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Constructing Abortion's Second Victim: Science and Politics in the Contemporary  
Antiabortion Movement

A dissertation submitted in partial satisfaction of the requirements for the degree of  
Doctor of Philosophy

in

Sociology (Science Studies)

by

April Nicole Huff

Committee in charge:

Professor Jeffrey Haydu, Chair  
Professor Steven Epstein, Co-Chair  
Professor Lisa Cartwright  
Professor David Serlin  
Professor Charles Thorpe

2014

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Co-Chair

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Chair

University of California, San Diego

2014

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## VITA

- 2002 Bachelor of Sciences, Psychology, University of Arizona
- 2002 Bachelor of Arts, Women's Studies, University of Arizona
- 2004 Master of Arts, Women's Studies, University of Arizona
- 2014 Doctor of Philosophy, Sociology (Science Studies), University of California, San Diego

## PUBLICATIONS

Steven Epstein and April N. Huff. 2010. "Sex, Science, and the Politics of Biomedicine: Gardasil in Comparative Perspective." In *Three Shots at Prevention: The HPV Vaccine and the Politics of Medicine's Simple Solutions*, ed. Keith Wailoo, Julie Livingston, Steven Epstein, and Robert Aronowitz, pp. 213-228. Baltimore: Johns Hopkins University Press.

## FIELDS OF STUDY

Major Field: Sociology (Science Studies)

Studies in Sociology of Social Movements  
Professors Jeffrey Haydu and Steven Epstein

Studies in Science and Technology Studies  
Professors Charles Thorpe, David Serlin, and Lisa Cartwright

## ABSTRACT OF THE DISSERTATION

Constructing Abortion's Second Victim: Science and Politics in the Contemporary  
Antiabortion Movement

by

April Nicole Huff

Doctor of Philosophy in Sociology (Science Studies)

University of California, San Diego 2014

Professor Jeffrey Haydu, Chair  
Professor Steven Epstein, Co-Chair

This dissertation examines the development and consequences of what I call women-centered strategies within the prolife movement in the United States. While this movement has been characterized as a religious movement devoted to the rights of the unborn, I argue that since the early 1980s an important faction within the movement has contended that women, as well as the unborn, are victims of abortion. Drawing on textual analysis and interviews, I trace the rise of attempts to restrict

access to abortion based on the claim that abortions are harmful to women who have them.

The use of women-centered strategies has three consequences. First, the argument that abortion harms women has shaped scientific inquiry. Antiabortion organizations claim that abortion is associated with an increased risk of breast cancer and various mental disorders. However, these claims have been disputed by scientists and scientific institutions. Comparing the controversy over breast cancer risk with that over mental health outcomes, I show that researchers who are critical of abortion employ a range of tactics to prolong conflict and further politicize these scientific issues. Second, these strategies have led to new understandings of women who regret their abortions. These understandings are constructed within a network that includes women who regret their abortion, prolife researchers, therapists, movement leaders, and mental health researchers. Finally, women-centered strategies have had a profound impact on the policies that regulate abortion care in the United States. By juxtaposing scientific claims alongside narratives of abortion's harm to women, prolife groups have developed a framework that resonates with policymakers and federal judges.

This research makes significant contributions to science studies and studies of social movements. Analyses of the process by which scientific debates end typically focus on the mechanisms that foreclose further inquiry and exclude dissenting voices. My research demonstrates that these mechanisms work differently depending on the social context and can, in some cases, serve to continue rather than end controversy.

Additionally, this work expands on previous studies of the construction of identity and role of expertise in social movements as well as the impact of framing on social movement success.

## INTRODUCTION

On January 24<sup>th</sup> of 2011 about 15 women braved the freezing temperatures in Washington, DC to stand on stage for the duration of the annual March for Life. The held signs that read, “I regret my abortion.” These women are members of the organization Silent No More, and each January since 2003 they have carried out a particular ritual within this prolife event: These women stand on stage for the duration of the rally while prolife leaders, religious officials, and politicians give speeches on the need to end legal abortion in the United States. Then they march with the rest of the protestors to the steps of the Supreme Court and give testimony of how abortion has harmed them. Throughout the afternoon, other prolife activists meet with their elected officials in the warm offices of the Senate and House of Representatives, but the women of Silent No More continue to tell their stories of how they were harmed by abortion.

The antiabortion movement in the United States has endured for over 40 years, and the March for Life brings together disparate prolife factions to mark the anniversary of the Supreme Court decision that legalized abortion. In popular accounts, antiabortion activists are often depicted as religious zealots who are determined to protect the life of the “unborn.” And attendees at the 2011 event carried many signs with quotes from the Bible, Pope John Paul II, and Mother Teresa and placards that depicted babies and free-floating fetuses. Yet, alongside posters that read “Abortion stops a beating heart” were some that read “Abortion – one heart stops and

one heart breaks.” While all antiabortion activists believe that the unborn are victims of abortion, there is a growing consensus among mainstream prolife organizations that abortion also has a second victim – the pregnant woman. The suffering of this second victim is embodied by women who come to the March to express regret over their abortions.

What are we to make of the politics of abortion regret and the women who come to embody it? Some within prolife movement contend that many women suffer from Post Abortion Syndrome, a variant of Post-Traumatic Stress Disorder, and that abortion additionally increases their risk of future infertility and breast cancer. Others within the movement claim that these women suffer because they rejected their roles as mothers and are experiencing unresolved grief over the loss of their child. Some see these women as harmed by a medical system that devalues women, that presents abortion as an easy option, and that then abandons women when their need support afterwards. Or as Georgette Forney, a co-founder of Silent No More, put it at the March, “We are consumers of the product and we are here to say the product is no good” (Field Notes). While there are competing understandings of abortion regret within the prolife movement, proponents of abortion rights view this phenomenon differently. Women who regret their abortions are typically characterized as being brainwashed and taught to feel guilty about their decision by prolife religious groups and post abortion healing programs.

This dissertation examines the rise of women-centered strategies within the antiabortion movement. These strategies have not received the same degree of



scholarly analysis as other aspects of the movement. Women-centered strategies or women-protective strategies contend that abortion needs to be prohibited because women experience a number of negative consequences from abortion including mental illness, breast cancer, and infertility (Cannold 2002; Siegel 2007; Siegel 2008). Advocates of these strategies also argue that women frequently do not willingly choose to end their pregnancies, but are pressured or coerced to do so by others (Cannold 2002; Elliot Institute 2010). As Leslie Cannold asserts, women-centered strategies are considered within the antiabortion movement as a means to correct the weaknesses of the fetal-centered strategy, which is seen as an “expression of care and concern only for the fetus” and a “condemnation of nearly all aborting mothers as immoral, careless, and or selfish murderers” (2002: 172). Women-centered strategies re-position “the anti-choice movement as the defenders (rather than the critics) of pregnant women who have had or are considering abortion” (172). The existing scholarship on women-centered strategies is quite small and focuses very little on the scientific claims made by antiabortion organizations about how women are harmed by abortion. My dissertation expands this scholarship by bringing scientific questions and processes to the center of scholarly attention.

The argument that women are victims of abortion has many consequences. First, within the movement this argument has led to the construction of a new collective identity, the post-abortive woman. I argue that this identity is co-constructed in a network composed of women activists, prolife researchers, post abortion healing programs, antiabortion movement leaders, and mainstream researchers. This identity

gives women a legitimate place within a movement that otherwise might see their actions as the result of selfishness and immorality. Additionally, I argue that the construction of this identity relies on tropes of “empowering victims” that are similar to those utilized within other self-help movements on reproductive events, like support groups for women with postpartum depression or who experience miscarriage.

Second, the argument that abortion harms women has impacted scientific inquiries of abortion’s potential harm to women. Antiabortion organizations claim that abortion is associated with an increased risk of breast cancer and various mental disorders. These claims have been disputed by scientists, professional associations, and government organizations. Through a comparison between the controversy over a possible association of abortion with breast cancer and the corresponding controversy over mental health, I argue that researchers who are critical of abortion employ a range of tactics to prolong conflict and further politicize these scientific issues. Finally, despite widespread scientific consensus that abortion is not associated with breast cancer or mental illness, many states require doctors to inform women seeking to terminate a pregnancy that these associations do exist. Support for these types of informed consent laws relies on the narratives of women who claim that they were harmed by their abortions and on the contested work of researchers who are critical of abortion. Using a recent informed consent bill from South Dakota as a case study, I argue that legislatures and courts struggle to make sense of what scientific evidence is valuable when making decisions about regulating abortion.

## **Scientific Controversies**

Within science and technology studies (STS) there has been a long history of scholarly analysis of scientific controversies. Historians of science have argued that scientific controversies provide unique opportunities to study science in action as well as the social aspects of how scientists build credibility, enroll allies, and bring closure to debates (Bloor 1976; Shapin and Schaffer 1985; Shapin 1995; Latour 1987). A common theoretical and methodological tradition that underlies most studies of controversies is the adherence to the principle of symmetry in analysis. This principle dictates the analyst must invoke the same kinds of causal factors to explain the success or failure of claims on both sides of a controversy. One cannot assume that the reason one side of the controversy became dominant is because it simply was the most logical, rational, or true (Bloor 1976). Thus, studies of controversies must attend to the ways that evidence is mobilized, the tactics researchers and institutions deploy to appear credible, and the work scientists do to define the boundaries between science and nonscience and expert and nonexpert (Gieryn 1999). Many studies focus on debates in which people or social movements with little power within the scientific community were able to marshal resources and have an impact on scientific debates (Martin 1991; Richards 1991; Epstein 1996). By giving examining the scientific claim of each side of a debate as well as the social factors involved in building credibility, approaches that follow the principle of symmetry tend to favor the “underdogs” in scientific controversies.

Additionally, some scholars have noted that rather than reaching a state of closure, many controversies either continue (Simon 2002) or are prevented from closing by powerful forces (Latour 2004; Oreskes and Conway 2010). In these cases, scholarship tends to focus on the tactics that are used to prevent full closure. This can happen when a small group of dissenters set up their own conferences and journals to continue scientific discussion as happened in debates over cold fusion (Simon 2002). Or, more dramatically, closure can be prevented by industry and political interference with scientific practices like peer-review and the work of advisory committees (Oreskes and Conway 2010). Some of these researchers have advocated for the abandonment of symmetrical analysis in favor of making normative and prescriptive claims about scientific practices (Collins and Evans 2007) or have asserted that science needs to be defended from industry and political interlopers (Oreskes and Conway 2010).

In this dissertation, I present a largely symmetrical analysis of the debates over possible links between abortion and both breast cancer and mental illness. I also draw upon the work of Oreskes and Conway (2010) to illustrate similarities in the types of credibility tactics used by researchers who are critical of abortion and by dissenters in other scientific debates, such as those over tobacco regulation and climate change. These tactics are used to promote uncertainty and prevent closure. However, in the case of scientific disputes about abortion's harm, the role of industry is largely absent. My case, like many cases that involve science and sexuality, provides insight into how these processes of "selling doubt" work within a larger context. Further, by comparing

the two debates about abortion's potential harm to women, I am able to broaden the scope of controversy studies by examining how different social contexts, organizational cultures, and credibility tactics influence the degree to which closure can be reached within the scientific community. My examination of these debates also expands the literature on scientific controversies by drawing a broader portrait of how scientific knowledge is produced and evaluated in arenas governed by different standards of evidence and different values. Rather than abandoning symmetrical analysis, I advocate that STS scholars should follow controversies as they traverse the boundaries of the scientific community in order to better understand the changing status of scientific authority in society.

### **Expertise and Credibility**

The social construction of expertise and credibility is another important subfield of STS research that informs this project. Much of this research focuses on the social factors that contribute to the building of credibility, which includes the adoption of particular practices or techniques, the use of instruments, and patronage or funding for research (Barnes and Edge 1982; Shapin and Schaffer 1985; Dear 1995; Porter 1995; Shapin 1995). As Steven Shapin argues "all propositions have to win credibility, and credibility is the outcome of contingent social and cultural practices" (1995: 257). Within scientific communities, propositions are generally introduced and championed by scientists who must build their own credibility to be successful in this task. Thus, research on expertise has emphasized the tactics used by scientists to build

credibility as well as the social and cultural factors that make certain tactics more successful in particular time periods and locations.

Beyond examinations of how expertise and credibility are constructed, there is also a wealth of scholarship that examines different kinds of experts and expertise. Often included within this literature are “lay experts” who would not be considered experts in the traditional sense, but who possess some kind of unique experiential or local knowledge that becomes important in scientific debates (Wynne 1992; Taylor 1996; Epstein 1996; Murphy 2006; Epstein 2007a). For example, Brian Wynne’s analysis of Cumbrian sheep farmers in the wake of the Chernobyl disaster describes how the sheep farmers, who possessed a specialized, local knowledge of soil conditions and farming practices, clashed with government scientists, who wanted the farmers to change their grazing patterns in light of potential soil contamination due to radioactive fallout (1992). Additionally, scholarship on health movements and patient advocacy movements has brought to light the ways in which the lived experiences of those who suffer from diseases (or their advocates) have shaped scientific research funding, the scope and design of clinical trials, and understandings of diseases (Brown et al. 2004; Murphy 2006; Epstein 2007b; Klawiter 2008; Eyal et al 2010). Finally, in a recent article, Gil Eyal (2013) has advocated a new understanding of expertise as a network that includes numerous types of experts. Using the example of autism, Eyal argues that as expertise networks changed so too did understandings of what constituted autism, how it was diagnosed, and the extent to which it could be treated.

Expertise networks are dynamic systems that can include medical professionals and technicians, patients, patient advocates, and research scientists.

This dissertation engages with both these aspects of the study of expertise. In my analysis of the scientific debates over abortion's potential harm to women, I examine how epidemiologists, breast cancer researchers, and mental health researchers as well as researchers who are critical of abortion deploy a range of tactics to build their own credibility and to dismiss or diminish the concerns of their opponents. I also analyze the social and cultural practices in which these debates take place, in particular the organizational cultures of public health, cancer research, and psychological and psychiatric research to further illuminate the impact of these credibility tactics on scientific debate. Additionally, I draw on Eyal's concept of expertise networks to understand the history of prolife claims about Post Abortion Syndrome (a mental illness created in the prolife movement and advocated for by antiabortion researchers). By analyzing expertise as a network, I am able to draw attention to how networks shift over time and trace how understandings of what constitutes Post Abortion Syndrome within the antiabortion movement also changed along with the expertise network. My work contributes to STS understandings of expertise by applying Eyal's theory of expertise to a new case and by grounding my analysis in the practices of a social movement rather than a traditional community of experts. The interactions between different kinds of actors and changes in the power or authority over time are brought into sharp relief when expertise is analyzed as a network.

## **Identity, Narrative, and Experience**

Since the 1960s, there has been a marked increase in the number of social movements in the United States that mobilize around a shared or collective identity. Rather than organizing around a shared profession, class background, or political ideology, people in the 1960s and 1970s began to join movements and work to address grievances that were thought to be shared among all members of the same race, gender, or sexual orientation (Taylor and Whittier 1992; Morris and Mueller 1992; Laraña et al 1994; Melucci 1995; Taylor 1996; Armstrong 2002; Pichardo 2001; Polletta and Jasper 2001). Much of the scholarship on identity movements has focused on how identities are constructed within social movements. This is accomplished through a process of determining the boundaries of the movement, developing a group consciousness, and engaging in political expression and action (Taylor and Whittier 1992). While most social movements scholars recognize that identities are not stable (Melucci 1995), many of the cases examined by these scholars do not attend to the changes in identity over time. The long history of the victim identity within the prolife movement provides an opportunity to do just that.

Further, the use of narrative in the process of identity formation has not been fully explored by social movement scholars. Many social movements are fleeting and few leave documents about initial formation and how activists came to understand their shared experiences and grievances as a shared identity. Scholarship on the use of narrative within movements has largely focused on this issue of social movement impact (Polletta 2004) rather than on the ways that narratives can reflect and shape



collective identity. This dissertation uses the narratives of women who regret their abortions to analyze both how the victim identity came to be defined within the movement and how it shifted over time.

Finally, there is a wealth of scholarship within science studies on the interactions between social movement activists and medical experts (Epstein 1996; Taylor 1996; Brown et al. 2004, Murphy 2006; Klawiter 2008; Eyal et al 2010). Social movement actors often possess a particular kind of expertise based in their own experiences (Scott 1991) which is often held up as a personal truth about the lived experience of suffering from a disease (Murphy 2006). As activists share information with, challenge the assumptions of, and make demands on medical experts, understandings of disease often change (Epstein 1996; Taylor 1996; Murphy 2006; Eyal 2010). In some cases these interactions lead to changes in scientific funding and research (Epstein 1996), and in others activist understandings of disease have to be modified or revised in order to fit medical knowledge of disease etiology or to gain access to treatment (Taylor 1996 and Murphy 2006). Also, research on feminist self-help movements has demonstrated how these kinds of movements develop their own knowledge claims based on women's lived experiences and reject expert definitions and systems of medicine (Murphy 2012). My dissertation brings these concepts from science studies to bear on social movement issues, examining the ways in which expert knowledge of mental illness have shaped and been shaped by activists understandings of victimhood and mental illness. This approach also highlights the relationship between experiential and scientific evidence in different contexts, which

provides new ways of thinking about the relative power of different kinds of expertise. My analysis highlights the ways in which women in post-abortion organizations contend with expert knowledge and mobilize experiential evidence to help achieve movement goals.

### **Science, Law, and Social Movement Impact**

Controversies involving science and medicine seldom stay exclusively within the domain of the scientific community, especially in cases where the scope and direction of policy is dependent on the outcome of those debates. In the case of the antiabortion movement's claims about the procedure's potential health consequences to women, the issue of how to regulate abortion practice and whether to impose restrictions on access are determined by state legislatures and the federal court system. Legislative bodies and federal judges are increasingly required to evaluate scientific evidence in order to determine whether state mandated informed consent procedures about abortion's harms are truthful or whether they are misleading. Political institutions and courts have their own standards for evaluating evidence and determining credibility, so it is no surprise that these entities often weigh scientific claims differently than the scientific community itself.

STS scholars have conducted a great deal of research on how scientific evidence is engaged with and evaluated by policy-makers and courts. This includes historical work on the development of standards for admitting scientific evidence and experts into court proceedings (Golan 2004) as well as numerous case studies of how

scientific evidence was taken up or ignored by expert advisory committees (Jasanoff 1990) and court systems (Jasanoff 1995; Angell 1996; Foster and Huber 1997; Jasanoff 2001). What emerges from this scholarship is a disturbing picture of the inadequacies of the legal system to effectively evaluate scientific claims and to apply standards in any consistent ways (Angell 1996; Jasanoff 2001). Given that how judges weigh scientific claims is highly dependent on context, as well as on the content of the information presented, bringing in theoretical tools from the sociology of social movements helps develop a more robust analysis of science and the law.

Sociological studies of social movement impact often focus on how successful a movement is at changing policy and enshrining movement goals into law (Giugni 1999; Amenta 2014). Movements deploy many tactics to achieve their goals, including the development of frames that articulate grievances and demands. One way to measure the influence of framing on the outcomes is to examine the degree to which the framing of the movement's grievances and proposed solutions resonate with and persuade the target (or targets) of the social movement (Snow and Bedford 2000; Cress and Snow 2000; Reese and Newcombe 2003; McCammon et al 2007). As Holly McCammon and her co-authors contend, the ability to influence policy depends not just on how well the frame resonates but also the social context in which the frame is presented (2007). For example, frames that tap into hegemonic discourses are more likely to resonate and persuade than frames that rely on less dominant or marginalized discourses (2007). Attending to the ways that advocates frame their arguments about abortion restrictions and scientific evidence as well as the social and cultural context

in which these arguments are presented opens up new possibilities for analyzing science, the law, and social movement impact. Unlike previous approaches to social movement outcomes, I examine the role of expert knowledge and empirical claims in the development of frames and the larger sociocultural context in which frames are deployed.

In examining the entanglements of science, policy, law and social movements in the revision of South Dakota's abortion informed consent law, I bring STS approaches to science and the law into conversation with theories of framing and social movement success. My analysis suggests that as both sides present evidence about the safety of the procedure and its impact on women's health, courts are unskilled or unwilling to engage with scientific research on the topic. Instead of dealing with scientific evidence in detail, the judges in the South Dakota cases were more interested in making determinations about the role of scientific evidence in governance in order to form a conclusion about the constitutionality of the informed consent law. Moreover, my comparison between the South Dakota Task Force on to Study Abortion and the legal proceedings in *Rounds v. Planned Parenthood of Minnesota, North Dakota, and South Dakota* illustrates that on a topic as politically charged as abortion, citizen reviews and courts are both ill-equipped to make decisions about abortion based in scientific evidence or to develop their own standards to determine what counts as good evidence and who is considered an expert. This raises important questions about how scientific evidence is evaluated within the policy sphere and how much of an impact scientific experts can make in governance and

policy-making. By broadening the scope to include how evidence is presented, my work contributes to a more robust understanding of how political and legal systems contend with scientific information and expert opinion.

