology does not provide a means through which judgement can be passed about the significance of contrasting constructions.

However, as I indicate in the final chapter, the analysis of my data did raise questions that led me to want to ask questions about the status and legitimacy of the different discourses I discuss. It became apparent to me that some ways of constructing abortion have gained a much higher degree of legitimacy and are far more commonplace than others. As I result, I felt it necessary to provide some explanation of why this is the case, rather than contend that all constructions of abortion carry equal weight, and are therefore equally valid.

In my concluding remarks I discuss this issue further, and make some additional comments about theoretical and political questions that have been raised for me in the course of my research. Before presenting my results however, I will conclude this chapter by briefly commenting on the process of transcribing, coding and analysing the interviews.

## Transcription

Potter and Wetherell argue that the kind of transcription a discourse analyst does will make a significant difference to the kind of analysis that results. While transcription is inevitably a lengthy process, the degree of detail that is required of the transcription depends on what the researcher wants to find out:

> The question of exactly how detailed the transcription should be is a thorny one....for many sorts of research questions, the fine details of timing and intonation are not crucial, and indeed they can interfere with the readability of the transcript.....it is important to think very carefully about what information is required from the transcript, and at what level the analysis will proceed (ibid: 166).

I transcribed the words spoken in my interviews in full, but did not pay attention to the lengths of pauses in speech, or the intonation of my interviewees. My reason for proceeding this way was that full transcription was required first for the ethical reasons discussed previously, and second because I wanted to be able to access in as much detail as possible the language interviewees used. However, for my purposes, it was the language used, rather than the demeanour of interviewees (which might be expressed in pauses in speech, intonation or body language) that was of interest. I did however transcribe all of the questions I asked, as well as interviewees' responses because, as Potter and Wetherell have indicated, in discourse analysis, unlike traditional interviews: '...the researcher's questions are seen as active and constructive and not passive and neutral' (ibid: 165).

Coding

After transcribing the interviews (and changing them according to interviewees' requirements) the next stage was to code them. In doing so, the main aim was, as Potter and Wetherell have pointed out, not to find results, but to '...squeeze an unwieldy body of discourse into manageable chunks' (ibid: 167). My aim was to identify the main themes in interviewees' narratives, identifiable through the words they used. Themes used for coding are, in all discourse analysis, obviously crucially related to the research questions of interest, but potentially difficulties arise in deciding which words or phrases to begin coding with.

Potter and Wetherell have suggested that this can be made more straightforward by first selecting out all references to main topic of interest to begin with (ibid: 164). I therefore began by coding for references to 'trauma' followed by other psychological categories and terms, including 'denial', 'guilt', 'regret', 'counselling' and so on. After this, I was left with a substantial amount of text, and it was less clear how to approach coding. I therefore adopted a 'trial and error' approach, coding for words which might be significant, and seeing which featured most frequently.

As a result of this process, I identified a long list of words and phrases, which had been mentioned at least once, but often very frequently, by my interviewees. These could be termed concepts, and were the key or central issues and themes identified by interviewees themselves. I then grouped these concepts into what might be termed categories, that is observer-identified classifications, through which concepts could be grouped. I ended up with a number of central categories, within which most concepts were grouped, and these form the section headings found in the three chapters which follow. Central categories from narratives of counsellors in abortion service organisations were: The Opportunity to Talk; Empowerment and Choice; Therapy; Providing Information; and Who Needs Counselling? For pro-life counsellors, central categories were: Post-Abortion Syndrome; Counselling for Denial; Feminist Constructions; and Counselling and Information Provision. For women who had had an abortion central categories were Factors Leading to the Abortion Request; Trauma; Post-Abortion Trauma; Regret; and Counselling.

The other point I bore in mind in the course of coding was that:

> Analyses which identify only the consistent response are thus sometimes uninformative because they tell us little about the full range of accounting resources people use when constructing the meaning of their social world and do not so clearly reveal the function of participants' constructions (ibid: 164).

I was therefore concerned not only to identify consistencies within and between the narratives of interviewees in the three groups, but also contradictions and inconsistencies. In the chapters which follow, I have drawn attention to these features of the data.

Analysis and presentation of results

Finally, I will comment briefly on the issues of data analysis and presentation of the interview data. Regarding data analysis, I concur entirely with Potter and Wetherell's following observation:

> Words fail us at this point, it is not the case of stating, first you do this and then you do that. The skills required are developed as one tries to make sense of transcript and identify the organisational features of documents....Often it is only after long hours struggling with the data and many false starts that a systematic pattern emerges. False starts occur as patterns appear, excitement grows, only to find that the pattern postulated leaves too much unaccounted, or results in an equally large file of exceptions (ibid: 168).

In my experience, it was indeed a matter of struggling with the data, with many false starts and abandoned efforts, to find patterns, and properly identify inconsistencies. In particular, I was concerned to ensure I was not manipulating the data, through ignoring important themes, and leaving out significant sections of the transcripts. It would have been easy to do so given the large amount of material that accrued from long, fully transcribed interviews. I hope however, that in the end, I have provided a balanced and accurate account of the concepts in interviewees narratives. I now present this analysis, beginning with a discussion of the narratives of counsellors in abortion services.

# Chapter 7: COUNSELLING IN ABORTION SERVICES

In this chapter and the next I present an analysis of data from interviews with abortion counsellors. My aim overall in these two chapters is to assess whether discourses discussed previously, which construct abortion as 'traumatic' or in some way psychologically damaging, feature in counsellors' narratives about their work. Is the mandate for counselling in their accounts based on the argument that abortion has negative psychological effects? If so, how do counsellors construe counselling as beneficial for women, in alleviating negative feelings? What do they think counselling can achieve? If, in contrast, counsellors do not discuss the mandate for counselling in psychologised terms, what terms do they use, and how does this lead to a justification of the need for counselling?

As I discuss in the next chapter, the construction of abortion as 'traumatic', and the justification of counselling on this basis, was most evident in the narratives of 'pro-life' counsellors. As I discuss in this chapter, counsellors working for abortion provision organisations by contrast did not generally describe abortion as a 'traumatic' experience, or justify the mandate for counselling on this basis, other than where they talked about guilt after abortion. Whilst the term 'trauma' did not therefore figure frequently in their narratives, a number of themes relevant to my discussion in earlier chapters did however emerge.

Two themes were most commonplace. First, as I discuss in the section which follows, whilst the term 'trauma' did not feature prominently in their accounts the mandate for counselling was frequently constructed by this group of counsellors in psychological terms. The most common construction in their narratives can be categorised as the opportunity to talk about negative feelings, which was deemed necessary for women before and after abortion. Counsellors did therefore construe the need for counselling in psychological terms, in that their interaction with women was discussed primarily as a response to negative feelings, which women needed to be able to talk about.

Second, the significance of Rose's observation, discussed in Chapter 2, about the 'power of speech', was borne out in my interviewees' construction of the need for counselling. As I detailed previously, Rose argued that in the modern construction of subjectivity, talking in a particular setting, with a counsellor or other 'expert', has been deemed beneficial. This approach was reflected in my interviewees' narratives where they frequently claimed that it was better to talk to a counsellor than to a friend or colleague. Talking about feelings in a counselling setting was considered better than doing so in other situations. Counsellors also justified the importance for women of being able to talk to a counsellor, rather than someone else, where they contrasted themselves positively with doctors. They problematised doctors' attitudes towards women seeking abortion, which they discussed as unhelpful and

sometimes psychologically harmful for women, in contrast with the positive experience they claimed women have when talking with a counsellor.

Other themes also emerged, if less frequently. A third category I highlight, which is also relevant to Rose's analysis, is counselling construed as 'empowerment', where, as Rose has pointed out, counselling is considered beneficial in that it allows the self to become free to choose. Fourth, I discuss instances where a discourse associated with feminist psychoanalysis were evident in counsellors' narratives, and 'therapy' before and after abortion was advocated on the grounds that abortion has significant effects on the unconscious. Fifth, a construction of the mandate for counselling was evident, which ran counter to a psychologised construction of abortion, where counselling was discussed as 'information giving'. Finally, in the last section of this chapter, I consider comments made by my interviewees about the extent of the need for counselling before abortion, and afterwards, and how counsellors' discussion of this need related to discourses about women's psychology discussed previously.

**The opportunity to talk**

The most common theme in counsellors' narratives was the importance for women of the opportunity to talk about their feelings when they were considering an abortion. As I illustrate below, counsellors emphasised different reasons why they thought women needed this opportunity. I discuss first counselling before abortion, and then post-abortion counselling.

Counselling before abortion

Of those I interviewed, Sandy argued most strongly that women needed the opportunity to talk about their feelings before abortion. In the organisation for which Sandy worked, counselling had recently been defined as 'communication' with women. This had happened because this organisation had come to view the practice of counselling women, to explore their feelings, as problematic. The organisation believed, on the basis of experience, that the majority of women had already made their minds up about their decision to have an abortion, and therefore did not need or want to talk about how they felt. Sandy expressed her disagreement with this approach:

> *EL: What is counselling?*
> Sandy: Everybody sees counselling as something different, don't they? My definition of it was to facilitate the exploration of a woman's feelings around the possibility of having a termination. There is a discussion in this organisation about the word

'feelings', so it's now something like: 'to enhance communication with a woman using counselling skills'.

*EL: Do you think it's more about feelings?*

Sandy: Yes I do. It's not just about communication. Communication is a conversation, counselling isn't a two-way conversation. Conversation is you talk, I talk, you ask for information, I give it. Counselling isn't about that. It's about allowing her to explore her own stuff, and I'm not there to feed back into it, and to make comments on it or judge it. A two-way conversation is where you learn about each other. Counselling isn't, she's not going to learn anything about me....It's not about 'can you tell me your address'? That's not using counselling skills and it's not counselling. That is communication. The organisation believes that 90 per cent of women have made their mind up before they even get here. I wonder if that's true. They have obviously made their mind up to talk about having a termination or they wouldn't be here. They've decided that they want to explore it and talk about it. I don't know if that means they have made their decision to go ahead with it, or just made a decision to find out all their options.

Sandy explained that she thought counselling was not about communication, or about the transfer of information. Rather, it was about allowing the woman to 'explore her own stuff', which she thought women needed to be able to do before abortion. The opportunity to talk about feelings was thus construed by Sandy as the defining feature of counselling. Other counsellors also emphasised that the key aspect of what they did was to talk to women about how they felt. Most counsellors specified certain aspects of the experience of abortion which they claimed led women to experience negative feelings, and need to talk with a counsellor. These were secrecy surrounding abortion, relationship difficulties, contraceptive failure and the destruction of a fetus.

As I indicate in my discussion, in some instances it was simply the act of talking that counsellors claimed was beneficial for women. It was not what the counsellor said that mattered - rather the counsellor's role was simply to listen, while the woman talked. In other cases, counsellors framed the mandate for counselling as additionally encouraging the woman to reconsider or re-think her views. In these instances, it was the content of what the counsellor said to the woman that was deemed important.

(i) Secrecy

Maxine contended that secrecy about abortion meant women needed the opportunity to talk:

*EL: Why do you think it is important for women to talk about having an abortion?*
Maxine: Probably because I'm a counsellor! Because I think it's a taboo area. Most other decisions you can talk to people about. But this is something you don't talk about. It makes it harder, all the secrecy. It's just as pressurising as the thing itself. There are so many women slipping out and doing it. You don't tell your parents, you don't tell your sister, because she's pregnant, you don't tell your friend because she's just had a baby. It's this huge sensitive feeling. Where are you going to get support from?
*EL: So talking about it is like making it normal?*
Maxine: I think that's part of our job, to normalise it. And why should it not be talked about? This is happening every day. It makes me very angry.

Maxine said you 'can' talk about other decisions, where with abortion women 'don't'. The contrast she drew between abortion and other decisions construed talking about decision making in general as socially accepted, but as ruled out of bounds with abortion. Part of the job of the counsellor was therefore to 'normalise' abortion, through talking about it with the woman. This construction of the function of counselling was interesting in relation to the counselling debate discussed in Chapter 5. There I discussed how critics of counselling had problematised the claim that women considering abortion needed to talk to a counsellor on the grounds that such a claim acted against the normalisation of abortion. Here, counselling was justified on the grounds that it did precisely the opposite. In this instance, it was simply being able to talk that was of benefit for women.

Alice also emphasised that talking could help where abortion was a secret, but in this case it helped because she could let women know they were 'not alone' in seeking an abortion:

*EL: What do you think would be the implications if women didn't have counselling pre-abortion?*
Alice: Ones who eventually come back for counselling later say that at the time they just felt dreadful about it, that they couldn't talk to anyone and they felt they were going to have to live with this big secret for ever. Probably just an hour talking about it would have made quite a difference to making them see they are one of many people who go through that experience, because I can show them they are not alone.

This justification of the need for counselling rested on the representation of abortion as a 'big secret' which women could not talk to anyone about. The psychological effects of keeping abortion secret could be such that women needed counselling after abortion. Construing

counselling before abortion as a counter to secrecy therefore functioned to create a powerful argument for the practice, as a means to prevent negative feelings following abortion. The main way it could help women feel better, and prevent negative feelings afterwards, was by explaining to women that many other women had abortions too. It was therefore not simply the act of talking that helped but telling women something specific about their experience.

(ii) Relationship difficulties

Another aspect of women's experience of abortion discussed by counsellors was 'relationship difficulties', and in this case it was simply talking about feelings about relationships that was deemed beneficial for women. Liz defined relationship difficulties, and their emotional effects, as what was 'special' about abortion. This meant that, in contrast with other surgical procedures, women needed counselling when they had an abortion:

> *EL: Is there anything specific a counsellor does?*
> Liz: Well often you are into the realms of relationship counselling anyway with abortion counselling. It's primarily to do with relationships. Sometimes the partner will actually say they will end the relationship if she doesn't terminate it. Sometimes he's not as committed to the woman as she'd hoped. So sometimes the women are desperately depressed. Because not many women choose to be single parents. They choose to be in a relationship. It's the emotional aspect that is special about abortion. It's not a purely medical procedure. What other surgeries involve the emotional well-being?
> *EL: Childbirth?*
> Liz: They have chosen it though. So it's a different thing.
> *EL: So abortion counselling is needed because there may be negative effects?*
> Liz: Yes indeed, that is it. It's their emotional health that is at stake, and they need to be able to talk.

Many counsellors said that negative feelings about abortion resulted from 'relationship difficulties'. Liz typically contended that for some women, this was the most important factor that explained their negative feelings. The significance of the woman's relationship with her partner was emphasised in important ways in her narrative. First, it was this that was construed as emotionally difficult in abortion, not the abortion itself. Abortion was an emotional experience primarily because it brought up difficulties and tensions in a woman's relationship with her partner. Second, Liz claimed, there was a significant difference between abortion and other medical procedures on this basis. Abortion, she contended, was not like other operations because it is centrally concerned with 'emotional well-being'. The mandate

for counselling arose from this construction of abortion. Because the abortion decision was made on emotional grounds, rather than medical ones, counselling was needed. Third, the importance of counselling was strongly emphasised. It was necessary because women's 'emotional health' was at issue. Relationship difficulties were therefore construed as sufficiently psychologically significant to lead to damage to a woman's health: her health would be 'at stake' if she was not counselled.

The elevation of the significance of relationship difficulties in this way could be considered an example of what Rose termed the 'psychologisation of the mundane'. As I discussed in Chapter 2, he contended that the construction of day to day aspects of life as psychologically significant was a key aspect of the construction of the modern self. Liz's argument that 'relationship difficulties' were very psychologically significant, and meant women needed to talk to a counsellor about their feelings about their partner, could be understood as an exemplar of this construction of the contemporary self.

Where relationship difficulties were discussed, it was simply the opportunity to talk about their feelings that counsellors considered important for women. As I discuss next, where interviewees discussed women's experience of contraceptive failure and becoming pregnant accidentally, they presented counselling as necessary on two grounds. They again emphasised that it was positive for women to be able to talk about their feelings surrounding contraceptive failure, but also that counselling was necessary in order for the counsellor to impart certain information or advice to women.

(iii) Contraceptive failure

Alice and Sally explained that women needed to be able to talk prior to an abortion of their feelings about and experience of contraceptive failure:

> Alice: ...they are influenced by the way they are told by the media how they ought to be. Everybody knows about contraception, so you don't have unplanned pregnancy in the first place. If you are pregnant then you are supposed to feel wonderful about it, so they feel as if somehow they are failures....So I think it does good....it doesn't matter even who I am, just coming here and hearing yourself talking about it, and thinking, well the heavens didn't fall on me. Maybe it's something I can get beyond.
>
> Sally: It's almost like they're coming to explain why they're doing it, why it's happened....Sometimes it might be that they feel they just want to tell you anyway. But you get the feeling....it's because of the whole thing surrounding abortion. They feel the need to explain how it's happened, the condom's burst or whatever. 'I was

> taking care anyway though'....I think the majority, you get the feeling they want to tell you why they're doing it, justify their actions.

Both Alice and Sally emphasised that women needed to talk about how they came to be pregnant by accident. Alice claimed that for women, just being able to hear themselves talk about their accidental pregnancy made them feel better, and Sally said that they needed to explain how unplanned pregnancy had happened, and justify their actions. In these instances, the benefit of counselling was presented as the opportunity it provided for women to be able to talk about their feelings and experiences.

Gwen and Liz also said women talked to them about how they came to be pregnant by accident, but it was not simply talking that counsellors said made women feel better. Rather counsellors aimed to help women feel better by responding to their concerns about contraceptive failure, and giving them advice or information:

> Gwen: A lot of women actually don't realise about their own fertility until they actually get pregnant. Everybody says you get pregnant if you have sex, so use the pill, use condoms, use this, use that. But until you actually get pregnant, you don't know what your fertility is about....Women often come in and say I've been stupid, I've been so stupid. I've really got to say 'look, let's talk about this. I don't think it's about being stupid, it's about OK something has happened, there is something you could have been more enlightened about but hey look, let's try and work on that so you don't have to come back every day'.

> Liz: They feel cross with themselves. 'I feel very cross with myself for getting pregnant, especially at this age. I should know better'. If they are say 27, not a teenager, they feel they should know the risks. But it's easy to get pregnant, and I tell them this. But they are very cross with themselves. They don't want to be pregnant and they blame themselves, feel stupid. They feel they should have been more careful with contraception. A lot of pregnancies resulted from the pill scare. They came off it for a break, and used condoms, and then got caught. They took a risk, as everyone does.

Gwen emphasised she talked about the extent of 'enlightenment' the woman had about her fertility, which she and her clients could 'work on' to avoid the need for abortion in the future. Gwen's role was thus construed as discussing with the woman how to control her fertility. Liz specified only that she told women it was easy to get pregnant. Counselling in this case

aimed to normalise unplanned pregnancy through Liz informing women that it was easy to get pregnant by accident so as to alleviate the woman's negative feelings.

(iv) The destruction of the fetus

The final aspect of counsellors' narratives, where the opportunity to talk before abortion was considered important, was where women's feelings about the destruction of a fetus were emphasised. These feelings were talked about in two distinct ways. One construed counselling as not simply about the opportunity to talk, but as an activity which aimed to achieve something specific, namely to encourage the woman to think of abortion and miscarriage as no different from each other as regards the embryo:

> Liz: The guilt is quite a big issue they need to talk about....I sometimes point out it is illogical to feel a miscarriage is any different from an abortion, for the embryo....None of us like to think we are murderers....It is to do with the feeling that they are taking life, stopping life from developing. There's no getting away from it. That's what it is. They are very acutely aware of it, especially if they are religious - Catholic for example. Also it's about parental attitudes to abortion, the culture's attitudes to abortion.

Liz talked of feelings of guilt in relation to aspects of culture which originate from a source external to the woman, but are perceived by her as in conflict with her decision to abort. She said that women needed to talk about this, but described the benefit of counselling not as arising from talking *per se*, but rather from what she talked to women about. It was her argument put to those she counselled, that there was no logical reason to feel guilty about the 'loss of life' through abortion, that made them feel better. Counsellors also construed negative feelings about the fetus as a product of a woman's imagination:

> Liz: We talk also about the feelings of loss she might have afterwards. That depends on the extent to which she's bonded in her imagination with the embryo. I ask her if she has imagined herself with the child, has she projected that into the future? What sort of fantasies she has had? Dreams one will look at, whether she has had dreams about it, and what the emotional content of the dreams was.

> Alice: ...they are sad at what can't be, at the reality of everyday life which is not the way they want it to be, and it's good for them to talk about that....They are mourning that baby, which in their minds is often much more developed than it actually is, and they may even have thought it's probably going to be a boy, and I probably would

have called him Liam. So they are mourning a real person almost, or the idea of a person. My baby, that I had with my boyfriend, and he's really beautiful.

Liz discussed the feelings of loss as dependent on an imaginary process, where the woman bonded with the fetus. Alice also described the origin of negative feelings as imaginary: women had an image of a baby in their minds, which they needed to mourn. In these instances, it was simply talking, rather than talking about something specific, which counsellors claimed helped women.

Post-abortion counselling

Counsellors mostly talked about counselling before abortion. However, some did comment on post-abortion counselling. In these cases, they again emphasised that women needed the opportunity to talk, but this time about why they had chosen abortion in the first place, and about loss and guilt.

(i) Why abortion had been chosen

A recurrent theme in counsellors' discussions of women who returned for counselling after abortion centred on women's doubts about whether their decision to have an abortion had been right. The following three extracts illustrate this theme, and show that counselling after abortion was consistently discussed as not simply about providing women with the opportunity to talk about how they felt, but as offering them reassurance about the decision they had made.

*EL: What are they looking for when they come here?*
Dawn: Reassurance. They need to reiterate what was said at the beginning. Perhaps they go away and become a bit confused. Maybe I could have proceeded? Maybe I did the wrong thing? I need to come back. So I say put yourself in the position of before the operation, what was it about? And they can see things haven't changed. It's not the right time.

Alice: I need to get them to go back to what they were considering before the abortion. What were the reasons for choosing it? What were the issues involved then? And they consider that they had no partner, their mother was going to throw them out of the house, all sorts of things. So I say that it sounds as if you tried to do the best you could, you made a really difficult decision, but you didn't feel there were any possibilities for you to do the opposite. And once she's reminded herself of

that....I suppose if you feel that bad you must think 'I never thought about it at all, I must have just rushed through it'.

*EL: Can you tell me more about post-abortion counselling?*
Liz: What's important is to take them back to why they made the decision. Now often, however distressed they are, they realise they would have made the same decision. Sometimes it's worth looking at what they would do if they became pregnant again. They quite often say they would have made the same decision. So it's a question of coming to terms with it. They often forget that....Really they only have mild depression, in clinical terms. It's not a deep depression. They feel very distressed. I do ask them if they have felt any better since they had the abortion. And they will say 'Oh yes, there was a day when I felt better about it'. You can say that those times will increase, that's how the healing process goes.

A clear purpose to counselling was put forward in all these extracts, where the aim was to reassure women that they did make the 'right decision'. This was achieved through encouraging women to remind themselves of why they made the decision. Underlying this account of post-abortion counselling was a construction of the abortion decision as determined by the woman's circumstances. The choice to abort was legitimised on the basis that these circumstances made abortion a rational and reasonable choice.

(ii) Loss

Another common theme in discussion of post-abortion counselling was abortion experienced as loss. Where feelings of loss were discussed, the purpose of counselling after abortion was not made clear by any interviewee, and in fact some counsellors explained that they found it difficult to explain where women's feelings of loss come from:

*EL: Why do women experience loss?*
Sarah: They feel loss, but I don't think they can explain it really, and I don't think I can. It's on their mind all the time. It's not like having an operation to take a growth away, so you don't feel upset about it afterwards, you're just pleased it's gone. But with a pregnancy, it's very different. Whether that is all linked to the woman, or whether your pregnancy prepares your body in all ways for a pregnancy to continue, emotionally as well as physically, and when it's gone your body reacts to that. I don't know whether it's totally that, or whether it's the way society teaches us to think about pregnancy, maybe that comes into it. A lot of women not so much today, but have been in the past, girls have been brought up to expect to have children. It's the

normal thing. Maybe that's somewhere in the back of their minds. That's something I've wondered about myself, you know we're not doing what's expected of us.

Dawn argued that the fact that some women experienced abortion as loss afterwards explained why counselling was needed beforehand:

*EL: Is it a physical loss?*
Dawn: More a mental loss. A lot of people know if they had proceeded with the pregnancy when the baby would be due. They've imagined themselves with a baby. And while they have chosen the termination, yes it is their choice, they sometimes have to deal with that. That's why they mustn't make a rash decision and that's why it's brilliant that you don't terminate on the same day as the person comes along, and have counselling beforehand. Because it can be a spur of the moment decision - I was in a temper, and I've done something I regret. That's why it's important to have time to consider it.

Both Sarah and Dawn put forward explanations of why some women felt loss after abortion, but nether explained why counselling after abortion was needed or would help alleviate loss. For Dawn, counselling before abortion was needed to prevent feelings of loss. Counselling would make sure the woman did not make a 'rash decision' that she would 'regret'. Counselling was produced as an activity which could mitigate against feelings of loss in the future, by making sure the woman had time 'to consider' her decision before she opted for abortion.

(iii) Guilt

Some counsellors also drew attention to feelings of guilt after abortion. In these instances, they talked about the psychological effects of abortion in terms of trauma. Counselling was construed as positive because it gave women the opportunity to talk about their feelings, which they might otherwise repress or deny. In post-abortion counselling, they were also given the opportunity to grieve:

*EL: What makes them come back?*
Sarah: Guilt. Sometimes they have bottled it up for many years. People can come back a couple of weeks after, sometimes it might be years and years afterwards. Sometimes it might be something that's happened in the family that has triggered it off, someone close has had a child, and they have perhaps thought....it's brought up all these feelings that they weren't aware were there, that they had buried....I think if

> something is hurtful, and you are distressed about it at the time, and you don't want to think about it because it's too painful, and you just blot it out and think about something else instead. After a while it becomes easier to do that and just not think about it. Then it becomes something that's just pushed to the back of your mind and you don't acknowledge it. If you go on too long like that, then it's still there somewhere, at the back of your mind. Something triggers it off one day....They start thinking about it, getting upset about it, and want to express those feelings, so they come here.
>
> Gwen: I think, just because a woman has requested an abortion, wilfully if you like, rather than having a miscarriage, there is this misconception I think, and it comes, I think it's to do with the guilt as well, about 'you don't deserve to grieve. You don't deserve to feel a sense of loss. You don't deserve to feel sad, because you willingly sat there and had an abortion'....The grief becomes stuck, and comes out in odd ways, if you don't deal with it appropriately. If you think you can just push it down, it will not. It will just bubble up and eventually just burst. And that's when things go horribly wrong. When you haven't gone through the process, the loss and the anger and the denial. That's why you have to talk about it, be able to grieve.

Sarah, utilising the language of PTSD, stated that guilty feelings were 'buried', and were later 'triggered' by an event in a woman's life. Following abortion, women 'want to express those feelings', and the provision of counselling afterwards was therefore needed to meet women's needs. Gwen also discussed women's response in terms of PTSD. Feelings were repressed and triggered at a later date. Women 'ignore' guilt and 'push it down' but it would 'bubble up'. In terms characteristic of the feminist approach to post-abortion feelings discussed in Chapter 5, Gwen problematised this view held by women that they did not 'deserve' to be able to show to others their negative feelings. Implicit in this representation of women's psychological response to abortion was a construction of the counsellor as truly 'on the side' of the woman, because she recognised the negative feelings that resulted from abortion. The counsellor's awareness of the negative feelings that could accompany abortion was the measure of her 'pro-woman' approach.

The special role of the counsellor

As I have illustrated, the mandate for counselling, as the opportunity for women to talk about their feelings, was a recurring theme in my interviewees' narratives. In some instances it was simply the act of talking that was considered beneficial, and in others counsellors argued that they needed to talk with women about something specific. There was a further

important aspect to this construction of the mandate for counselling, however, which was the emphasis placed not simply on talking, but specifically talking to a counsellor.

As I discussed in Chapter 2, Rose explained how a key aspect of the construction of the modern, psychologised self is the emphasis placed on the importance of speech in a specific context. Speech is therapeutic, but cures people best when they talk to an expert, such as a psychologist, therapist or counsellor. The need for such a context, where women talk specifically to a counsellor, was strongly emphasised by my interviewees. As I illustrate next, the advantage of talking to a counsellor was constructed through a comparison between talking in this circumstance, and talking to friends or family members:

> *EL: What is special about a counsellor?*
> Dawn: Being non-judgmental. We've all got friends and they play a different role. Never to judge that person never, ever. Never to be shocked. Just the listening ear. Somebody just to listen, to be here for you, so you can really talk....somebody they don't know, somebody from the outside, someone that they haven't got to justify themselves to.

> *EL: But what is it about the interaction between you and the client that helps?*
> Sarah: I'm not part of their social scene or family circle, so there are perhaps things that they would say to me that they perhaps wouldn't say to friends or family, and it's better to open up sometimes, which perhaps they can't....I think there's talking and talking. If you are talking to the family, that's just talking.

> *EL: Where women do have friends or family to talk to, would you still say it's useful to see a counsellor?*
> Liz: Yes, because I'm neutral. They push them in the wrong direction. They put them under pressure. 'I never wanted to keep the baby' they say, and then you find she wanted to have the child herself. The pressure is usually to terminate the pregnancy.

In all three cases, counsellors considered they were in a better position to talk to a woman about her decision to have an abortion than were her family and friends. Talking with a counsellor would help her in a way that talking to relatives or friends would not. For Dawn, Sarah and Liz, this was because the counsellor was in some way distanced from the woman. The counsellor was described as 'from the outside', 'neutral' or 'not part of their social scene....better to open up to'.

The need for the counsellor therefore rested on the construction of emotional closeness as a barrier to being able to talk. The bonds between a woman and her friends and family,

counsellors contended, meant she could not talk to them in the way she could to a counsellor. The contrast between the counsellor and friends and relatives also acted to produce talk in the presence of a counsellor as a special kind of talking. For Dawn in this situation the woman could 'really talk', and for Sarah there was 'just talking' and 'really talking', the latter of which took place in the presence of a counsellor.

The need for women to talk specifically to a counsellor was also discussed in another way, through a comparison between counsellors and doctors. Counsellors were very critical of the way doctors treated women, and presented themselves as far more sympathetic to women in comparison. In some cases, doctors were criticised for judging women who wanted abortions. In these instances, counselling was justified on the grounds that the counsellor would need to pick up the pieces after a woman's bad encounter with a doctor.

> Sally: A lot of people are surprised they are treated sympathetically here. That they are accepted, and their reasons are accepted. I have a lot of people say they thought it would be horrible. And of course sometimes doctors are. I had a lady once whose doctor had called her a murderer. That's just horrendous. But there are a lot of doctors out there who are still opposed to abortion. Or they have really talked down to them about it, or in some cases they have given them information that hasn't been correct. Then it's sometimes really hard work, initially, to reassure them and let them know they are not going to be put through that again, that we are here to support them.

In this case, the counsellor could help the woman because she, unlike the doctor, would offer support. Gwen also criticised the attitude of some doctors, and pointed out that women sometimes felt bad when they came to see her following their encounter with a GP:

> *EL: What do you think would happen if they didn't have counselling?*
> Gwen: I've noticed lots of women do come here, having been to GPs, maybe anti-abortion, who haven't been as non-judgemental as they could have been. And it's really upset them and crushed them. They've gone away feeling like a small child who's been scolded for not eating all her food. But they haven't continued....So I don't think it's going to stop them having the abortions, but it will make the experience a lot worse and traumatic, and add to the way they feel about themselves after.

In other instances, counsellors did not draw attention to doctors' negative attitudes, but nontheless claimed women would be better off seeing a counsellor than just a doctor.

Margaret drew attention to her counselling training which made her better suited to deal with women than even 'well-meaning' doctors. Alice explained:

> I've done a lot of training to allow me to offer the kind of non-judgmental help that a lot of even nice, well-meaning doctors can't do, because they find it difficult not to become paternalistic, and say well if you were my daughter I would....I suppose they feel taken for granted. All they are there to do is sign the form and get on with it. They almost feel that the woman owes them some thing perhaps, in return for what they are going to do for her. Whereas I'm the kind of space outside of it, where the woman can say and do what she wants to.

Alice said she could offer a special kind of help, which was 'non-judgmental' that doctors were not able to. Maxine also contrasted herself with doctors, this time those who worked in the abortion clinic where she also worked:

> I'm not particularly happy about women just coming in here and seeing the doctor. I don't think it should be down to the doctors either. I think it gives them a bit more choice, if they find they want to talk about it there is somebody there. It might be the doctor's job but they probably wouldn't do it. Doctors see their job as strictly medical.

Counsellors therefore contended they had a special role to play with women, which was defined through the contrasts they made between their own role or approach to women seeking abortion, and that of other people a woman might talk to. I now discuss other less prominent constructions of the mandate for counselling, where counselling was described as empowerment, as therapy and as information giving.

**Empowerment and choice**

Some counsellors explained that their interaction with women was helpful because it enabled women to make a choice. One version of this construction of the mandate for counselling emphasised 'empowerment'. In these instances, 'empowerment' through counselling was akin to Rose's notion of the creation of the 'freely choosing self', where, as I discussed in Chapter 2, counselling and therapy aimed to create a self which could choose, and which could therefore be happy:

> *EL: What is counselling about?*
> Sandy: I think anyone who's in a caring job, social workers or whatever, want to find solutions to people's problems. But that isn't what we are here for. They know the solution to their problem might be termination, so yes, we can provide that, so in that

> way, yes we provide a solution....But....it's so patronising to try and rescue someone. It's saying I'm in control and you're not. You're not capable of finding the solution for yourself, making the choice. It's not particularly empowering when you rescue someone. It might make them feel better for ten minutes, but they've got to walk out of that door and be on their own again.
>
> *EL: What do you mean by empowering?*
>
> Sandy: Making them realise they are capable of making their own decisions, and that it's OK to make decisions for yourself.
>
> *EL: Is that a function of counselling?*
>
> Sandy: Yes. It's empowering for someone to find out a solution for their problem, isn't it.

For Sandy, the point of an abortion service was not simply to provide abortion to women. Rather it was to empower women, by making them realise they could make decisions. The mandate for counselling was therefore construed as 'empowerment', where women come to be able to find a solution for their problem. Enabling women to discover they could do so, rather than simply helping a woman get an abortion was, for Sandy, the objective of counselling.

Gwen similarly emphasised that she saw her job as empowering women, by enabling them to make a decision about their pregnancy. She said:

> ...the decision about pregnancy, whether to continue or not, can leave some people feeling disempowered, like they've got no choice....That's where I come from when I talk about empowerment. And if they come in thinking there's nothing they can do, it's all out of control, to provide an environment where they might feel they have the strength, they can change things, they can take control, it's not out of control, out of their depth to do something about it either way.

Other counsellors also talked about the importance of helping women make a choice, but not in terms of 'empowerment'. Rather, they emphasised reducing the amount of 'hassle' a woman had to go through, so it was easier for her to get an abortion:

> *EL: What would you see counselling as being for?*
>
> Sally: I think really just to make it a reasonable process, you know. They've got to go through such a rigmarole, it's nice to think I can just sort of be there, you know....it's a bit soppy, being nice to them, but just make it as easy as it can be....it is relatively easy, but there's still a lot to go through, you know you've got to come here, and see

> the doctor, and that bit is....if I can just help them through, a lot of them are scared, they don't know what's going to happen, a bit frightened really....I think that's just really the way I see my job. I'm pro-choice, and I just really think women need the choice, with as less hassle as possible. There always seem to be things put in the way, you know.
> *EL: So you would see what you do makes it easier for women to have the choice?*
> Sally: Yes, I would hope so. Because they haven't got somebody sitting there saying, you know, 'you don't want this do you'. You're not judging them, just accepting. If that's what they want to do, that's fine.

Sally said that she hoped through her work to make it easier for women to choose abortion. She situated her role as a counsellor in relation to this aim. A third construction of the mandate for counselling was the most psychologised of those I have identified, where counselling was discussed explicitly as 'therapy'.

**Therapy**

Maggie was the only interviewee who discussed counselling as therapy, and she reiterated this theme through her narrative. She defined her role as counsellor as follows:

> As far as I'm concerned, for whatever reason they want a termination that's up to them. Otherwise it gets in the way of the whole counselling process. I see it more as based on the decision, but it is a therapeutic process from the word go. I'm interested in their feelings afterwards and I am working therapeutically.

Maggie drew a distinction between discussion of the reasons a woman had for requesting abortion, and the 'counselling process', in order to emphasis what she saw as the purpose of counselling, which was to 'work therapeutically'. She explained what she meant by this in the following comments:

> When somebody comes, how we are with them, putting this very basically, will affect how they cope with having an abortion. We enter the frame of the abortion and the process of decision making. We are in that frame, of their psychological and psychic experience of the abortion. It will be affected by how all of us are. What I hope is that our input will be therapeutic for her and help her manage all of those feelings.
>
> To put in simply, my work is influenced by the work of Melanie Klein. It's like the baby that cries and just feels upset. When the mother comforts the baby she takes that upset in. It's like that when we talk to somebody. If we can be accepting and

> share that, it can help to contain it, and it makes them feel better. It's like we're doing a containing process for upset feelings. It's an unconscious process really. We make it clear we can take it on, we're not going to run away from it, we're 'staying with it' - that's terribly important in counselling, just being there for someone.

Maggie explained how counselling could help a woman. 'Upset feelings' would be alleviated through the effect the counsellor had on the 'woman's psychological and psychic experience', and through the counsellor 'containing' the woman's feelings through an 'unconscious process'. Counselling was therefore construed as an activity that was necessary on wholly psychological grounds (the negative effects of abortion) and was defined by its effects on a woman's unconscious. The counsellor was produced in this account as an important, powerful figure in determining the outcome of the abortion experience for women, since the counsellor could determine whether or not abortion damaged a woman psychologically.

Maggie's emphasis on the importance of the unconscious is characteristic of a feminist psychoanalytic approach, which I described in Chapter 5. She also talked about the psychological effects of abortion in these terms where she discussed post-abortion counselling:

> They know it was the right thing to do, and cannot see why they are feeling so terrible. We will talk about that, but we can't answer it. I think what comes into it is very primitive feelings. You know we've been around for nearly five million years and there are parts of our brain....you can't just explain it with your head. It's bound up with very powerful feelings of life and death, and that is what the woman is struggling with. And you can't explain that. It's very hard to explain. When I see a tiny baby, the feelings are so powerful. I know it's a terrifically powerful hook into me when I see a new baby.

For Maggie, women she saw for counselling after abortion felt bad because of the conflict between the decision to have an abortion and its unconscious effects. The influence of a feminist psychoanalytic approach was also apparent where Maggie explained why she thought some women did not want to see a counsellor:

> We will have women coming in who are 'oh God, see a counsellor'. They don't think it's for them, just for women who know they are having difficulties. I think it is the case that in the past the feelings women have about having a termination of pregnancy hadn't been addressed or acknowledged because of fears that if women

admitted they can have difficulties, they dare not say this because then we might lose the right to abortion. This means women don't expect to get this attention.

Maggie was the only counsellor I interviewed who talked about counselling in feminist psychoanalytic terms. More commonly, where counsellors talked of a function of counselling other than talking to women about their feelings, they said they provided women with information.

**Providing information**

The mandate for counselling, which contrasted most with that of therapy, was where counsellors talked about giving women information. In these instances, counselling was not discussed as a response to negative feelings. Counsellors emphasised that they worked in a 'person-centred' or 'client-centred' way, which meant that if the woman did not want to talk about how she felt, but just wanted information, they would not push her to discuss her feelings:

Maxine: ...every woman that comes in sees a counsellor, but whether it's counselling or not....it's not counselling. We would fill in forms with them, give them information about what actually happens in a termination, and it can take up to an hour in a session, but on average about 25 minutes. Then they go through the rest of the procedures, seeing the doctors, that's it. The other part of the job is offering counselling sessions to women, which there isn't very much of. 50 minutes or an hour sessions when they are pregnant or post termination, if they are having problems with it.

*EL: When you say it's not counselling, tell me what you mean.*

Maxine: It's information giving as opposed to counselling really. It's not what I would term counselling, so I suppose that's a personal judgement on it. But no I don't see it as counselling. We would give the woman an opportunity to talk about it if she wants to. But...and we would give her support. But it's not in depth. It's not....there is some exploration of feelings, but it is person-centred, very much if the woman wants to talk.

*EL: Tell me more about pre-abortion counselling*

Sarah: It's to see how the woman feels about being pregnant, what her situation is, what she wants to do about it, and give her information....what we do depends on the woman, and a lot of the women when they come here have actually made the decision about what they want to do, and quite often, given the opportunity, they

> don't want to talk about it. They just want to go through the basic form filling, have the medical tour to the doctor, and see if they can arrange things as quickly as possible, so that's what we do.

In both Maxine's and Sarah's accounts, describing counselling as 'information giving' acted to produce a contrast between that activity and counselling for negative feelings. Where they gave women information, it did not involve talking about their feelings. The other important feature of this account of the mandate for counselling was the emphasis placed on doing what the woman wanted. Interviewees stressed that they did what the woman wanted them to do, and if she did not want to talk about how she felt, they did not demand that she should.

**Who needs counselling?**

In this final section I discuss counsellors' views about the extent of the need for counselling before and after abortion. As I discussed in an earlier chapter, some pro-choice commentators have emphasised that the psychological effects of abortion have been over-estimated, and that many if not most women do not need to be counselled. This argument seemed to have influenced those I interviewed, where they discussed counselling before abortion. No counsellor said that counselling should be obligatory. Opinion differed however as to whether all women should be offered counselling, with some counsellors contending that they should, while others said that few women seemed to need it, compared with the past. Where post-abortion counselling was discussed however, counsellors expressed a common concern that more women might need counselling than actually returned for it.

Counselling before abortion

Some counsellors emphasised that all women should be offered counselling, and that they did not agree with the idea of not offering it to women at all:

> Sandy: I think every woman has to be given a space to talk about what she's going through. If she chooses not to use it, then fine. I do believe that we are client led, and have to go with that. To not be would be patronising. I think if you took counselling away completely, it would be wrong, because women need to be able to talk if they want to.

> Liz: If the counselling wasn't there....I think it's very important, pre-abortion. If that wasn't there....it isn't necessary for everybody. But what worries me is the idea of

> cutting it out, just to give the woman choice about having it or not, is that some clients don't know what counselling is, so they think it's pro-life, and is about trying to persuade them to have the baby.

In these instances, counsellors said that counselling should be offered to all women, but also that some women did not want or need to be counselled. Sandy used the term 'client-led' to describe an approach where, if a woman was offered counselling but said she did not want to talk, her wishes would be respected, and Liz stated that is wasn't 'necessary' for everybody. Neither counsellor argued that all women should be counselled. Both however explained that they thought all women should be offered it, and expressed concern about a situation where women were no longer offered it. Their emphasis was therefore on defending the need for counselling, for some women at least, and they both wanted to express their concern about approaches to the provision of counselling that attempted to minimise the need for it.

Interviewees also justified the offer of counselling to all women. They argued against making counselling optional on the grounds that where women said they did not want to talk to a counsellor, it might turn out that they did in fact want to discuss their feelings:

> Sandy: ...we have to be client led, so if a woman comes here and says she doesn't want to see a counsellor, she doesn't get counselling....if a woman says she doesn't want to talk about her feelings, or about why she's reached her decision, we have to go with that.
>
> *EL: What do you think about that?*
>
> Sandy: I think to completely ignore it when someone says, that would be wrong, but the counsellor can acknowledge it might be difficult for her to talk about it, and that generally makes someone talk about it. If someone says they don't want to talk about it I wouldn't just say 'oh all right then'. I would say it seems to me you are finding this difficult today, I wonder if there is anything I can do to make it easier? Often they then do want to talk.

> *EL: When you are counselling before the abortion, what in particular are you trying to achieve?*
>
> Dawn: The main thing is for them to feel comfortable with the decision. People come in here, the ones that don't need the counselling, and say 'No, I know what I'm doing'. And you're saying 'Fine', but then they say 'Can I just ask you, can I just tell you...', and at the end of the day they are often the ones that take the longest, the ones that really need to talk.

In these cases, those women who said they didn't want counselling were construed as nevertheless sometimes needing to talk. Where all women saw a counsellor, the counsellor could meet that need, whereas if counselling were made optional, such women would be missed. Other counsellors expressed a different point of view, and emphasised in contrast that few women needed counselling:

> *EL: You said earlier that it would be good if women could go to their doctors. But then they wouldn't get counselling.*
> Sarah: Yes. The majority do not want it these days. Years ago when I was here, the majority were counselled whether they needed it or not. It was just automatic, and it was more well, we'll talk about this bit now, that bit next, it was ridiculous really. It's evolved from that, and this generation is more comfortable with it. Most people when you ask if they want to talk about say 'No'....Maybe they did think they wanted to talk about it, but the majority of people don't. Really it's an exchange of information. The only problem with abortion on demand via the GP is that some of them may be anti-abortion.

> *EL: Some women don't want counselling?*
> Sally: They just see it as something they are doing, class it as a form of birth control. No, that's a bit strong, but just a normal process, nothing unusual about it. Yes, definitely and when you get the point where you say 'How do you feel', they're 'Oh, fine'....They go through the whole process really easily, they haven't got the time and don't want to keep discussing it.

In these instances, counsellors emphasised that many women felt 'comfortable' with having an abortion, and saw it as a 'normal' process. They therefore did not want or need to talk to a counsellor about how they felt. In contrast with the approach discussed above, in these cases counsellors did not suggest that those women who said they did not want to talk might in fact need to, but rather that women who declined the offer of counselling simply did not want or need to discuss their decision.

Post-abortion counselling

Not all counsellors I interviewed had counselled women after abortion, and therefore some did not comment on their own experience of post-abortion counselling. However, all of my interviewees stated that very few women returned for this kind of counselling. Many

offered explanations for why that might be the case. Liz said this might be because women didn't need post-abortion counselling. She also suggested that they might not come back because they did not know they could.

> Liz: There is very little take up of the offer of post-abortion counselling, mainly because the women who come here are sure of their decisions, one assumes. Also perhaps some of them aren't aware of the service being available. It's written in the booklet, but unless we actually say at the end of seeing them that there is this service, they might not be aware of it.

The most common explanation for the small number of women counsellors saw after abortion however was that they did not want to return to the place where they had the abortion:

> *EL: How many women come back?*
> Gwen: Not very many. Of say 100 women, maybe five might come back. Not a lot at all. A lot more women come in ambivalent than come back. We have discussions about this. I think it could be about the fact that they come back to us. Coming back to the place that has caused them so much trauma might be quite daunting. Also, how are we going to perceive them. Are we going to say 'Told you so'. Or....we've often wondered why they don't come back. It could be great that only five per cent roughly come back. That means the other 95 per cent have made the right decision and still feel so. But the other five per cent don't think so.
>
> Sandy: We had figures that said it was less than one per cent, and I'm not sure about that. We don't know if that woman goes for counselling somewhere else. It's pretty difficult to come back to the place where you had the termination, or talk to the same person you saw before. You've told her that you're sure of the decision, and she might have challenged you on that, and then you want to come back a year later and say 'God that was the worst thing I ever did'. We don't really know how many people need counselling after abortion, but the national figure is one per cent, that's the women who come back to the organisation.
>
> Sarah: I sometimes wonder whether people do need it and don't actually come back. I have seen people come back for a second abortion and they have said they had a bad time after the first one. I ask if they came back for any counselling, and they say they didn't like to. Yet they obviously could have done with it, because they are still

> upset about the first time. So there are some who could do with help but are not asking for it. I think maybe because they don't want to come back to the situation where it all started. I think they come in here, they want to forget being here, never come here again. Therefore to ask them to come back to talk about coming here in the first place is not always an easy thing to do.
>
> Maxine: We don't do very much of it. I don't know why that is. There was more a couple of years ago, and I'm quite interested in why there isn't now. It's something I tell every client who I see, nearly, that if they have any problems afterwards, just come back. It's just such a low take up....So I'm always surprised. If something's offered, but it's not taken up. I don't know. Because I'm involved with a lot of counsellors, I suppose I have quite a positive view of it, and I can't really get a handle on how the wider feelings about counselling go. I mean do people think 'I have to be really bad before I go'? There is also the reluctance to come back here, if they are having problems with it. It's like that was just the worst day of my life. They don't want to come back and talk to somebody here. I do wonder if we are doing something wrong.

In all of these instances, counsellors claimed there was an need for post-abortion counselling which was not being met. Women did not return for it, not because they did not need to see a counsellor, but because they did not want to return to the place where they had the abortion in the first place. Abortion was construed, where counsellors discussed post-abortion counselling, as psychologically difficult, with more women in need of counselling than the few who actually returned for it.

**Conclusions**

While counsellors did not generally talk about the psychological effects of abortion in terms of trauma, they did discuss it as psychologically problematic for women, and the mandate for counselling was justified mainly on this basis. Before and after abortion, the availability of counselling was deemed necessary primarily on the grounds that it was helpful for women to be able to talk about their feelings. In some instances it was simply the act of talking that was deemed beneficial, and in others it was the content of what was said by the counsellor to the woman that mattered. Talking to a counsellor was considered preferable to talking to friends, family or doctors, because the talking with a counsellor had a more therapeutic effect that talking with anyone else.