### **Abortion and Stigma**

Much of the sociological scholarship on the practice of abortion focuses on the management of stigma by abortion providers, clinic employees, and patients. In her recent account of clinic practices, Carole Joffe describes the ways in which doctors and clinic staff face regular protesters at their place of employment (2010). The varying level of violence at clinics has also led to increased safety protections for doctors and their facilities including bodyguards for providers. Beyond this, employees of some clinics have also been targeted by prolife activists who will demonstrate at the employee's home and distribute flyers identifying the employee as a "baby killer" in the employee's neighborhood and church (Joffe 2010). Wendy Simonds documents that staff at some abortion clinics draw on feminist ideology to give meaning and value to their work and to guide their interactions with patients (1996). Other scholarship suggests that abortion providers often do not disclose their status as providers in their personal and professional interactions as a way of mitigating this stigmatized identity (Harris et al 2013). As Lisa Harris and her co-authors contend, many providers feel isolated from the professional colleagues who do not perform abortions and face a "legitimacy paradox" that "although many highly trained, legitimate physicians provide abortion care, abortion providers continue to be depicted as illegitimate, deviant, or substandard doctors" (2013: 11). Harris et al.

assert that the silence on the part of many providers is one factor that continues this paradox.

The silence and stigma that surround abortion are also seen as central to the issues faced by many abortion patients. In research on women who sought counseling services after abortion, the perceived or real lack of support by friends and family members was one of the main factors that contributed both to women remaining silent about their abortions and to their emotional difficulties after abortion (Kimport, Foster, and Weitz 2011). The presence of clinic protesters was found to upset some women seeking abortion but had little impact on their decision to go through with the procedure or their feelings about their abortion one week later (Foster et al 2013). The most recent research on abortion patients and stigma calls for greater discussion of abortion (Kimport, Perrucci, and Weitz 2012) and more accurate depictions of abortion and its outcomes in film and television (Sisson and Cockrill 2014).

I expand on work on abortion and stigma by taking up questions of how stigmatized identities come to be rehabilitated within the prolife movement. Most of the scholarship on this topic has focused on how most women come to experience the silence and stigma that attends this medical procedure, but issues of how management of stigma translates into social movement mobilization have not been addressed. My focus on the narratives of women in post-abortion organizations does not directly take on the Goffmanian lineage of stigma that this line of scholarship engages. However, my analysis of how abortion stigma comes to be incorporated into the identity of “post-abortive women” and motivates participation in prolife politics provides insight

into the relationship between stigma and political action about which these scholars are also concerned. Moreover, I examine how abortion stigma creates a social context in which the experiential evidence and contested scientific claims presented by the prolife movement are more likely to resonate with policy-makers. This insight provides a new understanding of how abortion stigma might be related to the increase in prolife policy victories.<sup>1</sup>

## **Methods**

In order to examine the rise and consequences of women-centered strategies in the U.S. antiabortion movement, I employed a number of different qualitative methods, including document analysis, observation of movement events, content analysis of abortion regret narratives, and interviews with key actors. First, I collected and analyzed a variety of relevant documents and audio-visual items including: published research and commentary on reproductive events and breast cancer, published research and commentary on mental health and abortion, newspaper accounts of scientific debates over abortion's potential harms and developments with the antiabortion movement strategy, government reports on reproductive events and breast cancer, professional association statements on abortion's potential harms, documents related to the American Psychological Association's reviews of abortion and mental health, Congressional testimony by activists and scientists over abortion's

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<sup>1</sup> This stands somewhat in contrast to social movements that have taken up stigmatized identities as both a movement tactic and in order to build solidarity. Examples of this include sex worker rights movements and SlutWalk. There are also instances in which pejorative terms (e.g. queer, bitch, slut) have been taken up by movements and reappropriated as a badge of pride.

potential harms, newsletters from a variety of prolife organizations, and information from prolife and prochoice organizations. These documents were analyzed to identify major themes. The analysis of these documents (along with secondary sources) allowed me to construct a history of scientific debates and changes in the prolife movement. Additionally, scientific publications, letters to editors, government hearings and documents, and professional reports were helpful in determining the ways that scientists created and maintained boundaries around the debates over abortion's potential health consequences as well as the credibility tactics deployed by researchers who are critical of abortion. Finally, the documents associated with the South Dakota Task Force to Study Abortion and the legal opinions in *Rounds v. Planned Parenthood* provided crucial insight in how political reviewers and federal judges engaged with scientific and experiential claims about abortion's harms.

Second, I attended a series of events surrounding the 2011 March for Life. This included a rally at the White House, a rally and march on the National Mall, an exhibition of prolife organizations, publications, and movies, and the Rose Dinner. During these events I took field notes and spoke with other attendees. In order to insure that my observations were typical of this event, I viewed footage of three previous March for Life rallies on C-SPAN and live footage from the 2014 March for Life. Observing these events in person (and virtually) gave me important information on how women-centered strategies were being adopted within the movement. By attending the event and observing signs and placards, I was able to determine how much the women-friendly message had been taken up by the rank and file members of



the movement. And by watching the speeches I was able to observe how much this strategy was being deployed by movement leaders and by elected officials.

Third, I collected a random sample of abortion regret narratives posted by women on the Silent No More website. These narratives are publicly available on the organization's website. I analyzed the narratives for dominant themes using Atlas.ti, a qualitative research software. Further details of the methods for this aspect of the research can be found in Chapter Four. These narratives provide the basis for my analysis of how the victim identity was constructed within the prolife movement as well as how it changed over time. By analyzing the stories of these women, I was also able to determine the extent to which they took up expert understandings of PAS.

Finally, I conducted interviews with eight individuals who have been active in scientific and political debates around abortion's potential harm. Interviewees include: two members and the chair of the American Psychological Association's Task Force on Mental Health and Abortion, a scientist with the National Cancer Institute that attended the Early Reproductive Events and Breast Cancer Workshop, a university professor associated with the Coalition on Abortion/Breast Cancer and the Breast Cancer Prevention Institute, a surgeon associated with the Breast Cancer Prevention Institute, the president of the Coalition on Abortion/Breast Cancer, and the co-founder of the Silent No More Awareness Campaign. Seven of the interviews were conducted in person and one took place over the phone; they lasted in length from 30 minutes to 90 minutes. Participants agreed to speak with me "on the record" and their statements are attributed to them by name throughout this dissertation. The interview questions

were open ended and each interview guide was specifically designed to gather information about the interviewee's particular expertise and experience with research or within the prolife movement. The interviews allowed me to get a better sense of the processes of evaluating scientific information, the viewpoints of researchers who are critical of abortion, and the change that some movement leaders have seen in prolife strategies.

It is worth noting that interviews were very challenging to obtain, despite my best efforts. Researchers who are critical of abortion and who have conducted research on abortion's connection to mental health either were unwilling to give interviews, or did not respond to my requests, or refused to be interviewed by people outside of the prolife community. Researchers who work on reproductive events and breast cancer were often unwilling to grant an interview because they felt that the science "spoke for itself" and were uninterested in talking about the potential political consequences of their research. Participants who did grant me interviews were often concerned about my motives, political affiliations, and how they would be represented in this work. With only three exceptions, I would say that my interviewees were generally guarded when answering questions. I attempted to build trust with interviewees by allowing some to review interview transcripts and providing two with audio copies of their interviews. I also promised to send two interviewees copies of the completed dissertation.

Finally, abortion seems to be a topic in American culture about which everyone is required to have an opinion, and since my views on abortion have

informed this project, they are worth examining here. As a feminist, I believe that the continued legality of abortion is important for issues of public health and women's reproductive autonomy. I am also aware of and deeply concerned by the undercurrents of racism, classism, ableism, population control, and eugenics that flow through the history and present movement of advocacy for legal abortion. As a white, heterosexual, middle-class, cisgendered woman, I am the benefactor of prochoice and feminist struggles to ensure reproductive autonomy. My privileged status ensures that I am able to reliably control my fertility, to make demands about contraception in my intimate relationships and have them be respected, and to handle an unexpected pregnancy through parenting or abortion without financial concerns or social judgment. My belief in reproductive autonomy is a commitment to helping build a future in which all women have the resources and tools to make their own decisions about reproduction.

Regardless of my own position on abortion, I have tried my best to handle the views and stories of prolife activists, researchers, and movement leaders in a way that represents them accurately. In journalistic and popular accounts of the debates over abortion's potential health consequences, the claims of researchers who are critical of abortion are typically dismissed as junk science or pseudoscience. In my research, they are treated as claims that are worthy of critical scholarly analysis. Similarly, women who regret their abortions are frequently characterized as "brainwashed" by the prolife movement. In this dissertation, I strive to draw attention to their agency in interactions with experts and movement leaders. Throughout this project I have

worked to ensure that quotes appear in context and that the views of my participants are represented accurately and respectfully.

### **History of Abortion in the United States**

From colonial times through the early 19<sup>th</sup> century, many states did not have laws or statutes that regulated abortion. In 1840 only eight states had laws that penalized abortion. These laws made a distinction in the harshness of the punishment at the moment of quickening, or the period in a pregnancy in which fetal movement can be felt (typically between 16 and 18 weeks gestation). The abortion of a fetus after quickening was treated as a felony and abortions before quickening were given greater leniency (*Roe v. Wade* 1973). Aside from the legal prohibition at later stages, abortion was likely quite common during this time period. Newspapers and magazines regularly featured advertisements for medicines and herbal remedies that could treat “blocked” or “obstructed” menstruation (Luker 1984: 18-20). Since there was no reliable test for early stage pregnancy, these remedies were likely used as abortifacients.

In 1858 the American Medical Association launched a campaign to criminalize abortion. Historians and sociologists argue that the mobilization of physicians was motivated by a number of factors. Physicians at the time were in competition with midwives and other healers to provide care. In order to consolidate power, gain recognition as a profession, and drive others out of business, physicians established medical schools, professional organizations, and licensing requirements (Starr 1982).

Opposition to abortion played a particular role in the establishment of the profession. First, by making abortion illegal, physicians would be removing an important source of revenue from their competitors (Luker 1984: 27). Further, in opposition to popular beliefs of the time, physicians argued that abortion was immoral and that embryos had an absolute right to life (Luker 1984: 32). They also asserted that in particular circumstances, abortion may be medically necessary. Physicians, with their medical training and reliance on scientific knowledge, would be best suited to determine when an abortion should be performed. Thus, doctors were able to both create a moral problem and position themselves as the obvious choice to control and regulate this problem (Luker 1984: 32). By 1900, nearly every state had passed a law making abortion a crime except when performed by a physician to preserve the life or health of the mother.

It is important to note that the campaign by the medical profession to criminalize abortion often put forth arguments about race and gender. During this time, writings by physicians against abortion observed that women believed in the concept of quickening and did not have access to scientific knowledge about embryonic life. Physicians, therefore, were in a position to save women from unknowingly committing immoral acts (Luker 1984). Doctors at the time additionally understood that middle-class Anglo-Saxon women were more likely to seek abortion than women from immigrant groups. Writings of this period indicated that physicians also believed that eliminating access to abortion was important in increasing childbearing among Anglo-Saxon women and preventing immigrant groups,

particularly Irish Catholics, from becoming dominant (Beisel and Kay 2004).

Criminalizing abortion was an attempt to maintain gender and racial hierarchies as well as a consolidation of physician's power.

Between 1900 and 1950, doctors were given a great deal of freedom in shaping the practice of abortion in the United States. Laws at the time did not indicate under what circumstances abortion would be medically necessary, and the medical literature of demonstrated disagreement among physicians about when abortion would be appropriate (Luker 1984: 45-47). After World War II, many of the medical conditions that would have prompted a doctor to perform a therapeutic abortion were able to be treated without harm to the mother or fetus. Thus, the medical necessity of abortion became more focused on the mental health of the pregnant woman than on her physical health. Disputes over how to judge whether an abortion was necessary to preserve the mental health of a woman were eventually delegated to hospital boards composed of internists, obstetrician/gynecologists, psychiatrists, and sometimes hospital administrators (Luker 1984; Solinger 1992). The establishment of hospital boards led to greater restrictions on access to abortion across the country. Ricky Solinger's work indicates that the experience of appealing to a board for abortion care was often humiliating for the woman and that in some cases boards abused their power by requiring sterilization to be performed as a requirement for obtaining abortion.

By the 1960s, public attitudes towards abortion had shifted significantly. The introduction of the birth control pill meant that many women could have sex without having to worry about becoming pregnant and the burgeoning women's rights

movement brought issues of women's bodily autonomy into public discussion. There were also a few high profile cases of women being denied abortion, and scholars have emphasized the effects of these cases on attitudes towards reproduction, abortion, and the role of women in society. The most famous of these was Sherri Finkbine's attempt to get a therapeutic abortion in 1962 after having taken Thalidomide, a medication that causes severe birth defects. Finkbine's local hospital board had initially approved the abortion, but after the decision became public the board rescinded the approval.

Having been denied care in her home state of Arizona, Finkbine traveled to Switzerland to obtain the abortion (Solinger 1992). In 1961, an abortion liberalization bill was introduced in the California Assembly. Between 1961 and 1964, a series of public hearings were held across California to discuss the proposed bill. Luker's analysis of the transcripts of these hearings reveal that proponents of legalizing abortion were concerned about the public health problem posed by illegal abortions and the growing medical and public consensus that abortion in the case of fetal abnormality was acceptable (1984: 66-91). In 1967, the California Assembly passed a law which broadened the circumstances under which abortion could take place and gave doctors considerable leeway in determining when an abortion was "medically necessary" (Luker 1984: 88). By the early 1970s, several states had liberalized their abortion laws allowing more women to undergo the procedure for a broader variety of justifications.

In addition to a growing number of states that reformed their abortion laws, two lawsuits, *Roe vs. Wade* (Texas) and *Doe vs. Bolton* (Georgia), challenged the

constitutionality of the states' abortion restrictions. These two cases were eventually heard before the U.S. Supreme Court. By the time *Roe* and *Doe* were argued before the Court, there had been a groundswell of support for abortion reform from women's rights groups, which considered the ability to make medical decisions and to have control over reproduction as central to women's social equality. Feminist and women's rights groups were not the only organizations invested in making abortion legal. The American Psychiatric Association filed a joint *amicus* brief along with the American College of Obstetricians and Gynecologists, the American Medical Women's Association, the New York Academy of Medicine, and a group of 178 physicians on behalf of the appellants. The brief largely frames the legal question of abortion provision as a professional concern among doctors. It's not surprising that the impact of abortion statutes on medical practice would be a central concern of doctors during a time when abortion laws were being liberalized. In fact, many scholars point to the involvement of doctors and medical professionals as central to the Supreme Court decision to legalize abortion (Halfmann 2011).

In 1973, the Supreme Court ruled that state laws criminalizing abortion were a violation of the privacy and equal protection rights of women and doctors. The Court set forth a trimester system to allow states to restrict access to abortion. During the first trimester of pregnancy, a state could do very little to restrict access to the procedure. Restrictions could be put in place during the second trimester of the pregnancy to regulate the safety of the procedure for women. This includes requirements about what facilities the procedure could take place in. During the third



trimester and after the fetus is viable, states could restrict access in the interest of protecting fetal life (*Roe v. Wade* 1973). In 1973, approximately 800,000 legal abortions took place in the United States and the number of annual deaths associated with abortion declined from 200 in 1965 to just over 40 in 1973(Guttmacher 2014a).

Since the *Roe* decision there have been numerous legal and political challenges to legal abortion. A more detailed discussion of these challenges is presented in the following chapters, but here I will briefly address two important cases that have fundamentally shaped abortion practice and jurisprudence in the United States. In the years following the legalization of abortion, the Court overturned most of the laws that restricted access to abortion including parental consent laws, laws that imposed mandatory waiting periods, and biased counseling laws. In 1992, the Court changed course in *Casey v. Planned Parenthood of Southeastern Pennsylvania* and set new standards for evaluating abortion restrictions. The Court determined that access to abortion could be restricted as long as it did not pose an “undue burden” on the woman seeking abortion. Though what constitutes an undue burden has never been fully defined, the Court has ruled that parental notification and consent laws that have a judicial bypass, mandatory 24 hour waiting periods, and regulations of the informed consent process are not considered undue burdens. Requirements for spousal notification or consent are considered undue burdens.

The *Casey* decision is significant because it provides a framework for state-level abortion restrictions. Many states that are considered hostile to abortion rights enacted laws in the years following the decision that met these guidelines for

regulating abortion provision. Similarly, many states have passed laws that push the limits of this framework. For example, there has been more state influence of the abortion informed consent procedure in the years following *Casey*. Additionally, *Casey* serves as a both a template for how to restrict access to abortion without creating legal challenges over constitutionality and as a guide for the areas in which restriction can be pushed further in ways that might be allowed by the Court. For example, a state can pass a 24-hour mandatory waiting period without provoking a long legal battle with Planned Parenthood or could push the boundaries and pass a 48 hour mandatory waiting period with the hopes that a majority of Supreme Court Justices will not consider it an undue burden.

In 2007 the Supreme Court ruled that a federal ban on a particular abortion procedure typically used late in pregnancy, intact dilation and evacuation, was constitutional. The federal ban did not allow an exception for the procedure to be used in cases where the woman's life or health would be endangered. Abortion providers testified that in some circumstances a dilation and evacuation would be the safest procedure, but the Court was persuaded by evidence from antiabortion doctors that this type of abortion is never "medically necessary." This case, *Gonzales v. Carhart*, is significant for two reasons. First, in the majority opinion Justice Anthony Kennedy acknowledge that "while we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort ..." (2007: 159). Kennedy only cites an amicus brief that contained numerous declarations of women who regret their abortions which were collected by Operation

Outcry. Second, in previous decisions the Court had relied more heavily on the testimony of abortion providers to determine the parameters of what was considered medically necessary. As the medical professionals who regularly perform abortions, there were seen as experts on this type of medical care. In *Carhart*, the Court, for the first time, gave more credence to medical professionals that testified on behalf of antiabortion interests, who do not perform abortions. This marks what might prove in the future to be a significant shift in how expertise on abortion is weighed by the Court.

### **Contemporary Practice of Abortion in the United States**

Abortion in the United States is quite common. According to the Guttmacher Institute, twenty-two percent of all pregnancies end in abortion. In 2008, 1.21 million abortions were performed in the United States, and from the point of widespread legalization through 2008, almost 50 million pregnancies ended in legal abortions (Guttmacher Institute 2014a). It is estimated that between one quarter and one third of women will have an abortion at some point in their reproductive years (Guttmacher Institute 2014a). However, these aggregate statistics belie a deeper reality of abortion for many women, particularly poor women and women of color. Recent research indicates a growing disparity in unintended pregnancies between poor women and high income women. In 2008, the unintended pregnancy rate for women below the poverty line was 137 per 1,000 women aged 15-44 while the rate for women living at or above 200% of the poverty line was 26 per 1,000 women of reproductive age (Finer and Zolna 2014: S45). Rates of unintended pregnancy among women from racial

minority groups were twice the rates for White women in 2008 (S45). In 2001 those rates were 120 and 41 per 1,000 women of reproductive age for poor women and more economically advantaged women, respectively (S45). Unsurprisingly, rates of induced abortion are significantly higher among women of color and poor women than among White and economically privileged women. According to the Guttmacher Institute, forty-two percent of women who have abortions live below the federal poverty line (2014a). There are significant class and race disparities in the experience of unintended pregnancy and the need for abortion.

Additionally, when asked about the reasons, a large majority of women indicate that financial concerns as well as a child's interference with "work, school, or the ability to care for dependents" are identified as important factors in the decision to end a pregnancy (Guttmacher Institute 2014a). Currently, just over 60% of women who have abortions have one or more children. These concerns about financial ability to care for a child are well founded. Research that compared women who were able to terminate an unwanted pregnancy to women who sought abortions but were not able to obtain them found that women who carried their pregnancies to term were doing worse financially than the cohort of women who were able to terminate their pregnancies (Foster, Roberts, Mauldon 2012).

In addition to higher rates of unintended pregnancy and abortion among poor women and women of color, access to abortion and other reproductive health care is affected by age, economic status, and geography. Legal restrictions on abortion disproportionately limit access to the procedure for minors, poor women, and women

living in rural areas. The most common types of restrictions limit funding for abortion, target abortion providers and abortion care facilities, limit the timing of when an abortion can occur, and seek to influence the decision of the woman seeking an abortion.

One way that access to abortion has been restricted since its legalization in the United States is through denying funding for abortion care. In 1976, Congress enacted the Hyde Amendment which bans federal money from being used to fund abortion through governmental programs like Medicaid.<sup>2</sup> These types of restrictions often make it difficult for poor women to obtain abortion care and in many cases causes women to have abortions later (i.e. at the end of their first trimester or during their second trimester) when risk of complications are greater and the procedure becomes more expensive. Similarly, concerns over funding for abortion and insurance coverage for abortion were central to debates over the Affordable Care Act. Currently, the House of Representative is considering a bill that would impose tax penalties on small businesses and individuals that purchase an insurance plan that covered abortion or from paying for an abortion with their pre-tax Health Savings Account (H.R. 7 2014). Through this bill has little chance of becoming federal law, it represents a modern twist on a long standing means for restricting access to abortion.