The mandate for counselling was also constructed in terms which psychologised abortion in other ways where counsellors talked of 'empowerment' and 'therapy' as the mandate for

counselling. Only where counselling was described as information provision was abortion not psychologised, and in this case counselling was in fact construed specifically as not talking about feelings or emotions.

Opinion on the extent of the need for counselling prior to abortion differed. Some counsellors were keen to ensure that all women were offered counselling, to make sure that all who needed it got it. Others emphasised that most women were not psychologically affected by their decision to the extent that they wanted to talk to a counsellor. Where post-abortion counselling was discussed, counsellors agreed that more women might be psychologically ill-affected by abortion than returned to them for counselling.

'Pro-life' counsellors also constructed the mandate for counselling in psychological terms, but there were significant differences between their narratives and those discussed in this chapter, as I illustrate next.

# Chapter 8: 'PRO-LIFE' COUNSELLING

In this chapter, I discuss pro-life counsellors' narratives (1). My aim, as with the previous chapter, is to consider how counsellors constructed the 'mandate' for counselling. As I argued at an earlier point, one particular construction of women's psychological response to abortion, that of 'Post-Abortion Syndrome' (PAS), is associated with recent pro-life argument. I therefore expected pro-life counsellors to construe the need for counselling in relation to PAS. I expected they would describe abortion as 'traumatic', claim that women's negative emotions following abortion are repressed, and justify the need for counselling on this basis.

As I discuss below, the pro-life counsellors I interviewed did talk about the psychological effects of abortion in these terms. However, it was by no means the only construction of the mandate for counselling in their accounts. I have therefore attempted in this chapter to give as full a presentation as space allows of the different themes which emerged.

## Post-Abortion Syndrome

(i) A serious condition

I first discuss instances where interviewees talked about the effects of abortion explicitly in terms of PAS. I illustrate how, in doing so, they emphasised that abortion had serious psychological consequences for the woman concerned. Geraldine described some women she has seen for counselling as follows:

> ...some people will present themselves with symptoms that are serious, with the definitions of post-traumatic stress. The types of exaggerated, extreme responses to big events in your life, which can be analysed. So what we are looking at is extreme symptoms. Sleeplessness, eating problems, bad dreams and weepiness. Issues where you realise you are not functioning normally.

Diana described the form of PTSD that follows abortion as

> ...what happens to a woman when she's had an abortion, she hasn't recognised she is traumatised by it, she's pushed it under and hasn't been allowed to grieve, and she gets post-abortion stress. It's been coined by somebody, who picked out all these things that happen in women, as a result of pushing it under and not having it recognised. Some can have really serious psychological disturbances.

In both of these instances the psychological effects of abortion were construed as 'serious'. Geraldine used the term post-traumatic stress to separate the effects of abortion from 'normal functioning'. She construed bad dreams or weepiness after abortion as evidence of an abnormal, serious psychological problem. The term 'post-abortion stress' functioned similarly in Diana's comments. She specified that women with 'post-abortion stress' can have 'really serious psychological disturbances'. Defining the possible psychological effects of abortion in terms of PAS therefore had the effect of constructing those effects as potentially very damaging for a woman's mind.

Where interviewees framed the effects of abortion in terms of PAS, they also often construed women as in denial of their feelings following abortion. As I discussed in Chapter 4, this is a construction of the psychological effects of abortion characteristic of the PAS claim. Penelope said:

> A lot of women suffer without it ever being recognised, so they don't come back. I don't think there are figures, but it probably has all sorts of other impacts on their life, even if it doesn't come out as Post Abortion Trauma. We feel that's probably the case. There may be some women suffering from Post Abortion Syndrome without realising that is what it is, or that help is available. Even if she was untroubled by her abortion at the time, she may repress the memory, and not connect it to her present problems.

In a previous extract, Diana had suggested that post abortion stress resulted when a woman traumatised by abortion 'pushed it under'. Penelope claimed similarly that a woman 'may repress the memory' of the abortion. The effect of constructing the possible psychological outcome of abortion in this way was to sustain the contention that 'a lot of women suffer' from PAS. Penelope sustained the claim that many women suffered through her argument that repression of the memory of abortion meant that a woman could fail to connect her 'present problems' with it. Thus, she argued, a lot of women suffered, even if 'they don't come back' for counselling.

A third way in which the seriousness of the effects of abortion was emphasised was through the construction of PAS as medical fact. Mary said, of PAS:

> There's quite a specific syndrome which....not all of them have all of the symptoms, but there's quite a list. Flashbacks, difficulty with sex, sexual relations, or um....not just with sex, with drink or drugs maybe, going into it more, to kind of subconsciously drown the sorrows. That sort of thing. So hitting the bottle, or yes, promiscuously

> rushing into relationships. These are considered to be part of the syndrome. I mean this is medically recognised, Post Abortion Syndrome. But not everybody has it.

Mary claimed that flashbacks, difficulties with sex or with drink and drugs were 'symptoms' of a 'specific syndrome'. It was not that she personally considered them so, but said 'these are considered to be', such by others. Mary implied the existence of a body of independent opinion which considered 'the syndrome' in this way. She made this clear when she contended that PAS was 'medically recognised'. She specified that it was medical opinion that had recognised the existence of PAS.

The description of PAS as 'medically recognised' could be considered an example of an 'externalising device'. Potter, with reference to the work of Woolgar, has argued that such devices are evident in speech and text, and that they act to construct descriptions as factual. These devices externalise the 'fact' by generating a separation between the description given of the 'fact' and the producer of that description. Potter suggests that these are procedures designed to provide 'a quality of what might be called *out-there-ness*' (Potter 1996: 150). The construction of PAS as a 'serious condition', through reference to others' opinion, apparent in Mary's description of PAS, acts in this way. PAS is 'out there'. It is deemed to exist independently of the opinion Mary holds herself about negative psychological responses to abortion.

In different ways, reference to PAS therefore constructed abortion as inflicting serious psychological damage on women. It was also notable that when interviewees talked about PAS they rarely talked from their own experience. Rather, as I discuss next, where they presented evidence for PAS, they almost always discussed it as a condition which others had proved existed.

(ii) <u>The evidence for PAS</u>

Only one counsellor, Jackie, talked about PAS as a 'condition' she had seen:

> We have been providing post abortion counselling for a number of years, long before many people realised Post Abortion Trauma existed. We don't get a large number of clients, largely because people don't realise it is a recognised condition that happens after abortion, or that there is someone who can help them through it. We do find they suffer considerable distress, some of them very severe distress, and it's interesting that it can happen immediately after the abortion, at the time the baby would have been born, at the anniversary of the abortion, and that could be in the first year. Or it could be months later, years later. In my own experience, the longest after the abortion was 30 years, sparked off by the fact that this particular lady was

> just about to lose an adored grandson, going to Australia, and this was about to happen at the time of the abortion all those years before. The thought of losing her grandson sparked off this amazing distress and grief.

Like Mary, Jackie constructed the existence of PAS as a fact: it is 'a recognised condition'. However Jackie also said she had seen a woman with the 'condition'. She also implied she had seen others. The woman whose situation she described was mentioned because the abortion was 'all those years before'. The use of the word 'longest' implied there had been other women whom Jackie had seen, who had also been traumatised, who came to her more quickly after their abortion.

More usual than Jackie's account, which drew on personal experience, was the construction of PAS as only 'out there'. Diana said:

> We read about people who perhaps even 25 years ago will suddenly come up with this problem [PAS]. They have been depressed for years.

Sarah said:

> Statistics I've read so far show that approximately 50 per cent of women who have abortion will suffer some psychological trauma, and of that, 10 per cent will be serious psychological trauma. Whether the statistics are right is difficult to tell, because you can't get people to admit that sort of thing. But there are some who will go through with it, and be totally unaffected, and it doesn't seem to bother them.

Neither Diana nor Sarah talked about their own experience of counselling women with PAS. In the following extracts, Louise on the one hand constructed the possibility of a form of PTSD after abortion as beyond question, but also chose on the other to emphasise it was not part of own experience of counselling women.

She defined the possible psychological effect of abortion explicitly in terms of PAS (as discussed in Chapter 4, as a form of PTSD). She described it as:

> ...an experience that's threatened your own life, or threatened the life of somebody near to you, in a violent way, or an experience that definitely wouldn't happen to you as an everyday experience. And abortion definitely does fulfil those criteria, no matter how clinically it is done, and how professionally it's done, it is an experience out of the everyday experience and routine, and it does threaten the life of a child.

Louise construed the definition of abortion as a PTSD stressor as beyond question. Abortion 'definitely' fulfilled the criteria. This construction contrasted strikingly with the following comments, where Louise discussed her own views about the psychological effects of abortion:

> *EL: How many women would you say suffer from PAS?*
> Louise: I'm not sure, because I haven't actually encountered those things actually. I've never actually worked in psychiatry, and I've not really done any post-abortion counselling either, so I'm taking it purely from an academic point of view....The way I conceptualise it is as like a bereavement, it's a loss, and you are trying to reconcile that loss, and the grief is being denied to you....because you took it upon yourself in the first place. I think I find that analogy more helpful really [than PAS].

When I asked her how many women suffer from PAS, Louise said she was 'not sure' and described her previous comments as taken 'from a purely academic point of view'. This point of view was counterposed to an approach which she said she found 'more helpful', where abortion was conceptualised as 'like a bereavement' or 'a loss'. Louise therefore constructed an alternative explanation of women's post-abortion psychological response to PAS.

In discussing their own experience of women they had counselled, interviewees also commonly adopted the approach of listing psychological problems they had seen, but without making direct reference to PAS. Geraldine said: 'For the most part, it's patterns of sleeplessness, numbness, apathy, and they want to be re-assured they are not the first person to feel like that'. Penelope described women she had counselled in the following way:

> Weepy, changing sleep patterns, not being able to sleep. Definitely damaged relationships, with partners, whether that partner was the father of the aborted baby or not. Inability to concentrate, not being able to cope with existing children, being short tempered, biting back.

Others named feelings women had experienced. Diana said: 'A big thing is shame, and the thoughts they have about themselves afterwards. And also guilt'.

Counsellors' contention that women suffered from PAS therefore rested mainly on the construction of PAS as 'fact' through externalising devices. It was a 'recognised condition' because they had read about or heard about it, rather than because they had come across it as part of their own experience of counselling women. Where they discussed their own encounters with women who have had an abortion, interviewees tended not to construct the experience of these women in terms of PAS.

Next, I discuss constructions of counselling. As I illustrate, women were described as 'in denial' after abortion by counsellors, with the need for counselling justified on this basis. Different aspects of the experience of abortion, that led to 'denial', were discussed however, but in all cases, where women were constructed as 'in denial', counselling was deemed necessary.

**Counselling for 'denial'**

(i) Denial of negative emotions

The first way in which women were construed as 'in denial' was characteristic of the PAS claim. In these instances, abortion was described as an event which leads to negative emotions. However women, according to pro-life counsellors, often denied their negative feelings, and needed counselling as a result. Mary framed denial in terms of PAS as follows:

> Mary: ...denial comes into it as well, for a lot of women. If they are counselled ill-advisedly, or not thoroughly enough, along the lines 'Well this is the best thing for you', and if they are counselled 'It's the best thing for your family, the best thing for your relationship, the best thing for your partner'. Then afterwards there is going to be a tremendous tendency towards denial, because they mustn't have a problem with that, because it was the best thing for them. And it gets pushed down, very strongly, and it takes something later in life to bring it to the surface. I think denial comes into play with a lot of women.
> *EL: What do you think they are denying?*
> Mary: That it upset them. That it went against the grain in any way, that they miss that baby. Anything like that. It comes back to if women are warned about how they might feel they get over the trauma more easily.

Mary presented 'denial' as a psychological response that was likely to occur in women who have had abortions. She emphasised that negative feelings resulted from abortion. She constructed a woman's likely response to such feelings in terms of PAS, where feelings about the traumatic event (abortion) are repressed, and re-emerge later. Mary contended, using the terms of this discourse that negative feelings following abortion were 'pushed down very strongly' and came to the surface later.

This description of the psychological effects of abortion led to two constructions of counselling. The first was negative, and construed counselling as 'ill-advised' in so far as it presented abortion as in some way the 'best' outcome of the pregnancy. This kind of counselling, Mary claimed, encouraged the tendency towards denial. The second was where

women were 'warned about how they might feel'. This kind of counselling was construed as beneficial. Mary constructed it in positive terms where she compared it indirectly with the version of counselling she had described previously, and where directly asserted that 'women get over the trauma more easily' where they are counselled in this way.

Construing women as in denial of their negative emotions after abortion was also central to other counsellors' arguments for counselling. Diana said:

> I think it's really important to delve with some people, post-abortion. Sometimes, when you really begin to delve into some of these feelings, and perhaps get them to give you another word for some of the feelings, it gets them to realise why they are reacting in a certain way, and that's very important. Their reaction to their feelings of guilt and shame....they have shut it all off, and perhaps they blame themselves, because they are a survivor, and the child didn't survive. I think that is important, to delve into this, their reactions to the abortion.

Angie explained:

> We do put a wall around our difficulties, and in our job we call it a wall of denial, and we say it hasn't affected my life, I can get on with my life, but we hide the deeper feelings. In fact we use a diagram when we are counselling, to show that this is what happens, what may happen if you go ahead and have an abortion. Those deeper feelings will come to the surface, may come to the surface, which means in counselling you can look backwards and say when I had the abortion, these feelings I had then are coming out now. I wasn't aware, and I put a hedge around those feelings.
>
> *EL: Why do you think that happens?*
>
> Angie: I think it's a protection for us, for women. In order to survive in her life, to go back to her job....I mean a lunchtime abortion means you go back to work in the afternoon. It's a way of protecting ourselves, and we have a lot to do. Women are busy, we have a lot of pressure in our lives, and in order to get on, they have to protect those emotions, so they can get on, back to work, back to the family, whatever situation they are in.

Diana stated that women denied how they felt about abortion and 'shut it all off'. This representation of women's response to abortion acted to construct a clear purpose to post-abortion counselling. The aim of counselling was 'to delve into some of these feelings'. Angie also suggested that women denied their feelings, which, having been denied, later 'come to

the surface'. Angie construed the purpose of counselling in similar terms to Diana: 'to show that this [denial] is what happens'. The purpose of counselling was to enable women to overcome the effects of 'denial'.

In both of these accounts, a significant distinction between the counsellor and the woman being counselled was evident, where the former understood better than the latter the truth of the woman's feelings about abortion. Angie said she used a 'diagram' to show a woman what happened to her feelings when an abortion takes place, and Diana said that she would 'delve' to 'get them to realise' what they had previously been unaware of. The counsellor was therefore constructed as 'aware' of the real effect of her abortion for the women being counselled, while the woman herself is not. Angie challenged this hierarchy of awareness about the emotional consequences of abortion in her latter comments, when she explained denial as a protection 'for us, for women....it's a way of protecting ourselves....we have a lot to do'. The function of this construction is to break down the distinction established in Angie's prior comment about the counsellor and the woman counselled, by putting forward a definition of women which includes both women who have abortions, and the counsellor herself.

Women were also construed as 'in denial' in other ways, as I discuss next. In these instances, they denied not only negative emotions, but also the aborted child, and the immorality of abortion.

(ii) Denial of 'the child'

Angie talked of the acknowledgement by the woman of the existence of her 'child' as an objective of counselling:

> *EL: When you're counselling the women, do you have an objective you are trying to achieve?*
> Angie: Yes, I have an objective for each session, and sometimes the objective would be that the woman could come to acknowledge that her child existed, and it did have an identity. That might be part of my objective, in the course of the counselling. And she could then say good-bye to that child and move on from there.

Angie made it clear that she 'has an objective for each session', which suggested an approach to counselling which did not rely on the ethos of 'client-centredness' discussed in the previous chapter. Her approach could be described as 'directive' in comparison: she formulated 'objectives' which she hopes the counselling session can fulfil.

In the above extract, unlike those discussed previously, an implicitly 'pro-life' objective was described. Angie emphasised that the purpose of counselling was to encourage the

woman to come to consider that the fetus, the life of which was ended through abortion, had the characteristics of a person. This objective was made clear in the terms used by Angie in talking about the fetus. She explained that the aim of counselling was that the woman 'acknowledge that her *child* existed and did have an *identity*' (my emphasis).

The benefit of counselling, according to Angie, accrued as a direct result of the woman coming to consider the fetus in this way. Having acknowledged her 'child', the woman could 'move on'. A pro-life objective, where counselling aimed to allow the woman to 'work through' her 'denial' of or lack of awareness of 'the child', was also evident in the following description of post-abortion counselling by Diana:

> So we will look very much at the fact that it was a baby, my baby, my child that I've got rid of. They still won't see it quite as clearly as that, but as they work through in the counselling, they come to this point of realising it's a baby. 'Fetus' is a convenient term really in the beginning, but they work through and feel the loss of this child tremendously. That's always the same. No matter what aspects are different there is always this terrible grief and loss.

As with the previous extract, the aim of counselling was to emphasise to the woman that the fetus was a 'baby' or 'child'. Diana encouraged women to look at 'the fact that it was a baby' that the woman 'got rid of'. Diana's approach also presented alternative views of abortion as trivialising the loss of valuable human life involved in abortion. The term 'fetus', used by women before they were counselled, was described as 'convenient', and contrasted with the 'fact' that 'it was a baby'. The 'terrible grief' and feelings of loss which emerge when a woman comes to realise that 'a child' was destroyed in the abortion are testament to the 'fact' that a living baby, rather than a mere biological fetus, was aborted.

It was noticeable that both Angie and Diana implied they had a different view than the women they counselled about the status of the fetus. In Angie's case, the woman had to 'acknowledge' something she didn't accept previously. Diana stated: 'They 'don't see it [that they got rid of a child] quite as clearly as that' and in counselling they come to 'realise it's a baby'. Women had therefore denied 'the child' prior to counselling, and counselling aimed to make them aware of it.

The final construction of 'denial' I want to discuss was closely related to this argument, in that it also implicitly construed abortion as the ending of valuable human life. Abortion was construed in this case as a moral wrong, and in these instances the mandate for counselling was the need for forgiveness of this wrong.

(iii) Denial of the 'wrong' of abortion

Jane discussed the need for counselling as follows:

> *EL: Why did she need counselling?*
> Jane: So she can seek forgiveness. It's only once you have acknowledged you have done wrong. It was this whole thing of....if you rob a bank and run away to Spain, are you still guilty, without having been condemned as it were? Just because you haven't paid the price, doesn't mean you aren't guilty. And that was quite a crucial point for her, to recognise that these things aren't....aren't....that you can be guilty without having been convicted. And once you have been convicted, sentence comes if you like. And at that point you are forgiven. You have admitted your guilt, yes you are guilty, here comes the forgiveness.
> *EL: Is that your aim in the counselling, to get to the point where that happens?*
> Jane: Yes. Because recognising your accountability and yes....she can then move on. Because all the time she is holding onto the guilt, she is trapped. You are attached to all of the things in your past, and you can't let go of them. They are sort of holding on....holding on to anger, the guilt, the shame all of those things, prevents her from going on, and recognising 'Yes I did wrong, but I am free of it. I don't have to be trapped in it'. She was very much trapped in the past and living with all the emotions of what happened to her 30, 40, 50 years ago. She was sort of trapped, locked into those emotions. So we had to sort of recognise that those emotions were valid in themselves, but for that time.
> *EL: So she had to accept she had done something wrong?*
> Jane: She knew she had done wrong in a sense, but was caught in the shame of it. So we looked at the difference between guilt and shame, recognising that guilt is a healthy recognition that you have crossed a boundary.

In this extract, abortion was framed in moral terms. It was a 'wrong' and the woman who had the abortion 'did wrong' and 'crossed a boundary' in having it. The purpose of counselling was to allow her to acknowledge the wrong. Three aspects of Jane's comments are noteworthy. First, a woman's guilt after abortion was construed as inevitable. Her feelings were an inescapable result of her decision to abort a pregnancy. Jane's use of the metaphor for abortion of a bank robbery and 'running away to Spain' illustrated this approach.

Where someone robbed a bank, and managed to escape without being caught, the lack of condemnation or punishment from an external source did not, according to Jane, prevent feelings of guilt about having done something wrong. Abortion was therefore, through this metaphor, similarly constructed as leading to feelings of guilt. Regardless of the fact that

forces external to the woman did not draw to her attention the 'wrongness' of abortion by 'convicting' her of what she had done, she would feel guilty nevertheless. The guilt the woman experienced must therefore be inevitable.

Second, counselling was justified in relation to this representation of guilty feelings. In continuing the bank robbery metaphor, Jane presented the possibility of 'forgiveness' of wrong-doing. Where the 'wrongness' of an act was admitted, it was possible to be 'convicted', 'sentenced' and finally forgiven. However this process of reaching the point of being forgiven for 'wrong' had not yet been brought about by a force external to the woman who had an abortion. Although not stated explicitly by Jane, implicit here through the use of terms such as 'sentence' and 'conviction' is a law court as a possible example of an external force which could achieve this end. The woman could in such a court be 'found guilty', 'convicted' and 'sentenced' for the wrong she had committed. In the absence of such a legal means to make apparent the 'wrong' of abortion, in Jane's account, counselling could act in a similar way. Counselling could bring about this process of 'sentencing', and eventually 'forgiveness'.

Finally, the woman was construed as in denial of the 'wrongness' of abortion. Counselling allowed her to 'acknowledge' the wrong that had been done, which implied that she denied the wrongness of the abortion prior to counselling. Jane claimed that the difficulty a client faced was due to this denial. She was 'caught in the shame' of the abortion, and had failed to 'recognise' she did wrong. It is therefore only through admitting to the wrong that the woman could 'let go' of her negative feelings about the abortion, and move on. Through 'helping' her to overcome her denial about the moral mistake she had committed in having an abortion, counselling was construed as beneficial. The woman's negative feelings about abortion were a direct product of this moral mistake, and could only be overcome through accepting that a mistake had been made. The mandate for counselling was also constructed in other ways as I discuss next. These constructions of counselling are significant in that they relied on women-centred discourses borrowed by pro-life advocates from those who support legal abortion.

**Women-centred constructions**

In their narratives, pro-life counsellors adopted arguments associated with the pro-choice abortion lobby. One such argument emphasised the importance of respecting the individual woman and of avoiding stigmatising her. It could be classified as 'woman-centred' in that woman's needs were construed as the central issue in abortion. The significance of this construction of the mandate for counselling was that a woman-centred argument was however deployed to problematise social acceptance of abortion. Geraldine, for instance, said:

> The individual wants to be reassured they are not outside the framework of some form of normality, and stress is a normal part of our lives....That's something a client wants to know, 'I'm not mad, am I?' So one will respond....there are patterns in what we see, but then you have to be careful that you're not just making someone a figure, a statistic, because they are also longing to be an individual, if they have been shut off from the usual support in society, through the public perception of abortion, put themselves in a corner, hidden away what they've gone through. But they also want to be themselves, and to reclaim themselves again, and I do find abortion does knock women's self esteem a lot, and so....you have to balance between the conditions, the diagnosis and the individual, because then looking at what's been experienced, it's an individual experience always.

Geraldine construed meeting women's needs as central to the counselling she provides. She talked of reassuring the women she sees, responding to what the client wanted to know and expressed concern about women's ability to 're-claim themselves' and about their 'self-esteem'.

This woman-centred approach was combined with the claim that the problem for women was the 'public perception' of abortion, and 'the framework of some form of normality'. The social 'norm' Geraldine talked of was not one which stigmatised women who cope psychologically after abortion, but rather those who did not. It was, in Geraldine's account, therefore those women who experienced abortion as 'stress', and who did have negative feelings afterwards, who were being made to feel 'abnormal' after abortion. The dominant perception of abortion was therefore construed as one which refuses to recognise what 'some women go through'. Society's alleged acceptance of the choice of abortion was construed as problematic for women, because it denied women the emotional 'support' they may otherwise expect to find, which therefore had to be provided through pro-life counselling.

The social acceptance of abortion was also problematised through use of the feminist argument for 'the right to grieve'. As I discussed in Chapter 5, during the 1980s, a feminist discourse emerged which emphasised the need for feminists to pay attention to the negative feelings women experienced after abortion. Some emphasised that women needed 'permission to grieve' or 'the right to feel' after abortion, not simply the right to abortion. This argument had been adopted directly by some pro-life counsellors. Its main function in their accounts was to call into question social acceptance of abortion, as exemplified in the following extracts from Jane's account of her work as a counsellor.

> Recognising that they have....it's a peculiar thing isn't it. The logical way through, for someone who has acted within the law, within their best....what they need to do is grieve. And it seems a strange thing to them, that what you do is actually choose to do something, that to actually deal with emotionally, you need to grieve. And that's really what we find that they need to grieve. And one of the things pre-abortion counselling tells them is you are moving towards a situation where you will have to grieve.

Jane said women 'need to grieve' following abortion. This need was construed as in conflict for women with legal abortion. Their negative emotions were experienced as 'strange' because they had been legally able to choose to end the pregnancy. It was this conflict that, in Jane's account, justified the need for counselling before abortion: it 'tells them' they would have to grieve afterwards. Counselling was therefore again construed as a purposeful, directive activity. Pre-abortion counselling had a particular aim, which was to tell women that they would need to grieve.

Mary also construed a woman's need to grieve and social acceptance of abortion as in conflict with each other. She said:

> But very often society doesn't let them grieve, because they've in inverted commas, "done the best thing", which with a miscarriage could happen at exactly the same point in the pregnancy. Then society allows them to grieve, 'Oh you've lost your baby'. But with an abortion at the same point in time, superficially society won't let them grieve, because you've made a wise decision, this was OK.

Mary contended that 'society doesn't let' women grieve after abortion. Women, she said, were told they had 'done the best thing' and 'made a wise decision' in choosing abortion. This alleged social support for the abortion choice was construed as unhelpful for women, since it prevented them from expressing their feelings of grief following abortion.

Constructing the social acceptance of abortion as a problem also functioned in Mary's narrative to produce feelings of grief after abortion as inevitable. This was evident where Mary compared a woman's feelings after miscarriage to those following abortion. Through highlighting the 'need to grieve', it was the 'loss of the baby' through either miscarriage or abortion, rather than the woman's desire to remain pregnant or to end the pregnancy, that was construed as the significant issue in determining how a woman felt when a pregnancy came to an end. She stated that a pregnancy could be lost 'at exactly the same point in pregnancy' through miscarriage as with an abortion. With the former, Mary claimed, women were encouraged to express their feelings of grief, but with the latter they were not. This

contrast constructed 'feelings of grief' as an inevitable result of the loss of a 'baby'. Feelings of grief in both cases resulted from ending of a pregnancy. By merit of its omission from Mary's account, the question of whether the woman *wanted* to be pregnant is construed as unimportant.

**Counselling and information giving**

In this section, I discuss a further construction of the mandate for counselling which has its origins outside of the anti-abortion movement. This is where counsellors talked of the importance of 'providing information'. One effect of this construction was to present pro-life counselling as unbiased and non-directive, a presentation of counselling which contrasted with the directive, purposeful accounts of counselling discussed previously. Mary discussed counselling in this way as follows:

> *EL: Tell me more about when you are counselling women considering abortion. Is there anything specific you are trying to achieve through it? What would you see the purpose of that being?*
> Mary: Answering their questions really. What do they know about it? What are their....what facts do they have already about abortion? And pointing out the after-effects of abortion, which we see as being basically divided into three. There are physical after-effects, although they are quite minimal, and it would be wrong of us to blow up future infertility problems, and miscarriage problems. But it is the emotional after-effects which, to a large extent, are pretty universal. Then there's what you might call the spiritual side, which hinges on your beliefs, your upbringing, your moral assumptions.

Mary defined the purpose of counselling as 'answering their questions' and as finding out 'what facts have already about abortion'. Another counsellor, Louise, defined counselling in a similar way. She said: 'They want the factual information, so you give them the factual information'. The purpose of counselling was therefore presented as the delivery of information and facts. It was construed as an activity through which the woman simply became better informed. Diana also presented the purpose of counselling in terms of information giving and the unbiased provision of facts:

> In a pregnancy crisis we obviously don't give advice. We are there to talk to people, listen to them, help them come to terms with their feelings, and help them to make an informed decision. There is no bias one way or the other, it's just about supplying

> the facts for them, in terms of dangers, emotional and physical, and their feelings about it. How they think they will cope, what's making them come to the decision.

Diana stated that counsellors did not 'give advice', that there was 'no bias' and that it was '*just* supplying the facts' [my emphasis]. Counselling involved nothing more than the provision of information. The purpose of counselling was not therefore stated as that of changing the woman's mind or persuading her to make a particular decision. Rather, while the woman should make 'an informed decision', based on the 'facts' she had been given, it was for her to make the decision. As Penelope put it, the purpose of counselling was 'to allow her to come to her own decision, having told her all we can - the pros, the cons and what we can do to help'.

It was noteworthy that this construction of the purpose of counselling existed in contrast with those discussed previously. These constructions produced counselling as a directive activity, which aimed to achieve a specified end, where the woman comes to share the viewpoint of the counsellor. In this case, the purpose of counselling was stated to be simply the delivery of 'information'.

Where counselling was defined as giving information, the construction of the responsibilities of the pro-life counsellor in relation to the woman was notable. Where counsellors talked about counselling as the delivery of information, they construed it as a necessary and important responsibility of health-care providers:

> *EL: But there are these three areas you like to cover?*
> Mary: Yes, just to briefly spell out, or they might pick up any of them, or maybe not. For some of them infertility might be a big thing, but with others not. We would just touch on all of them. It wouldn't be fair for us not to. But the decision is theirs. We say....
> *EL: Why would it be unfair of you not to touch on those areas?*
> Mary: Because it's part of the information sharing, part of giving information, which is why they come, go through it fully appraised of what the side-effects are, as with any surgical procedure. Normally you have to touch on the risks and possibilities. But we aim not to use it manipulatively, because it would be us taking responsibility for them.

Mary stated that it 'wouldn't be fair' if she were not to discuss with the women she sees the three kinds of after-effect of abortion she named previously. She therefore implied that there was a recognised standard of information delivery to women considering abortion: it would be 'unfair' for women not to receive this information, because they would then be treated

differently to the standard. Mary defined that standard: as with 'any surgical procedure' a woman considering abortion should be 'fully appraised of what the side-effects are'. Mary thus talked of her role as if she were responsible for 'providing information' to the standard set within medical service provision organisations. Such organisations are required to do so because they are then responsible for the provision of the medical service. Although the pro-life counsellor was not, she discussed her role as if she were.

Where counselling was defined as giving information, interviewees also talked negatively of the counselling provided by abortion providers. Geraldine said:

> ...aspects of our pregnancy counselling are about giving facts, and I've had issues in post abortion counselling where the woman was not given proper information. I had somebody recently who said to me 'I had an abortion, and I wasn't given much counselling. I did ask what was the baby like at this stage?'. And the doctor said to her 'it's just like a tadpole'. So she wasn't convinced about that, and she asked somebody else and they said it's absolutely nothing at this stage, there's no problem. But you know, talking about biology, an embryo is not a tadpole....when she was all confused and upset about what she'd done, she'd also got to get rid of this idea that she'd been aborting a tadpole. It makes you wonder what people know about, but this is not a stupid woman, it's someone with a degree. But that's the message you are given. You must be given proper information, so you know what the abortion is about, you know what's going on. Afterwards, we believe if you are given more information beforehand, you'll cope with it better too.

Geraldine stated that women 'must be given the proper information'. She justified this imperative on the grounds that women would 'cope with it better afterwards' if this process of information giving took place. The provision of facts and information before abortion was therefore construed as preventative of negative feelings after abortion.

In defining what 'giving facts' involved, Geraldine contrasted the approach taken by the organisation she represented with the approach taken in abortion provision organisations. In the latter, she suggested, there were instances where women were 'not given proper information'. Through using the example of a woman she had seen following an abortion, Geraldine constructed 'not proper information' as both a lack of counselling (the woman said she 'wasn't given much counselling') and the particular information women were given in counselling (the description of an early embryo as 'just like a tadpole' or 'absolutely nothing at this stage'). While she did not spell out what constituted 'proper information', it could be inferred that this would involve a greater amount of time given to counselling, and the provision of information which aimed to emphasise, rather than minimise, the 'humanity' of

the fetus. The construction of information which compared an embryo to a 'tadpole', or 'nothing', as a problem, relied on an preferred version of contrasting information. This would present the embryo as human, rather than animal and as 'something' rather than 'nothing'.

Some aspects of the version of counselling Geraldine preferred are specified in the following extract:

> *EL: If an abortion service provider gave women the information you do, would the demand for your approach disappear?*
> Geraldine: I think our approach and their approach should be the same. We're not stopping anyone from having abortions. That's not our role at all. I have a political side to me, but that's not relevant when I'm dealing with women. I'm not abusing that role of confidentiality and intimacy with the woman to score political points. Many of our clients walk out of here and have an abortion, and we're not stopping them. But I would very much like to feel that the abortion providers were giving the same amount of time. You couldn't convince me that they do give an hour, two hours, three hours to somebody who wants to talk about the dilemma she finds herself in. If they were able to provide the counselling we provide, we might be out of a job. That doesn't worry me. I'm concerned with whether women get the best. And that includes the support. I want to have my baby. Then fine, you won't get kicked out of your job, you won't lose your position at university, we're not going to victimise you. I'd like to see a lot of support, legislative help. The current thrust is not at all pro-woman.

An objection to the approach taken to counselling in abortion service organisations was defined as the lack of time given to 'somebody who wants to talk': Geraldine contended that such organisations were unprepared to give women the 'one, two, three hours' they needed. Geraldine presented an alternative, superior approach to counselling, which she contended should and could be adopted in all situations where women were counselled before abortion. This would involve not only spending a longer time counselling women, but also providing not simply information about abortion, but in addition would provide 'support' where the woman wanted to have a baby. The current situation, where this did not take place was described as 'not at all pro-woman'. Geraldine therefore posits the version of counselling she described as in line with women's needs.

The final aspect of the definition of counselling in terms of information provision was the construction of the psychological effects of this kind of counselling for women. Pro-life counsellors discussed these effects in contradictory terms. For Angie, the likely consequence of such counselling was to make some women 'feel worse':

> I would say certainly for some folks, those who have talked to us, it probably makes them feel worse. They have had our information and have gone ahead with it for various reasons, they've had their eyes opened, so they feel perhaps even worse than they would have done otherwise, because they understand what has happened. Because we don't want to hold out a sort of sop, 'There you are, go ahead and have an abortion, we're here for you'. We do say we are here if you decide to go ahead and have an abortion, but we don't want them to be thinking if I do go ahead and have an abortion, they're always there for me, to look after me. The decision is for them to make, but the decision that could be made, in the light of the information they've got, could be to not go ahead with the abortion, and that....obviously we have our own sense of what we would like underneath, and we have to be careful we don't bring that too far out, and as I said before, it's good for them to hear the opposite to having an abortion, if they've not thought of it before, what would happen if you did keep the baby.

Angie described the effect of giving women 'information' as possibly leading to a greater degree of negative feelings after abortion than if that information had not been given. As a result of counselling, women had their 'eyes opened' and would 'understand what has happened' in the abortion, and as a result may 'feel worse' than they might have done without counselling.

The purpose of counselling was not therefore to attenuate negative feelings after abortion. Counselling did not aim to make abortion less problematic psychologically for women. Neither could counselling after abortion be relied upon as a way of dealing with negative post-abortion feelings. The organisation Angie works for should not be thought of as a place that is 'always there' and which will 'look after' women in the event of abortion proving to be psychologically difficult.

In contrast, the effect for Geraldine of giving women 'facts' when they were thinking about having an abortion, was to attenuate 'trauma':

> I'm not saying you're not going to suffer from trauma, but I can definitely say from counselling, and helping people to get better, that you have certainly got less road to go along, to undo all of that. If you have to undo the fact that somebody told them it was a blob of cells, and nobody stopped and talked to them for a minute, looked at this possibility or that possibility. If it was never suggested there would be any emotional aftermath. Perhaps that particular person did it because their exams are coming up, had the abortion and can't face going into college. They just can't face

> anything, so the exams are not going to happen anyway, then they've had the abortion and can't take the degree anyway. Afterwards you've got to get rid of all of that, so from the point of view of getting better afterwards, having information before is likely to help. You know what's going to happen. Often women come to me, and they've been on their first trip to the abortion provider, and they haven't even been told things about the abortion itself, had their questions about the procedure answered.

In this account, counselling was construed as a beneficial activity: 'having information is going to help'. However, in contrast with Angie's argument, the need for information was justified by Geraldine on the grounds that having information would minimise the psychological effects of abortion. Women would have 'less road to go along' in recovering emotionally from abortion, if they were given information beforehand. The negative psychological effects of abortion were construed as a result of a lack of information, or the receipt of wrong information. Women were more likely to suffer psychologically if it was 'never suggested there would be any emotional aftermath' or if they were 'told it was blob of cells'. It could therefore be inferred that where women were not counselled they might suffer from trauma, and where they were informed of the 'humanity' of the fetus, they would cope better psychologically after abortion.

**Conclusions**

While the construction of the psychological effects of abortion in terms of PAS was evident in pro-life counsellors' narratives, the 'mandate' for counselling was not exclusively produced in these terms. Abortion was framed as psychologically problematic in a number of other ways: because it killed 'a child', was morally wrong, and was too accepted by society. There was however a fairly consistent feature to the various discourses identified in that all acted to psychologise abortion, that is to construct the 'problem' of abortion in terms of its likely negative psychological effects.

The purpose of counselling was discussed in a contradictory way. In some instances it was construed as an explicitly 'directive' activity. Counselling aimed to persuade the woman to consider abortion in a particular way, namely as the loss of a child, or as morally wrong. Where the same counsellors construed counselling as centred on providing information, they sometimes talked of it as a directive activity, but more frequently it was construed as 'non-directive'.

# Chapter 9: WOMEN'S NARRATIVES

This chapter is not meant to constitute a comprehensive account of the ways in which all women experience abortion. As I explained in Chapter 5, I interviewed eight women about their experience of having an abortion. The sample was therefore small, and was not randomly selected, and is not representative of all women who have abortions. Also, all interviewees, with the exception of Angela, had their abortions in clinics run by charitable, specialist abortion providers in the South of England and their experience is unlikely to reflect that of women who terminate pregnancies in NHS hospitals. My aim is not therefore to make statistically-based claims about women's experience of abortion in Britain today. Rather it is to provide a detailed account of the operation of currently pervasive discourses about abortion. In this chapter, I assess whether abortion was psychologised in the narratives of those women I interviewed, and if so, ways in which psychologising discourses shaped their accounts of their experience of abortion.

The interview questions I used were open-ended. I began by asking interviewees simply to tell me about their abortion, in order to establish as the focus for the interview the aspects of their experience which were primary to them. The questions I asked subsequently picked up on what they said and aimed only to elicit amplification or clarification in their own terms of what they had already told me about their experience.

A few main themes emerged. Two stand out, both of which are contrary to my hypothesis. First, counselling did not feature as a significant part of their experience of abortion. It was not memorable for most when they talked about their time spent at the abortion service premises. Neither did most say they wanted or needed counselling on the grounds that they found abortion psychologically difficult. Second, at the outset of the interview, most prioritised explaining factors which led them to have an abortion rather than their feelings or emotions following abortion.

I start with an account of this aspect of their narratives, followed by an account of their comments about counselling. I then illustrate three other important themes, specifically the ways in which they talked about their experiences in terms of trauma, regret and finally instances where interviewees voiced their resistance to the construction of abortion in psychological terms.

### Factors leading to the abortion request

Almost all interviewees responded to my initial question, 'Could you tell me about your abortion?', by talking about how they came to be pregnant. Their comments typically included reference to 'contraceptive failure' and their relationship with the man by whom they had become pregnant. Anne-Marie, a professional woman in her mid 30s explained:

> I had two abortions....I'd always taken precautions, and I hadn't realised I could get pregnant during the first or second day of my period, until I got Persona, which funnily enough has now sorted me out completely!....both times were with the same guy, who I actually loved, and spent six and a half years with, and only really finished our relationship last year sometime. In fact, it's never really over with him.

Similarly, Harriet, also a professional woman in her 30s, told me at the very start of the interview that she had '...got pregnant by accident because of....basically using a cap and it failed....and being very unlucky' and that '...at the time my partner was married, heavily married as they say with four children, and so there was no plan for us to be together as a couple'. Natalie, a student in her mid 20s, began by telling me she '...was living in a different town to my boyfriend, so we weren't seeing each other much. I wasn't taking any contraceptives at the time. I made a bit of a mistake.'

The prominence of references to contraceptive failure or its non-use is significant in relation to themes discussed previously in this thesis, particularly in relation to the medicalisation of abortion discussed in Chapter 3. As I highlighted previously, one effect of the medicalisation of abortion has been to construct the notion that there are 'legitimate' reasons for abortion (those which comply with the terms of the Abortion Act, namely that in the opinion of two medical practitioners, continuing the pregnancy represents a greater threat to the health of the woman than abortion) and 'illegitimate' reasons (those which fall outside the terms of the Act, in that they do not make reference to the effects of pregnancy on a woman's health).

While those women I interviewed did not justify their abortion requests in relation to the physical or mental health effects of abortion, or of having a baby, it is arguably the case that their narratives nevertheless indicate that the construction of 'legitimate' and 'illegitimate' reasons for termination is pervasive. Detailed discussion of the reasons why interviewees emphasised contraceptive failure or its non-use as their reason for abortion is outside the scope of this thesis. However, it would appear that, as other accounts of women's contemporary experience of abortion have pointed out (Berer 1993; Furedi 1996; Lattimer 1998; Albury 2000), a discourse which emphasises the need for contraceptive use, and stigmatises its non-use, significantly affects women's experience of abortion. Feminist writer Marge Berer, has commented on the implications of such a discourse for women:

> The prevailing belief is that no matter how responsible an act it is to use contraception, it is only responsible enough if the contraception doesn't fail you, or you don't fail with it. In other words, if you end up pregnant and you didn't want to be, it's probably all your own fault (Berer 1993: 41).

The assumption that fertility is controllable has had important implications for the experience of unwanted pregnancy and abortion. If contraception can enable every woman to avoid unplanned conception, a woman's need for abortion becomes a sign of weakness or incompetence. The disciplining effect of this discourse of personal responsibility in avoiding abortion through contraception was evident in the narratives of my interviewees.

Natalie, a professional in her 20s from overseas, working in Britain for a short time, commented, self-critically: '...there's a lot of easier ways of managing contraception than pregnancy and abortion. I suppose it was slackness'. Emily, a student in her early 20s, was determined that her contraception should never fail again: '...now, even if I get a bit of sperm near me, I get a morning after pill. I'm so cautious'. Anne-Marie, who had had two abortions, talked a lot about her negative feelings. These feelings were not about having aborted pregnancies, but about having become pregnant by accident:

> I regret having got pregnant. But I don't regret having got rid of it. There's a very big difference between the two. I really regret having got pregnant....
>
> ...and the second time, the guilt I felt, the guilt I felt at having got pregnant again. I just couldn't believe it, I was so mad at myself. I was so mad at everything. I felt awful, I felt guilty, I felt ashamed of myself. I felt awful for having got pregnant twice.
> *EL: Why was that?*
> Anne-Marie: I suppose having done it once, and it being such a horrible thing to have to go through, you feel that you should have taken every single precaution necessary to ensure you never have to go through that again. But as I say, I just hadn't realised I could get pregnant when I could get pregnant. I honestly thought I'd understood biology enough to know that you ovulate halfway through the month, or at least somewhere round that period, and you can't conceive at that end. I had no idea.

A construction of abortion as avoidable through contraceptive use (and unwanted pregnancy as therefore the 'fault' of the woman) influenced most interviewees' accounts.

The other aspect of their explanations of why they requested abortion was also important, namely their relationship with their partners. All of my interviewees were in a relationship with the man they conceived with. However, something about the relationship at the point at which they conceived meant that these women perceived ending the pregnancy as the preferable option to having the child.

Caroline, a professional in her early 30s, said: 'Then I thought it would have been lovely to have a child...But he was just unable to. He was actually married, involved with somebody

else, so it was an impossible situation'. Angela, a student in her late 20s, commented: 'We'd only been going out for three months. I didn't know what the situation was going to be like with him'. Anne-Marie and Emily talked about the 'circumstances' which led them to choose abortion, most important of which was their relationship with their partner. If this 'circumstance' had not been as it was, then continuing the pregnancy might have been chosen. Anne-Marie explained:

> ....we couldn't have this baby because we weren't sorted, and if we'd been sorted, it might have been different. So I kind of....it was that kind of regret, about the circumstances, and the fact that it was very sad that we were in those circumstances, and the fact that I loved him very much, and he would have stuck by me, absolutely....And looking back on it, Jesus he's still doing what he was doing, he hasn't even got a stable job....It was definitely the right decision

Emily similarly talked about the problems in her relationship as central to her decision to have an abortion:

> Emily: I think if I was in a different world, I'd have been able to say yes, that would have been nice.
> *EL: Did part of you want to have a baby?*
> Emily: Yes, I think so. And I liked the idea of pregnancy and stuff, and then it was sucked away, all of a sudden....If circumstances had been different, if I'd been happier I would have been able to. If I'd done all the things I want to do.
> *EL: Tell me a bit more.*
> Emily: I think because of me and my boyfriend, we had problems at the time, we weren't using any protection or anything, it was obvious what was going to happen, but the sort of problems we were having, it made it a sort of test to put on it.
> *EL: A pregnancy?*
> Emily: Yes, I think so. Although I knew deep down I wouldn't go through with it.
> *EL: So you wanted to find out how committed he was?*
> Emily: No, no. More about myself maybe, or just something, to do something with it, because it was awful, we just weren't getting on at all.
> *EL: So to bring the relationship to a head?*
> Emily: Yes, I think so. We weren't using any protection at all. Because we'd split up and everything. It was a really, really horrible time. I didn't at any point say to myself honestly look, this is going to happen. But at the same time, I'm not stupid, I know

> that if you don't use something then you'll get pregnant, but I wasn't really rational. I didn't let myself think about it. I just got carried away, it was silly.

For my interviewees, their abortion request was therefore centrally connected to difficulties or problems that were experiencing in their relationships with the man by whom they had become pregnant. As I discussed in Chapter 3, in so far as the Abortion Act states that doctors can take into account the woman's 'actual or forseeable environment' in assessing her abortion request, relationship difficulties could be potentially included as a 'health' ground for abortion. A liberally minded doctor could construe a woman's reluctance to have a child on her own, or with a partner who was not committed to her and her future child, as a threat to her health.

To construe the complexities of a relationship between a woman and her partner in this way, as a question of 'health', does however require the very broad definition of 'health' I discussed previously. There was no evidence that my interviewees shared this definition of 'health'. They did not discuss the issues at stake in their relationships in these terms. They did not speak of the importance of their relationship in leading them to request abortion as a 'health' issue.

This disparity between interviewees' own perceptions of their 'reasons' for seeking abortion and the terms of the law was made clear in Natalie's account of her encounter with the doctor at the abortion referral bureau. The doctor raised the issue of her relationship when he asked her if she had discussed her decision with her boyfriend. Natalie told me:

> It was when I had to say why I wanted an abortion. I said it was unplanned and not what I wanted, or what he wanted, but then I had to think of a few things....you know I didn't have reasons of poverty, lack of support. So I thought 'I hope I've convinced him enough.' I didn't put forward a great deal of reasons. I just didn't want a baby at that time. So when he asked, it seemed obvious to me.

It is very unlikely that the doctor at the referral bureau Natalie attended would have put barriers in the way of her getting an abortion. It was part of a charitable abortion service, and Natalie was very impressed with the way she was treated. However, the disparity between her account (and the accounts of other interviewees) between why they wanted an abortion and the provisions for abortion in the law is nevertheless important. It means that, even where the most liberally minded doctor is involved, a woman requesting abortion is placed in a problematic situation. What may be 'obvious' to her about why she wants an abortion, as it was for Natalie, is at odds with doctors' reasons for consenting to her request which, for legal reasons, have to be couched in medical terms.

**Counselling**

In this section I consider interviewees' accounts of counselling. I have prioritised this issue for discussion because while my hypothesis suggests discussion of counselling would have featured prominently in their narratives, in fact it did not. None of the women I talked to discussed counselling early on in their comments, nor did they ever spend much time talking about it.

Some mentioned seeing a counsellor in connection with discussion of their visit to the abortion referral bureau or the clinic. Some also commented briefly on the quality of the counselling they received, and generally talked about it positively; an assessment of encounters with counsellors in charitable sector abortion providers which has been noted in other, larger scale research (Allen 1985). However two interviewees, Amanda, who was in her early 30s, and training for a professional career, and Justine, a post-graduate student in her mid-20s, were critical of the approach of the counsellors they saw, as I discuss later.

Counselling was not generally raised again in the course of the interviews. Where it was, as I indicate in the latter half of this section, interviewees talked about which women they thought needed pre-abortion counselling. Post-abortion counselling was not discussed much. None of my interviewees had sought post-abortion counselling, but two discussed why they would have liked to have talked to a counsellor after their abortion.