A second way in which lawmakers have restricted access to abortion is through Targeted Regulation of Abortion Providers or TRAP laws. These regulations focus on the practices of abortion providers and facility requirements for clinics that perform

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<sup>2</sup> Some states, including California, still allow abortions to be covered through Medicaid. This money must be generated through state taxes rather than federally allocated Medicaid funding.

abortion. The federal prohibition on intact dilation and evacuation is one example. More recently, there have been numerous laws introduced that would require doctors who provide abortions to have admitting privileges at a hospital close to the clinic where they perform abortions. Other types of TRAP laws require abortion facilities to meet specific and often medically unnecessary conditions, such as having hallways with particular widths or demanding that all abortion care facilities meet the requirements of an ambulatory surgery center (Joffe 2010). While proponents of these types of laws argue that these restrictions make abortion safer, opponents claim that these laws are unnecessary given the limited complications that arise from induced abortion and serve to close clinics rather than make abortion safer. A recent report on reproductive health care in the Rio Grande Valley in Texas found that the confluence of cuts to state funding for reproductive health services and the enactment of a Texas law requiring doctors who perform abortions to have admitting privileges has left many women in this poor, rural, predominantly Latino/a area without access to adequate health care (Center for Reproductive Rights 2014). Women seeking abortions now travel over 150 miles to the nearest abortion clinic, and one doctor who had to suspend his abortion care practice told *Al Jazeera America* that in the 45 days following the law's enactment he treated over 100 women for complications that resulted from self-induced abortions (Beyerstein 2014).

Additionally, lawmakers have attempted to restrict access to abortion through banning abortion after a particular gestational period. The original *Roe* decision allowed for legislation that banned abortion after the point of viability (at that time, 28

weeks). Since then, the Court has acknowledged that advances in medical technology have made it possible for a child to survive outside of the womb at 24 weeks of gestation (*Casey* 1992). In the past few years, numerous states have passed laws that ban abortions after 20 weeks on the basis that a fetus is capable of feeling pain at that point.<sup>3</sup> The vast majority of abortions are performed during their first trimester (88%) and almost all abortions are done before 21 weeks of gestation (98.5%) (Guttmacher Institute 2014a). However, these bans are most likely to restrict access for women who decide to terminate after a diagnosis of fetal abnormality, after a fetus is deemed nonviable, or when facing a serious health issue. Though the Supreme Court has not weighed in on the constitutionality of these bans, some states have begun to pass laws that prohibit abortions early in the pregnancy. For example, North Dakota passed a ban on abortions after six weeks of gestation, which is when an embryo begins to have a detectable heartbeat.

One final way that access to abortion has been limited is through laws that intervene in the decision-making process of the pregnant woman. These types of restrictions set guidelines for informed consent (often requiring doctors to give women medically inaccurate or scientifically contested information), require a waiting period between abortion counseling and the procedure (typically 24hours), and mandate that women receive an ultrasound and description of the embryo/fetus. Currently, five states require doctors to inform women of a link between abortion and breast cancer and eight mandate that doctors advise women that abortion can lead to negative

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<sup>3</sup> The claim that fetuses are capable of experiencing pain similar to humans after they are born is heavily contested. See for example (Lee et al 2005; Belluck 2013; McDonough 2013).

psychological outcomes (Guttmacher 2014b). An analysis of the scientific and political debates around these claims makes up the bulk of this dissertation. Further, 26 states have mandatory waiting periods of at least one day. Both Utah and South Dakota passed laws extending their waiting period to 72 hours, and South Dakota's law requires women to visit an antiabortion crisis pregnancy center before consenting to the abortion (Guttmacher 2014c).<sup>4</sup> Waiting periods are particularly burdensome to poor women and women living in underserved areas. It is not uncommon for women to incur additional expenses in lost wages, childcare, and travel expenses to meet these requirements. Twenty-two states regulate the provision of ultrasounds by abortion providers. According to the Guttmacher Institute, three states require that providers display and describe the ultrasound image, seven states mandate that the provider perform an ultrasound and that the client be given the opportunity to view it, other states require that women be given the opportunity to view an ultrasound image (Guttmacher 2014d). Though prolife activists claim that 90% of women who see an ultrasound of their embryos decide to carry the pregnancy to term, recent research indicates that viewing an ultrasound has very little impact on women's decision to end a pregnancy (Gatter et al 2014). The shift in strategy that makes these types of restriction favored by the prolife is examined throughout this dissertation.

### **Plan of the Dissertation**

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<sup>4</sup> Both the Utah and South Dakota laws are the subject of ongoing legal disputes and have been temporarily prevented from being enacted.



The first chapter provides information on how the antiabortion movement has changed over time. This chapter primarily traces the rise of woman-centered strategies within different types of organizations in the movement. The use and proliferation of women-centered strategies has been contested by some prolife activists, but they have become central to the incrementalist approach of the mainstream prolife movement. The incrementalist approach seeks to limit access to abortion through changes to state laws and to test the degree to which of the Supreme Court will allow abortion to be restricted and on what grounds. This stands in contrast to earlier “purist” approaches that favored a bolder attempt to recriminalize abortion through federal policy change or a constitutional amendment.

Beyond the initial chapter the dissertation is divided into two parts. The first focuses on two of the scientific and political controversies at the heart of the claim that abortion is harmful to women: a link between induced abortion and an increased risk of breast cancer, and a possible association between abortion and a constellation of mental disorders, typically referred to as Post-Abortion Syndrome (PAS). Claims that abortion increases risk for breast cancer and mental illness are important components of women-centered strategies and have been central to the construction of the victim identity and to state-level informed consent policies. The comparison between the two cases illustrates the similarities and differences between the credibility tactics used by different scientists, the strengths and limitations of each type of research, and the professional standards of evidence in each field.

In Chapter Two, I examine the history of scientific research on a possible link between abortion and breast cancer. Within the scientific community, the question of whether there is an increased risk of breast cancer associated with abortion has moved from being an answerable question to an answered question in a fairly typical manner. Researchers who are critical of abortion have often used political connections and pressure from prolife groups to delay closure and promote uncertainty.

In contrast, and as explored in Chapter Three, the history of research on the relationship between abortion and mental health has been haunted by the limitations of mental health research. In this case, researchers who are critical of abortion began to conduct their own research on possible associations between abortion and depression, anxiety disorders, suicide risk, and substance abuse. Their research has been published in peer-reviewed journals, though it is often subject to critique and has many methodological weaknesses. By becoming producers of scientific knowledge, researchers who are critical of abortion have been able to delay closure in a different way than those exhibited in the abortion/breast cancer dispute.

The second half of the dissertation examines how these two scientific controversies have come to shape and are shaped by the victim identity within the prolife movement and the types of policies pursued by antiabortion groups. The fourth chapter analyzes the co-construction of the victim identity within the prolife movement and the changing roles of women within various antiabortion organizations. Using the theoretical concept of the looping effect (Hacking 1995), I trace how this identity is created, reproduced, and modified by women who regret their abortions,

leaders of prolife organizations, and researchers who study the aftereffects of abortion on women. My analysis draws on the narratives produced by women who regret their abortion and ascertain how these stories have changed over time as the definition of PAS has changed. Additionally, I explore the roles of narratives in identity creation and the impact experiential evidence has on the prolife movement.

Chapter Five examines the policy implications of scientific conflicts over abortion's potential harm and the evidence presented by women who regret their abortions. Specifically, this chapter uses two events in South Dakota to compare how citizen-based task forces and federal courts weigh scientific and experiential evidence. In 2005, the South Dakota legislature passed a revision to the state's abortion informed consent law to require doctors to inform women that terminating a pregnancy might put them at significant risk for suicide. The informed consent law was eventually challenged in the Eighth Circuit Court of Appeals (*Rounds v. Planned Parenthood*). At the same time, the legislature formed the Task Force to Study Abortion. The group was tasked with reviewing relevant research on abortion and providing a suggested policy agenda for the state to pursue. This chapter examines the different ways in which each group – the citizen-based task force and the Appellate Court – struggled to weigh scientific knowledge about abortion to come to conclusions about what restrictions on abortion were warranted. Additionally, I explore the impact that movement framing of abortion has on how these two groups came to their conclusions about the proposed abortion restrictions.

Finally, in the conclusion, I review the major findings and themes of the dissertation as well as articulate the scholarly contributions this work makes to science and technology studies and to the sociology of social movements. I also examine the implications of the rise of women-centered strategies for the scientific community, for abortion policy, and for the debate over abortion and its continued legality in the United States. Moreover, I explore how advocates of abortion rights have responded to the deployment of women-centered strategies and what the abortion debate may look like in upcoming years.

## CHAPTER ONE: SHIFTING GROUND

“One cannot help a child without helping the mother; one cannot hurt a child without hurting the mother.”

- David Reardon, 1996a

“Why can’t we love them both? Why can’t we all stand with the pregnant woman? Why can’t we tell her that we share the agony of her decision? ... Why can’t we tell her that we stand with her, not against her?”

- John C. Willke and Barbara H. Willke, 1997

In popular accounts and much of the scholarly literature, the antiabortion movement in the United States is characterized as a political movement dedicated to ending abortion and instituting rights for all human beings from the moment of conception. We often think of the movement as solely, or at least primarily, concerned with the rights of the “unborn.” This depiction, however, does not fully capture the complexity of organizations, ideologies, strategies, and goals that constitute the contemporary antiabortion movement. Since the founding of the National Right to Life Committee in 1970, the movement has grown and experienced a number of important shifts in strategies and ideology. Of particular importance is the rise of *women-centered strategies* during the mid-1990s (Cannold 2002; Siegel 2008). The quotes above signal that activists within the prolife movement were interested in advocating for the interests of women as well as those of the unborn and began to see the mother and fetus as having shared or intertwined interests. Rather than being just the champions of the unborn, prolife activists saw an opportunity to also represent the rights of women and take ground from the movement for abortion rights

This chapter examines the history of the antiabortion movement and the changes to movement's goals, ideologies, and strategies that were ushered in during the 1990s. Much of the sociological research on the antiabortion movement has concentrated on the initial formation of prolife organizations, the struggles for federal legislation and a Human Life Amendment to the Constitution, and the emergence of more radical organizations within the movement. Less scholarly attention has been given to changes within the movement in the wake of *Casey v. Planned Parenthood of Southeastern Pennsylvania* (1992). After reviewing the scholarship on the rise of conservative movements and the early research on the antiabortion movement, I analyze four central axes of change that are important for the configuration of the contemporary movement. During this time period the prolife movement shifted from a purist ideology of recriminalizing all abortions to a more incrementalist ideology and approach that restricted access to abortion. Additionally, there was a change in focus from federal-level changes to state-level activism and legislation. These shifts are also related to a growing adoption of women-centered strategies as a complement to fetal-centered strategies. This increased focus on women required new and, in some cases, revised engagements with scientific research on abortion's potential harm to women. And finally, I conclude the chapter by charting out the how these changes have been taken up by different "streams" or types of organizations within the prolife movement. This uptake of these new strategies by the various streams of the prolife movement plays a central role in the chapters that follow.

### **The Abortion Debate within Conservative Politics**

At the time of the *Roe v. Wade* decision, opposition to abortion was largely the domain of the Catholic Church and its parishioners (Luker 1984; Gorney 1998; Greenhouse and Siegel 2010). Throughout the 1970s, the Catholic Church was instrumental in providing organizational and financial support to the nascent prolife movement (Diamond 1989; Gorney 1998; Munson 2008). Among elected officials, opposition to or support of legal abortion was not divided along party lines. And religious groups other than Catholics voiced a variety of opinions about abortion (Munson 2008). For example, the Southern Baptist Convention considered abortion a “responsible personal decision” and the National Association of Evangelicals supported the repeal of restrictions on therapeutic abortions (Greenhouse and Siegel 2010: 71-73). Some Republican leaders saw opposition to abortion as a potential means to gain the votes of Catholics, who traditionally supported Democratic candidates (Gorney 1998).

By 1980, many evangelical Protestants had come to oppose abortion and founded their own prolife groups, like the American Life Lobby (Diamond 1989). Scholars disagree about the role of abortion in the coalescence of the Christian Right. While some claim that abortion was the issue that brought together these disparate groups of conservative Protestants (Diamond 1989), others argue that the 1978 IRS ruling that penalized Christians schools that did not comply with civil rights policy was responsible for this new coalition (Edsall and Edsall 1992; Williams 2012: 2). Regardless, the prolife movement expanded with the inclusion of conservative

Protestants and, in turn, opposition to abortion played a large, if not primary, role in the growth of the Christian Right.

With the founding of national organizations like the Moral Majority, the Family Research Council, and Focus on the Family, the Christian Right gained significant power and helped Ronald Reagan win the presidency in 1980 (Williams 2012). Through a grassroots mobilization campaign that includes religious television and radio stations, publishing houses, and churches, the Christian Right has maintained an important influence on Republican electoral politics that continues today (Diamond 1998; Greenhouse and Siegel 2010). Opposition to abortion is a central value of the Christian Right and with the movement's influence on conservative politics, it has become increasingly important to the Republican Party, just as support for legal abortion has become a litmus test among Democratic candidates. Daniel Williams argues that the close alliance between conservative Protestants and the Republican Party happened in two stages. The first, which lasted from the 1940s to the 1960s, is characterized by conservative Protestant's recognition that the Republican Party stood against communism and for the "protestant moral order" (2012: 3). During this stage, conservative Protestants had close relationships with prominent Republican leaders, but did not exert much influence over the Party's positions. The second stage, which began in the late 1960s, is characterized by greater conservative Protestant mobilization around the "culture wars" issues of opposition to abortion, feminism, gay rights, and pornography. During this second stage, conservative Protestants were able to use their alliances within the Republican



leadership to change the Party's position and to become the largest special interest group within the Party (Williams 2012).

Evidence of Republican support for the prolife movement can be traced through the Party's platform. In 1976 Republicans acknowledged that abortion was an unsettled issue within the party, but by 1980 the Party had adopted platform that supported a constitutional amendment that granted "the right to life to unborn children" (Republican Party Platform 1976; 1980). Despite some opposition (see Diamond 1998), the antiabortion position has remained within the Party's platform. Though the antiabortion movement has become closely connected to both the Christian Right and the Republican Party, it is important to examine the history and structure of the movement separate from its alliance with these larger political institutions. Further, the transition to women-centered strategies that is at the center of scholarly attention in this chapter seems to be primarily motivated by changing opportunity structures (Tarrow 1998; McAdam 1982/1999) and challenges from the prochoice movement.

### **The Prolife Movement, 1970-1990**

The vast majority of the scholarship on the antiabortion movement examines the movement before 1996 (Luker 1984; Ginsburg 1989; Petcheskey 1990; Solinger 1992; Blanchard 1994; Solinger 1998; Maxwell 2002; Ferree et al. 2002; Meyer and Staggenborg 2008). Three central themes emerge from this scholarship. First, the movement against abortion is characterized as representing the interests of the fetus.

The arguments made on behalf of the fetus are both moral (that human life is sacred and must be protected) and scientific (that a fetus is a genetically distinct human with biological qualities similar to those of infants). Scientific claims are usually supported by evidence from embryology and fetal development as well as imaging technologies like ultrasound. During the 1970s and 1980s, the prolife movement was largely focused on overturning *Roe v. Wade* or recriminalizing abortion through a constitutional amendment that recognized the right to life of the embryos and fetuses (Diamond 1998: 133-134). The focus on establishing the fetus as a person with rights shaped the strategies and framing of the issue within the prolife movement through much of the 1970s and 1980s.

A second theme of this scholarship is the characterization of the debate over abortion rights as a proxy battle over the role of women in society. Those opposed to abortion rights argue that access to legal abortion degrades human life and devalues the role of mothers in society, while proponents of abortion rights claim that only through control over fertility and reproduction can women be full and equal participants in society. In *Abortion and the Politics of Motherhood*, Kristin Luker contends that prolife and prochoice activists operate under different worldviews. Prolife activists believe there is a strong and intrinsic difference between men and women. Men occupy the public sphere of politics and paid labor, and women occupy the private or domestic sphere and motherhood is considered a sacred calling (159-165). Prochoice activists, on the other hand, see men and women as substantially similar and deserving of equality in the public sphere. Control over reproduction is

thought to be essential to women being able to fully participate in the public sphere and reach their full human potential (175-179). According to Luker, the debate over the legality of abortion is not just about the status of the fetus and whether it deserves legal protection. It is also a conflict over the appropriate role of women in U.S. society and whether motherhood is a sacred calling or just another job (205). These sentiments have been echoed by other scholars of the early prolife and prochoice movements (Ginsberg 1989; Petchesky 1990).

Finally, many scholars mark the shift in power within the prolife movement to more radical organizations focused on shutting down abortion clinics through direct action. While the antiabortion movement worked to overturn *Roe* through legislative and legal means throughout the 1980s, these efforts were largely unsuccessful. Congress failed to move forward on constitutional amendments to nullify *Roe* and recognize legal protections to fetuses or embryos. The Court also did not uphold many restrictions on access to abortion.<sup>5</sup> Certain organizations within the prolife movement had always participated in direct-action at clinics, primarily through picketing, sidewalk counseling, and prayer (Diamond 1998). In the late-1980s, this direct action became more aggressive and prolife leaders like Randall Terry (the founder of Operation Rescue) and Joseph Scheidler (of the Pro-Life Action League) advocated for blockading clinics and forcing them to shut down. From 1988 to 1990, Operation Rescue staged a number of civil disobedience actions at abortion clinics across the

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<sup>5</sup> The major exception to this was laws that restricted funding for abortion. For example, the Court upheld state funding bans on abortion in *Beal v. Doe* (1997) and *Maher v. Roe* (1977) and federal funding bans in *Harris v. McRae* (1980) and *Williams v. Zbaraz* (1980). The Court, during this same time period, prohibited bans on abortion, spousal consent, parental consent without judicial bypass, biased counseling, and waiting periods for abortion (Halfmann 2011: 228-230).

United States. Members would block clinic entrances with their bodies, chain themselves to clinic facilities, and occupy clinic waiting rooms. These actions generally lead to arrests and were prominently featured in the media (Diamond 1989: 135-142). Scholars have examined why people participate in these types of activism (Maxwell 2002), the implications of this more radical approach to ending abortion for the movement in general, and for the increase in clinic violence that occurring after these acts of civil disobedience ceased (Blanchard 1994; Diamond 1998; Risen and Thomas 1998).

Recent research on the prolife movement has provided new insights into how organizations weathered the changing political landscape. Zaid Munson analyzed mobilization within the movement through interviews with activists and found that most members report becoming active within a prolife organization before fully developing an opposition to abortion (2008). This work challenges a social movement convention that dictates that people join social movements based on a shared grievance or identity (See for example Blee 1991; 2002). Munson's work demonstrates that many within the antiabortion movement join a movement and then develop a grievance. Munson also challenges previous characterizations of the prolife movement as monolithic. By dividing prolife organizations into streams, Munson asserts that we should consider the movement as united in a single goal (recriminalizing abortion), but divided over how to best achieve that goal.

Additionally, Drew Halfmann's comparison of political institutions, social movements, and abortion policy in the United States, Britain, and Canada highlights

important differences that have shaped the abortion debate and policy in the United States. Halfmann argues that after the *Roe* decision, doctors and medical groups became less involved in abortion politics. Further, while Canada and Britain reformed their abortion policies through Parliamentary systems, the main policy venue for reform in the United States has been the Supreme Court. The political parties in the United States are more open to the demands of new social movements than the “closed, disciplined parties” that compose the political systems in Canada and Britain (2011: 209-211). These factors, Halfmann contends, explains why abortion has become so politicized and the movements for and against it are so entrenched in the United States. Halfmann’s analysis illustrates the importance of examining larger, macro level structures and institutions to explain the persistence of the abortion debate, the shape of the movements for and against its continued legality, and the influence those movements are likely to have on policy.

In the following pages I update these historical accounts of the movements for and against abortion rights, particularly the changes in the movement from the mid-1990s to the present. This will be accomplished through the examination of how scientific claims about the harms of abortion are used to gain restrictions on access to the procedure as well as to legitimate the claims of antiabortion groups that they are the “true” representative of women. My research will also expand upon previous research by giving a meso-level account of the movement.

Some scholars have conducted detailed ethnographic and interview based field work at particular locations (Luker 1984; Ginsburg 1989; Maxwell 2002). This has provided a

wealth of information about how small groups develop and deploy goals, strategies, and recruitment techniques from larger, national organizations in order to successfully adapt them to local particularities. Other studies have focused more on the movement as a whole by simply analyzing whatever group was most prominent at the time (Blanchard 1994). By using the multi-institutional politics approach to the study of social movements (Armstrong and Bernstein 2008), my research presents a more complicated account of the movements for and against abortion by attending to the variety of actors and organizations involved in the movements as well as their diverse goals, interests, and tactics.

### **The 1990s: Times of Change**

Throughout the 1990s, the prolife movement faced a number of changes and challenges that profoundly affected their ideologies and strategies. After the rise in prominence of direct action organizations that blockaded clinics, many within the mainstream movement reassessed their strategies. Additionally, the decision in the Supreme Court case of *Casey vs. Planned Parenthood of Southeastern Pennsylvania* (1992) and the passage of the Freedom to Access Clinics Act in 1994, changed the political landscape and created new opportunities for certain kinds of activism while foreclosing others.

In *Casey v. Planned Parenthood of Southeastern Pennsylvania (Casey)*, the Supreme Court considered the legality of four different abortion restrictions: parental consent for minors seeking abortions, a mandatory counseling process in which

clinicians were required to give a woman state-created materials describing the fetus and explaining the resources available to her should she decide to continue the pregnancy, a mandatory 24 hour waiting period before the abortion, and a spousal notification law. In the past the Court had rejected parental consent laws (*Gerstein v. Coe* 1976; *Planned Parenthood of Central Missouri v. Danforth* 1976; *Bowen v. Gary-Northwest Indiana Women's Services* 1977; *Guste v. Weeks* 1977), counseling requirements (*Ashcroft v. Freiman* 1979; *Akron v. Akron Center for Reproductive Health* 1983; *Thornburgh v. American College of Obstetricians and Gynecologists* 1986), waiting periods (*Akron v. Akron Center for Reproductive Health* 1983) and spousal notification/consent (*Gerstein v. Coe* 1976; *Planned Parenthood of Central Missouri v. Danforth* 1976; *Guste v. Weeks* 1977).<sup>6</sup> However, in *Casey* the Court upheld the parental consent, mandatory counseling, and waiting period restrictions while continuing to prohibit the spousal notification requirement.<sup>7</sup>

The *Casey* decision prompted many antiabortion organizations to lobby state legislatures for similar laws requiring parent consent, 24-hour waiting periods, and specific informed consent procedures (Borgmann2013). The prolife movement focused much more on state and federal legislative action in the wake of prochoice victories in the court system (Meyer and Staggenborg 2008), thus, they were well positioned to quickly advocate for new restrictions. As I examine in more detail below,

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<sup>6</sup> The Court began to uphold parent consent and parental notification laws that had a judicial bypass option that would allow a minor to get relief from consent or notification through a judge in 1979 (*Hodgson v. Minnesota* 1990; *Bellotti v. Baird* 1979)

<sup>7</sup> Many legal scholars have analyzed the impact of the *Casey* decision in terms of the new “undue burden standard” set for by the Court (Siegel 2008; Borgmann2013) and its impact on how the Court considers issues of gender and decision making (Manian 2009).

the antiabortion movement had pursued state-level restrictions to ban or restrict abortion since 1973, but *Casey* offered a new roadmap for what kinds of restrictions the Court would uphold as well as a legal standard for additional restrictions. Further, the *Casey* decision allowed insight into how the Court saw the relationship between pregnant women and the state. As Justice O'Connor reasoned, "Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed" (872). Thus, the Court was willing to uphold restrictions that the states imposed for the purpose of ensuring the decision to terminate a pregnancy is "thoughtful and informed" as well as those that ensured the procedure was safe. This opened the door for new limitations that were deemed by states as necessary to protect the health or decision-making of women. As legal scholar Caitlin Borgmann asserts, "The joint opinion all but encouraged new encroachments on abortion rights. The mainstream antiabortion-rights movement readily accepted the invitation" (2013: 11).

It is also important to note that the *Casey* decision marked an important change in dynamics between the prolife and prochoice movements. As Meyer and Staggborg (2008) argue, defeated in the Supreme Court in the *Roe* decision, prolife organizations turned their efforts on the legislative branches of state and local government. Prochoice organizations, on the other hand, sensed that they could have more success within the court systems and then spent much of the 1980s trying to make up ground by targeting federal legislatures (2008). While both sides of the



debate declared *Casey* to be a defeat, it did represent an opening for the prolife movement to refocus their efforts within the legal system.

While *Casey* opened up new opportunities for organizations within the prolife movement that focused on legislative actions against legal abortion, direct action organizations began to face a series of setbacks. As mentioned previously, in the late 1980s and early 1990s there was a rise in prominence of groups like Operation Rescue that blockaded clinics. This type of activism was targeted by prochoice groups and elected representatives on two fronts. First, the clinics began to sue Operation Rescue for monetary damages related to loss of business (Blanchard 1994). In 1990, Randall Terry had to close the headquarters of the organization and relinquish control of the group when the fines levied against Operation Rescue totaled over \$450,000 (Blanchard 1994: 65). Other Operation Rescue affiliated groups faced similar financial difficulties. Second, in 1994 Congress passed and President Bill Clinton signed the Freedom to Access Clinic Entrances (FACE) Act which made it a federal crime to physically interfere with a person's ability to enter a reproductive health clinic. The FACE Act was a significant victory for the prochoice movement, and essentially criminalized the direct action tactics of organizations like Operation Rescue. Further the purview for prosecution rested with the federal government rather than local governments that might be more sympathetic to the goals of prolife organizations.

### **Axes of Change**

As some political opportunities opened and others closed, organizations began to see the states and the courts, rather than the federal government, as a more productive arena to fight abortion rights. In pursuing more state-level measures to decrease access to abortion, an ideology of incrementalism or chipping away at abortion rights became more prominent within the antiabortion movement. The purist ideology, which holds that abortion should be made illegal through the overturning of *Roe v. Wade* and the adoption of a constitutional amendment that grants a right to life at the moment of conception, fell out of favor. In addition to these shifts in ideology and arena, the development of women-centered strategies to restrict abortion became more important within the movement. As John Willke, the former president of the National Right to Life Committee, recounted the language of “choice” had come to dominate the abortion debate and polls showed that prolife were largely seen as anti-woman (2001). By framing opposition to abortion as grounded in concerns for women’s wellbeing, the prolife movement was able to respond to prochoice criticism and provide a new message that could broaden the appeal of the movement to less religious folks. Organizations of women who regret their abortions and crisis pregnancy centers have existed in the earlier period of the movement. In the 1990s, prolife leaders started to see these organizations as central to a “double argument” that abortion was harmful to both fetuses and women (Colmar 2009), and as important in policies to limit access to abortion. Finally, with a greater emphasis on pursuing state-level, incrementalist legislation focused on protecting women from abortion providers,

there was an increased interest in the science of how abortion impacts women, particularly in regards to mental health, breast cancer risk, and future fertility.

### Federal to State

The prolife movement originated in state-level grassroots activism to oppose the liberalization and legalization of abortion, but coalesced into a national movement after the *Roe v. Wade* decision with the financial help and organizational support of the Catholic Church (Munson 2008:85). Many activists within the early movement reported shock at the sweeping scope of the *Roe* decision (Luker 1984). During the first twenty years of the movement (1970 to 1990) the “primary venues of battle over abortion” were state legislatures, the U.S. Congress, and the courts (Munson 2008: 87). During the early years of the movement, several federal-level restrictions on abortion were achieved. In 1976, Congress passed the Hyde Amendment, which bars the use of certain federal funds to pay for abortions. This restriction has been attached to annual appropriations since its passage and primarily affects the use of Medicaid funds by states. Similarly, Ronald Reagan enacted the “Mexico City Policy” in 1984 which withholds USAID grants and assistance from non-governmental organizations (NGOs) that perform or promote abortions, prevents NGOs receiving USAID money from lobbying for the liberalization or decriminalization of abortion, and prohibits health workers in USAID-funded NGOs from “actively promoting” abortion in countries where abortion is legal (Cincotta and Crane 2001). With conservative presidents in office from 1981 to 1993 and Republican Senate majority from 1981-1987, changing abortion law at the federal level was a viable option

During the 1980s the antiabortion movement also faced many defeats. None of the federal bans on abortion or the Human Life Amendment were seriously considered in Congress and the Supreme Court overturned many state-level restrictions on abortion. By the mid- 1990s the political landscape had changed dramatically and opened up new opportunities for prolife policies. As previously mentioned, in 1992 the Supreme Court upheld a series of state-level abortion restrictions including parental consent, mandatory waiting periods, and mandatory counseling requirements. With this decision, antiabortion groups could work to pass similar restrictions in other states. Additionally, the election of Bill Clinton, a vocal proponent of abortion rights, to the office of President meant that any federal prolife legislation faced a likely veto at the White House. Finally, a greater emphasis on state-level restrictions was facilitated by the work of the Christian Right, which focused on electing social conservatives to office in elections both big (e.g. federal offices) and small (e.g. local school boards) (Diamond 1998). Regardless of the reigning political party in Washington, prolife activists could make significant gains in states controlled by Republicans.

Data from the Guttmacher Institute shows that there was an increase in abortion restrictions enacted in states in the years following *Casey* and Clinton's election. For example, in 1992 states enacted fewer than 10 abortion restrictions. By 1997 that number was just under 30 (Gold and Nash 2012). This trend has since accelerated. In 2007, the Supreme Court upheld a federal ban on a particular abortion procedure in *Gonzales v. Carhart*. This decision marked the first time that the Court

was willing to allow a procedure to be banned under all circumstances without any exception to protect the life or health of the pregnant woman (2007) and gave hope to many antiabortion activists that the Court would be more willing to consider greater restrictions on abortion. Additionally, in 2008 President Barack Obama was elected and again federal antiabortion legislation would be subject to veto. Additionally, the prochoice organizations would have more sway with the executive branch. The Guttmacher Institute notes that in 2005 states enacted 35 new abortion restrictions. In 2011 that number had reached a record level with 92 new abortion restrictions (Gold and Nash 2012). Within the prolife movement the courts as well as state and federal legislatures remain the primary arenas in the battle over legal abortion. However, shifts within the Supreme Court's thinking on abortion and the election of Democratic presidents during the 1990s and late 2000s made the states much more appealing venues to enact abortion restrictions.

#### Purist to Incrementalist

The changes in the political landscape of the 1990s also reinvigorated an ongoing debate within the antiabortion movement between factions that wanted to pursue strategies that sought to completely recriminalize abortion in all cases except to save the life of the pregnant woman (purists) and those that saw greater opportunities for success towards that goal by gradually restricting access to abortion (incrementalists). Throughout many of the early years of the movement, prolife organizations favored purist strategies such as legal challenges to ban all abortions or constitutional amendments to recognize human life as beginning at conception

(Borgmann 2013). However, there was always a faction within the movement that advocated for an incrementalist approach to end abortion. Incrementalists had a significant victory with the *Casey* decision, and as Caitlyn Borgmann argues, incrementalism has become entrenched among mainstream prolife organizations like the NRLC and Americans United for Life.

In addition to pointing to a string of successes of enacting abortion restrictions, advocates of incrementalism (or pragmatic approaches to ending abortion) argue that their approach measures target those in the “mushy middle,” people who do not identify as either prochoice or prolife or who feel that abortion is morally wrong, but a necessary evil. In his extended argument for women-centered incrementalist legislation, David Reardon argues that “the general public is quite receptive to expanding women’s rights in ways which would reduce abortion or make it safer” (1996a: 27). Reardon proposes that informed consent laws, greater safety regulations of abortion clinics, and mandatory waiting periods are all abortion restrictions that could be framed as expanding women’s rights and that the general public would accept. Incrementalist strategies also better mirror the logic of legislative institutions. For example, Ainsworth and Hall argue that federal legislators typically propose incremental abortion policies and face significant incentives to do so (2011).

Incrementalism has a very vocal, if not large, contingent of critics within the antiabortion movement. More radical direct action organizations like Operation Rescue still characterize incrementalism as a serious threat to the goals of the prolife movement. Other organizations such as Personhood U.S.A. have continued to lobby

states to adopt human life amendments that are more in line with purist approaches to ending abortion. Further, some within the movement have critiqued incrementalism for conceding that abortion might be acceptable in some circumstances (Beckwith 2007). Despite these concerns, most prolife organizations have adopted an incrementalist approach of chipping away at access to abortion.

### Women-Centered Strategies

Since the mid-1990s there has also been a sustained engagement with women-centered strategies to limit access to and recriminalize abortion. These strategies are based in the belief that abortion should be recriminalized because it is harmful to women and include policies that aim to restrict access to abortion under the auspices of protecting women.

As will be discussed in greater detail, a few prolife researchers in the early 1980s began to propose that some women suffered from Post Abortion Syndrome, a variant of Post-Traumatic Stress Disorder that was characterized by acute anxiety in the months and years following their abortions (Rue 1981). Around the same time, some women began to form support groups based on their negative experiences following their past abortions, and these women also began to be involved with prolife organizations (Mann 1987). One of these women, NancyJo Mann, approached Dr. John Willke, then president of the National Right to Life Committee about her struggles following a botched saline abortion. Willke recounts that upon meeting Mann he realized that he could make a “double argument” against abortion. Willke reasoned that abortion should be recriminalized because it ends the life of an unborn

child and because it damages women (Colmar 2009). The argument that women were harmed by abortion gained some traction within the prolife movement and many post-abortion support groups were formed, but there was not a clear way to translate the argument into policy action.

In the aftermath of the *Casey* decision, organizations within the prolife movement began to have a clearer sense of exactly how to use the argument that abortion harms women to restrict access to and recriminalize the procedure. As stated above, the Court reasoned that the state had a valid interest in insuring that abortions were performed in medically safe environments and that the woman's decision to end the pregnancy was thoughtful and informed when considering the mandatory counseling and waiting period requirements in *Casey* (1992). Thus, abortion restrictions that were enacted under the banner of protecting women were a viable option for antiabortion groups. The adoption of incrementalism provided a means for operationalizing women-centered strategies.

In addition to this change in the political opportunity structure (Tarrow 1998; McAdam 1999), the National Right to Life Committee also conducted research on what prolife frames were most appealing to people who were not aligned with either the prochoice or prolife positions, often referred to as the "mushy middle." The results indicated that while most people agreed with the prolife position that abortion ended the life or potential life of a fetus or embryo, many within that same group also felt that women should have the right to abortion (Willke 2001). Similarly, David Reardon, a prolife activist who has written extensively on abortion's harm to women,



argued that the trauma caused by abortion was a significant public health issue that was left unaddressed (Reardon 1996a). Thus, collective action frames and policies that focused on protecting women from the harms of abortion served multiple purposes. According to Willke, it gave the prolife movement a rebuttal to feminist arguments that antiabortion activists lacked compassion for women struggling with an unintended pregnancy (Willke 2001). And according to Reardon, it allowed the movement to push for several abortion restrictions that were acceptable to the “mushy middle,” such as parental consent, mandatory counseling, and waiting periods (1996a). Many organizations within the antiabortion movement have taken up the argument that abortion harms women. In some cases these women-centered strategies are the primary argument the organization makes against abortion, and in others it complements more traditional fetal-centered arguments (Borgmann 2013).

The turn to women-centered strategies reflects both changes in political opportunity structures as well as a response to the changing dynamic between the prochoice and prolife movements (Lo 1982; Meyer and Staggenborg 1996; Rohlinger 2002; Esacove 2004; Meyer and Staggenborg 2008). Research has shown that as one of these movements finds success in particular arenas of conflict, tactics, or demands, the other attempts to change tack to slow its opposition’s progress (Meyer and Staggenborg 2008). For example, when prolife organizations started to see gains in getting Congress to write laws restricting funding for abortion, the prochoice movement shifted strategy in order to build relationships with members of Congress to oppose these efforts (Meyer and Staggenborg 2008). And, as Anna Esacove found, the

two movements have even modified their framing of particular issues, like the ban on partial birth abortion, to respond to the challenges of their opponents (2004). The shift to women-centered strategies represents, in part, an attempt by the prolife movement to address challenges posed by the prochoice movement about how it represents the interests of women. It is also important to note that this shift in strategy is partially an attempt to influence public opinion. Those in the “mushy middle” were seen as sympathetic to both the struggles of women facing an unplanned pregnancy and some restrictions on access to abortion. The movement that could best frame their position to capitalize on those sympathies would have a better chance of winning more supporters.

#### Science of Abortion’s Harm to Women

The prolife movement has often been portrayed as a primarily religious movement that is invested in making moral arguments against abortion based on the belief that human life begins at the moment of conception and that terminating a pregnancy is morally wrong because it is the illegitimate ending of a unique and innocent life. This moral argument is certainly at the heart of many activists’ opposition to abortion. It does not, however, fully encompass the ways in which antiabortion groups contend with scientific knowledge about fetal development and abortion’s impact on women. Many scholars have analyzed how the antiabortion movement has effectively utilized scientific knowledge about fetal development and imaging technologies like ultrasound to make the case for fetal personhood. Ultrasound images are often taken to exemplify the way that medical imaging allows

us to see the fetus outside of the context of the mother's body (Haraway 1997; Hartouni 1997). The commodification of babies through the use of reproductive technologies has also served to develop the idea that the fetus is separate from the mother and has interests that are distinct and sometimes in competition with those of the mother (Franklin and Ragoné 1998; Berlant 1997; Ginsburg and Rapp 1995). However, to engage in policy relevant debates about abortion's harm to women, antiabortion organizations had to cultivate new engagements with science. Though the prolife movement continues to make scientific claims about the fetus, since the mid-1990s it has also had a more extensive engagement with scientific claims about abortion's harm to women.

It is not entirely clear how much the shift to making scientific claims about abortion's potential harm to women was a deliberate or calculated effort on behalf of the movement leadership or if some activists simply identified an opportunity. As discussed in greater detail in the following chapters, new intellectual opportunity structures (Waidzunas 2013) opened up in both the debate over the potential role reproductive events might play in breast cancer research and the expansion of diagnostic criteria for Post-Traumatic Stress Disorder. Researchers who were critical of abortion certainly capitalized on both of these. It is also possible that movement leadership found benefit in being able to frame their opposition to abortion in terms of scientific claims about fetal development and anticipated that similar scientific arguments about abortion's harm to women would grant them more credibility with policy-makers.

In general, scientific arguments about the fetus differ from scientific arguments about abortion's harm to women in at least one significant way. The prolife movement typically relies on scientific arguments about fetal development and genetics that are produced by researchers with no ties to the movement. As I will demonstrate in Chapters 2 and 3, scientific knowledge about abortion's harm to women, particularly possible associations between the procedure and breast cancer and mental illness, often is produced by or interpreted by researchers aligned with the antiabortion movement. Additionally, since the mid-1990s the prolife movement has engaged much more with contested scientific knowledge about both fetal development and abortion's harm to women. During the 1980s many of the scientific claims made about fetal development by the prolife movement were drawn from medical textbooks or common understandings of genetics (i.e. that from the point of fertilization the embryo has DNA that is distinct from its mother). Many of the earliest mandatory counseling laws required women to receive information about the different stages of fetal development with widely accepted milestones like heartbeat, appearance of distinguishable fingers and toes, and development of facial features. Since 2010, however, thirteen states have passed laws that ban abortion at or before 20 weeks gestation based on the highly contested claim that the fetus can experience pain at that point in development (Johnson 2013). Similarly, five states have enacted laws that require doctors to inform patients that abortion is associated with an increased risk of breast cancer and eight require women to be informed of the long-term negative mental health consequences of having abortions (Guttmacher Institute 2014b). These

claims are also highly contested and many scientific institutions, including the American Medical Association, the American College of Obstetricians and Gynecologists, and the American Psychological Association, maintain that legal, first trimester abortions are safe and not associated with these harms. In the proceeding chapters, I examine more completely how the antiabortion movement has engaged in knowledge production about abortion's potential harms.

### **Streams of the Pro-life Movement**

In addition to these shifts in ideology, targets, and strategies within the antiabortion movement, there have also been changes in how different types of organizations have taken up these new strategies. In this section, I review how more recent scholarship on the antiabortion movement has begun to view the movement as a collection of "streams," each focused on different types of activism but united in a common goal to end abortion (Munson 2008). Ziad Munson identifies four distinct streams of the pro-life movement: the politics stream, the direct action stream, the individual outreach stream, and the public outreach stream. Munson's breakdown largely focuses on the commonality among organizations in each stream in terms of *what* they do. Though this goes a long way towards challenging a monolithic view of the movement, it does not include ideological dimensions, particularly along the purist vs. incrementalist dimension. For example, many of the organizations that would fall under the politics stream are divided on whether to pursue purist approaches. I build on Munson's analysis by adding other types of organizations that engage in activism

not accounted for in his taxonomy, including post-abortion organizations and professional and health policy organizations. The process of categorizing organizations within the movement by target and strategies uses concepts from the multi-institutional politics approach by demonstrating that organizations with a similar goal target different institutions as well as culture and that organizational strategies vary depending on the target.

Additionally, I highlight three types of organizations - crisis pregnancy centers (Munson's individual outreach stream), post-abortion groups, and professional and health policy organizations - that have been understudied within the scholarship on abortion. Although these organizations have existed since the beginning of the movement, it has only been in the past decade that they have become prominent within the movement. I argue that their prominence is associated with their role in developing and promoting in women-centered strategies and scientific arguments about the alleged harm of abortion and facilitating women-centered strategies. Finally, I demonstrate that this women-centered strategies and scientific arguments about abortion's harm have been taken up by most of the antiabortion movement.

The following sections give details about different types of organizations within the field of antiabortion contestation. For each category of organization, I provide an example of a specific group that is representative of that category, as well as what that group identifies as its targets and what strategies it commonly uses to bring about change. Finally, I discuss the extent to which these organizations have adopted women-centered strategies and how they use information about the health

consequences of abortion to further their goals. Table 1 summarizes these categorizations and provides a visual representation of the types of organizations that comprise the antiabortion movement.