Counselling before abortion

(i) The meeting with the counsellor

The fact that counselling was not a defining aspect of interviewees' experience was evident in the brevity of their comments about counselling and in their lack of clarity about their meeting with the counsellor. This contrasted with other dimensions of their experience, recalled repeatedly and in detail. Where interviewees commented on their meetings with counsellors, they were generally positive about their experience:

> *EL: Tell me about your visit to the bureau.*
> Harriet: The first thing was a consultation with a male doctor, who did a scan, just looking at the medical side I guess. Then I talked to a middle-aged woman who asked me a lot of questions about whether this was the right thing etc.
> *EL: A counsellor?*
> Harriet: As I remember it, yes, they described it as a counselling session to enable you to make a decision about what was the right thing for you. That lasted about half an hour.

*EL: What did you think about that?*

Harriet: I thought she was very good. Given I haven't got any experience of counselling over that kind of issue, I think she was very good. As I remember it, she got the balance between being challenging enough, and being empathic and sympathetic and respecting my wishes, so I think she struck a good balance.

Caroline: I....my memory isn't actually all that strong, of the encounter. I met a very nice woman. I mean it's all rather indistinct. A very nice woman, who asked me a few questions about why I felt I needed to do this. So I explained the situation, that the father's not going to support me in having a child, and I don't think I can cope with being a single mother. And that was it. She said that's fine. I think she gave me the opportunity to talk some more about how I felt, but I didn't want to, so that was it....And at the time I was extremely anxious not to prolong the encounter, because I just felt like I'd made up my mind. I was completely emotionally shut down, I just did not want to discuss it at all, and that was it....Anyway, the thing is about the actual counselling, I wanted it to be brief, non-intrusive, and that's exactly what it was.

Anne-Marie: I think I saw two people there. I seem to remember it was a slightly longer procedure [than in the NHS], and they spent longer with you. And there was more empathy, and more sympathy. And I felt I could talk about my doubts, as well as my actual wanting to do it. Which was good, because there were things that I did feel slightly shaky on, like I was in love with my boyfriend, I was still going to be living with him, it wasn't like we were splitting up over it or anything like that. It was a decision we had both taken. It was a hard decision, and I talked to them about that, and they were great. They asked me if I needed more time to go away and think about it, and in fact I think at that point they said we do have to wait another week anyway. So they said why don't you go home, talk to your mum, have a think, see how you feel, and if you're not. And then when I went back I think they gave me another check just to make sure that I really wanted it still, and they were very....I felt it was more a service for me, and that nobody who worked there had very strong views on life, or pro-life or anything like that. Because it was their choice to work in a place like that I just felt different, really different.

These interviewees all drew attention to the vagueness of their recollections of their meeting with a counsellor, but also evaluated it positively. They all emphasised that they valued the counsellor attending to their wishes and needs. Harriet discussed this aspect of her experience as 'respecting my wishes'. Caroline wanted a certain kind of counselling ('brief

and non-intrusive') which was what she got. Anne-Marie said her experience in the private sector was better than in the NHS because it focused on what she wanted: 'it was more a service for me'. Natalie also discussed her positive experience of counselling in similar terms:

> I suppose....she gave me an opportunity to ask questions, raised any concerns I had. She explained things like I could change my mind, said I could discuss any concerns....She also explained about the procedure which was helpful. I found it useful, because the doctor....it would have mean....there was a feeling that you could ask questions. It was helpful in that way. It gave me an opportunity to bring anything up if I wanted to.

Again it is the relationship between counselling and the perceived needs of the interviewee which acts in these extracts to produce counselling as a positive experience. Natalie said she found the encounter useful because she could 'ask questions' and 'bring anything up if I wanted to'. The counsellor is construed as responsive to Natalie, rather than having her own agenda.

I suggest therefore that, while interviewees did deem abortion psychologically significant, in so far as they discussed counselling as an opportunity to talk about their feelings the dominant discourse in their accounts constructed the counselling they received as 'woman-centred' or 'client-centred' counselling. They construed the counsellor paying attention to 'what the women wants' as central to 'good' counselling. It was not simply a matter of talking about feelings.

(ii) Criticisms of counselling

Two interviewees, Amanda and Justine, talked of their meeting with a counsellor in negative terms. Amanda said:

> They had someone who was called a counsellor, but I wouldn't really say they were a counsellor. They just asked more or less did I know what I was doing, it was a five to ten minute conversation, it wasn't counselling really in any way shape or form. To me it seemed like a formality, something on paper, you see a counsellor because this is what we have to do. You've made your mind up, you seem to know what you want, sign the paper and on to the next stage. It wasn't counselling in the true sense of the word. At the time it just seemed to be a bit of a joke really, a bit of a waste of time, because it wasn't....there was no purpose to it. It was more or less you've

> made your mind up. I don't know if it would have been different if I'd gone in there and said 'well I'm not really sure'.

Later in the interview, Amanda explained that she needed a different kind of counselling than she received:

> I think I'd have liked there to be something else there. If anyone had been there and offered a way out of it I'd have taken it. If they'd said this is available to you, that's available to you. Although counselling isn't giving advice, if someone had asked the reasons why we'd come to that decision, and made it clear that there were things available, that we didn't have to go down that way we would have gone ahead with it....Even when people get older they are still quite naive to what is available. I'd never been brought up to think that you take money off the state. You work and you pay your way. So I think that was probably one of the reasons, it never crossed my mind that you could just go and ask for money.

This account of counselling centred on the notion that women are more ambivalent about choosing abortion than is often assumed, and that counselling should have a 'purpose' in relation to this ambivalence. On these grounds, Amanda experienced the counselling she received as inadequate. She discussed that what she wanted was a 'way out', and to have been told she could have accessed resources if she had a baby. In this respect, Amanda's approach to counselling resembled the argument for 'directive' counselling, characteristic of pro-life discourse.

Justine criticised the counsellor she saw on very different grounds: because she practiced 'basic psychology' in the counselling session. Because the counsellor's focus was on Justine's feelings about her relationship, and about having an abortion, Justine said the counsellor 'probed' and 'asked questions too much', which she found 'irritating' and 'insulting':

> Justine: The discussion with the counsellor was irritating, transparent. It was basic psychology she was driving at.
> *EL: What kind of things?*
> Justine: Going on and on about stable relationships.
> *EL: What do you think she wanted to find out?*
> Justine: Whether I was in a position to make the decision OK on my own. Well, she was trying to find out whether there was some other thing going on there, whether there was some dispute or....you just feel she was scanning for something, was I

> being pushed into having this abortion, do I really want to have the child but can't? All the usual sort of stuff really, about whether you've got the sort of support you need, whether I'd made up my mind.
> *EL: What did you think about her doing that?*
> Justine: It embarrassed me because it was so much going through the motions. It was so obvious, like trick questions that were not so trick. It just got on my nerves, because she was the last person on this planet I wanted to talk to. She really was a sort of basket-on-bicycle type. It was all a bit insulting really.

In other parts of her narrative, Justine contrasted her experience of counselling with what she would have found it helpful to talk about:

> *EL: Would you have wanted to talk to anyone?*
> Justine: If I really did have a problem, and I wanted to talk to somebody about it, I'd be more inclined to talk to a nurse.
> *EL: Why do you say that?*
> Justine: It has a sense of being more matter-of-fact, less....counsellors dramatise everything you say. You get the feeling they want to comment on everything, and actually you want to get the whole procedure over quickly.

Justine experienced a significant disparity between what she wanted, which was to 'get the procedure over with' and be 'matter-of-fact', with the approach of the counsellor. Caroline was also negative about her experience of counselling, but this was where she had seen a counsellor privately, rather than at the abortion service:

> I've only ever twice actually paid privately to go and see a counsellor, and both times I've been very disappointed. I've just found that the people I've seen....absolutely daft. It really disappointed me so much. What I wanted was to talk to somebody really intelligent, who can listen to what I'm saying, and not say really absurd things. They suggested to me unbelievably silly unconscious motivations, that I just couldn't accept.

Again Caroline construed what could be positive about counselling as 'client-centred'. She wanted someone who would 'listen to what I'm saying' rather than second-guess her motivations and say things to her that she couldn't accept.

(ii) Who needs counselling?

Some interviewees also discussed abortion counselling generally, rather than their own experience of it. Harriet and Angela talked about their views on the need for counselling before abortion, and both emphasised that different women have different needs:

> Harriet: I would think it very remiss of an organisation that didn't do a thorough counselling job.
>
> *EL: What makes you think it should be there?*
>
> Harriet: I think that you....within an organisation like that, or wherever you go, you are going to get people that are more or less self-aware, more or less aware of options more or less decided. You're bound to get a spectrum, with all the different ages. The women who were early 50s and caught out by menopause, were probably extremely clear in their minds, which isn't to say they didn't have emotions, or moral issues running round in their heads, but there were probably clear that for their bodies, themselves and their families, it was the only option. I would imagine there are a large number of people who go in and are not clear about it, and they need to have those questions asked of them. My feeling would be that if you went along and your view was, which would be a fair enough view, that this is what I want, and I don't want anybody challenging me, that they would probably pick that up and go with it. But I think they have a kind of moral responsibility to ensure that as far as possible, you end up making the right decision for you at the time.

> Angela: I would have thought counsellors are there for women who are unsure whether to go through with an abortion or not. I would have thought if you've made up your mind, then they don't play any role. If a woman is not sure about her social circumstances, or wants to talk about adoption, or doesn't know, then they can talk to somebody. But otherwise women don't need it.

Harriet said that counselling was of great importance as part of an abortion service. She made this case by distinguishing between women who were very clear about their decision, and those who were not. She construed the latter group as large in number, and as made up of women who 'need to have those questions asked of them'.

Angela also made a distinction between women who had 'made up their mind' and those who were 'unsure', but unlike Harriet, she said that where a woman has made up her mind counselling has 'no role' and women 'don't need it'. Her contrast between women who were 'sure' and those who were not constructed counselling as unnecessary for some women, rather than as generally necessary.

Post-abortion counselling

Two interviewees, Caroline and Emily, talked briefly about counselling after abortion. Neither had sought post-abortion counselling, but both said they thought they might have benefited from it:

> Caroline: What I really would have liked, and definitely needed, was some sort of post-abortion counselling. I really, really needed to talk to someone afterwards, because I was absolutely shattered about Ben, and then obviously pretty traumatised by the whole experience as well.

> Emily: I suppose....I just....I think maybe they could have said come back in two weeks to have your post-operative check, and a chat. Rather than go in there, have this doctor examine me, say how are you, I say I'm finding it really difficult, and it's 'Well you know, horrible thing abortion' and that was it. I think it would have been nice to have seen the doctor, and then gone to see someone else, and I probably would have talked to someone at that time. I think I would have had to say to the doctor, 'I'm feeling really terrible, can I have some counselling please', and I'm not about to do that. So I just think it should have been like that.
> *EL: What would you have like to have talked about?*
> Emily: Just run of mill things, that everybody experiences, that I know now are just normal things to experience, but at the time I just thought things were closing in on me. Things were going wrong. But it's just normal to feel like that.

For Caroline, it was the 'neutrality' of the counsellor (as compared to friends) that was key to her construction of the benefits of counselling after abortion. This claim for counselling was evident in the counsellors' narratives I discussed in Chapter 6. Emily said that she needed to know that her experiences 'are just normal things to experience'. This perhaps corresponds with the case made by counsellors I interviewed that after abortion women are mainly seeking what they termed 'reassurance' when they return for counselling. It was notable that needing to deal with 'loss' after abortion was not mentioned by any of my interviewees, although it was referred to by several counsellors I interviewed.

In considering these extracts as a whole, it is striking that criticism of counselling was infrequent. While the sample of women I interviewed is too small to sustain any major conclusions about the reasons for the absence of criticism, I suggest that this perhaps reflected the 'client-centred' counselling that these women received in the charitable abortion services they attended. The ethos of 'client-centredness' has arguably acted to diminish the

extent to which assumptions are made by counsellors about women's feelings regarding abortion, and has placed the onus on counsellors to interact with women in relation to what women say they want to know or talk about. I now turn to interviewees' accounts of their experience of abortion where they talked of their feelings.

**Trauma**

In the first half of this thesis, I discussed ways in which abortion has been construed 'traumatic' in abortion discourse. I now consider instances where interviewees talked about their experience of abortion in these terms. Two interviewees, Caroline and Amanda did so and in my account of their narratives, I draw attention to how they describe and conceptualise trauma, and the relationship between their comments, and the constructions of trauma discussed previously.

Reason and emotion

The common theme running through Caroline's narrative was a contrast between reason and emotion. Near the start of the interview she said her experience of abortion:

> ...was very traumatic. Deciding was traumatic emotionally because of my relationship, and then subsequently, it was traumatic because yes, there was a real feeling of loss. And while rationally I knew I couldn't have that child, there was a real feeling of loss.

While Caroline did not give an explicit definition of what she meant when she described her experience of abortion as 'traumatic', she raised the main theme that ran through her interview, the tension between what she knew 'rationally' and her 'feelings of loss'. She used the term 'traumatic' in relation to such feelings, which she said she felt both about her relationship, which eventually ended after her abortion, and about the abortion itself, which she saw entailed the loss of 'a child'.

The tension between what could be reasoned about, and the emotion experienced was constructed in different ways. In some of her comments Caroline said her feelings could be 'rationalised', because they could be explained as a result of the circumstances which led to the abortion decision. The very reasons which explained why Caroline 'couldn't have a child' also accounted for her 'feelings of loss'. In her comments about her relationship for example, Caroline explained that her feelings resulted from the circumstances surrounding the abortion. Central to these circumstances was her relationship (with a man already in a long-

term relationship, which Caroline described as 'marriage'), and the fact that she wanted to have a child:

> ...I was really traumatised by the fact that the relationship wasn't going to work out, and that he wasn't willing to commit to the child.
>
> I do actually think about it a lot. Mostly because I was very ambivalent when I did it anyway. I actually would have liked to have had the child, but couldn't anyway, mostly because the father was absolutely not into it.
>
> A lot of it was the circumstance. I really was in love with this man. I really wanted to have a child. I wanted to have a child anyway. I was 34, really starting to want to have children. Which was a completely new experience for me, because I've always been totally obsessed with my career.

Here, the 'trauma' of abortion was construed as a consequence of Caroline's strong desire to have a child, and the fact that her partner did not want to 'commit' himself. In addition, Caroline constructed a relationship between her feelings and her religious background:

> And it has to be noted, I was a Catholic, I was brought up a Catholic, in an extremely strong Catholic family, so you can't leave that stuff out. Of course it affects me very strongly, and my mother for a time was an extremely strong anti-abortion activist. So, not any more actually, now she's all pro-choice, which is a totally amazing thing. She's still very Catholic.

At certain points, she constructed her feelings and explanation for the decision to have an abortion as in clear conflict with each other. For example she said: 'I certainly....I can rationalise the experience, I can, but I still can't leave out my feelings'. She discussed her feelings as a part of the abortion experience which existed in separation from what could be reasoned about. They were however of great importance as part of Caroline's experience, and were something she could not 'leave out'. This aspect of Caroline's account also emerged in her discussion of the conflict between her political views and her feelings.

Feelings and political conviction

In talking about the difficulty of reconciling her beliefs and political convictions about abortion with her emotions Caroline constructed her rational pro-choice commitment as at odds with feelings of shame about having had an abortion:

> I certainly haven't talked about it this much before. Nor have I ever told anybody that I am ashamed of it, which I am I guess. I wish I wasn't. Politically it's totally unacceptable to be ashamed of it. But I think that must be part of it. Rationally I'm not ashamed of it.
>
> I'm sure guilt is part of it. But that's what I mean by bad karma. It's more than that. It's....you know I am 100 per cent pro choice....But at the same time I think there is just something really dreadful about the experience and about what's going on. I'm afraid I just can't kind of rationalise it, and flush it out. So it's not just guilt. It's just this feeling that it was something wrong, that it was a bad thing to do. It goes against....life I suppose. I'm not anti-abortion. I'm very pro-choice. It's just....it's just a very bad thing that stays with you I think.

The description of what was beyond reason as 'bad karma' occurred at several points in Caroline's narrative, as she tried to explain what it was about her experience of abortion that she found so negative. She also talked about trauma in terms of nightmares and the unconscious.

Nightmares and the unconscious

Caroline expanded on her description of abortion as 'bad karma' where she said:

> ...this is going to sound really ridiculous....abortion is bad karma! I know it sounds silly, but it doesn't go away. So I've had nightmares about it, recurring...recurring.

In discussing her nightmares, Caroline discussed that she thought 'bad karma' resulted from the effect of her 'subconscious':

> *EL: Were you surprised about these dreams, when they started happening?*
> Caroline: Yes, I was. I do have vivid dreams, but I was surprised at how obvious they were.
> *EL: What, so obviously connected to the abortion?*
> Caroline: Yes. But that my subconscious was telling me that I was unable to care for a child, or properly deal with a child. It was so obvious, as if my subconscious was rehearsing everything that was happening in real life anyway.

Caroline's explanation of what had made abortion 'bad karma', and what she meant when she said abortion was 'traumatic' relied on an explanation which directly, where she referred to her nightmares, and also indirectly constructed the unconscious (or 'subconscious') as significant in her experience of abortion. Recounting one of her nightmares she said:

> Often it would be for some reason a dream about twins, and one would die, always through my neglect. One would drown, or I'd put one in a drawer (laughs) and then forget about it. Awful things! Or I wouldn't have enough milk to feed them both, and one would die. Very specifically twins, twin boys. Weird. But not always about twins, sometimes there would be one baby. But always about babies. At least the ones I associate with the abortion. So like having one baby, and not knowing how to care for it, and putting it in a shoe box, and then realising days later that I'd put it in a shoe box. Awful stuff like that. Horrible.
>
> Actually it wasn't always about babies, come to think about it, because there were dreams about breastfeeding as well. Or blood coming out of my breasts. Ugh! I'm sure this is the weirdest interview! Horrible dreams!....I still occasionally have these weird dreams about not being capable of caring for a child, but nothing like before.

Grief and loss

Amanda also talked about her experience of abortion in terms of trauma, but, unlike Caroline, she described it specifically in terms associated with Post Abortion Syndrome. As I discussed in Chapters 4 and 8 this construction of the psychological effects of abortion includes an argument for the 'right to grieve' after abortion, and construes negative feelings following abortion as the product of the 'loss of a child' involving emphasis on the 'humanity of the fetus'. These constructions are all evident in Amanda's account.

She had two abortions. The first was when she was 16. Near the start of the interview she explained how she was '...forced into it' and that it '...wasn't anything of my own choosing at all'. Amanda said she and her boyfriend wanted to have a baby, but that she was 'frog-marched' to the doctor by her mother, who then with the doctor decided that she should have an abortion. She said of her second abortion, two years later, that it was '...quite different in the way I felt'. She added: 'It was really odd, because that was almost like a cold, clinical decision....it seemed easier that time'. She discussed how, with her second abortion:

> I was very happy with the person I was with but we had nowhere to live, didn't have an income, so it was very cold and clinical. I can almost justify it myself....I discussed

> it with my partner, we were living in rented accommodation and had to pay the rent, it was looking at it from that point of view.

A recurrent theme in Amanda's account was the problem of the way society responds to abortion which she characterised in terms of its lack of understanding of the emotional effect of abortion, evident in the lack of formal arrangements or customs, such as a funeral, to mark the loss involved:

> It's socially unacceptable to talk to people, because there's not the understanding that it hurts. You have lost someone. To me it was a life, and I needed to grieve.
>
> It's hard to separate them. The hurt, feeling lonely, the fact you can't talk to anyone. It's not like when someone dies, you have a funeral and things happen, whereas when you have a termination there's nothing. People think you have an abortion and you just forget about it, but to me it certainly wasn't like that. It's a thought that that child would have been so old now, what it might have been doing.
>
> The only way I can describe it looking back on it now, it's like a bereavement. Trouble is you can't really talk to people.

Amanda emphasised not simply the negative psychological effects of abortion, but the lack of recognition of these effects. Amanda constructed this problem through emphasising the humanity of the fetus. In the above extracts, Amanda needed to talk because she had 'lost someone. To me it was a life'. She said it was like 'bereavement', and the lack of a funeral was notable because it suggested that it was not as if 'someone' had died. Amanda also emphasised the humanity of the fetus in other ways:

> You're never going to hold them. It's your hopes and dreams. Although it may not have happened in ideal circumstances, your dreams for what you want, things that you do together. You think about the things you'd do together, you'd talk to them. The pain is the immediate thing. It's such a deep ache, it's almost indescribable. To me it's a baby, it's a living baby. The thoughts are of the baby being small, I see others and think it would have been such and such an age, but I still generally think of it as a baby.
>
> Even then I didn't really understand like I do now, how much developed the baby is, that never came into it. Years later when I started to think about it, I thought what is

> happening at various stages in pregnancy, and how developed is the baby? That's when it really came home to me. It's so many weeks, and the heart's beating.

Amanda talked about her first abortion as traumatic and in doing so emphasised the age of the fetus. When she did so, she contrasted her extremely negative psychological response she experienced the first time with her second abortion:

> I don't particularly think about how old it would have been. My tendency is to think of the first one. Most probably, because it was so much more traumatic it stands out more in my memory. I knew the date it would have been delivered, that sort of thing.

This emphasis on the fetus and it's age was absent in her account of her second abortion, and only emerged when I asked specifically about it:

> *EL: Do you think of the second one as a baby?*
> Amanda: No, not at all. I don't know why, but I don't....it just doesn't happen the same at all.
>
> I felt sad about it in some ways, I felt a bit guilty but I didn't feel angry. Those feelings weren't anywhere near as strong, and they certainly didn't last. Now it's just like a blur, almost like it happened to someone else. Then again I think, I've just had so many bereavements and things that have happened. It's one of many things that have happened but it's almost....maybe the reason it was different was although we felt pushed by circumstances, we came to that decision ourselves, whereas before I wasn't allowed to come to any decision by myself. It was forced upon me. That made quite a difference. The only things I could have got angry with were things beyond my control, that I couldn't do anything about.

In her explanation of the difference between her second and first abortion, Amanda utilised a pro-choice discourse, where emphasis was placed on the importance of the woman making the abortion decision for herself. Amanda connected the absence of negative feelings to coming to the 'decision by myself'.

**Regret**

Harriet also talked of experiencing negative emotions after abortion, but did not use the term 'traumatic' to describe her experience. Rather, she talked about regret. In her narrative, she consistently emphasised that, looking back on her abortion, she had come to wish she

had decided to continue the pregnancy. Like Caroline she contrasted her feelings with her reasons for having an abortion:

> Harriet: I was terribly relieved it was all over and terribly relieved I could go back to my relatively tranquil existence. And I didn't have any really remorseful feelings about it for quite a long time.
> *EL: So did you later on?*
> Harriet: Yes. I now totally regret it. I still think my rational, intellectual side, my rational side says it was right at the time, therefore you can't be saying it was right at the time, but now it is wrong, well you know for obvious reasons, so you know I did what was right at the time.

The balancing act between her feelings of regret, and her reasons for having the abortion featured throughout her narrative. In the following extract she explained her feelings by listing the reasons which gave rise to them. These included tracing her natural mother:

> I think I have the regrets because of (a) my age and I don't think I'm ever likely to have a child now, (b) because I think I would have been a good mother (c) because I see it as an experience I've missed out on. And (d) because after I'd lost the child through IVF, I decided to trace my natural mother who I subsequently found. So I now have in my head two families, I have my natural family and my adoptive family, and I now have a very strong, and it's partly a romantic notion I know, a very strong desire to carry on my natural hereditary line. I want there to be someone who comes after me because I would like there to be a reflection of me in that person, as I now have the reflection of me in my mother, and grandmother. So if you like it's another issue that's come into the scenario and altered my perception of the scenario.

It was this experience, not the abortion itself, which Harriet said caused her feelings of regret. She described meeting her biological mother as leading her to consider her abortion as a 'cop-out':

> Harriet: When I met my mother, which was obviously highly emotional, I told my mother about it, and she told me I was a complete accident. I didn't mind her telling me that, it didn't hurt because it wasn't that she didn't want me, just a baby. But I had to feel a lot of admiration for her, for her generation, and that I had a cop-out, that was simply a fact of technology and changing moral codes.
> *EL: When you use the word cop-out to describe your own....*

> Harriet: I don't feel I should have made myself go through with it. But I feel almost guilty that her life was fucked up for quite a while by the trauma of the way she was treated by her family and society I suppose. And by comparison I was able to just deal with it. Balanced against that is the fact that she now has me and I have her, which is a double edged sword. So it's a cop-out in a sense that I didn't have to go through her suffering, but it's a loss. It's appalling what women had to go through. The stories are just appalling. But for those women who have had a positive experience of reunion, many would I now know say they were glad, it was worth it and they were glad they didn't have the option of abortion.

Harriet's experience of regretting her abortion had led her to think about the difference between her circumstances, and those of her mother. Her commentary is not confined to a discussion of her personal experience however. It moved between this and a discussion of women's experience more generally. For example she talked of admiration for her mother, and also 'her generation', and of her own experience compared to 'what women had to go through' in the past, who are 'glad they didn't have the option of abortion'.