**Table 1: Targets and Strategies of the Antiabortion Movement Streams**

Type of Organization	Example	Targets	Strategies	Women-centered strategies	Tie to Health Policy
Policy and lobby organizations	National Right to Life Committee; Americans United for Life	Federal, state, and local government officials	Letter writing; Candidate endorsement; Marches; Writing sample legislation	For many (NRLC; AUL; ALL) women-centered strategies are complementary, for “purist” organizations they are absent	Used on website as justification for recriminalization; sample legislation typically designed to ensure “women’s safety” by restricting abortion
Direct Action at Clinic Type I: Shutdown Organizations	Operation Rescue; Operation Save America	Clinic doctors, employees, vendors, and patients	Shutdown clinics through nonviolent barricades (pre-’94)	Absent	None
Direct Action at Clinic Type II: Picket Organizations	American Life League	People entering clinic; Clinic doctors and employees	Educational campaigns; Picketing; Sidewalk Counseling	For some, primary; for others, complementary	Used in distributed materials as a way to avoid religious claims
Direct Action Away from Clinic	Justice for All	General public, particularly young adults	Large photo displays or billboards about abortion	Complementary	Used as part of the photo displays and on billboards
Crisis Pregnancy Centers	Heartbeat International; Carenet	Women experiencing unplanned pregnancies	Pregnancy and post abortion counseling	Primary	Used in printed materials and counseling to dissuade women from having abortions
Post Abortion Organizations	WEBA; Silent No More; Rachel’s Vineyard	Women who have abortions; General public	Collect and present testimonials of women harmed by abortion	Primary	Use research to back up experiential evidence; Participate in research



**Table 1: Targets and Strategies of the Antiabortion Movement Streams, continued.**

Type of Organization	Example	Targets	Strategies	Women-centered strategies	Tie to Health Policy
Professional and Health Policy Organizations	Physicians for Life; Association of Pro-Life Obstetricians and Gynecologists	Patients or clients; Professional peers; Policy-makers	Educational campaigns; Endorsements of policies; Expert testimony	Primary	Part of educational campaign; Endorse policies and statements about abortion's harm; Provide expert testimony for restricting abortion

#### Policy and Lobby Organizations

One set of organizations in the contemporary antiabortion movement targets federal and state government officials to restrict access to abortion and to eventually recriminalize the procedure. Organizations within this set would be equivalent to Munson's "politics stream." Their activism and strategies are entirely based on achieving change through democratic political channels at the local, state, and federal level. The NRLC tracks voting records of legislatures and gathers information about candidates' views of "life" issues during elections. The types of activism promoted by the organization include writing letters to elected representatives, encouraging voting for candidates who are against abortion, lobbying elected officials, and writing abortion laws. Most organizations that fall within this stream have fully adopted incrementalist approaches to recriminalizing abortion. Within policy and lobby organizations, women-centered strategies are used alongside fetal-centered strategies.

Given John Willke's tenure with the National Right to Life and his advocacy for the "double argument," it is not surprising that the organization has adopted women-centered strategies. American Victims of Abortion, a post abortion organization, is affiliated with the NRLC. The NRLC has also incorporated the potential health risks of abortion for women into their justification of why abortion needs to be recriminalized, but it is not entirely clear how this information is used in their activism (NRLC Educational Trust Fund 2006).

While the National Right to Life Committee lobbies for antiabortion legislation and promotes prolife candidates, another policy and lobby organization, Americans United for Life (AUL), writes model legislation that has been used to restrict abortion access at the state-level. Americans United for Life was incorporated in 1971 and was critical in many prolife successes including defending the Hyde Amendment before the Supreme Court and establishing fetal-homicide laws in 36 states. In 2006, AUL began publishing *Defending Life*, a guidebook of prolife model legislation (AUL website 2014). AUL's model legislation covers nearly every aspect of prolife concerns, from abortion restriction to assisted suicide bans. In its current catalogue, it offers two informed consent acts – the "Woman's Right to Know Act" and "The Woman's Ultrasound Right to Know Act" - and the "Women's Health Defense Act" which proposes to ban abortion after 20 weeks. These pieces of model legislation exist alongside more traditional prolife initiatives that defund medical facilities that provide or advocate for abortion, restrict health insurance coverage for abortion, and TRAP laws ("About AUL" 2014). From January 2011 to June 2012 state legislatures had

adopted 109 new abortion restrictions with about one-third of those being written by the AUL (Bazelon 2012: 22). The model legislation written by the AUL uses claims about abortion's potential harm to women to justify further restrictions on the procedure. For example, the AUL's "Women's Right to Know Act" includes a specific requirement that women seeking abortions be informed of "the immediate and long-term medical risks associated with the proposed abortion method including ... increased risk of breast cancer," (Defending Life 2012: 260).<sup>8</sup>

### Direct Action at Clinics

Three types of organizations target abortion clinics and utilize them as sites of activism. The first are organizations that seek to shut down clinics or to interrupt operation of the clinic. During the late 1980s and early 1990s, these organizations staged activism as abortion clinics across the country. Operation Rescue was founded in 1986 by Randall Terry and became the most well-known of these organizations. Members would block access to the clinics by disabling doors and putting their own bodies in the way of clinic entrances with the goal of temporarily shutting down the clinic. In interviews conducted by Carol Maxwell (2002), activists involved in this type of direct action drew on a long tradition of non-violent strategies and felt that this

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<sup>8</sup>Not all antiabortion policy and lobby organizations have fully adopted incrementalist or women-centered strategies. Personhood U.S.A. lobbies state legislatures to enact laws recognizing that life begins at conception and granting full citizenship rights from that point. Rather than laying out the ground work for future legal attacks on abortion, Personhood Amendments are designed to be a legislative attempt to make all abortions illegal, the hallmark of the purist approach. . Since 2006, a number of states, including Florida, Mississippi, and Ohio, have attempted to pass personhood amendments to their constitutions through legislation or ballot measures (Eckholm 2011). These measures have been unpopular with voters because they are written in ways that could outlaw common types of contraception, like birth control pills and IUDs, and interfere with assisted reproductive technologies. Personhood amendments have been opposed by prochoice groups, but also by national prolife organizations, such as the NRLC and Roman Catholic bishops, that have committed to the incrementalist strategies (Eckholm 2011). Claims about abortion's potential harm to women are absence from the website of Personhood U.S.A.

extreme tactic was needed to draw attention to the immoral act of abortion. In 1994, the Freedom to Access Clinic Entrances Act (FACE Act) was signed into law by President Clinton and made much of this type of activism illegal. By this time Operations Rescue had a national organizations and a number of regional groups and after this change in law, Operation Rescue split into two organizations – Operation Rescue and Operation Save America.<sup>9</sup>

Operation Save America and Operation Rescue have been two of the most vocal organizations in opposition to the incremental approach to end abortion. For example, Operation Save America has a number of brochures that make Biblical arguments against incrementalism, including “Incrementalism - The Lie from the Pit of Hell!” (Benham n.d.). Operation Rescue supported Personhood Amendments in a number of states and South Dakota’s attempts to ban abortion (Eckholm 2011). Additionally, these organizations have not fully taken up women-centered strategies. Operation Rescue has a section of their website dedicated to defining and listing the symptoms of Post-Abortion Syndrome. Operation Save America’s website is largely silent on the issue of abortion’s potential harm to women and does not link to any post-abortion organizations. This illustrates the strong connection within the

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<sup>9</sup>Operation Save America gave up on earthly interventions to end abortion. In the brochure “To End All Abortion” the organization denounces the effectiveness of legislative change to restrict access to abortion and declares that the only way to end abortion is to repent before the Christian God and to institute a Christian theocracy in the U.S. (Benham 2008). The organization still encourages activism at clinics, but aside from converting people to Christianity, it is unclear what exactly members are being asked to do. The other, operating under the name Operation Rescue continues to protest at clinics and targeted providers of second and third trimester abortions. A central target of Operation Rescue was the George Tiller’s Wichita clinic, Women’s Health Care, which performed abortions during up until the point of fetal viability. As Carole Joffe documents, prolife activists were not just a central presence outside of the clinic until Tiller’s murder in 2009, but also harassed clinic staff at their homes and attempted to close the clinic by threatening boycotts of any business that provided services to the clinic or clinic staff (2010).

movement between adopting an incrementalist approach and engaging with scientific arguments and women-centered strategies.

The second type of direct action at clinics involves picketing abortion clinics and counseling women as they enter the clinic to dissuade them from going through with the procedure. Organizations such as the America Life League, the Pro-Life Action League, and 40 Days for Life are involved in this type of activism (American Life League website; Pro-Life Action League website; 40 Days for Life website). These organizations do not attempt to directly interfere with clinic operations, but rather attempt to keep clients from entering and thereby prevent them from terminating their pregnancy. The strategies employed by these organizations fall along three lines. Some activists will picket in front of the clinic with signs that tell of the moral dangers of abortion. Other activists participate in “sidewalk counseling,” which is intended to be a less confrontational way to educate women about the dangers of abortions and to convey empathy for their situation. The training manual for sidewalk counselors provided by the American Life League, a Catholic organization, instructs counselors to introduce medical and scientific information about abortion and its consequences before discussing religious beliefs. The goal of this particular strategy is to provide “neutral” information rather than moralistic arguments that can be dismissed as beliefs rather than facts (Fetrow 2005). Often sidewalk counselors will encourage women to seek services at a nearby crisis pregnancy center. Finally, some direct action organizations will simply pray outside of abortion clinics. Once a year, 40 Days for Life organizes a national prayer and fasting vigil to end abortion.

Members are asked to conduct a 40 day, round the clock prayer vigil at their local abortion clinic. Participants are tasked with praying for “innocent children who are at risk of perishing,” “women who are at risk of having an abortion,” and “men and women who carry pain of a past abortion experience” as well as clinic workers, elected leaders, and churches (Website). In each of these cases women-centered strategies are used, often complementing arguments about the fetus.

Policy and lobby organizations and organizations that engage in direct action at the clinic are the most well recognized types of antiabortion organizations. In fact, the majority of scholarship has focused on these types of groups (Maxwell 2002; Blanchard 1994; Ginsburg 1989; Luker 1984). An ideology of incrementalism and the use of women-centered strategies have become common in most of these types of organizations. Additionally, it is also clear that many of these organizations use scientific arguments about the harms of abortion as part of their rhetorical repertoire. This indicates that the science frame has diffused to the traditional organizations associated with the movement against abortion. There are three notable exceptions to this trend, Personhood U.S.A, Operation Save America, and Army of God. With structural changes, like the passage of the FACE Act, as well as increased negative media coverage of violence at abortion clinics, these types of organizations declined in prominence within the movement.<sup>10</sup> If these organizations represent the more radical spectrum of the antiabortion movement, it may indicate that the scientific frame is more resonant with the moderate or mainstream organizations within the movement.

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<sup>10</sup> With the recent Supreme Court decision in *McCullen v. Coakley*, which struck down a Massachusetts law that created buffer zones near the entrances to clinics that provide abortion, it is unclear whether there will be an increase in direct action outside of clinics.

I turn now to four other types of antiabortion organizations that are largely responsible for the development and promotion of scientific arguments against abortion and the claim that women are harmed by abortion. Some of these organizations, like post-abortion groups and professional and health policy groups, are actively involved in furthering the characterization of women as victims of abortion and claiming to be the true representatives of women's interests about abortion and its potential effects on future health. These types of organizations have been understudied by scholars of the antiabortion movement.

#### Public Outreach

Munson refers to organizations that conduct educational campaigns about abortion in order to raise public awareness of the issue at locations other than the clinic as the public outreach stream of the prolife movement. While these organizations will conduct public protests like those done by organizations that target the clinic, its employees, and its clients, the targets in this case is the general public. An example of this type of organization is Justice for All, which focuses on changing the cultural attitudes that make abortion an acceptable medical procedure for women. The organization states that its mission is to “train thousands to make abortion unthinkable for millions, one person at a time” (Justice for All 2003). This is accomplished by setting up large, provocative photo displays on college and university campuses across the U.S. Organization volunteers then stand around the exhibit answering questions and engaging in debate about the issue of abortion with people passing by. The photo displays feature pictures of aborted fetuses, statistics about

abortion and fetal development, as well as comparisons of abortion to other instances of genocide. The display also features a full panel on the health risks that may be associated with abortion. The organization states: “We also want women to be spared the physical and psychological perils associated with abortion, as well as the violence of abortion that takes the lives of their unborn children” (Justice for All 2003). Again, the attempt here is to represent their opposition as based on both scientific and moral reasons that incorporate empathy for women who may face physical danger from having an abortion.

### Crisis Pregnancy Centers

Crisis pregnancy centers (CPCs) target women who are experiencing an unintended pregnancy and are considering abortion and are sometimes referred to as pregnancy help centers or pregnancy resource centers. Munson (2008) describes CPCs as composing the “individual outreach stream.” In 2013, it was estimated that there were about 2,500 crisis pregnancy centers (Belluck 2013) and most are affiliated with either Carenet, Heartbeat International, or Birthright International. Centers are typically run by volunteers in association with local churches or antiabortion organizations. Commonly, these facilities will provide a free pregnancy test as well as counseling on the dangers of abortion and the benefits of adoption and parenting. In some cases resources such as help with rent payments and baby supplies are given to women who decide to parent or place the child for adoption rather than terminate the pregnancy. Many CPCs also run post-abortion counseling programs, such as Forgiven



and Set Free, a post-abortion treatment program that emphasizes overcoming the unresolved grief associated with abortion and seeking forgiveness from God.

Crisis Pregnancy Centers have also come under criticism for giving women medically inaccurate information and for masquerading as medical facilities. A study of CPCs that were recipients of federal funding found that 20 of 23 centers provided false or misleading information about the health effects of abortion including that abortion was associated with increased risk of breast cancer and mental illness (U.S. House Committee on Government Reform 2006). Additionally, several cities including Austin and New York have attempted to regulate CPCs by requiring them to post signs indicating that they do not provide abortions or contraception and whether medical staff is present on site (Belluck 2013).

#### Post-abortion Organizations

Post-abortion organizations are activist organizations that are composed of individuals who have come to regret their abortions and treatment regimes designed to help those suffering from “post-abortion syndrome.” Most of these programs are aimed at women, but in many cases men whose female sexual partners have had abortions are included in these groups. The targets for these types of organizations are the general public, women who have had abortions, and men who have come to oppose the abortions a previous sexual partner had. The central goal of these organizations is to educate the general public about the harms of abortion. The types of activism that these organizations typically participate in is the collection and publicizing of abortion regret stories as well as claims by individual women that they

have experienced psychological or physical danger from their abortions. For example, the website for Silent No More features testimonials of women and men who been negatively impacted by abortion (Silent No More website). Additionally, post-abortion organizations frame women's concerns about abortion in terms of empowerment and overcoming a previous state of victimhood. In the testimonials, women often claim to be have been pressured to get an abortion by family members, partners, and friends and have been influenced by pro-abortion rhetoric. The process of telling the story of their exploitation, the consequences of abortion, and their healing (usually accompanied by a religious experience) is associated with empowerment.<sup>11</sup> Post abortion organizations often claim to be more legitimate representatives of women's interests than feminists associated with the prochoice movement.

This contest over who represents the rights of women is not new to the conservative movement. Schreiber argues that conservative women's movements, like Concerned Women for American and the Independent Women's Forum, often claim that feminists do not represent the majority of American women and assert that they are the legitimate and authentic representatives of women's interests (2008, see also Klatch 1986). Schreiber also notes that these organizations use scientific claims about

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<sup>11</sup>Further evidence of the transition to scientific frameworks that characterize women as victims of abortion can be seen in the rise of the organization Feminists for Life (website). To mark the 30<sup>th</sup> anniversary of the Supreme Court case, Roe vs. Wade, Feminists for Life launched a new antiabortion campaign called "Women Deserve Better Than Abortion" (Foster 2003). This campaign provides an example of the contestation over identity categories associated with the feminist movement. First, the use of the term *feminist* in the organization's name signifies an allegiance with the women's liberation movement that sought to free women from their traditional social roles. Additionally, the campaign focused on the harm that legal abortion has caused women over the past 30 years and demands something better for women. For Feminists for Life this "something better" is an examination of the reasons women choose to have abortions and more resources to help young, college-aged women parent.

women's health to bolster their status as representatives (97-106). Post abortion organizations demonstrate that this trend extends from the conservative movement into the antiabortion movement and illuminates the consequences of identity politics as well as the complicated way that identities are deployed strategically depending on context.

### Professional and Health Policy Organizations

Professional and health policy organizations, like Pharmacists for Life, American Association of Pro-life Obstetricians and Gynecologists (AAPLOG), and the Elliot Institute, are groups that share a common profession as well as a common belief that abortion is morally wrong (Physicians for Life website; Pharmacists for Life website). While these organizations may not be the most recognizable face of the antiabortion movement, they play a larger role in lending credibility to the claims that abortion is harmful to women. Members of this type of organization are encouraged to educate their professional peers, patients/clients, and the general public about the dangers of abortion. The use of scientific arguments about abortion is particularly salient in antiabortion organizations of health professionals who can use their authority as healthcare providers to endorse position statements or even legislation of other antiabortion organizations. For example, the Coalition on Abortion/Breast Cancer lists eight medical associations that recognize a causal link between abortion and breast cancer, including the American Association of Pro-Life Obstetricians and Gynecologists (Coalition on Abortion Breast Cancer 2014).<sup>12</sup>

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<sup>12</sup>In *Abortion and the Politics of Motherhood*, Kristen Luker argues that the nascent prolife movement in California was comprised of individuals who belonged to professional associations like Catholic

In addition to lending credibility to claims about the dangers of abortion to women's health, occupational organizations have also been a major part of attempts to restrict access to abortion and contraception. Most states have enacted legislation that allows health care providers to refuse to participate in medical procedures with which they are morally opposed, especially abortion, sterilization, and the distribution of prescription contraceptives without fear of losing their jobs (Guttmacher Institute 2014e). Pharmacists for Life has been active in protecting and expanding these refusal or conscience clauses and have been successful (Pharmacists for Life 2014).<sup>13</sup> This example demonstrates how scientific and moral arguments about abortion are both deployed by similar organizations. The establishment and expansion of conscience clauses as well as the endorsements of occupational organizations to statements about the health consequences of abortion indicate that the role of these types of organizations needs to be analyzed further.

Professional and health policy organizations within the antiabortion movement have sought to fund and publicize scientific research on the physical and psychological dangers of abortion. Currently there are three main areas that such

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doctors groups (1984: 128-137). According to Luker, the movement to reform abortion law in California was spearheaded by doctors and lawyers who identified illegal abortion as a serious health issue and sought to decriminalize the medical procedure to address a public health problem. Organizations of Catholic professionals were able to oppose these attempts at reform based on the legitimacy of their status as medical professionals and lawyers. While the role of occupational organizations was emphasized in Luker's work, this segment of the antiabortion movement has since fallen out of the purview of scholars of antiabortion politics, but the work of Carole Joffe tells a parallel story of the role of physicians and professional health organizations in the movement to provide abortions (1995).

<sup>13</sup> Lori Freedman's *Willing and Unable* (2010) is an excellent resource for how the expansion of Catholic hospitals and health care groups (which utilize these conscience clauses) have restricted the practice of abortion among doctors who would otherwise provide this type of care. These types of limitations have a broad impact on the kind of reproductive health care women can receive, including the safe management of miscarriage.

health movements focus on: a potential link between induced abortion and breast cancer, a potential increased risk of mental illness after undergoing an abortion (often referred to as post-abortion syndrome), and a potential increased risk of infertility following induced abortions. These social movement organizations tend to target federal health regulatory agencies such as the National Institutes of Health and affiliated institutions like the National Cancer Institute, professional organizations such as the American Psychological Association, and health charities like Susan G. Komen Race for the Cure. These organizations have had some success in creating uncertainty outside of the scientific community about the health risks of abortion. Within the antiabortion movement these types of organizations fulfill an important role. First, they use the authority and credibility of science, understood as an objective enterprise, to make arguments about abortion that cannot be dismissed as moralistic or religious. Also, professional and health policy organizations strengthen the claims of post-abortion organizations by legitimizing the experiential or anecdotal evidence provided in women's stories. Finally, these types of organizations open up new groups of targets for the antiabortion movement. While other organizations target the general public's beliefs about abortion, clinics, and government legislative bodies, health policies organizations engage with federal regulatory agencies.

## **Conclusion**

The changing political landscape for the prolife movement in the 1990s gave rise to more state-level activism that was based in an incrementalist strategy of

gradually increasing restrictions on access to abortion. These new laws were often designed to limit abortion on the basis that abortion is harmful to women's health and the rationale that women needed additional protection from abortion care providers. In order to claim that abortion is harmful to women, antiabortion organizations had to engage in new ways with scientific arguments about abortion potential connections to breast cancer, mental illness, and infertility. As my analysis indicates these women-centered strategies and scientific claims about abortion's harm have proliferated into almost all the different streams of the prolife movement.