A dominant feature of Harriet's assessment of the extent to which the availability of legal abortion has proved advantageous to women is her use of a psychological vocabulary. She assessed the difference between her experience, and that of a previous generation in terms of their experience of 'trauma' and 'suffering' against hers of feeling guilt and loss. Of the discourses discussed in previous chapters, this aspect of Harriet's account included features which have most in common with the discourse of Post-Abortion Syndrome. While many of the dominant features of this discourse are not evident in Harriet's account, the problematisation of the availability of legal abortion in terms of its psychological effects is.

**Minimising negative feelings**

I want finally to discuss instances where interviewees talked about their lack of negative feelings about abortion. They did so quite frequently, and in my discussion of this aspect of their narratives, I draw attention to the relationship between discourses which psychologise abortion and the ways in which interviewees talked about their experience of abortion.

No regrets

As I discussed previously, Harriet talked about regretting her abortion. 'Regret' also featured in interviewees' accounts in a different way, where interviewees talked about their lack of feelings of regret, in order to emphasise that abortion was the 'right' decision. In these

instances, a psychological vocabulary was used to discuss the experience of abortion, but its meaning was reversed, and acted to construct a positive account of the abortion decision.

Justine described how she had 'tested' herself to see if she could make herself feel guilty about her abortion, but since she could not, she concluded it was the right decision:

> *EL: Have you thought about the abortion since?*
> Justine: Well I wouldn't have thought about it except for the fact....I've tested it out on myself in relation to an idea that I know can happen, if you want to get pregnant and you found out that you couldn't....I didn't think about it and spontaneously feel emotion about that, I just tested the idea on myself, whether I could make myself feel guilty, and overwhelmingly, four years ago I was so obviously different. I don't have any regrets. It would so obviously have been such a stupid thing to do then, have a baby. Because what's important is what you want at the time, and at the time it wasn't an emotional wrench at all.

Anne-Marie also made it clear that having an abortion is something she did not regret at all:

> ...looking back on it, Jesus, he's still doing what he was doing now, he hasn't even got a stable job, and....I mean it would have been possible, but it was my choice, and it was a choice I've no regrets about making....I look back now, and think I made the right decision, even though it was a hard decision to make. It was definitely the right decision

> ...I just think both times, that was the right decision for me. I'm not saying it would be for everyone, but for me....I can't possibly say whether it's right or wrong, but I just did what's right for me. And although there's a part of me that feels a little bit guilty because of what you hear people saying, that it's this or it's that, it wasn't wrong for me, and I don't regret it one bit.

The striking aspect of Anne-Marie's comments is the correlation between the definition between abortion as 'right' and the absence of feelings of regret. It is, in this construction, the emotional effect of abortion which was made central to the judgement as to whether the abortion decision was justified. Her abortion could be judged 'right' because it was 'right for me' since the decision was not regretted. However, any broader moral judgement about 'whether it's right or wrong' was a different matter altogether, which Anne-Marie suggested she 'can't possibly' comment on. Here, psychologising discourse acted to individualise the

abortion choice. It was a choice which could not be judged according to general, moral criteria, only against the criteria set by the individual woman who makes the choice.

Angela also explained that she had 'no regrets' in order to make it clear that abortion was the right choice. This time, it was an account of her circumstances which explained why having an abortion was something she did not regret:

> *EL: Anything else since the abortion?*
> Angela: I still read in the papers about women getting pregnant and having abortions left, right and centre, and I get angry because it's not that simple, but I've got no regrets, not at all. I know now that carrying on with University, the financial strain, I've had to work all the time, so there's no way I could have managed it. I know, the more the years have gone on, I could not have done it if I'd had a child. My first reactions were the right ones....As far as I'm concerned, it was a sad day it happened, but I could not go through with it. It was the best option I had. It would have been absolutely disastrous if I'd had a child.

In these instances, interviewees utilised the terms of discourses which psychologise abortion, but reversed them in order to emphasise the 'rightness' of their choice to have an abortion. In other instances, they drew attention to their lack of negative feelings by talking negatively about instances where other people had made it clear they considered abortion to be psychologically damaging.

Resisting psychologising discourses

Natalie emphasised her lack of negative feelings about abortion where she discussed a colleague's response to her decision to have an abortion:

> It was strange because as I said the woman I lived with guessed....She was quite, fairly straightforward, but immediately 'How do you feel about this?', expecting some emotional aspect from me that I didn't feel, which was strange. I guess that was why I didn't want to tell anyone really, in case I got that response. With her it was there, though in a way....she was saying did I really want to come back on Monday, if I was feeling upset, just call her. But I wanted to come back to work, and....I was pretty sorted in my own head. But there was a feeling of indiscreetness, that you're not feeling guilty about it, or you're somehow being flippant because it was almost black and white for me. It's not like you're not aware of those issues about the potential of life, but at that time, I didn't want a child....People were....I got the feeling it would be a big issue for people and they would want to discuss it like that, and....In a way the

> actual issues about it and my thoughts about it weren't things I would discuss with other people who didn't know about it. It is difficult to discuss with someone you don't know. It's complex and difficult, and too subtle for that.

The assumption on the part of Natalie's colleague, that she would have negative feelings about the decision to have an abortion, was construed as at odds with her own experience. She also suggested that an assumption that she would feel bad was shared by people other than her colleague, who thought of abortion as a 'big issue'. In the following extract Natalie drew attention to the way such assumptions made her feel:

> A friend of my boyfriend was here when I came back after it, and we went to the pub, and it took me ages to tell him, and then when I did I felt really indiscreet. Especially, this is a friend whose wife is now pregnant, and they were thinking about kids at that stage. So it was funny, with someone who is in that position, or a very different position, and I felt I wasn't being remorseful enough, or guilty. I don't know why, it was a strange feeling to have.

Natalie's description of feeling that she wasn't 'remorseful' or 'guilty' enough has been noted in other accounts where women have spoken of 'feeling guilty for not feeling guilty' (Brien and Fairbairn 1996; Stotland 1999; Klein and Kaufmann 1992). Natalie's description of her feelings of discomfort about the absence of guilt or remorse as 'strange' suggested she was confronted by a situation she had not expected to experience. Her inability to talk freely and openly about having had an abortion was something she found disconcerting and hard to explain.

Anne-Marie also talked about being psychologically untroubled by abortion, through a comparison between herself and the attitudes of others, this time of women she knew who had had abortions:

> Anne-Marie: You know, there have been occasions when I've had a little cry when someone else has had an abortion. But I'm not like....you know some people know the age that their child would be. That wouldn't even occur to me to think like that! Somebody asked me the other day if I knew. She said how old would your baby have been? I've got no idea. I don't even know how old I was, never mind how old the baby would be. That seems like unbelievable torture to put yourself through. I don't know how people do that to themselves....it just seems a really unnecessary thing to put yourself through. If that's the decision you've made, and that's a decision you're happy to have made. Happy, that's the wrong word, but one you've made

knowing that it's probably the best thing for you, then what's the point in dragging it up every year on the abortion day, or 'Oh he would have been such a year'. I just think that's a crazy thing to do.

*EL: So with people you've spoken to, that's come up in conversation?*

Anne-Marie: Yes, yes. I find that very distressing, if that's what they do. I think it's guilt. They haven't as much said it's guilt, but perhaps they are people who haven't felt comfortable with the fact that they are killing something. And so it's almost like to make themselves feel eternally guilty, or remember what they've done forever, they remind themselves that it could have been a person. But why? Why do that? I don't know, you'd have to ask them why, I've never, ever done that. I can't imagine it. Very odd....I suppose if you wanted to grieve, and you've got something to grieve over, that's fine. But not for twenty years, or fifteen years, that's a bad thing. That strikes me as someone who's made the wrong decision.

Anne-Marie made it clear that dwelling on a past abortion harmed women who did so: 'it is ....unbelievable torture'; that she could not in any sense identify with women who did this: 'why do they do that?'; and that such 'torture' was essentially self-inflicted and so could be avoided: they 'make themselves' feel guilty.

A key feature of her narrative was the notion that feelings following abortion could be controlled. This is exemplified in her description of thinking about how old a baby would be as torture 'to put yourself through'; something 'people do to themselves'; an 'unnecessary thing to put yourself through'; and a 'crazy thing to do'. She thus construed a woman 'traumatised' after abortion as having chosen to respond emotionally to abortion in this way. Anne-Marie's narrative differed in this way from Natalie's. The latter discussed instances where other people had psychologised abortion, while Anne-Marie construed it an internal process, which the woman could choose to do, or should more wisely avoid.

**Conclusions**

In this chapter I have illustrated that some disparity exists between the discourses I discussed in previous chapters and the narratives of the women I interviewed who had had abortions. I hypothesised that psychologising discourses would significantly influence their accounts of their experience, and they would discuss that experience in terms of 'trauma', or make reference to other negative emotions. Three interviewees (Caroline, Amanda and Harriet) did make their experience of negative emotions central to their narratives. However, other themes emerged too, in the both narratives of these interviewees, and in those of other interviewees.

Discussion of the reasons for requesting abortion was common to all accounts. My interviewees' experience of contraceptive failure or non-use, and their relationship with their partner at the time of the abortion request, were the dominant themes. Counselling was discussed by all interviewees, but it was not prioritised in their accounts. Further, their positive experience of counselling was constructed in terms of its 'client-centred approach', rather than in terms of its focus on negative feelings and trauma. Some interviewees also expressed resistance to psychologising discourses, either by reversing the terms of the discourse, where they talked about not regretting abortion, or by making clear their disagreements with those who construe abortion as psychologically damaging.

In the final chapter which follows, I summarise my theoretical findings and the results of my interview studies overall. I discuss some issues raised by the set of interviews discussed in this chapter, and those with abortion counsellors, and discuss briefly the implications of my findings for future research.

# Chapter 10: CONCLUSIONS

In this chapter I first summarise the preceding chapters, before reflecting on my findings, and finally discussing briefly their implications for future research.

**Psychologising abortion: a summary**

I began this thesis with an account of the recent debate about 'lunchtime' abortion. I argued that a notable feature of this debate was the tendency for commentators to construe abortion as psychologically damaging, and even as traumatic. I contended it was striking that the objection put forward to an abortion service which aimed to make abortion a simple, quick procedure was not framed in terms of concern for the fetus, but in terms of women's psychological well-being. Specifically it was claimed that counselling was an essential part of abortion services, if such services were to meet women's needs.

Taking this debate as my starting point, I argued for a sociological approach to examining the claim that abortion is psychologically damaging and that women therefore require counselling when they terminate pregnancies. I made this case on the grounds that a sociological approach can provide a framework to explain the disparity between data regarding the psychological ill-effects of abortion and the public debate about it.

Available evidence suggests that abortion does not damage women psychologically. Where negative psychological effects of pregnancy have been measured, childbirth has been shown to represent a greater threat to women's mental health than abortion. Nonetheless, it seems that regardless of the evidence, abortion is construed, in public debate, as a psychologically damaging experience. In order to explain this disparity I have argued that an approach which interrogates the social construction of abortion is needed. Specifically, I have made the case for an analysis of the relationship between psychology and abortion which draws on the work of feminist social scientists, influenced by the work of Michel Foucault.

This involves analysing psychology (and psychiatry) not simply as a science which measures and assesses mental states in an objective way, but as a discourses, which acts to construct objects and subjects. This constructive role of psychology is not made apparent, but rather is hidden, through the use made by psychologists of methods of research and analysis adopted from the natural sciences. Psychologists have, for example, been concerned to utilise methods in their research which standardise research, use control groups, and adopt accepted, tested research methods.

While this approach has produced a large amount of data that can be taken as an accurate measure of the numbers of women who experience certain, specified feelings after abortion, the claim that psychology and its findings are neutral and objective is questionable.

Psychology, like other components of bio-power, first relies on certain values and assumptions about its research objects, and second through its research, plays a powerful role in constructing them. I have argued, following Boyle, that psychological research into abortion includes the unstated assumption that mental states exist as a facet of the make up of individual women, which can be measured and assessed. On this basis, a representation of the totality of the psychological effects of abortion for women as a whole can, once sufficient research has been carried out, be put forward.

The unstated assumption here is that emotions and feelings after abortion exist as a measurable, definable, objective phenomenon, present in individual women. As a result, the tendency in psychology is to separate emotions from the social context of abortion, and to treat them as if they can be studied and measured, in a similar way to the effects of abortion on physical health. The 'psychological effects of abortion' have thereby been placed on an equal footing with 'the physical effects of abortion'. As Foucault (and Boyle) has pointed out, however, the notion that the mind and the body can be investigated and researched using similar methods, is mistaken. The effect of an abortion procedure on the latter can be considered a medical question, which is best investigated using methods developed in medical science. The relationship between abortion, and a women's feelings about it is, in contrast, a highly socialised one. As a result, methods which fail to place the issue of social context at the centre of their approach, may be unable to contextualise abortion in a sufficiently rich way.

A second striking assumption of research into the psychological effects of abortion is that it has focused primarily on the *negative* psychological effects. Even if research finds time and again that such effects are not widespread, the formulation of the 'research problem' in relation to negative feelings is highly significant. Where research agendas are formulated in terms of a focus on post-abortion feelings of regret, guilt, loss, and depression after abortion, the implication is inevitably that abortion may be psychologically damaging for the women involved.

Psychology's contribution to the construction of abortion has thus been contradictory. On the one hand its findings have provided extensive evidence that abortion does not harm women's minds. On the other hand it has played a significant role in the construction of an agenda which focuses predominantly on negative emotions following abortion. Despite its claim to objectivity, psychology has thereby acted powerfully to determining the terms of the public debate about abortion. In Chapters 3, 4 and 5, I examined how this has been the case in parliamentary and extra-parliamentary debates about abortion.

In my discussion of the parliamentary debate, my main contention, made through reference to the work of feminist scholars Sally Sheldon and Mary Boyle, concerned the 'medicalisation' of abortion in Britain. I also discussed how the emphasis placed on the

possible psychological ill-effects of abortion for women was developed after 1967. I explained how this took place, through an analysis of the Lane Report, in which it was argued that the decision whether or not a woman could legally have an abortion should rest with doctors, not with the patient, to ensure that the psychological difficulties associated with choosing abortion could be fully dealt with. The Lane Report also made the case for counselling women regarding their request to have an abortion. This was presented as part of the project of providing 'holistic' medicine, aimed at treating the patient's mind as well as her body. I returned to the issue of abortion counselling in Chapter 5, in considering arguments made by supporters of legal abortion.

In considering the debate about abortion law, I also noted that, while in 1967 those opposed to abortion made their case on the grounds that abortion was immoral or unnatural, in 1990 opponents of abortion framed their arguments additionally in terms of medical knowledge and women's health. These arguments included the claim that abortion was bad for women's mental health, specifically that it could lead to a form of psychiatric illness, called Post-Abortion Syndrome (PAS). I described and discussed PAS in Chapter 4, in relation to the social factors contributing to the 'invention' of the psychiatric diagnostic category Post-traumatic Stress Disorder (PTSD).

In Chapter 5, I went on to discuss the response to PAS from pro-choice campaigners - that is from those supporting women's right to choose whether or not to have an abortion. I also discussed other arguments, emanating from those who considered themselves pro-choice, that abortion could have psychological ill-effects, and that women choosing abortion therefore required counselling. I also discussed the fact that other supporters of women's choice in abortion had refuted the claim that most women needed counselling in abortion. They claimed in contrast that the psychological ill-effects of abortion were not sufficient to warrant counselling in most cases and that counselling could make the experience of abortion more psychologically difficult than it need be.

My overall resulting hypothesis was that discourses which psychologise abortion would be reflected in counsellors' accounts of their work in counselling women regarding abortion, and in accounts given by women who have had an abortion of their experience. I presented my analysis in Chapters 7, 8 and 9 of data gained from interviews with abortion counsellors and with women who have had an abortion, which I collected to test this hypothesis. As my discussion of the data in these chapters illustrates, I found there to be a more complex relationship that I had predicted between psychologising discourses, and the both practice of counselling and the experience of abortion, as I will now discuss in more detail.

**Post-Abortion Syndrome and 'Pro-Life' Discourse**

I first discuss the construction of abortion as 'trauma' and in particular the claim that 'Post-Abortion Syndrome' can result from termination of pregnancy. What was striking in considering my interview data as a whole, was that key components of this claim about abortion (that abortion has severe psychological consequences; that women deny the trauma of abortion; and that women should be considered victims of abortion, who would if possible choose to continue pregnancies to term), were not reflected in the narratives of most of my interviewees. Most of those I interviewed did not describe abortion as a traumatic experience, or discuss the psychological effects of abortion in terms associated with the PAS claim. In the next section of this chapter, I offer some explanations as to why this was the case, where I discuss the limited influence of the arguments made by those who have advocated the PAS 'diagnosis', in the abortion debate in the U.S. and Britain. First however, I will make some concluding observations about cases where interviewees did talk about abortion in terms of PAS.

Some of the vocabulary associated with the PAS claim was evident, albeit in an inconsistent way, in the descriptions given of their experience of abortion by women I interviewed who have had an abortion. I discuss this aspect of my interview data later in this chapter. The psychological effects of abortion were talked about explicitly and consistently in the terms of PAS by 'pro-life' counsellors only. In relation to the PAS claim, these interviewees' narratives were therefore clearly distinguishable from the others. On the basis of the data from my interviews with pro-life counsellors, what observations can be made about the construction of abortion in current 'pro-life' discourse?

One striking aspect of pro-life counsellors' narratives was the absence of religious language. As I noted at a previous point in this thesis, one of the dominant ways in which those opposed to abortion have justified their viewpoint, has been in religious terms. Abortion has been construed wrong because, it has been claimed, God said this is the case. It was undoubtedly the case that the organisations which counsellors I interviewed belonged to, had roots in established churches (the name of one of the organisations included the word 'Christian'; the venues I visited, where some of the counsellors I interviewed worked, were churches; there were often religious pictures or icons in counsellors' offices). However counsellors did not situate their explanations of why they counselled women, or why they thought women needed counselling, in religious terms. Abortion was not constructed as a problem in their narratives on the grounds that it was morally wrong, because it went against religious imperatives. The problems that counsellors claimed women experienced after abortion were not construed as a consequence of women behaving in a sinful way, which had resulted in them being punished by God. Rather, abortion was problematised on the

grounds that individual women found it psychologically difficult, for a range of reasons that were not explicitly related in these counsellors' narratives, to sinful behaviour.

There was in fact only one instance where an argument was made by a pro-life counsellor about the existence of some form of external authority, against which a woman's actions in having an abortion might be judged. This was where Jane used the metaphor of a law court, and discussed the effects of counselling after abortion in terms of allowing the woman to be 'convicted' and 'sentenced' for the 'wrong' the woman perceived she had done. This example could be considered as an equivalent to a religiously based argument about the reasons why a woman might need counselling after abortion, in that Jane did make the case that a source of authority external to the individual was needed, in order for people to find a way of accounting for their actions.

She argued that, in the case of women who have aborted a pregnancy, only in accounting for their actions to an external authority, could women overcome and deal with their emotional difficulties resulting from abortion. In this respect, her construction of the mandate for counselling is akin to that of religious confession. However, it is significant that even in this instance, the source of external authority was presented as the law court - the epitome of secular, rather than religious authority. Where religious language was absent, other forms of language, not primarily associated with the anti-abortion movement, were present. Psychologised and 'woman centred' language was present, and counselling was construed as information provision.

Pro-life counsellors' narratives were littered with psychological terms. In many instances, the terms they used were characteristic of diagnostic criteria for PTSD and/or PAS. Interviewees talked of post-traumatic stress and post-abortion stress, trauma, psychological disturbances, repression, denial, anniversary reactions, survivor guilt, and the diversity of syndrome symptoms. Counselling was commonly justified on the grounds that it could help women deal with their 'symptoms' of 'post-abortion trauma' or 'Post-Abortion Syndrome'.

Counsellors also justified their role in offering women counselling in 'pro-woman' terms. They framed their role as normalising women's experiences, raising women's self-esteem, providing women with rights (the right to grieve and to have their experiences recognised by others as problematic). Counselling was also described as information provision. Counsellors discussed their role as providing women with facts, with information, as facilitating informed choice (but not giving advice or direction), and as helping women make their own decision.

The presence of this kinds of language in the narratives of pro-life counsellors is an interesting phenomenon, in that poses questions about the ways in which the pro-life movement is modifying and re-formulating its arguments, and why it is doing so. Why were these counsellors' arguments not framed in the language of religion? Why have other forms

of language been adopted? How widespread geographically and culturally is this phenomenon? Is it restricted to the case made against abortion by British abortion opponents? And is it apparent in arguments made in all forms of activity, for example in Parliamentary lobbying, contact with journalists or meetings, as well as where anti-abortion organisations are involved in providing counselling? Whilst I have commented in earlier chapters on some possible explanations for the development of the PAS diagnosis in pro-life discourse, these are questions which are substantively unanswered at present, and which I hope to address in future research.

**Explaining the limited influence of PAS**

I will now however address a further question posed by my interview data. I have observed that there was a disparity, with regard to the construction of abortion in terms of PAS, between different groups of interviewees. It was dominant only in the narratives of pro-life counsellors. This would suggest that PAS can, at present, be considered a construction of the psychological effects of abortion which has little power. It is put forward almost exclusively by those associated with the anti-abortion movement, and has not been adopted significantly by those who do not overtly identify themselves with this movement. How is this limited effect of the construction of the psychological effects of abortion as PAS to be explained?

As I discussed in Chapter 2, Foucault conceptualised power as a function of discourse. When power is understood in this way, laws and institutions are the end point, rather than the centre of power. Whilst this approach is compelling as a framework which can explain how power operates, and how law and policy come to be formulated in particular ways, it does not seem to provide a way of analysing why certain discourses act more powerfully than others, or how they act differentially. Whilst overall the argument that control over bodies and minds is exercised through medicalised discourses is convincing, from my research, it seems that all such discourses do not operate equally powerfully. Some components of discourses which construe the psychological effects of abortion as negative have proved more widely influential than others, with PAS having relatively little impact. This calls into question the tendency of the Foucauldian framework to treat all discourses as equally powerful.

To consider this issue further, I will return to the debate about PAS as it has been played out in America and Britain. Through doing so, I will question Foucault's statement: 'What matter who is speaking; someone has said: what matter who is speaking' (Ransom 1993: 123). In contrast, I suggest that, at least in the case of PAS, 'who is speaking' is significant.

In the American debate about PAS, this was evident in the way in which those who spoke on behalf of the recognised institutions of American psychology, psychiatry and medicine

were most favourably reported in the media. Occasionally journalists presented a picture of a powerful debate that was yet to be resolved. For example a *Chicago Tribune* article was titled 'Both sides in abortion issue also remain divided over post-operation stress' (Brotman 1990: 4). More often however, as I indicated in Chapter 5, it was evidence against PAS put forward by the American Associations of Psychology and Psychiatry that formed the basis for newspaper headlines. Examples of media reporting of this kind are: 'Study shoots down 'abortion syndrome' (Kotulak and Van 1989: 7); 'A Setback for Pro-Life Forces, New studies find abortions pose little danger to women' (Thompson 1989: A5-2); Psychiatric Panel Condemns abortion restrictions' (Specter 1990: A03); Post-abortion trauma existence questioned' (Boodman 1992: Z05); 'Doubt cast on trauma in abortions' (Vogt 1992: 5).

It was therefore those who spoke on behalf of institutions already recognised as authorities, for example those which were accepted as the voice of the psychological or psychiatric professions, who were taken seriously in the debate about PAS in the U.S.. In contrast, those in the U.S. who argued in favour of the PAS diagnosis had no such authority. The fact that they used a vocabulary which drew on medical or psychological terms was insufficient to empower them.

While the crucial role of recognised institutions in refuting PAS is very evident in the U.S. debate, their role in Britain is rather different. In Britain, it was not the case that such organisations publicly refuted PAS. As Boyle (1997) has pointed out, the British Psychological Society has never issued a statement about abortion or had any official involvement with the issue. This can perhaps be understood as a reflection of the lack of politicisation of abortion in Britain compared to the U.S.. Whereas in America, debate about PAS was part of an explicit political agenda on the part of the Republican Party, in Britain no political party has ever made abortion central to its platform or policy when in office (1).

In contrast with the U.S., there has therefore been little political pressure exerted on organisations such as the British Psychological Society, the Royal College of Psychiatrists, the British Medical Association or the Royal College of Obstetricians and Gynaecologists to respond to claims made for PAS, for example in the Rawlinson Commission Report. Other than one response from the Royal College of Psychiatrists, no major scientific organisation responded to the Commission's report. Compared with the aftermath of the Koop report, when media coverage was extensive, reporting about the Rawlinson Commission report was minimal. Professional institutions in Britain either did not notice claims regarding PAS, or chose to ignore them. However, this lack of response can be seen as decisive in ensuring that PAS did not gain support beyond the anti-abortion movement. An active refutation of the PAS claim in Britain was not needed to ensure its lack of success. The absence of its endorsement by representatives of British psychology and psychiatry was sufficient.