In the next chapters, I examine the scientific claims about abortion's possible association with breast cancer and mental illness in greater detail. Within the prolife movement, the validity of these claims has become important for enacting women-centered strategies. Though these potential links have been contested by experts in breast cancer research, epidemiology, and mental health, researchers who are critical of abortion have been successful at maintaining that until it is certain that such associations do not exist, policymakers should protect women through state-mandated counseling requirements.

## PART ONE: SCIENTIFIC CONTROVERSIES

The study of scientific controversies has been a central component of science and technology studies (STS) since the field's development. Controversies and conflict in science touch on many of the central questions that sociologists of science investigate, including how scientific knowledge is constructed, who is considered an expert or authority on scientific matters, and how scientific communities reach consensus over their shared knowledge and methods (Shapin and Schaffer 1985; Shapin 1995). Most studies of controversy take up the theoretical traditions of Sociology of Scientific Knowledge with its emphasis on symmetrical analysis, attention to forums of contention, and focus on the closure or resolution of debate.

Many studies of controversies adopt the tenets of the *strong programme* (Bloor 1976) and, in particular, the imperative to conduct symmetrical analyses. This means that scholars should not assume that they can rely on historical explanations that treat our current knowledge as though it emerged and stabilized because it was the most logical, rational, or true. Alternative knowledge claims must be considered as potentially valid, and scholars should invest as much time explaining why claims are rejected as they do examining why others are accepted (1976:7). In practice, this has led to studies of controversy that examine how more powerful actors use resources to limit debate as well as how less powerful actors deploy strategies to prevent debate from ending (Shapin and Schaffer 1985; Martin 1991; Richards 1991). An important implication of this approach is that groups that are typically considered “underdogs” in

scientific controversies occupy a more elevated position in symmetrical analyses than they would in other accounts of debates.

Additionally, studies of controversies in STS highlight the ways in which social factors impact the evolution, continuation, and end of debates. Harry Collins and Trevor Pinch describe two forums in which scientific controversies take place: the “constitutive forum,” which is comprised of all that is traditionally believed to constitute scientific knowledge production, and the “contingent forum,” which is made up of everything that is supposed to be “external” to scientific practice, like political maneuvering and nonscientific arguments (Collins and Pinch 1979). Collins and Pinch maintain that scientific arguments are formed through both of these forums. For example, in his analysis of the AIDS causation controversy, Steven Epstein found the debate continued because prominent scientists were able to align themselves with gay rights organizations that shared similar doubts about HIV’s role in causing AIDS (1996).

Finally, there is an emphasis on how controversies end in many of these studies. However, the issue of closure or resolution is often contentious. As H. Tristram Engelhardt and Arthur Caplan argue, controversies often exist within multiple communities (1987). While scientists are likely concerned with evaluating evidence and rival theories to explain a dispute, others might be more driven by the larger political and ethical concerns that are connected to the scientific issue. For example, the following chapters examine debates around a possible association between abortion and breast cancer and between abortion and mental illness.



Researchers in these debates are involved with research design, weighing different methodologies and evaluating research findings. Beyond this, political actors are concerned about the impact these findings will have on legal access to abortion and the types of interactions between doctors and patients that could be transformed by the results. The controversy also raises ethical issues about patient autonomy, the role of scientists in public debate, and the relationship between scientific reasoning and religious belief. Thus, the controversy does not exist in one arena, but in multiple arenas that all have different and competing standards of evidence and rules for debate. As Engelhardt and Caplan contend, sound scientific argument might bring about the end of debate among scientists, but would not necessarily impact the controversy in other arenas.

Further, there is no consensus about what closure means within STS. Engelhardt and Caplan examine three different approaches to defining closure, including Beauchamp's five types of closure (sound argument, consensus, procedural, natural death, and negotiation), McMullin's three types (resolution, closure, and abandonment) and their own five types (closure through loss of interest, closure through force, closure through consensus, closure through sound argument, and closure through negotiation) (1987: 5-15). Others have pointed to cases in which the end of debate or closure is elusive or never fully achieved. For example, in his study of the cold fusion controversy, Bart Simon found that almost all scientists were convinced within a matter of months that cold fusion was not possible. Nevertheless, a small group of researchers continued to meet, hold conferences on cold fusion, and

attempt to replicate the initial flawed experiment. Simon characterizes the liminal state of cold fusion research as “undead” (2002). Additionally, Epstein identifies four dimensions of concerns about closure – epistemological (When do we know an association has been proven?), methodological (How should evidence be evaluated and compared?), empirical (Has new evidence changed conclusions we can draw?), and political (Who is most qualified to participate in knowledge production?) (1996: 29-30). In the two cases examined in the following pages, I illustrate moments in which scientific consensus seems to form, but also argue that these controversies have still not achieved closure in all arenas.

In the past decade a number of prominent STS scholars have called for a move away from the *strong programme*'s commitment to symmetry and have developed theories that offer a normative view of science. Many express concern that conservative thinkers, social movements, and corporations “artificially maintain ... controversies” (Latour 2004) or capitalize on scientific uncertainty to stall political action (Oreskes and Conway 2010). Among scholars who have advocated for a normative turn, there has also been a diversity of positions about how far STS should go down this path. For example, Latour's distinction between “matters of fact” and “matters of concern” provides guidance for new types of critique that remain relatively loyal to constructivist leanings (2004). Others, however, have advocated for re-evaluations of the role of expertise in scientific and public debates, such as Collins and Evans's *Rethinking Expertise*. Additionally, Oreskes and Conway, in *Merchants of*

*Doubt*, argue that one way to combat scientific misinformation is to value evidence that is peer-reviewed and vetted by expert panels.

At the heart of this reappraisal is a growing concern that dissenters in scientific controversies are more powerful and are using a different set of resources than before. One only needs to compare the scrappy anti-fluoridation activists in Brian Martin's work to the industry-backed climate change scientists studied by Oreskes and Conway to see this shifting dynamic. Oreskes and Conway examine multiple controversies, including tobacco regulation, the ozone layer, missile defense, and global climate change, and found that well-placed, politically-connected, and industry-sponsored scientists were able to promote uncertainty and stall (or prevent) political action in each of these cases. The strategies used by these scientists, honed through the campaign to promote uncertainty about the health consequences of tobacco use, include critiquing mainstream scientific findings, manipulating the peer-review process, creating industry financed institutions that appear to be scientific research organizations, and disrupting expert reviews of research. In my examination of controversies over abortion's potential harm to women, I draw attention to the types of strategies used by researchers who are critical of abortion to continue controversy and promote uncertainty. I find that many of the tactics used are similar to those deployed by dissenters in the cases analyzed by Oreskes and Conway. However, my analysis diverges from the larger, normative theoretical program proposed by these scholars. Rather than arguing that scientific processes need protection from politically motivated outsiders, I explore the ways in which our understandings of how

controversies work can be expanded through greater attention to how scientists and dissenters appeal to different understandings of science and its role in society.

In the following chapters, I analyze the controversies surrounding a possible association between abortion and breast cancer and an alleged link between abortion and mental illness. In addition to providing a narrative account of how each controversy unfolds, I also examine how scientists and invested actors engaged in struggles over credibility. Credibility struggles are defined as “the constant attempt by different players to rephrase the definition of ‘science’ so that their particular ‘capital’ – their forms of credibility – have efficacy within the field” of contestation (Epstein 1996: 19). This includes disagreements over what constitutes good evidence, who counts as an expert, whether a study is definitive or fatally flawed, as well as the types of strategies used to either contain debate or continue controversy. In both cases, there are significant differences in how scientists define the question, whether they think the question is answerable, and how studies are evaluated.

Moreover, the cases highlight the types of strategies employed by mainstream researchers to contain debate and draw a boundary between the scientific concerns over a possible association and the political concerns about abortion’s legality. These strategies include many examined in other studies of controversy including ignoring dissenters’ claims, appealing to consensus, publicly defending their work, and highlighting discrepancies between the norms of scientific practice and the behavior of dissenters. Dissenters, also used many strategies previously studied, to continue debate and promote uncertainty. For example, researchers who are critical of abortion present

critiques of research, appeal to invested groups (namely the prolife movement), and demonstrate how the behavior of mainstream researchers is at odds with shared norms.

Finally, I compare how the differences between the cases and the credibility tactics used by the actors involved shape the outcomes of the controversies. This includes an examination of how the research projects were conceived, implemented and evaluated. For instance, in the case of a potential link between abortion and breast cancer, scientists were able to identify methodological flaws within the research and correct them fairly quickly and to the satisfaction of the majority. In the mental health case, the flaws of the early research were not quickly remedied and their remains considerable doubt that any study could ever truly address the issue definitively. Beyond these differences in how the research evolved, I examine how the differing strategies used by the actors influenced whether mainstream researchers were successful in their struggles over credibility and their ability to contain debate.

## CHAPTER TWO – THE ABORTION/BREAST CANCER DEBATE

In February of 2012, Republican presidential candidate and long-time abortion opponent, Rick Santorum, was asked during a FOX News Sunday appearance about the decision by the leaders of Susan G. Komen For the Cure to no longer provide funding for Planned Parenthood’s breast health services.<sup>14</sup> Santorum responded that he did not “believe that breast cancer research is advanced by funding an organization that does abortions where you’ve seen ties to cancer and abortion” and that he did not “think it’s a particularly healthy way of contributing money to further the cause of breast cancer” (Fox News Sunday 2012). According to the leaders of the prolife movement, this was the first time a major presidential candidate had addressed the “link between abortion and breast cancer” (Johnson 2012). Santorum’s assertion that abortion causes breast cancer came nearly a decade after a review of the research by scientists at the National Cancer Institute had concluded that there is no such causal link. Research published in the years between 2003 and 2012 has only supported that conclusion. Yet conservative politicians like Santorum, together with prolife activists, have been so successful in asserting the opposite that five states currently require women seeking abortions to be informed that they may be increasing their risk of developing breast cancer in the future if they end their pregnancy (Guttmacher Institute 2014b).

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<sup>14</sup> Komen later reversed their decision and restore funding for Planned Parenthood’s breast health services.

Despite widespread scientific consensus that there is no link between abortion and breast cancer, political debates and policy decisions have played an important role in continuing this controversy. As discussed in the previous chapter, the debate over an abortion/breast cancer link is a central component of the prolife movement's women-centered strategies. This chapter examines how the controversy over a potential link unfolded within the scientific community and how that debate was influenced by the larger political debate about abortion as well as invested groups, like the prolife movement. Over time, breast cancer researchers and epidemiologists began to characterize the research over a potential link as definitive: no such association exists. As research methods improved and previous flaws were corrected, a consensus emerged among these scientists. Dissenters (researchers who are critical of abortion and who advocated for a link) began to be characterized as outsiders whose concerns were political, rather than scientific. While breast cancer researchers and epidemiologists performed various types of boundary work to shore up their authority, assert scientific consensus, and push out dissenters, researchers who argued that abortion is associated with an increased risk of breast cancer drew on a different set of resources. Through political maneuvering, appealing to invested movements, and promoting uncertainty, advocates for the abortion/breast cancer link have been able to continue the controversy, particularly within the political arena.

### **Research on Reproductive Events and Breast Cancer**

The first study of a possible relationship between abortion and breast cancer, published in 1957, examined reproductive events and breast cancer rates among 2,145

Japanese women (Segi et al. 1957). Between 1957 and 1996 over 20 epidemiological studies were published that examined a possible association between induced abortion and increased breast cancer risk.<sup>15</sup> This research fit into a longer history of concerns about possible associations between various reproductive events and breast cancer risk. By 1970, it was widely known within the breast cancer research community that having a least one full term pregnancy relatively early in a woman's reproductive years reduced lifetime risk of breast cancer (MacMahon et al 1970).<sup>16</sup> Research has demonstrated that a multitude of reproductive factors including the number of pregnancies a woman has, the timing of those pregnancies in a woman's life, whether or not a woman breast feeds, her age at menarche, and her age at menopause are all associated with an increase or decrease in lifetime breast cancer risk. However, concerns about the possible impact of incomplete pregnancies (i.e. pregnancies that end in either induced abortion or miscarriage) on breast cancer risk had not been fully researched.<sup>17</sup>

Beginning in 1990, the United States went through a period of increased attention to women's health issues (Weisman 1998). During this time, federal

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<sup>15</sup>The majority of the early research on a possible link between abortion and breast cancer was published in the 1980s and 1990s. However, most studies published in the 1980s are from research conducted outside of the United States. Louise Brinton of the National Cancer Institute has claimed that "the body of research is incomplete partly because scientists using government funds were banned during the Reagan administration from using the term 'induced abortions' in survey questions. 'We were prevented from studying the issue because the government didn't support abortion,' Brinton said. 'We don't have that problem now.'" (quoted in Goodstein 1993: A1).

<sup>16</sup> Carrying at least one pregnancy to term is associated with a decrease in breast cancer risk over a woman's lifespan, but each full term pregnancy is also associated with a transient increase in breast cancer risk in the years immediately following the pregnancy. The MacMahon study examined age at first full term pregnancy and indicated that doctors had noticed associations between later full term pregnancy and elevated breast cancer risk as early as 1926 (1970: 217).

<sup>17</sup> A more thorough history of research on abortion and breast cancer through 1996 can be found in Patricia Jasen's "Breast Cancer and the Politics of Abortion in the United States" (2005).



lawmakers, activist organizations, research scientists, and federal agencies pushed for greater research into the health concerns of women, to reform health care policies to be more inclusive, and to institutionalize these reforms (Weisman 1998; Epstein 2007a). The Office of Women's Health was created within the Department of Health and Human Services in 1991. Additionally in 1992, the National Institutes of Health began work on the Women's Health Initiative, a large, multi-year study of heart disease, breast and colorectal cancer, and osteoporosis in women (Epstein 2007a). With this increase focus on women's health, a significant amount of funding was allocated for breast cancer research. In fact, breast cancer receives the most funds of all cancer research ("Cancer Research Funding" 2013).

Breast cancer activists also exerted some influence in pushing for cancer research funds to be funneled towards their cause (Yadlon 1997).<sup>18</sup> In the past, breast cancer activism had focused on issues around autonomy and treatment (Klawiter 2004; 2008). In the mid-1990s, activists advocated for research funding to examine risk factors, increased screening, and prevention (Yadlon 1997). Of particular importance to some lesbian health activists was a higher rate of breast cancer among lesbians, which was thought to be due to lower rates of childbirth in that group (Yadlon 1997).

The confluence of increased funding for research and a more hospitable political climate for research on reproductive events like abortion led to a marked increase in the amount of research that examined the role of reproduction in

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<sup>18</sup>Scholars have noted that breast cancer activism is distinguished by two waves (Yadlon 1997; Klawiter 2008). The first is characterized as focusing on doctor/patient relationships, the need for patient autonomy in treatment decisions, and advocacy for less invasive treatment procedures. The second wave largely draws on AIDS treatment organizations, like ACT UP, to intervene in the research process as well as to direct research funding and topics (Weisman 1998; Epstein 2007).

relationship to breast cancer risk. Since the mid-1990s there have been several attempts by scientists, professional organizations, and government agencies to evaluate this research, set agendas and methodological parameters for future research on the topic, and when appropriate, develop guidelines for clinicians who regularly interact with women seeking abortions. Moreover, this shift in breast cancer research funding and focus opened up a new intellectual opportunity structure (Frickel and Gross 2005; Waidzunas 2013) that researchers critical of abortion capitalized upon to draw attention to the possible role of abortion in breast cancer risk.

#### Early Reviews of the Research and Debates over Uncertainty

In 1996, two comprehensive but contradictory reviews of the existing literature on abortion and breast cancer were published in epidemiological journals. The first of these reviews was conducted by Karin Michels and Walter Willett, both Harvard epidemiologists. Their review of five cohort and 39 case-control studies found that the existing literature had too many methodological flaws to be able to determine whether or not an association was present. Michels and Willett examined studies on both induced and spontaneous abortions and concluded that “studies to date are inadequate to infer with confidence the relation between induced or spontaneous abortion and breast cancer risk, but it appears that any such relation is likely to be small or nonexistent” (1996: 521). The authors argued that study design could greatly impact the outcome of the study. For example, decisions about the reference group (women who had children versus women who had no children), how data is collected about if or when a woman had an abortion, and using appropriate controls for confounding

factors can all influence whether or not an association is found. Michels and Willett did not pool the results of the studies together to come up with an odds ratio because for them the study designs and results were too heterogeneous.

While the Michels and Willett review found that the field of research on this topic was too flawed to support a conclusion about the possible relationship between either induced or spontaneous abortion and breast cancer risk, a meta-analysis conducted by the leading proponent of an abortion-breast cancer link, Joel Brind, came to a different conclusion (Brind et al. 1996). After examining the existing literature on the topic Brind became convinced that induced abortion was associated with increased breast cancer risk in multiple ways (Interview with Brind 2011).<sup>19</sup> Brind and his co-authors found a pooled odds ratio of 1.3 (95% CI 1.2, 1.4), which would mean that a women with any exposure to induced abortion would have a 30% increase in risk of developing breast cancer compared to a woman who never had an induced abortion (1996: 488). The authors noted the large degree of heterogeneity in methodological design and data collected among the 28 studies they examined, which made the pooled odds ratio less reliable than if the studies' designs were more similar. To address this concern, the authors included a narrative review of all the studies and maintained that pooled odds ratio was reliable because 76% of the studies favored a positive association (1996: 489). They wrote, "We are convinced that such a broad

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<sup>19</sup> Brind and other proponents of the link argue that abortion is connected to breast cancer in four ways. By terminating a pregnancy rather than carrying it to term, women miss out on the protective effects that completed pregnancy, breast feeding, and larger family size have on breast cancer risk. In addition to missing out of these three protective effects, Brind and other also contend that abortion is independently linked to an increased risk of breast cancer.

base of statistical agreement rules out any reasonable possibility that the association is the result of bias or other confounding variable” (495).

Brind and his colleagues also provided a plausible biological explanation for why induced abortion would be associated with increased breast cancer risk – an important step for establishing a causal relationship. Drawing on a study of mammary tissue cancer in rats and human breast development, the authors asserted that when a woman becomes pregnant she experiences an increase in hormones that cause her breasts to develop undifferentiated cells. Over the course of the pregnancy, these cells are exposed to other hormones that transform them into cells needed for lactation. Women who experience a miscarriage or who terminate a pregnancy would be left with a greater number of undifferentiated cells, making them more vulnerable to developing cancer (Brind et al. 1996; Russo et al. 1992).

At the time the reviews were published concerns about a potential link between abortion and breast cancer had gathered some public attention due to awareness campaign produced by antiabortion and family values groups. In 1993, Concerned Women for America asked their members to call the American Cancer Society, Planned Parenthood clinics, and the Rush Limbaugh show demanding “the truth” about abortion and breast cancer (Goodstein 1993:A01). Joel Brind and Scott Somerville, a lawyer, had appeared on Christian radio programs to talk about the link and sold pamphlets about the possible association at conferences for families that home-school and to groups like Concern Women for America (Goodstein: A01). Additionally, a Christian organization, Christ’s Bride Ministries, paid to for

advertisements in the Philadelphia and Washington, D.C. transit systems in January 1996 that read, “Women Who Chose Abortion Suffer More & Deadlier Breast Cancer” (Yeoman 2003; “Abortion and Breast Cancer”1999).<sup>20</sup> And by 1996, informed consent bills requiring doctors to tell women seeking abortions that they may increase their future risk of breast cancer if they terminate a pregnancy had been introduced in ten states (Gammon, Bertin, and Terry 1996: 322). Increasingly, epidemiologists and public health experts were asked to weigh in on this research.

The review conducted by Michels and Willett was largely ignored by newspaper reports, but the Brind meta-analysis was the subject of more media attention. Brind attributed some of this attention to the fact that Baruch College (where he is a biology professor), the Milton S. Hershey Medical Center (where his co-authors are affiliated), and the British Medical Association (which maintains the journal that published the article) all issued press releases announcing the publication of the meta-analysis (Interview with Brind 2011). In most cases, media stories did not highlight Brind’s work with prolife organizations or that funding for the research was arranged through conservative, prolife Pennsylvania State Representative Joseph Pitts (Interview with Brind 2011; Brind et al. 1996). Newspaper reports on the study in the *New York Times* and *Washington Post* did point out that an odds ratio of 1.3 was quite low. For example, in the *Times* Geoffrey Cowley and Mary Hager explained that a

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<sup>20</sup> The posters were removed from the Philadelphia transit system after Dr. Philip Lee, Assistant Secretary of Health at the U.S. Department of Health and Human Services wrote a letter to the Southeastern Pennsylvania Transportation Authority stating that the ad was “misleading, unduly alarming, and does not accurately reflect the weight of the scientific literature” (*Christ’s Bride Ministries INC v. Southeastern Pennsylvania Transportation Authority*1998). Christ’s Bride Ministry successfully sued the Transportation Authority for a violation of First Amendment rights. Joel Brind served as an expert witness about the link between abortion and breast cancer for Christ’s Bride Ministries (Yeoman 2003).

family history of breast cancer “can push a woman’s odds ratio to 3 or 4” (1996: 73) and David Brown for the *Post* wrote that “men who smoke a pack of cigarettes a day have 18.8 times the risk of developing lung cancer as men who don’t.” (1996: A03). Lynn Rosenberg, interviewed in the *Post* article asserted that such a small odds ratio could be easily explained by the use of retrospective data or studies that did not adequately control for confounding factors (Brown 1996: A03).