The argument that unless official institutions endorse particular claims, those claims are likely to have little success is further illuminated by the contrast between debate about the psychological effects of abortion and other syndrome claims. As Young (1995) and Scott (1992) have pointed out, the success of the PTSD diagnosis rested in large part on its endorsement by official bodies of American psychiatry and psychology. Without their support, PTSD might have had a very different history. Similarly, where other syndrome claims have gained high visibility, and have come to be accepted, support offered by official institutions has been crucial (Downs 1996; Figert 1996; Peele 1989; Tavris 1992). The story of PAS indicates that where this endorsement is absent, a claim will remain just that. It will fail to reach a position of dominance in relation to the construction of law and policy.

In summary, my explanation of the limited effect of the PAS claim suggests that a key component in the amount of power exercised by specific discursive constructions is their endorsement or rejection by official, recognised bodies. In both the U.S. and Britain such bodies have either not responded to the PAS claim, or have actively challenged its credibility. I suggest that this, above all, explains why the claim for PAS remains confined to its initiators in the anti-abortion movement and has not gained wider acceptance. Whilst power can be rightly considered a function of discourse, I suggest than in addition the role of institutions with recognised authority is significant in determining the power of particular discursive constructions.

**Pro-choice abortion counsellors**

I now turn to the narratives of the counsellors I interviewed who worked for abortion providers. As I indicated in Chapter 7, they did not construe the psychological effects of abortion in terms of PAS. There were instances where they referred to 'burying', or 'pushing down' negative feelings after abortion, but they did not suggest that such psychological processes were 'symptoms' of some kind of 'condition' or 'illness'. Indeed they did not offer explanations of why women might react psychologically to abortion in this way. Arguments associated with a feminist psychoanalytic approach, which emphasise the importance of the unconscious and the need for therapy after abortion, also seemed to exert little influence in their narratives. Only one counsellor, Maggie, construed the problem of the psychological effects of abortion in such terms. Her account of the psychological effects of abortion was idiosyncratic. She was the only interviewee who advocated an explicitly therapeutic approach to abortion counselling.

This suggests that, just as with PAS, feminist psychoanalysis has not significantly influenced abortion policy and service provision. This may be a result of the lack of endorsement of this approach by other opinion formers, other than those who argued for a feminist psychoanalytic approach to abortion in the first place. However, this explanation is only speculation, since, unlike in the case of PAS, there does not appear to have been an

explicit debate about this approach to abortion counselling. Where PAS has been publicly debated, the feminist psychoanalytic approach has not achieved the same degree of public visibility or debate. A possible further research project would be to investigate the historical development of this approach, and consider the relationship between its proponents and those involved in abortion service provision.

Counsellors' narratives therefore indicate that the two most overtly psychologising discourses considered in this thesis do not significantly influence the approach taken by counsellors who work in abortion services. Constructions of the psychological effects of abortion which emphasise that abortion can have very serious psychological effects, and which place the role of the denial of feelings and the importance of the unconscious at their centre, were not commonplace.

Why then did counsellors construe the mandate for counselling as they did? As I suggested in Chapter 7, they did tend to construe the mandate for counselling in terms of the emotional effects of abortion. Overall, the impression conveyed by counsellors was that abortion is difficult emotionally (if not traumatic, or a precursor to some form of serious psychological damage), and that counselling was therefore important as part of the process of abortion. Few thought counselling unnecessary, and most conveyed that they considered it part of the responsibility of abortion services to take care of women's emotional, not just their physical, well-being. They argued that women needed the opportunity to talk about their feelings about their abortion decision, that it was advantageous for women to talk specifically to a counsellor, and that women would cope better after abortion if they did so. However, as I have suggested already, the relationship between such constructions of the mandate for counselling, and psychologising discourses discussed previously, is not straightforward. This construction of the mandate for counselling did not seem to reflect discourses emerging from the abortion debate explicitly construing abortion as traumatic.

I contend on this basis that there was no single, consistent discourse which produced counselling as beneficial and desirable in counsellors' narratives. Rather, two discursive strands which tended towards construing counselling as necessary in abortion - namely the abstraction of feelings from their context and the claim for the psychologically beneficial effects of talk - co-existed with 'woman-centredness' or 'client-centredness', in which terms counselling was produced as often unnecessary.

How did counsellors talk about women's feelings? In some instances, they did so in a way that was in line with a key aspect of the construction of abortion as psychologically problematic. As I discussed previously in this thesis, the dominant approach taken by psychologists and psychiatrists in their research about abortion has been to categorise and measure feelings and emotions in an abstract way, as if they were objective, a-social phenomenon. Tana Dineen, a critic of the approach of contemporary psychology, has

described the effect of such an approach as '...using psychological constructs to reduce real experiences to theories' (Dineen 1999: 27). For Dineen, this can have the effect of turning what people say about their feelings '...into ideas which are very different and even disconnected from [their own] descriptions. Presenting these ideas as facts, psychologists can then apply them to other peoples' lives' (ibid).

In this approach, descriptions people give of how they feel are turned into categorisations disconnected from the individual and social context in which a person narrates their experience of their feelings. Once this happens, emotions become subject to the making of general statements and theories, where a certain emotion is ascribed the status of a 'root cause', which can be applied to all who describe their feelings in a particular way.

The clearest case where this kind of psychologising took place was where counsellors discussed post-abortion counselling. Their narratives were often organised around discussion of specific emotions, particularly feelings of loss and guilt. They gave generalised explanations of these feelings. Some explained feelings of loss as a result of 'imaginary bonding' with the fetus, and 'projection', where the woman imagined herself with the child in the future. Guilt was discussed in terms of PTSD, as involving feelings being 'bottled up', and re-emerging at a later date. In these instances, the terms used for a particular emotion were linked to a claim about a psychological process which it was said explained why that emotion had been experienced. It was on this basis that counselling was advocated.

In other instances, in contrast, interviewees' narratives were not organised around naming and explaining specific, negative feelings, and they did not put forward general theories about why a particular emotion might be experienced. Rather, counsellors' accounts were structured around ways *women themselves* had talked about their experience of abortion. Counsellors talked in this way about women's doubts after abortion, about their abortion decision, their experience before abortion of keeping abortion secret, relationship difficulties, experience of contraceptive failure and their views and comments about destroying a fetus. In these instances, counsellors did not generally put forward explanations or hypotheses about why their clients had experienced abortion in the ways they did. Rather, they simply recounted what women had said to them during counselling sessions.

In this respect, while counsellors did emphasise negative emotions surrounding abortion as central to the experience of abortion, those feelings were, at least to some extent, contextualised. They talked about women's feelings in relation to what women said they found difficult about opting for abortion, rather than as an abstract phenomenon which resulted from internal psychic processes. The argument would therefore be inaccurate that counsellors' narratives were predominately produced by psychologising discourses, if that is defined as a discourses where negative feelings are abstracted from broader aspects of women's lives.

I suggest on this basis that, while counsellors did accentuate the negative emotional consequences of abortion, at the same time this was mediated by another influence which could be termed a 'woman-centred' or 'client-centred' discourse. This discourse construes counselling as a response to what the individual woman or the client says. As such, it mitigates against the introduction of theories or generalisations about the psychological effects of abortion into interaction between the counsellor and the woman. Counselling in this sense, is not defined by any particular theory of argument about how abortion affects women psychologically. Rather, it is reduced to talking to the woman about how she feels, on the basis of how she describes her feelings.

This combination of psychologising discourses, and a counter-discourse of woman- or client-centredness, was also apparent in other aspects of counsellors' narratives. It was particularly striking where counsellors discussed the mandate for counselling in relation to the idea that it is beneficial for women to talk about their feelings before, or after abortion. On the one hand, the importance of giving women the opportunity to talk about how they felt was a dominant aspect of their accounts. Counsellors voiced resistance to the idea that counselling should not be offered on a routine basis, or that the function of counselling, as providing women with the opportunity to talk, should be diminished. This aspect of their narratives is in line with the construction of abortion evident in the Lane Report, where deciding to end a pregnancy, without counselling, was construed as detrimental to mental health. Counsellors constructed women's mental health as potentially 'at risk' if they did not talk about their feelings surrounding the decision to have an abortion. They construed counselling as significant in ensuring future mental health. As well as reflecting this aspect of the construction of the mandate for counselling in abortion, interviewees' emphasis on the importance of talking about feelings can also be considered in line with the argument made by Rose (1989) about the construction of the modern self.

As I discussed previously, Rose contended that a defining feature of modern society is the primacy placed on the importance of talking about feelings, especially to a counsellor. This aspect of the construction of the importance of counselling, is, I suggest, relevant to the narratives of my interviewees with regard to the mandate for counselling in abortion, but, as Rose's analysis suggests, it is sustained by discourses which operate beyond the construction of abortion specifically.

His emphasis on the significance of a psychologised conception of the modern self, reflected in the ethos of the positive effects of talking to a counsellor, would appear to be verified by the growth of counselling in many areas of society. There has been a steady growth in counselling services since the 1960s, but especially in the 1980s and 1990s. The UK Register of Counsellors has 1400 members, and one estimate has put the number of unregistered counsellors at 25 000 (Ironside 2000: 18). A study by the Royal College of

General Practitioners published in 1996 noted that: 'While counselling services in general practice are not a new phenomenon, they appear to have increased rapidly in recent years' (Sibbald et al 1996: 2). Counselling is not just offered to people with medical problems however. According to Furedi: 'Counselling has become institutionalized in British society. These new experts advise people on virtually every aspect of life' (Furedi 1997: 134). Furedi notes 36 different areas where counselling has become well established, including counselling about alcohol use, bereavement, old age, redundancy and winning the lottery. Carter notes similarly that '...society has come to see counselling as beneficial after a wide range of experiences - accidents and illness, marital disharmony, job insecurity and predictable bereavement amongst others' (Carter 1997: 15).

On this basis, it could be argued that counselling has become seen as a requirement where any difficult or challenging life event takes place. Almost any event in life that could in some way be deemed unpleasant is seen as best dealt with by 'talking it through' with a counsellor. Counsellors who work in abortion services are working in a context where counselling in general has come to be seen as a 'good thing', and is provided by a wide range of institutions. In this context, the argument that women can benefit from abortion counselling is perhaps bound to be reflected in the abortion debate, and in the narratives of counsellors in particular.

I suggest therefore that this construction of counselling as necessary if people are to 'cope with' difficult experiences was reflected in counsellors' accounts. At the same time, however, it seemed to co-exist with some ambivalence about this therapeutic ethos. This tension was again evident in counsellors' emphasis on 'client-centredness', which stressed the need to respect instances where women did not want to talk to a counsellor. The effects of a discourse of 'client-centredness' were most evident where counsellors talked about who needed counselling, and where they discussed counselling as information giving.

In the first case, even those counsellors who had previously expressed strong support for the importance of talking about feelings, emphasised they advocated a 'client-centred' approach. They problematised the policy of obligatory counselling, based on an assumption that all women need to talk to a counsellor. Others made it clear that they believed that the assumption that counselling was needed or wanted by most women was inappropriate. The effect of the construction of counselling as 'client-centred' was most apparent however where counselling was defined as information giving. In this instance it was made clear that in many cases the counsellor did not talk to the client about her feelings, but rather simply provided information because this was what most clients said they wanted.

The interaction between the therapeutic ethos and the discourse of client-centredness thus acted to make counsellors' narratives contradictory in relation to psychologising discourses. I would suggest therefore, that in contrast to the psychologising of abortion

evident in the approach taken to counselling in the Lane Report, and shaped by the broader influence of the therapeutic ethos, the existence of a discourse where counselling was construed as 'client-centred' acted to construct *resistance* to counselling as always necessary for women undergoing abortion.

**Women who have had an abortion**

In drawing conclusions about the data from interviews with women who have had an abortion, it is important to emphasise again that my sample cannot be taken as representative of all women who have an abortion. Taking this limitation into account, how were my interviewees' accounts influenced by psychologising discourses? Like counsellors in abortion provision, the way they situated themselves in relation to available constructions of abortion was complex. Whilst it was the case that their narratives suggested that psychologising discourses were influential in shaping their accounts, there were a number of unexpected aspects of the data, which raise questions in relation to my hypothesis. In some instances, their accounts could be considered a product of psychologising discourses. However, in many instances this was not the case, and in others psychologising discourses influenced their accounts in ways I had not predicted. How can the complexities of my interviewees' accounts of their experience be explained? In the following section I discuss this issue with regard to theoretical questions, specifically those raised by Foucauldian theory, about the nature of experience and subjectivity. In the remainder of this section, I want to illustrate this issue with reference to my interview data.

In some instances, interviewees clearly drew on available, dominant discourses to account for their negative feelings. This was most apparent in the cases of Caroline and Amanda. In Caroline's case, negative feelings were psychologised, and discussed predominantly in line with feminist psychoanalysis, as a product of conflict between reason and emotion, or conscious and unconscious processes. Amanda emphasised, in the terms of the discourse used by pro-life counsellors, that her feelings resulted from the loss of a child, and that she needed to grieve. In some places, Harriet's narrative could be considered to have exemplified themes from the case made by PAS advocates, where she discussed the problems she perceived there to be with increasing social acceptance of abortion.

This raises the question could Amanda (and even Harriet) have been 'diagnosed' as suffering from PAS? In response to this question, I will argue that this is not the case, on the grounds that the concept identified by the pro-life counsellors I interviewed, and in literature produced by anti-abortion organisations, as central to PAS - denial - was not discussed by my interviewees. Those women I interviewed who had had an abortion did not discuss their feelings in these terms.

For example, it was notable however that whilst Amanda construed her feelings in terms of pro-life discourse, she, like all other interviewees, did not talk of repressing or burying

feelings. This aspect of the construction of women's psychological response to abortion, central to the PAS claim, was notably absent from her accounts. To the contrary, Amanda and my other interviewees, whether they had found abortion an emotionally negative experience or not, seemed to have thought a lot about how abortion had made them feel, and had considered how to conceptualise and represent their experience of abortion and their emotions. This may indicate that their narratives reflected the dominance of a psychologised construction of abortion, in the sense that emotions surrounding abortion are produced as a significant aspect of what is meant by 'experience', where abortion is discussed. However, the argument, central to the PAS claim, that women have been encouraged to deny and repress their feelings by a pro-choice society was not borne out by my interviewees' narratives.

Other aspects of their narratives were harder to situate and explain, and raise more questions than answers in terms of my hypothesis. In order to discuss some of the issues raised I will focus on four aspects of the data where, I suggest, psychologising discourses had influenced interviewees in unexpected ways. These are narratives about regret, feelings of guilt, counselling and resistance to abortion considered as psychologically damaging.

Narratives about regret emerged in various ways in interviewees' accounts, including where interviewees talked of regretting they had had an abortion, regretting becoming pregnant and the absence of feelings of regret. These different ways in which interviewees talked about what appeared to be the same feeling emphasise Boyle's (1997) contention that the method adopted by mainstream psychology can fail to illuminate much about the experience of abortion. Where interviewees talked of regret, they did not in fact describe a common experience, which meant the same to each of them. In so far as there was a common element, it was that feelings of regret were discussed in relation to a range of aspects of my interviewees' lives and circumstances, which can each in turn be considered in relation to broader aspects of ideas about women and pregnancy.

For example, Harriet situated regret in her narrative in relation to her experience of infertility, her relationship with her natural mother and with her partner. Each of these aspects of her experience exists in relation to a set of ideas about pregnancy, mothering and motherhood. Regret figured in Anne-Marie's account as a device to make a distinction between her feelings of regret about accidental pregnancy and the act of abortion itself. Again, her account indicates that a set of ideas about contraception, female responsibility, and the 'rightness' of the choice to have an abortion surround narratives of regret. 'Regret' cannot therefore be understood abstractly, but only makes sense when situated in the context of a number of competing discursive constructions surrounding the abortion decision.

A further interesting aspect of Anne-Marie's account was the way her discussion of her absence of regret about her abortion functioned to produce abortion as the 'right choice'. This was significant in that it indicated that her argument for her choice to have an abortion was not constructed in relation to claims about women's rights, but through a psychologised vocabulary. This raises issues about how to conceptualise the ways in which resistance against dominant discourses is expressed, a question I discuss further at the end of this section. In this instance, it seems that resistance to the idea that abortion leads to negative emotions was constructed in terms of the dominant discourse. Anne-Marie utilised a psychologised construction of abortion, but reversed it, to construe her choice to have an abortion in positive terms.

A second aspect of the data, which drew attention to some similar issues as those raised by narratives of regret, was where interviewees talked about guilt. Dominant discourses discussed throughout this thesis construe guilt as a key, significant emotion following abortion. As I indicated at the start of this thesis, the notion that women can feel guilty after abortion featured in the lunchtime abortion debate, and it has been central to the approach of mainstream psychology and accounts of the psychological affects of abortion put forward by both opponents of abortion and by some feminists.

However, 'guilt' did not feature prominently in my interviewees' narratives. Caroline and Amanda, who in general experienced the greatest extent of negative feelings about their abortions, mentioned guilt, but it was not central to their accounts. Other interviewees did not mention it at all. This may suggest that in so far as interviewees did experience negative feelings, it was not because they considered they had done something wrong or immoral in aborting a pregnancy. The absence of discussion of feelings of guilt may suggest that abortion is now construed in less morally pejorative terms than it once was. My interviewees' narratives may have reflected a shift in the construction of abortion, where ideologies which construe abortion as 'the taking of life' and as therefore morally reprehensible are less powerful than in the past.

It was noticeable that where guilt was mentioned and discussed, it was in terms which presented it as a powerful feeling. When Anne-Marie described her response to discovering her second unplanned pregnancy, she emphasised how bad she felt when she felt guilty about having become pregnant by accident for a second time. It was striking in this instance that it was having become pregnant by accident through contraceptive failure that was the most emotionally negative aspect of her experience of abortion. Anne-Marie did not feel guilty about having an abortion, but rather about allowing herself to be in a situation where she needed one. Her experience of feeling bad about accidental pregnancy was shared by other interviewees. The fact that they emphasised the negative emotional effects of this aspect of their experience of abortion may indicate that the construction of efficient

contraceptive use as not just desirable, but as an indicator of moral behaviour (with accidents or non-use of contraception indicating immoral behaviour and therefore leading to feelings of guilt), is significant in the contemporary social construction of accidental pregnancy and abortion.

A third area where my data were surprising was where interviewees talked about counselling. My expectation was that counselling would feature as a significant, central aspect of interviewees' narratives, and that it would be construed predominantly as a necessary and important part of the of abortion services. In fact, this only held true for Amanda. She put forward an argument about what counselling should be about, which was in line with the construction of the psychological effects of abortion in her narrative in pro-life terms. Caroline, in contrast, who described abortion as 'traumatic' and emphasised throughout the negative emotions she had experienced, did not go on to construe counselling as an activity which should be primarily concerned with discussing or managing negative feelings. In so far as counselling on this basis was explicitly discussed, Justine construed it as unhelpful and irritating. It seemed therefore that there was little demand from my interviewees for counselling which took as its starting point the notion that abortion is traumatic or that women necessarily need to discuss their feelings with a counsellor before and after they end a pregnancy through abortion.

Whilst interviewees talked about their experience of counselling in positive terms, this assessment was not made on the basis of any clear or specific expectation of what counselling was about. Harriet was the most specific, talking of an 'obligation' on the part of abortion services to ensure clients were sure that they were making the right decision. Apart from this case, and with the exception also of Amanda, regardless of whether they had experienced negative emotions before abortion or not, interviewees did not express either a strong desire, or a lack of it, for counselling as part of abortion services. They did not seem to have formed any clear impression of the role of counselling in abortion services. In so far as there was any common idea expressed about what counselling should be about, it was formulated, on the basis of experience, as support for counselling which responded to what the client said she wanted, rather than as driven by any other agenda.

The final aspect of interviewees' narratives, which is perhaps the most interesting in relation to the effects of psychologing discourses, is where interviewees voiced resistance to abortion construed as psychologically damaging. I have already discussed instances where this took place in terms of such discourses, where abortion was construed as the right choice, on the grounds that it was not regretted. However, interviewees also occasionally directly challenged the representation of abortion as psychologically damaging. Natalie drew attention to her dislike of others assuming she would feel bad, and Anne-Marie criticised women she knew who had not managed to accept their choice to have an abortion without

experiencing negative emotions for a long time afterwards. I will now consider this issue in some depth.

**Resisting psychologising discourse**

Such resistance to dominant psychologising constructions of abortion is not easily situated within a Foucauldian framework. As Deborah Lupton has suggested, a difficulty with the Foucauldian concept of medicalisation is that medical power is presented as everywhere, and as overwhelming. She has argued:

> Indeed, at its most extreme, the conception of power as 'everywhere', as an inevitable element of knowledge and as constitutive of reality, tends to suggest the individuals are enmeshed in a sticky web of medical power from which they will never be able to emerge, their struggles only further imprisoning them (Lupton 1997: 101).

Lupton goes on to suggest that Foucault himself could not be accused of such an extreme representation of the effects of medical power. He was careful to emphasise frequently that '...where there is power there are always resistances, for power inevitably creates and works through resistance' (ibid: 102). For Foucault, strategies of power do not always necessarily lead to a single, coherent outcome, where power is uniformly expressed. Disciplinary strategies can break down or even fail. Nevertheless, Foucault's writings do not provide a clear indication of how to conceptualise such breakdowns and failures of disciplinary power. Lupton argues that:

> Frustratingly enough....Foucault's concept of resistance was never really explained in detail. Instead he made various somewhat elliptical comments about the interrelationship of power, embodiment and resistance, such as the statement: 'Power, after investing itself in the body, finds itself exposed to a counter-attack in the same body' (ibid).

The problem of how to conceptualise resistance within a Foucauldian framework has also been highlighted in some feminist commentary. In particular attention has been drawn to the way in which a constitutive conception of discourse leaves little space for the human subject, who is capable of being anything other than passive in relation to the power of discourse. Ransom has summarised this criticism of Foucault in the following way:

> Broadly, this charge sees Foucault's work as problematic in focusing on discourses and the production of subject positions, viewing it as unable to account for the place of human experience and consciousness in acting to change the world. It might be argued that the prime mover here is discourse and the human agent simply a *tabula rasa* on which society writes its order (Ransom 1993: 134).

Ransom quotes feminist philosopher Nancy Hartsock, who explains the consequence of such an approach: 'Discourse....is identifiable without reference to subjective experience, intentionality or personal aspiration. This has the effect, as Hartsock has noted, of generating a language which constitutes 'a world in which things move rather than people' ' (ibid: 133). Whether this was Foucault's intention or not, Ransom points out that the question of human agency is not an issue that Foucault wanted to resolve:

> But what is the relationship between discourse and the human subject implied here? Is it one in which the human agent exists in some sort of tension with discourse, as Foucault's theory of power and resistance might imply? The question is one which Foucault systematically refuses. He is clear that it is not the task of the theorist to address the complexity of the world as experienced by the human subject. When he discusses the place of the experiencing subject, he tends to do so in terms of the constraints which he places on himself (ibid).

For feminists, however, a refusal to address the issue of how to conceptualise subjectivity, in such a way that can explain and encourage resistance, is clearly a problem. Given that the experience of women is at the centre of feminist concerns, and it could be argued that it represents the rationale for having feminist theory in the first place, experience and agency surely have to be included in feminist theorisation of 'women's issues'.

In relation to Foucauldian analysis, some feminists have attempted to resolve this difficulty by bringing a concept of the active, experiencing subject into discourse analysis. Ransom points to Weedon, for example, who has suggested it is possible to have a concept of the active subject within a Foucauldian framework. Weedon (1987) argued that while the subject is socially constructed through discourse: '...she nonetheless exists as a thinking, feeling and social subject and agent, capable of resistance and innovations produced out of the clash between contradictory subject positions and practices' (Ransom 1993: 134).

Weedon's case is that discourse analysis can incorporate the challenge given by feminism to the traditional conception of woman, for example as mother, and generate the possibility of resistance. In this approach, it is the clash between discourses, say that of motherhood, and that which seeks to legitimise the need and desire for women to avoid childbearing at particular times through fertility regulation, that brings about resistance by women and women's movements to the traditional view of women as mothers.

Other feminists have gone further and suggested that Foucault's concept of subjectivity as produced by discourse provides a better framework for understanding the active subject than that given by Enlightenment thought (ibid: 135). For Hekman for example, the strength of Foucault is that '...he refuses the false alternatives of the free individual on the one hand or the conditioned, passive subject on the other' (ibid). Ransom explains that in this view of Foucault:

> ...the social and historical constitution of the subject is not a limit on women's agency but the precondition for women taking action. It is because, and not in spite of, our embeddedness in discursive practices that political action is possible (ibid).