The meta-analysis conducted by Brind and his co-authors was critiqued within scientific publications as well. In an editorial for *Journal of the National Cancer Institute*, Douglas L. Weed and Barnett S. Kramer (both of the National Cancer Institute) argued that the meta-analysis was limited because there was no “attempt to constrain the analysis on the basis of quality” (Weed and Kramer 1996: 1699) and that, in general, meta-analyses are one way to measure consistency of results in a body of research, but they cannot correct for possible confounding variables or systematic bias within the research (1698). Weed and Kramer also expressed concern for how easily Brind and his colleagues dismissed the possibility of bias in the research. They wrote that Brind and his co-authors “argue that *any* bias is unlikely to be been responsible for their finding because there is ‘consistency across the independent studies,’ as reflected in the overall result of the meta-analysis. This argument ignores the possibility that a systematic bias may affect all (or nearly all) studies” (1699, emphasis in original).

These reviews and media reports reflect the general uncertainty about a potential relationship between abortion and breast cancer within the scientific

community at that time. Some large studies conducted at prestigious cancer research centers and funded by the National Cancer Institute found similar small positive associations between induced abortion and an increased risk of breast cancer (Daling et al. 1994; Newcomb et al. 1996). Additionally the National Cancer Institute acknowledged that such an association was possible but that it was unlikely to have a great impact on overall breast cancer rates (Jasen 2005).

The debate over a possible link touched upon a particular tension within the epidemiological and public health community – how to deal with small increases in risk factors and the epistemological limits of epidemiology. Stuart Donnan, then editor of the *Journal of Epidemiology and Community Health*, defended the publication of the Brind meta-analysis this way:

Some readers may consider that the calculation made by Brind and colleagues of possible numbers of breast cancers following – conceivably caused by – induced abortion is alarmist. It is certainly true that a relative risk of only 1.3 adds up to a large absolute increase in risk with a very high prevalence of the underlying factor. ... [I]t will surely be agreed that open discussion of risk is vital and must include the people – in this case women – concerned. I believe that if you take a view (as I do) which is often called ‘pro- choice’, you need at the same time to have a view which might be called ‘pro-information’ without excessive paternalistic censorship (or interpretation) of the data (Donnan 1996: 605).

While some epidemiologists would consider a 1.3 odds ratio too small to warrant a serious discussion over a possible association between abortion and breast cancer, particularly among a group of studies with so many methodological problems, Donnan claimed that such a discussion is not only necessary but also required in order to serve the interests of women.

Donnan's position, however, did not reflect a general consensus within the epidemiology and public health communities. In an often cited report in *Science*, Gary Taubes argued that epidemiology had been successful in "identifying the more conspicuous determinants of noninfectious diseases" (1995: 164), such as the relationship between smoking and lung cancer. However, the tools of epidemiology might not be up to the task of identifying smaller, non-conspicuous determinants of disease. Or as Michael Thun of the American Cancer Society put it, "With epidemiology you can tell a little thing from a big thing. What's very hard to do is to tell a little thing from nothing at all" (quoted in Taubes: 164). Of particular concern to Taubes and the epidemiologists he interviewed was the reporting within the mainstream media of studies that found small associations between lifestyle or environmental factors and various kinds of cancers, such as links between alcohol consumption and breast cancer or electromagnetic fields and brain tumors. These results were often reported by media outlets as "facts" without concern for the study's methodological flaws or inconsistent results within the larger body of research on the topic. While Donnan's editorial reflected a "pro-information" position, epidemiologists interviewed for Taubes's report were concerned that information that was not properly vetted by experts would lead to an "epidemic of anxiety" and erode public trust in health professionals.

In reaction to the *Science* article, most epidemiologists were reluctant to concede that the field had reached its limits and was no longer socially useful. Though many felt that science reporting was largely to blame, there were also renewed calls



within the field for epidemiologists to be even more vigilant about possible bias within their research and to interpret small associations with even greater skepticism. The two reviews of a possible relationship between abortion and breast cancer spoke directly to this tension within the profession. Michels and Willet published a very careful analysis of how previous research on a possible link could be explained by biases within study designs or confounding factors. Though the Brind meta-analysis included a fairly lengthy discussion of possible bias within the original studies, the authors were largely dismissive of any effect it might have on the results of their analysis.

### **Emergence of Standards of Evidence**

The publication of the Brind meta-analysis and the Michels and Willet review prompted an important discussion among researchers on reproductive events and breast cancer about what makes a good study of the possible impact of induced abortion on breast cancer risk. The critiques of earlier studies not only indicated the degree to which their results should be considered reliable, but also marked a preference for certain types of studies that might bring certainty to this question. The most prominent critiques of the earlier studies pointed out methodological problems dealing with the ability to control for a variety of confounding factors, and the ability to accurately determine whether or not a woman has had an induced abortion.

Most of the early studies controlled unevenly for known and suspected risk factors for breast cancer, and some studies were conducted before certain risk factors were even known. While many studies controlled for major risk factors such as age and family history, a woman's reproductive history can affect breast cancer risk in a

variety of ways. Lynn Rosenberg, an epidemiologist at Boston University, wrote: “Reproductive factors are clearly of importance, but the nature of their influence on risk is complex and under continuous reassessment” (1994: 1569). The ability to control for reproductive factors indicated a preference for larger studies (to have enough respondents to be able to statistically control for a wide variety of factors) and a general discounting of earlier studies on abortion and breast cancer.

Though failure to control for reproductive factors was a prominent critique of the general research on the subject at the time, by far the most common and serious critique of study methodology was the recall bias thought to be produced through the use of retrospective data. Researchers suspected that women, and especially healthy women, might not accurately report previous induced abortions when interviewed or asked to fill out a questionnaire about their reproductive history. This would lead to a general inaccuracy in the measurement of the independent variable in all studies based on retrospective interview and questionnaire data. Furthermore, researchers found that women who had illegal abortions (most of the abortions that occurred before the liberalization and legalization of the procedure in the early 1970s in the United States would have been illegally obtained) were even less likely to accurately report their reproductive histories because it would involve disclosing not only that they underwent a stigmatized medical procedure, but also that they engaged in criminal activity (Newcomb et al. 1996).

In addition to inaccurate reporting of abortion within the case and control groups of studies, many researchers argued that women who have been diagnosed with

breast cancer were more likely to report a previous induced abortion. These women were participating in research about the potential risk factors for a disease they are suffering from and were thought to have more incentive to accurately report their reproductive histories. Women in control groups were often times randomly selected (for example, through random phone number sampling or door-to-door solicitations in studies that utilize interviews),<sup>21</sup> and these women might be less inclined to disclose a stigmatized medical procedure to a researcher. In 1991, the *American Journal of Epidemiology* published a study on Swedish women that examined this type of response bias (Lindfors-Harris et al. 1991). Data from a study on reproductive factors and breast cancer based on interview data was compared to a study that used the same set of women but gathered information about induced abortion from a national health registry. The authors found that there was a difference between cases and the controls in disclosing abortion and that up to a 50% increased risk for breast cancer associated with induced abortion might be explained by recall bias (Lindfors-Harris 1991: 1006). Since the elevated risk associated with induced abortion in much of the early research on breast cancer risk indicated an increased risk between 30 – 70%, evidence

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<sup>21</sup> Methods for acquiring controls and getting accurate histories from controls are also fraught with complications. Studies show that research participants are more likely to accurately report stigmatized behavior (like the amount that they drink or the number of sexual partners that they've had) using more anonymous data collection techniques such as phone interviews and questionnaires rather than face-to-face interviews. However, studies have also shown that seeking controls through random digit dialing and conducting interviews over the phone introduces a possible bias in terms of income. Having a phone line, being home during the day to answer your phone, and having an answering machine to collect messages are all indicators of higher income levels. Using these methods for data collection tend to result in having a control group with higher incomes than your case group, which means that poverty might be a confounding factor and calls into question the reliability of your results (Taubes 167).

of recall bias seemed like a reasonable explanation for such a small association.<sup>22</sup>

Other research on response bias produced mixed results about whether or not it exists and the extent to which it might affect the results of a study (Beral et al. 2004; Daling et al. 1994; Tang et al. 2000a).

In the mid-1990s, most epidemiologists argued recall bias was a major methodological flaw within the research and that while the relationship between induced abortion and breast cancer was still uncertain, any potential positive association was likely to be small (Gammon, Bertin, and Terry 1996; Weed and Kramer 1996; and Rosenberg 1994). In an editorial in the *Journal of the National Cancer Society*, Lynn Rosenberg suggests that one way to avoid recall bias is through case-control studies that use medical records rather than interviews or questionnaires and prospective cohort studies that collect information about reproductive history well before anyone in the cohort is diagnosed with breast cancer. Also, epidemiologists called for studies to analyze differential rates of risk among different subgroups of women (Gammon, Bertin, and Terry 1996; Wingo et al. 1997). In addition to creating more subgroups within studies, epidemiologists argued that at a minimum future studies should differentiate between induced abortion and spontaneous abortions

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<sup>22</sup>However, the estimation of error due to recall bias in the Swedish study has been called into question, particularly over the issue of overreporting. In addition to finding that some women within the control group were more likely to underreport a history of induced abortion when compared to women within the case group, Lindefors-Harris also found that seven women within the case groups reported an abortion during the face-to-face interview about reproductive history that was not accounted for in the national registry (compared to one woman in the control group that reported having an abortion in the interview that was not accounted for in the registry) (1991: 1005). While it might be the case that overreporting of abortion is happening, more likely explanations for this phenomena might include a woman obtaining an abortion outside of Sweden (which would mean that it would not be included in the national registry) or women misremembering the year of their abortion (which would mean that it would be outside of the time frame the researchers are examining, but still included in the national registry) (Meirik et al. 1998: 209).

(miscarriages) and the risk should be compared between multiple referent groups in terms of parity. Because of a full term pregnancy's protective effect on future breast cancer risk, researchers should evaluate risk of breast cancer in reference to both women who were childless (nulliparous) and women who had children (parous) (Gammon, Bertin, Terry 1996: 321). In order to reliably determine rates of risk among many different subgroups of women, studies would need to be much larger than previous case-control studies.<sup>23</sup>

In a review of the research on abortion and breast cancer risk in *Cancer Causes and Control* published after the Michels and Willett review and the Brind meta-analysis, researchers for the American Cancer Society and the Centers for Disease Control and Prevention argued that the current body of studies was too inconsistent and too flawed to be able to make conclusions about any possible relationship (Wingo et al. 1997).<sup>24</sup> Unlike previous reviews, the authors laid out an agenda for future research that included the usual calls for prospective data and cohort studies over case control studies and analysis of additional subgroups. In addition, the authors claimed that future research might benefit from doing cohort studies in national contexts where

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<sup>24</sup>The review by Wingo and her colleagues was accepted for publication before the Melbye study was published but appeared in print a few months afterwards. Because of this, the Melbye study was not included in the review and the authors addressed concerns within the scientific community that were of greater importance before Melbye.

abortion is more common, such as former Soviet bloc countries, and including more women who had early onset breast cancer (106).

In addition to calls for larger studies, systematic ways to measure reproductive factors, and methodological techniques to root out recall bias, many critiques and reviews of the research were concerned about the lack of consistency in the results. In his 1995 article in *Science*, Gary Taubes interviewed epidemiologists about what makes a study worth taking seriously. Most epidemiologists agreed that a study that shows “a very strong association between disease and risk factor and a highly plausible biological mechanism” are the most important criteria (1995: 168). When studies fail to show a strong association, epidemiologists tend to rely on consistency in results to determine whether there is a valid association (Taubes 1995: 168). Thus, consistent results across a variety of study designs are an important measure of whether or not an association actually exists. Calls by epidemiologists for larger case-control and cohort studies, studies on a variety of national populations, and studies based in medical records or health registries are motivated not just by a professional concern over reducing or eliminating bias but also by a concern about achieving consistent results using a variety of observational research methods.

#### The Denmark Study: Definitive or Politically Correct?

In January of 1997, the *New England Journal of Medicine* published the results of a large, cohort-based study conducted by a research team in Copenhagen that found no association between induced abortion and breast cancer (Melbye et al. 1997a). The study’s design avoided all of the major pitfalls of most of the previous research on the

topic – it was very large (using medical information from 1.5 million women) and most importantly, the study was conducted by linking records within the Danish National Registry of Induced Abortion –all induced abortions performed within Denmark must be reported to this Registry – and the Danish Cancer Registry. Using medical records, rather than interviews or questionnaires that asked women to retrospectively report their reproductive histories, essentially eliminated the potential for recall bias.

The Denmark study was almost immediately heralded as the definitive study on abortion and breast cancer by some epidemiologists. In an editorial that accompanied the Melbye study, Patricia Hartge wrote, “The study thus provides important new evidence to resolve a controversy that previous investigations have been unable to settle” (Hartge 1997:127) and “a women need not worry about the risk of breast cancer when facing the difficult decision of whether to terminate a pregnancy” (128). Reporting on the study in the *New York Times* touted the study’s strength compared to earlier research and stated that it “may put to rest a longstanding concern” (Brody 1997a: A12).<sup>25</sup>

While the Denmark study did not convince everyone, particularly Joel Brind<sup>26</sup>, it marked an important shift in the research on a potential link between abortion and

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<sup>25</sup>The Denmark study certainly overcame the issue of recall bias that had undermined earlier research, and the number of respondents made the study statistically powerful. However, the study raised questions about the effect of later term abortion (i.e. abortions occurring after 18 weeks) on breast cancer risk. While the researchers acknowledged that it might be the case that late-term abortions are associated with an increased risk of breast cancer and that this result would be in line with previous research, they argued that the number of women who have late term abortions is too small to determine whether the positive association was due to chance (Melbye et al. 1997a: 84).

<sup>26</sup> Joel Brind has been one of the most vocal critics of the Denmark study. In the *Washington Post*, Brind is quoted calling the study “terrible” and insisting that “this is an apparently large and powerful

breast cancer. It was the first study that was widely recognized to have met the standards for “good research” on a possible association and to have a great deal of statistical power due to the large number of women who were included.<sup>27</sup> Shortly after publication of the study, the National Cancer Institute shifted its position on the possible relationship between abortion and breast cancer. While the previous fact sheet indicated that evidence about such an association was “inconsistent” (“Abortion and Breast Cancer ” 1996). In February 1997, the NCI conducted a periodic review of “Abortion and Breast Cancer” and concluded:

Although it has been the subject of extensive research, *there is no convincing evidence of a direct relationship between breast cancer and either induced or spontaneous abortion*. Available data are inconsistent and inconclusive, with some studies indicating small elevations in risk, and others showing no risk associated with either induced or

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study with the politically correct result that is not scientifically correct” (quoted in Weiss 1997: A01). In a letter to the editor of the *New England Journal of Medicine*, Brind and Vernon Chinchilli write that the study misclassified some of the older women in the cohort as not having had abortions when it could be the case that they did obtain abortions before the mandatory reporting policies were enacted and the national registry was set up (Brind and Chinchilli 1997: 1834). Brind and Chinchilli also critique the study for using different follow-up times for women with a history of induced abortion versus women with no such history and for not taking into account birth-cohort differences (1835). Melbye and his co-authors argue that these critiques are “based on fundamental misconceptions about the cohort design” and provide evidence for why the suggestions posed by Brind and Chinchilli (the use of birth-cohort matching rather than controlling for age) do not produce different results than those originally found in the study (Melbye et al. 1997b: 1835). Melbye and his co-authors respond to this claim by arguing that if the misclassification of older women had a significant impact on the results of the study, they would expect to find elevated rates of risk among younger women “because they would have been less likely to have had a previous abortion and would have been minimally misclassified” (Melbye et al. 1997b:1835). They provide evidence that relative risk remains mostly stable across age and this indicates that the potential misclassification likely did not impact the results in an important way (1835).

<sup>27</sup> It is important to note here that a study conducted in the United States used a similar methodology of linking the New York state fetal death registry with cancer registry (Howe et al 1989). The Howe study found a positive association between both induced abortion and miscarriage and breast cancer and its findings were included in the Michels and Willet review, the Brind meta-analysis, and the Wingo review. However, by 2002 the study had largely fallen out of the scientific conversation and original data from the study could not be tracked down to be included in the large review by Beral et al. (2004). Howe reports that there may have been some inaccuracies in the reporting of pregnancy interruptions within the fetal death registry and there have been no additional studies using these databases to replicate these results.



spontaneous abortions (“Abortion and Breast Cancer ” 1997– emphasis added).<sup>28</sup>

The fact sheet still maintained that the available data was “inconsistent and inconclusive,” but contained a much stronger statement about the lack of evidence for a direct relationship. Given that this change occurred about a month after the publication of the Denmark study, it can be understood an indication of the study’s importance in this debate.

Despite the acceptance of the study among epidemiologists and breast cancer researchers, the Denmark study also served as a catalyst for the further politicization of the debate over abortion and breast cancer. In another review of the NCI fact sheet in June 1999 this position was softened to:

The relationship between abortion and breast cancer has been the subject of extensive research. However, evidence of a direct relationship between breast cancer and either induced or spontaneous abortion is inconsistent. Some studies have indicated small elevations in risk, while others have not shown any risk associated with either induced or spontaneous abortions (“Abortion and Breast Cancer ” 1999).

According to Joel Brind, this review and the change in the NCI position was the result of political pressure on then director of the Institute, Richard Klausner. Brind contends that the change happened after NCI and National Institutes of Health officials were questioned about the link and 1997 revision of the fact sheet during a House Subcommittee on Health and Environment hearing. The hearing resulted in the Chairman of the House Commerce Committee, Tom Blilby, sending a letter to

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<sup>28</sup> The National Cancer Institute has maintained a fact sheet on abortion and breast cancer since October of 1994 and, as is the case with all Institute’s fact sheets, it is periodically reviewed and updated to reflect new scientific findings.

Klausner that critiqued the science that was used to justify the 1997 revision, specifically Brind's criticisms of the study (Interview with Brind 2011).

The use of political pressure to create a change in how scientific information is presented on a federal agency's website might be considered an infringement of scientific autonomy and a violation of the ideals of free inquiry, but for Brind leveraging political connections was a way of insuring the quality of science. Brind has argued repeatedly that the National Cancer Institute is ultimately run by "corrupt ideologues" that are determined to cover up the link between abortion and breast cancer (Interview with Brind 2011). In Brind's view the NCI is not an impartial institution that funds and evaluates scientific research on cancer, but rather is a political institution that suppresses some scientific findings and validates others in order to bolster a political position, in this case, one that supports the legality of abortion or at least considers it a safe medical procedure. For Brind, politics, not a dispassionate pursuit of knowledge, is the currency of the NCI, so using political pressure is the only way of ensuring that "the truth" about the link between abortion and breast cancer is made public.<sup>29</sup>

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<sup>29</sup> Brind has established a particular understanding of how and why the link between abortion and breast cancer has been covered up by scientists and politicians, particularly at the NCI. Brind argues that the majority of research on this topic actually supports the finding that there is a positive association between induced abortion and breast cancer as well as enough evidence to indicate that induced abortion causes breast cancer. Researchers, whose work is largely funded through the NCI and National Institutes of Health, are too fearful to claim that this link exists because they would risk losing their research funding. While the directorship of the NCI and NIH as well as the leadership of the DHHS are political appointees and change with each new president, there are NCI scientists who have long careers at the Institute and are able to keep the link covered up by exerting considerable influence over the extra-mural scientists. In some instances, Brind describes the NCI scientists as beholden to radical feminist interests, the abortion industry, atheism or act to cover up the link simply because they are corrupt. International scientists, like Mads Melbye, researchers at Karolinska Institutet, and researchers at Oxford, are all engaged in a global conspiracy to undermine the abortion/breast cancer link and to preserve the legality of abortion in the United States. However, it is important to note that while parts of

During this time, Brind and other prolife researchers began to establish formal organizations to promote research and educate the public about the link between abortion and breast cancer. In 1999, Karen Malec, founded the Coalition on Abortion/Breast Cancer (CABC) after hearing about the early research on an abortion/breast cancer link from a friend (Interview with Malec 2011). The goal of CABC was to inform women about the link and Malec served as the group's public spokesperson. Joel Brind has served on the advisory board since the organization's founding along with other medical professionals who are critical of abortion and former prolife elected officials (CABC "About Us" 2014). Also in 1999, Joel Brind, Angela Lanfranchi (a breast cancer surgeon), John Bruchalski (an obstetrician-gynecologist), and William Toffler (a physician) founded the Breast Cancer Prevention Institute (BCPI) to educate "healthcare professionals and the general public through research publications, lectures, and the internet, on ways to reduce breast cancer incidence" (BCPI "About Us" 2014). The BCPI maintains that abortion and hormonal contraceptives are linked to higher breast cancer incidence. Though both organizations are independent, Joel Brind continues to serve on the advisory boards of both and Karen Malec and Angela Lanfranchi have collaborated on projects together.