The point for Hekman is that discourse analysis, when utilised by feminists, can actually explain activity and choice making on the part of women. It can do this through providing an account of what makes women act in a way that is counter to dominant discourse, in a way that is more convincing than a theory of the 'free individual'. The conclusion that Ransom draws from her investigation of the tensions between feminism and Foucault is that:

> Arguably then, it is not the agency of people as such which is undermined in Foucault's work. Foucauldian subjects are like Marx's subjects in being able to act and resist within, and in relation to the constraints of historical context. Foucault departs from Marx in taking the deployment of power as his central notion, but he retains a form of theory in which human agency can have effects (ibid: 135-6).

For Ransom, it is therefore possible to resolve the difficulties with regard to women's experience and agency within discourse analysis. This framework can be used without the portrayal of women as passive constructions of competing discourses.

In relation to my data, this approach might suggest that more attention needs to paid to the role that critiques of medicalising and psychologising discourses have played in the construction of abortion. It may be the case that I have focussed insufficiently on the ways in which argument for women's choice in abortion, and campaigns against medical control, have provided a discursive resource for women, which has created the space for resistance to medicalising and psychologising discourses. This may have influenced abortion service provision to a greater extent that I had assumed at the outset. A process of de-medicalisation may be the result, which has been expressed in the approach of defining counselling as 'communication', 'information giving' or as a 'client centred' activity.

**A final note**

What are the implications of my research findings for further research? I suggest that feminist investigation of the construction of abortion might benefit from paying further attention to detailing how resistance takes places. Deborah Lupton's observation about future research within a Foucauldian framework in general could be taken, in this regard, as a starting point:

> In their focus on the disciplinary regimes and apparatuses that surround the body in the medical or institutional context, there is little discussion in many Foucauldian accounts of....how people respond to the external discourses and strategies that attempt to discipline them....While it is clearly important to trace the discourses and practices of medicine and to demonstrate shifts as well as continuities over time, it is

> equally important to attempt to investigate empirically the ways that members of the lay population respond to the clinical gaze, to 'bring them alive' rather than represent them simply as docile or passive bodies constrained as every turn by hegemonic discourses (Lupton 1997: 103).

Future research about medical power and abortion could usefully address this issue. It would aim to provide a more detailed and nuanced account than I have been able to, of the experience of abortion. It would emphasise and explain the ways in which women in contemporary Britain are not passively produced by, but actively respond to and resist, medicalisation. As we have seen, an investigation of the development and operation of psychologising discourses has been my concern throughout this thesis. But, as I hope I have illustrated, women are not passively produced by such discourses. They respond to and interact with discourses, and it is the features of this interaction which demand attention and further exploration of future research.

# NOTES

## Chapter 2

(1) Many reports of research by psychologists and psychiatrists emphasise that a test which is generally thought to be reliable was used in their research. See for example the comments from Zolese and Blacker (1992) on Mc Cance et al (1973) who used the Beck Depression Inventory at 13 and 24 months after abortion, to study longer term psychological responses; and on Brody et al (1971) who used Minnesota Multiphasic Personality Inventory to look at why some women become pregnant when they do not want a child.

(2) There are numerous studies from the 1970s and early 1980s which report similar findings. See for example Osofsky and Osofsky (1972); Adler (1975); Greer et al. (1976); Brewer (1977); and Handy (1982).

(3) I have used the terminology 'medical procedure' to describe abortion since it is currently construed as a procedure that must be authorised by or carried out by medical professionals (as I discuss in Chapter 3, in Britain it is a legal requirement that registered medical practitioners authorise abortion requests, and in other countries where abortion is legal, the involvement of the medical profession in abortion decision making is also either legally required or required through policy or practice guidelines). As a result, abortion is commonly considered to be a 'medical procedure'.

However, as I also explain in Chapter 3, I have not used this terminology in order to support this construction and indeed, as I hope I make clear in this thesis, I believe there to be good reasons for criticising many aspects of the 'medicalisation' of abortion. The designation of abortion in this way is central to the current social construction of abortion, and it should not therefore assumed that abortion has always been, or will always be in the future, considered a 'medical procedure'.

## Chapter 3

(1) Sections 58 and 58 of the 1861 Offences Against the Person Act

> s.58 Every woman being with child, who, with intent to procure her own miscarriage shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of an offence and being convicted thereof shall be liable to imprisonment.

> s.59 Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of an offence, and being convicted thereof shall be liable to imprisonment for a term not exceeding five years.

These sections contain no time limit and make no distinction between abortions at different stages in gestation.

(2) Many laws which restrict abortion have been passed by individual states in the U.S.. According to the latest report from the Alan Guttmacher Institute (www.agi.org), 29 states require parental involvement in minors' abortion decisions; 22 states require state-directed counselling before an abortion, with 14 of those requiring a mandatory delay following the counselling; 14 states restrict private and/or public employee insurance coverage for abortion; 34 states restrict Medicaid-funded abortion except in cases of rape, incest or when the woman's life is endangered; 29 states have passed laws banning 'partial birth abortion' (in 20 the laws have been blocked by state or federal courts); and 40 states restrict later abortions.

The Center for Reproductive Law and Policy (www.crlp.org) has documented a host of other attempts to restrict access to abortion, including the introduction of needless regulations for clinics, covering such 'vital elements of treatment' as doorway width and lawn care. If passed, other prospective laws will introduce penalties for women whose behaviour during pregnancy may harm the fetus; force women to inform the 'father' about an abortion; and force funding for anti-abortion groups. In addition to all this, there are vast swathes of the mid-western and southern states with few, if any, abortion providers, and at least 90 small cities have no provider at all.

(3) David Paintin (1998) notes that abortion is allowed if the risk of abortion is less than that of continuing the pregnancy. He points out that the death rate from legal abortion has been less than one per 100 000 abortions since the early 1980s and the risk of death if pregnancies continue is about seven per 100 000. Hence abortion can, if doctors are so inclined, be provided within the terms of the Abortion Act for all women who request it.

(4) After the 24th week of pregnancy, abortion is still legally permissible under two clauses of the Abortion Act as amended. Clause (c) of the Act states that abortion can be carried out if the continuance of the pregnancy represents a threat to the life of the pregnant woman, greater than if the pregnancy were terminated, and clause (d) that abortion is permissible

where there is a substantial risk that if the child were born it would suffer from such serious physical or mental abnormalities as to be seriously handicapped.

It should be noted that the second of these two clauses has generated substantial debate and criticism. Feminist scholars and pro-choice commentators have contended that the imposition of a time limit for abortion, other than where the fetus is abnormal, rests on the clear assumption that there are 'good' and 'bad' reasons for abortion, which are deemed such by those other than the woman concerned (namely by law-makers and medical professionals). However, the notion that abortion for abnormality can be justified, but abortion cannot be justified where abnormality is absent makes no sense from the point of view of the pregnant woman. A 'normal' pregnancy may be just as unwanted as an 'abnormal' one (Radcliffe-Richards 1982; Furedi 1998a; Furedi 1998b).

Disability rights activists and some feminists have also criticised the clause on the grounds that it expresses 'eugenic' thinking. They contend that singling out fetal abnormality as a ground for later abortion rests on the notion that disabled people are less 'valuable' than the able-bodied. The Abortion Act is therefore seen to either encourage, or itself constitute, discrimination against disabled people (Fletcher 1998; Rose 1994). Anti-abortion groups have also adopted this line of argument as part of their critique of legal abortion (Darke 1997; Garrett 1998).

**Chapter 4**

(1) In DSM III-R, the symptoms of PTSD are grouped into three section: (1) re-experiencing of the traumatic event; (2) numbing of responsiveness to or reduced involvement in the external world; and (3) a miscellaneous section which included memory impairment, difficulty concentrating, hyperalertness or an exaggerated startle response. In addition, in line with clinical experience, the DSM named three forms of PTSD: acute (symptoms emerge within six months of the event and last for less than six months); chronic (symptoms lasting six months or more); and delayed (symptoms emerge at least six months after the event). The main original criteria are as follows:

> 1. The existence of a recognizable stressor that would evoke significant symptoms of distress in almost anyone.
>
> 2. Re-experiencing of the trauma as evidenced by at least one of the following:
> (a) Recurrent and intrusive recollections of the event.
> (b) Recurrent dreams of the event.
> (c) Sudden acting or feeling as if the traumatic event were re-occurring, because of an association with an environmental or ideational stimulus.

3. Numbing or responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:
(a) Markedly diminished interest in one or more significant activities.
(b) Feeling of detachment or estrangement from others.
(c) Constricted affect.

4. At least two of the following symptoms that were not present before the trauma:
(a) Hyperalertness or exaggerated startle response.
(b) Sleep disturbance.
(c) Guilt about surviving when others have not, or about behaviour required for survival.
(d) Memory impairment or trouble concentrating.
(e) Avoidance of activities that arouse recollection of the traumatic event.
(f) Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

The Manual also states: 'The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally *outside the range of such common experiences* as simple bereavement, chronic illness, business losses, or martial conflict. The trauma may be experiences alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps)...' [my emphasis] (Joseph et al 1997: 9).

(2) In the article 'The Psychological Safety of Abortion: The Need for Reconsideration' (published in *Post-Abortion Review*, the newsletter of the Elliott Institute, Fall 1997) Vincent Rue says that he first identified and presented evidence for PAS as a type of PTSD in 1981. This was when he gave testimony about PAS to the Subcommittee on the Constitution, US Senate Judiciary Committee, 97th Congress, Washington DC. Some of Rue's talks given in the 1980s have been published (1984, 1986). Anne Speckhard's unpublished doctoral thesis is titled 'The Psychological Aspects of Stress After Abortion' (University of Minnesota 1985). It is referred to in a range of writings by anti-abortion commentators. See for example Doherty, P. (ed.) (1995).

(3) Discussion of the 'symptoms' of PAS can be found on the Elliott Institute website (www.afterabortion.org). According to its website, the Elliott Institute is 'a non-profit tax exempt corporation that was founded in 1988 to perform original research and education on

the impact of abortion on women, men, siblings and society. The Elliot Institute publishes research and educational materials and works as an advocate for women and men seeking post-abortion healing'.

David Reardon, director of the Elliott Institute, has explained why he believes it is important for 'pro-life forces' to emphasise the negative psychological effects of abortion: 'While efforts to educate the public about the unborn's humanity may help to motivate pro-lifers, such efforts will have no effect on those who support abortion....the *only* way to reach them is for us, too, to focus on the woman. This point is absolutely crucial for pro-lifers to understand.' ('A New Strategy for Ending Abortion: Learning the Truth - Telling the Truth', published on the Elliott Institute website).

**Chapter 5**

(1) The Hearing was held before the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations of the House of Representatives, and chaired by a representative from New York, Ted Weiss. The following gave verbal or written statements: Nancy Adler, on behalf of the American Psychological Association; Henry David, on behalf of the American Public Health Association; Jacqueline Darroch Forrest, the Alan Guttmacher Institute; Wanda Franz, National Right to Life Committee; David Grimes, professor of obstetrics and gynaecology and preventative medicine, University of North Carolina; Fabian Hulka, professor of obstetrics and gynaecology, University of North Carolina; Everett C. Koop, Surgeon General of the United States; Ralph Reed, U.S. Public Health Service; Anne Speckhard, psychotherapist.

(2) The following note is based on comments made to me during an interview with a key member during the 1980s of The Women's Therapy Centre.

> The Centre was opened by Susie Orbach in 1976. Between 10 and 12 people used to work there, and there were also lots of sessional therapists, and a whole number of workshop leaders. There was a regular programme of workshops on a range of issues. They started off on a number of core issues, based around Susie Orbach's book, *Fat is a Feminist Issue*. There were compulsive eaters groups, groups for bulimics, groups for working-class women, groups about dealing with anger and so on.
>
> The baseline work was individual psychotherapy, based on what was described as a feminist approach to psychotherapy, and there were lots of debates about whether such a thing existed. There was also the development of an interest in group analysis, and women's analytic groups. There was a genuine feeling that long-term therapy was best, which meant an unlimited amount of therapy.

There was a huge demand, especially for what was called 'feminist psychotherapy'. Almost immediately there was the problem that the Centre could not meet the demand. There quickly developed a cluster of private psychotherapists attached to the Centre who declared themselves to be feminist psychotherapists as well.

The workshops were really just short-term groups, and more humanistic in their orientation. It was politically informed as well - more like consciousness raising, and didn't pretend to be psychoanalytic. The individual and group work was psychoanalytic however.

Feminist psychotherapy had been described in the book *Outside in, Inside Out.* It was about recognising that social structures were internalised by the baby through the medium of the mother, and women learn from an early age to repress their needs. It is about mothers projecting onto their daughters especially, that they did not have legitimate needs, or were not entitled to getting their needs met within patriarchal society, and that this message was unconsciously communicated from mother to daughter.

They were saying that culture and society did effect the unconscious. The idea was that women met their needs vicariously by meeting the needs of others, and that idea is communicated to the daughter. She then grows up thinking she is not allowed to have any dependency needs herself. Feminist psychotherapy works mainly by offering, and this is the important point, by offering a different sort of mothering relationship. The therapeutic relationship replaces or offers an alternative, healthy relationship, in which dependency is seen as a necessary relationship on the road to mental health. A woman has to allow herself to do this. The policy implication of this was that psychotherapy was unlimited, until that woman experienced being totally emotionally dependent and felt she had an entitlement to that.

There was also therapy offered for women who had had an abortion. I remember clearly at a meeting Marie Maguire saying very clearly 'Well it is murder after all'. This is not an accusation against her, because everyone agreed with her at some level. If you look at it psychoanalytically, the unconscious perception of it is that you are killing off some kind of internal object and all it represents. It not something that is a straightforward choice without repercussions. Post-abortion counselling must therefore be necessary, because it must be a traumatic experience. If not then there is some denial going on. Also, the more you look at the unconscious meaning of the act, it can be pathologised straight away.

Especially if a woman has more than one abortion, there is the idea there is something about the ritual that is meeting an unconscious need. The point is to find

out what this is - there is no such thing as a straightforward mistake. The more one is interested in the unconscious, the more important this becomes. This is not say this view is not pro-choice. It is absolutely.

The main person who did this therapy also made bulimia her issue, and think of the similarities. It is about ambivalence about sex, food, the body, one's desires. Similarly, conceiving and having abortion possibly has these unconscious motivations.

A lot of the therapy was about allowing the woman to grieve. This assumes a bereavement or loss. It was also about getting her to stop her blaming herself and feeling guilty, or using this as a way to oppress herself. I think there was an assumption abortion would be problematic and it was a kind of bereavement. It must have emotional connotations, and there must be feelings. It is better that these are made explicit.

It was only offered after abortion. This was because a responsive service could not be offered. It was about long-term work, not for someone who wants to make a decision in a week or two.

Post-abortion work was seen as short term, two or three sessions. One result might have been that the woman needed more therapy. That might lead her to seeing she needed long-term psychotherapy. Other than that it was to help her understand what was going on and move on.

There is an unconscious meaning. The message was about understanding this so that you can then find alternative ways of expressing your feelings in a direct way, in a powerful way, rather than in a indirect way of coping with an oppressive situation that results in self-harm, like eating disorders, or having an abortion when you don't want to.

**Chapter 8**

(1) Throughout this chapter, I refer to the counsellors I interviewed as 'pro-life', rather than 'anti-abortion'. This is because they described themselves in this way. In earlier chapters however, where I presented my argument about the construction of the abortion debate, I used the term 'anti-abortion', which I think more accurately describes the views of those involved with organisations such as SPUC and Life.

**Chapter 10**

(1) The difference between the two societies with regard to politicisation of abortion is apparent in comparing the Koop inquiry and the Rawlinson Commission. The former, as I have noted, was commissioned by the U.S. President and substantial human and financial

resources were spent by the U.S. state to make the inquiry possible. The Rawlinson Commission, in contrast, was entirely unofficial. Whilst its chair, Lord Rawlinson of Ewell, was a respected member of the British Parliament, a life member of the House of Lords, and Attorney General under the Conservative Party administration during the 1980s, it is important to note that, unlike the Koop inquiry, there was no governmental involvement in the commission. Of the seven MPs who were members of the Rawlinson Commission, none were close to the government, or held a position in policymaking on health. Where the Koop inquiry involved government officials at the highest level, the British Department of Health 'did not feel it appropriate' to give evidence to the Rawlinson Commission, agreeing only to 'respond to a specific question' which arose from evidence that was given to the commission (Birth Control Trust 1994). In parliamentary terms its findings were unofficial.

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## APPENDIX 1: Interview Questions

Questions for counsellors

What do you think counselling is?
How would you define it?
What do you aim to achieve in counselling?
Do you think women requesting abortion need to see a counsellor, not just medical staff?

What do the women you see before abortion talk about?
How much time do you spend counselling the women you see?
Do all the women who come here need counselling?

Do you do post-abortion counselling?
What does post-abortion counselling aim to achieve?
What sorts of issues are discussed?
Do you think post-abortion counselling should be offered to all women who have an abortion?
How long should it carry on for?

Are counselling skills transferable between different kinds of counselling, or is specialised training required for counselling in different situations?
What about abortion counselling as compared to other types of counselling. Is it different?
Do those giving abortion counselling here have any special training?

How could counselling services be improved?

Questions for women who have had an abortion

When did you have the abortion?
Can you tell me what you remember about it?

When did you first suspect you might be pregnant?
Who did talk to about it?
What did you talk about with that person?

How did you feel about being pregnant?
How sure were you about having an abortion?
How long did it take to decide to have an abortion?
Did you have any second thoughts?

What sort of arrangements did you make to have the abortion?
Did you go to see your GP?
What did your GP say to you?
Had you already made your decision before you went to your GP?
Did you have to give your GP reasons for wanting an abortion?
If you did, what did you say those reasons were?
Did you think the conversation with your GP was useful?
Would you say your GP counselled you in any way?

Where did you have the abortion?
Who did you see at the clinic?
What did you talk about with that person?
What did you expect from that conversation?

What counselling did you receive and from whom?
What issues were discussed?
What did you think of the counselling you received?
What did you think the counsellors were trying to achieve?
Were you offered post-abortion counselling?
Did you have any counselling after the abortion?

If so:
How much counselling did you have?
What did you talk about with the counsellor?
What do you think the counsellor was trying to achieve?
Do you think the counselling achieved its aims?

If not:
Do you think you might see a post-abortion counsellor in the future?

## APPENDIX 2: Application to ORGANISATION X for permission to carry out interviews with counselling staff

Description of project

My project is the researching and writing of a PhD thesis, provisionally entitled *Psychologising Abortion*. The content of this project is an analysis of the way abortion has been viewed in Britain, and its relationship to abortion services, with particular reference to the psychological / emotional effects of abortion. The backdrop to my study is the 1967 Abortion Act and the debates which surrounded it, in particular those concerned with the psychological effects of abortion. I will also examine the debates which emerged subsequently including that which took place as part of the Lane Committee inquiry, and the debate about the possible traumatic effects of abortion in the 1990s, which focussed on the claim that women suffer from Post-Abortion Syndrome. Throughout, I will address how such participants in such debates have envisioned the provision of counselling by abortion providers.

My research therefore addresses theoretical and practical mental health issues raised by current debate about abortion. I will be addressing the relation between social factors, mental health and the provision of abortion services.

My research

In my thesis I will detail the gradual development, from debate before and since the 1967 Act, of a discussion about abortion in terms of its impact on women's psychological wellbeing. Key existing texts relevant to this part of my thesis are Sheldon, S. (1997). *Beyond Control: Medical Power and Abortion Law.* Pluto Press and Boyle, M. (1997). *Re-thinking Abortion: Psychology, gender, power and the law.* Routledge (a full bibliography of relevant literature can be supplied if necessary). I will then outline ways in which this discourse has recently been taken up in the political debate about abortion, by opponents of abortion and their critics, in particular in the debate about 'Post-Abortion Syndrome'. My reference points here are published materials and leaflets produced by campaign groups which oppose abortion, and their critics, which discuss the psychological effects of abortion. The research for the above parts of my thesis (namely discussion of the legal and also the political debate about abortion and mental health) is a textual analysis i.e. an account and analysis based on already published materials.

I will then move to the empirical part of my study which consist of interviews with two main groups of people:

a. abortion counsellors

b. women who have had an abortion

In this part of the project, I aim to consider the way abortion and its psychological effects are approached in the provision of abortion services and in women's accounts of their experience of abortion. A key existing text is this area is Allen, I. (1985). *Counselling Services for Sterilisation, Vasectomy and Termination of Pregnancy*, Policy Studies Institute (a full bibliography of relevant literature can be supplied if necessary). The focus for this part of my work is the current provision of counselling in abortion. This will include research about the work of counsellors in abortion, and also about the experience of women who have abortion, with particular reference to counselling they received. It is for this part of my research that I am asking for assistance from ORGANISATION X.

Specific objectives

The part of my project which is based on analysis of the debates about abortion and psychology aims to provide an explanation of the way in which abortion and mental health have come to be linked, in the legal framework on abortion in Britain, and in the political debate about whether or not access to abortion is of benefit to women, on the grounds of its effects on their mental health. The empirical research will aim to provide insights about the work of abortion counsellors (and whether / how that work has changed since, for example the study by Allen referred to above). I also aim to provide insights about the way women experience abortion psychologically, and where this experience coincides with or differs from the way that experience is discussed in the political debates, and by counsellors.

Potential benefit for ORGANISATION X clients

My thesis has at its centre the relation between the social and political debates about abortion and the psychological effect of abortion. This is clearly of interest to those interested in the interaction between the social context of abortion and individual experience. It is also centrally concerned with way this social context effects service provision and the relationship between current provision of abortion counselling, and women's experience of abortion and their perceived needs. Research that provides such insights can act as a resource for organisations concerned with service provision, as well as those concerned with social policy and political aspects of the abortion issue.

Proposed design of the research work

I will not give detail here about the component of the project research based on textual analysis, since this is not something I am asking ORGANISATION X for help with. My comments refer only to the research about abortion counselling and women's experience of abortion.

Fieldwork

In total (including research carried out through assistance from organisations other than ORGANISATION X) I expect my fieldwork to take around 8 months to complete. The aspects of the fieldwork carried out at ORGANISATION X can happen at any point during those eight months, at the convenience of ORGANISATION X. The research I will carry out will be qualitative, based on interviews. Therefore while there are certain issues that I will expect to raise during the interviews, the aim is for them to be free-flowing, to allow for maximum input on the part of the interviewee. The analysis included in the final thesis will be based in transcripts of the interviews conducted.

(1) I want in total to interview 20 counsellors. I am asking for permission from ORGANISATION X to write to 10 counsellors working for the organisation, to request interview. This is my main request for assistance from ORGANISATION X.

(2) I want to interview 15 women who have had abortions. Those who have had late term abortion, or abortion for fetal abnormality are excluded from the sample. The abortion will have taken place within the last two years. In addition to (1) I am therefore also asking for assistance with this part of my research, if there was an acceptable way for me to request interviews with women who have had an abortion at an ORGANISATION X clinic. If it were possible for example to leave a leaflet in an area where clients would see it, which gave my contact details and asked for anyone who would be prepared to be interviewed to contact me, I would be most grateful.

Ethical considerations

(i) Ethics and confidentiality

I am aware of the issues of ethics, confidentiality and privacy involved in this research, and of the difficulties involved in collecting data due to the sensitive subject of the research and intimate nature of the information involved. My research requires I am ethical in my interaction with service provision organisations which have both an interest in providing a good service to women that matches with their needs, and a duty to maintain client confidentiality. I will also pay attention to the ethical issues raised by my contact with women clients who, particularly because of the socially sensitive nature of abortion may a) hold confidentiality at a premium b) take a personal interest in the research results.

Measures I will take to ensure ethical standards are:

a) Where I write to request an appointment to carry out an interview, a stated guarantee of confidentiality will be included; I will offer access to the interview transcript on request; I will

guarantee that information will be removed from the transcript where the interviewee in retrospect would have preferred not to have given that information.

b) It will be made clear that the interviewee is under no obligation to answer questions they would rather not answer.

c) Where counsellors are interviewed, special care will be taken to guarantee that any comments made about clients will be anonymous (with regard to both client and counsellor).

d) Where clients are interviewed, special care will be taken to ensure confidentiality and anonymity, if this is what the woman desires. In this instance, access to research results on request will be highlighted.

e) In the interview transcripts all names and references to organisations will be changed or removed.

(ii) Resource Implications

The time I would need from staff is between one hour and ninety minutes per interview. I am entirely flexible with regard to time and venue for the interview, and given permission to write to potential interviewees, would schedule interviews to their / ORGANISATION X's convenience. The other time I would need, were this to prove acceptable, is for staff to place leaflets in a suitable place, to allow clients to consider my request for interview.