### **Early Reproductive Events and Breast Cancer Workshop: Consensus vs.**

#### **Conspiracy**

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this conspiracy are echo by other colleagues of Brind, particularly the part about extra-mural scientists being very afraid of losing their grants, not all of his colleagues ascribe to the full conspiracy theory (Interview with Brind 2011).

By 2002 additional studies on a potential relationship between abortion and breast cancer had been published that found no statistically significant association (Davidson 2001; Fioretti et al. 1999; Goldacre et al. 2001; Robertson et al. 2001; Sanderson et al. 2001; Tang et al. 2000b; Tavani et al. 1999; Ye et al. 2002). An additional review of the research pointed to the serious flaws in the earlier case-control studies and concluded that based on the U.S. Preventative Services Task Force rating system, fair evidence exists to support the claim that “induced abortion does not increase a woman’s risk of breast cancer later in life” (Bartholomew and Grimes 1998). Epidemiologists and public health officials had increasing reasons to believe that there was no link between induced abortion and breast cancer. Newer studies were based on cohorts and relied on prospective data of reproductive history, and some studies were conducted in places where abortion was much more common. For example, two studies of women in Shanghai, China found no significant association, especially if the abortion occurred after the woman’s first full term pregnancy (Ye, et al. 2002; Sanderson et al. 2001).

The National Cancer Institute conducted another review of its fact sheet on abortion and breast cancer and changed its position from stating that the evidence was “inconsistent” to stating that “the current body of scientific evidence suggests that women who have either induced or spontaneous abortions have the same risk as other women” (Kaiser 2002: 171; “Abortion and Breast Cancer” 2002). The new language was approved by NCI director Andrew von Eschenbach within a few days of his

confirmation into the position and was posted on the Institute's website in March. Between March and June 2002, the fact sheet contained this new position.

However, Joel Brind and other prolife activists continued to argue that induced abortion was independently associated with breast cancer. Brind used his political connections to push for a review of the research by the National Cancer Institute. With the election of George W. Bush, Brind thought that the political climate might be more open to such a review:

Finally the Bush administration came along and we felt we might have an administration that was a little more sensitive to something that was viewed as a prolife issue, even though it's not. It's pro-women's health. ... [At] that point, I had enough contact with congressional people and we got 28 congressmen to write a letter to President Bush and to his appointee to fill the directorship of the National Cancer Institute, Andrew von Eschenbach, saying this is scientifically misleading" (Interview with Brind 2011).

The letter from the prolife Congressmen was delivered to Bush-appointment Secretary of the Department of Health and Human Services (HHS), Tommy Thompson in the early days of June 2002. On June 19<sup>th</sup>, von Eschenbach ordered that the fact sheet be removed from the Institute's website and "asked several NCI divisions to prepare reviews of the science" (Kaiser 2002: 171).<sup>30</sup> In the interim, the Institute posted the previous version of the fact sheet that claimed that the evidence was inconsistent.

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<sup>30</sup> Department of Health and Human Services officials and von Eschenbach have repeatedly claimed that the removal of the fact sheet from the website was part of a routine review of the research and deny that the removal was in any way influenced by Congressional intervention. However, most analysts include this incident as an example of conservative interference and distortion of scientific practice and policy, which included the removal of sexual health information from federal websites, the appointment of social conservatives and industry representatives to scientific advisory committees (including the appointment of Joel Brind to the CDC's Breast and Cervical Cancer Early Detection and Control Advisory Committee), and the use of financial audits to attack non-profit HIV/AIDS organizations (Mooney 2005). Additionally, the removal of the abortion and breast cancer fact sheet from the NCI website along with the removal of a fact sheet about the efficacy of condoms in preventing the

The removal of this information from the NCI website drew political and media attention, particularly because it happened during a time in when many HHS organizations removed from their official websites sexual health information including information about the effectiveness of condoms in preventing the transmission of HIV and other STIs and information about sexual education programs that had been shown to reduce risky sexual behavior among teens. In a letter to Thompson, Representative Henry Waxman and other Representatives wrote about the removals:

We are extremely concerned about these alterations and deletions of important scientific information. They appear to be part of an Orwellian trend at HHS. Simply put, information that used to be based on science is being systematically removed from the public when it conflicts with the Administration's political agenda (Waxman 2002; see fn #15 for additional details).

By November of 2002, the NCI announced that rather than conducting an internal review of the research, it would hold an expert review on Early Reproductive Events and Breast Cancer during the first months of 2003 to perform a comprehensive evaluation of published and forthcoming studies and to make recommendations to the NCI about the fact sheet (Thompson, Letter to Waxman 11/27/02).

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transmission of sexually transmitted infections from the CDC's website were the subjects of inquiry by the House Committee on Oversight and Government Reform into public health information on federal websites (Waxman Dec. 18, 2002). In a letter to Tommy Thompson, Committee Chairman Henry Waxman, requests that Thompson provide the committee with "all instances in which scientific information has been removed from any HHS website since January 2001 on the basis of a request from someone inside or outside the Department, the name of the requester, and the reason for the removal" as well as an explanation for any scientific basis for that removal (Waxman, Oct. 21, 2002). In regards to the NCI fact sheet on abortion and breast cancer Thompson responds that the information was removed "to review the accuracy and completeness of the content" and does not mention the request that was made by the prolife Congressmen (Thompson, Nov. 27, 2002). Despite additional requests for information about the removal from the oversight committee (Waxman Dec. 18, 2002) no additional information was given by HHS.

The NCI's Early Reproductive Events and Breast Cancer Workshop was held in Bethesda, Maryland, in late February 2003. The Institute invited 101 scientists, including Joel Brind, to participate in the workshop. The three-day workshop included presentations of research and discussions of what was known from epidemiological, clinical, and animal model research on reproductive events and breast cancer. Another goal was identifying gaps in these research areas and how the National Institutes of Health might be helpful in sponsoring research to fill these gaps (Interview with Deborah Winn 2011). Attendees and presenters were affiliated with a wide variety of prestigious research institutions such as the Keck School of Medicine at University of Southern California, the Fred Hutchinson Cancer Research Center, and the Memorial Sloan-Kettering Cancer Center as well as European research facilities like Karolinska Institutet in Sweden and the Statens Serum Institut in Denmark.

As opposed to being a focused review to determine whether abortion was associated with an increased risk of breast cancer, the NCI framed the workshop as a comprehensive review of how all reproductive events may influence breast cancer risk. The issue of abortion and breast cancer loomed large, however. Workshop participants were particularly invested in drawing a distinct boundary between the political debate over the legality of abortion and the science of an epidemiological relationship between induced abortion and breast cancer. In her remarks at the beginning of the morning session on epidemiological research on reproductive events and breast cancer, noted breast cancer researcher and a co-founder of the National Breast Cancer Coalition Susan Love stated, "We understand, and I think everybody

here understands, that the whole issue of therapeutic abortion has become a political issue, but our goal is not to really discuss the politics today, but rather, to explore the science of that as well as spontaneous abortion and pregnancy in general” (National Institutes of Health VideoCast 2003a).

During the Saturday morning session of the workshop, attendees heard presentations from many NCI- funded scientists who summarized existing published research in the fields of epidemiology, clinical studies, and animal model studies about pregnancy and its relationship to breast cancer. Dr. Leslie Bernstein presented the epidemiological findings about pregnancy and breast cancer risk. She framed the trajectory of knowledge on the topic as moving from inconsistency and uncertainty of results to a consistent result of no association (National Institutes of Health VideoCast 2003a). For Bernstein, the fact that multiple kinds of large studies had produced similar results indicated that professional standards for good evidence had been met and the debate over a potential link was over.<sup>31</sup>

During the afternoon, participants heard brief presentations on new, unpublished research from eight researchers including Mads Melbye, the first author of the Denmark study. In the final session on Saturday, participants were divided into smaller groups to discuss what is known about the impact of pregnancy on breast

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<sup>31</sup>She also presented a critique of the biological model that has been proposed by Brind and other researchers who claim that the link exists. While Bernstein agreed that breast tissue does proliferate at an increased rate in the first half of a pregnancy and that cell differentiation occurs at a greater rate during the second half of pregnancy, hormones like human chorionic gonadotropin (hCG), which has been demonstrated to have a protective effect against breast cancer in some research, is present in great quantities early in the pregnancy. Thus, according to Bernstein, women who terminate a pregnancy through abortion or who experience a miscarriage may benefit from the protective effects of hCG and this may be responsible for the lack of association between incomplete pregnancy and risk of breast cancer (National Institutes of Health VideoCast 2003a).



cancer risk and what questions about reproductive events and breast cancer still needed to be answered (NCI “Workshop Agenda” 2003). Group leaders compiled the findings, drafted a summary, and assigned each a “strength of evidence rating.” These ratings spanned from one to four, with one indicating that a finding was “well established” and a four indicating that it was “suggested from laboratory or theoretical considerations but essentially unevaluated in human populations” (NCI “Summary Report” 2003).<sup>32</sup> Workshop participants found that “induced abortion is not associated with an increase in breast cancer risk” and this finding was ultimately assigned a strength of evidence rating of one.

On the final morning the summary findings were presented to all the participants to assure that there was general agreement. With one exception, the participants comments focused on the clarifying the wording of the findings and gaps, and participants did not call into question the strength of evidence ratings assigned to findings. Joel Brind, the only participant on the record to raise questions about the induced abortion finding, framed his critique of the summary findings as an issue with consistency. He stated, “I found it rather astonishing that, with regard to the issue of ... induced abortion and breast cancer that it should have been considered generally of level 1 evidence, that there is no association in consideration of the long history of studies ... which have shown a significant positive association” (National Institutes of Health VideoCast 2003b). Brind asserted that the majority of studies showed a

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<sup>32</sup> The strength of evidence ratings key for biological and laboratory studies are similar with just a few words changed to indicate that the evidence comes from a different field. For example, the “4” rating in the biological changes category is would indicate that the finding is “suggested from laboratory findings or theoretical considerations but essentially unevaluated in humans” (NCI “Summary Report” 2010).

positive association between induced abortion and breast cancer, and this association was consistent throughout the history of research on the topic. This narrative of the research stands in contrast to the one presented the previous day by Leslie Bernstein – that early studies were inconsistent, but more recent and better designed studies demonstrate a consistently null association.

The presenters responded to Brind’s critique by pointing to the general consensus of the workshop participants and to the biological support for the claim that there is no increased risk of breast cancer associated with induced abortion. Dan Medina, the session presenter, responded, “With respect to these questions, there was widespread view that the statement that was written there and presented before you reflected accurately the literature as we understand it today” (National Institutes of Health VideoCast 2003b). Similarly, Dimitrios Trichopoulos, another session presenter, argued, “[T]o the extent that the empirical evidence can provide a powerful argument, this is almost philosophical now. We feel quite confident now that there’s no association there” (National Institutes of Health VideoCast 2003b). Trichopoulos’s statement indicated a strong boundary between an “empirical” or scientific argument and a philosophical argument. The implication is that Brind’s contention with the finding is based in a philosophical issue with the result rather than a scientific critique of the evidence.

The workshop functioned to provide an expert review of the evidence as well as to draw demarcations between scientific concerns about induced abortion and political concerns about abortion as well as between “legitimate” scientists and

researchers like Brind, who are seen as motivated by politics. These attempts to demarcate “science” from “non-science” are considered a type of boundary work (Gieryn 1983; 1999) that functions to assert the professional authority of scientists. Dr. Love’s opening remarks frame the discussion as one about the epidemiological research on a possible association that should not be influenced by therapeutic abortion as a political issue. Additionally, the exchange among Brind, Medina, and Trichopoulos illustrates a moment in which a boundary is drawn between those who adhere to the “widespread view” that there is no association and the one participant who engaging in a “philosophical” rather than empirical argument.

A few days after the workshop, Leslie Bernstein presented the participants’ findings at the March 3<sup>rd</sup> joint meeting of the National Cancer Institute’s Board of Scientific Advisors and Board of Scientific Counselors. The findings were unanimously accepted at the meeting and were passed on to Andrew von Eschenbach for further review and public comment. The workshop findings were also meant to guide the revision of the fact sheet on breast cancer and early reproductive events (NCI “NCI Boards Accept Scientific Workshop Findings” 2003).

Ultimately, the findings of the workshop were incorporated into the NCI fact sheet on “Abortion, Miscarriage, and Breast Cancer Risk.” The May 2003 version of the fact sheet described the workshop and stated that workshop participants “concluded that having an abortion or miscarriage does not increase a woman’s subsequent risk of developing breast cancer.” Additionally, the historical development

of this finding fits into a narrative about the increasing purity of, and certainty in, the research:

The relationship between induced and spontaneous abortion and breast cancer risk has been the subject of extensive research beginning in the late 1950s. Until the mid-1990s, the evidence was inconsistent. . . . Since then, better-designed studies have been conducted. These newer studies examined large numbers of women, collected data before breast cancer was found, and gathered medical history information from medical records rather than simply from self-reports, thereby generating more reliable findings. These newer studies consistently showed no association between induced and spontaneous abortions and breast cancer risk (“Abortion, Miscarriage, and Breast Cancer Risk” 2003).

By the middle of 2003, the scientific debate over a potential association between induced abortion and breast cancer had reached a point of apparent consensus. The standards of “good research” that had been set in the mid-1990s had been met by newer studies according to experts. The newer studies were largely free of the methodological flaws of earlier research and the newer evidence was consistent across a wider variety of study designs. Additionally, the research had been reviewed by experts on the topic of reproductive events and breast cancer, their findings had been accepted by the scientific advisory boards of a national health agency, and the director of the NCI had described the findings as based on the “absolute best information.”

However, Brind remained critical of the workshop process and the findings of the workshop. In a dissenting opinion submitted to the NCI, Brind contended that due to time constraints, a lack of diverse viewpoints among the researchers, and workshop participants’ inability to review unpublished raw data, the expert workshop fell short

of the claimed goal of providing a comprehensive review of the evidence surrounding reproductive events and breast cancer.<sup>33</sup> Reflecting on the workshop, Brind stated,

The workshop wasn't a workshop. I was prepared to review all the data. They didn't do any kind of data review. It's not unusual to have a conference where you have a controversial issue that needs to be discussed and hassled out by the people who research the issue, right? So you have like a debate. You have one side being presented; you have the other side being presented. Guess what? On this one, only one side. Only the side that said there is no link" (Interview with Brind 2011).<sup>34</sup>

In some ways the desire of the NCI to downplay the politics of the question led to a workshop format that precluded the types of evaluation and debate that Brind wanted. Rather than being asked to consider a specific question, "Is induced abortion associated with breast cancer risk?" participants were asked to consider a broader question, "How do reproductive events influence breast cancer risk?" and to provide feedback on how the federal government might better support research in this area.

In addition to his claims that the workshop failed to properly review the research, Brind also questioned whether the standards of good evidence have really been met on this issue. In his dissenting opinion, Brind called into question the consistency of the evidence. He claimed that of "38 epidemiological studies published through 2002, 29 have reported relative risks greater than 1.0, with 17 of these

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<sup>33</sup> This claim is contested by other workshop participants. For example, NCI scientist and workshop participant Debbie Winn claims that "given the time frame that we had, we were able to cover the territory and think we did an adequate job" (Interview with Winn 2011). However, it is the case the scientists were not tasked with poring over large amounts of research with unlimited time.

<sup>34</sup> A review of the videocast of the workshop indicates that some of Brind's critiques have validity. Most of the researchers moved quickly through a brief discussion of a possible association. Much of the discussion focused on the potential role of human chorionic gonadotrophin in pregnancy and subsequent breast cancer risk (National Institutes of Health VideoCast 2003a). This does not appear to be part of some plot to cover up an honest discussion, rather the researchers appear to be more interested in hearing about new research and new approaches than discussing a topic many of them likely consider settled.

achieving at least borderline statistical significance” (Brind 2003). His assertion was that the research shows a consistent positive association between abortion and breast cancer. For Brind, while newer research may have overcome previous flaws, these studies are not entirely free from potential error and bias. These concerns largely fell on deaf ears. The NCI website indicated the existence of a “minority dissenting comment,” which indicated that one participant remains convinced of a positive association, but provided no details about the participant’s reasons for this belief (NCI “Summary Report” 2003).

### **After the Workshop**

In the years following the Early Reproductive Events and Breast Cancer study, several very large prospective cohort studies that analyzed the relationship between induced abortion and breast cancer were published. These findings of these studies were consistent with the conclusion that induced abortion was not associated with an increased risk of breast cancer (Paoletti et al. 2003; Palmer et al. 2004; Reeves et al. 2006; Rosenblatt et al. 2006; Michels et al. 2007; Henderson et al. 2008). Each of these studies had study populations over 30,000, most had follow-up times over six years (the exception being Palmer et al. 2004), and, since the reproductive history information was collected either through medical records or before the time of diagnosis, they are considered to be free of recall bias. The NCI’s fact sheet, “Abortion, Miscarriage, and Breast Cancer Risk” has been updated several times to reflect this research, but the conclusion remains that “having an abortion or miscarriage does not increase a woman’s subsequent risk of developing breast cancer”

(2011). Deborah Winn, an NCI scientist, indicates that updates to the fact sheet after the workshop have been less contentious and none have received the same level of political scrutiny (Interview 2011). The stability of the NCI's fact sheet is also an important marker of the status of this debate within the scientific community. Over time, the language of the fact sheet has shifted from one that contains acknowledgment of uncertainty or doubt to one that is an unwavering denial of any potential association. Additionally, statements from the ACOG (2009) and the American Cancer Society (2014) use similar language about the lack of association. As Bruno Latour observes the status of scientific controversies are shaped by and reflected in the language used to describe them (1987). Scientific facts are usually described in a way that hides both the work that went into constructing them and any lingering uncertainty (1987). While the NCI fact sheet still has a great deal of explanation about the research and evaluation that went into constructing this particular fact, the lack of uncertainty in the statement indicates that for the scientific community this debate is largely settled.

Of the research published after the NCI workshop, the study considered to be the most influential was a meta-analysis of 53 epidemiological studies published in *The Lancet* (Beral et al. 2004). The meta-analysis included any study on the topic that had 100 or more women in the case group, that were conducted in countries with liberal abortion laws, that systematically obtain information on the subject's reproductive history, and that separated incidents of induced abortion from

miscarriage.<sup>35</sup> Ultimately, the researchers used original data from 53 studies and found that when reproductive history was collected prospectively, relative risk of breast cancer was 0.93 (95% C.I. 0.89-0.96) (1007). When using only studies that collected reproductive information retrospectively the relative risk was higher, suggesting that differential reporting of induced abortion between cases and controls influenced retrospective studies.

This meta-analysis was considered to be the most definitive study by many researchers in this area (Interview with Winn 2011). It was also considered an improvement on Brind's meta-analysis because the authors analyzed the pooled original data as opposed to just pooling the results. Furthermore, the separating of the prospective and retrospective studies as well as the use of original data allowed researchers to overcome the problem of heterogeneity that was identified in earlier reviews (Michels and Willet 1996; Brind et al. 1996; Wingo et al. 1997). According to Deborah Winn, the lack of contention over more recent reviews of the NCI fact sheet on reproductive factors and breast cancer is due to this meta-analysis. She said, "The most definitive of them, the one that was done with the meta-analysis of 53 studies in 16 countries just has the statistical power. They're all prospective studies. You know, there's really nothing to argue about there" (Interview 2011).

This stable consensus among most breast cancer researchers and epidemiologists about the general lack of association between abortion and breast cancer has not stopped research on the topic or on new possible associations with

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<sup>35</sup> Not all the studies that met these inclusion criteria were included in the meta-analysis. In some cases the original data was not available and in others the original authors declined to make the data available.



particular types of cancer. With the rise of genetic research, scientists now understand that there are several types of breast cancer. Breast cancer is now categorized by location (ductal v. lobular), invasiveness (in situ v. invasive), and hormone receptors (estrogen positive, triple negative, etc.). Many of the studies conducted in the early and mid-1990s also collected tumor samples from subjects and now are studying how reproductive events might correlate to particular types of cancer (Dolle et al. 2009, for example). Most of these studies have not revealed any new information about abortion and breast cancer.

### **Heretical Science**

According to Engelhardt and Caplan, the resolution of scientific controversies often presumes that the involved parties agree on “how to acquire evidence relevant to the dispute” and “how to reason with the evidence in order to reach a rationally defensible conclusion” (1987:6). Many controversies, including the debate over a possible link between abortion and breast cancer, are composed of multiple different controversies. Some of these are scientific, some are political, and some are ethical. Each different forum has its own rules and methods for what counts as evidence and how that evidence should be used. Examining just the scientific component of this controversy reveals that breast cancer researchers and researchers who are critical of abortion have differing views of the scientific enterprise as well as how to collect and evaluate evidence.

Mainstream breast cancer researchers and proponents of the abortion breast cancer link present two different, but compelling views of science. Since the late 1990s, breast cancer researchers have told a narrative of science as gradual linear progress. At the time the relationship between abortion and breast cancer risk was unknown and many contended that the research on the subject had serious flaws. Over time better designed studies that relied on prospective methods have provided a consistent and clear result – there is no significant association between abortion and breast cancer. This is the narrative told in the changes to NCI Fact Sheet, by Leslie Bernstein in her presentation of the Early Reproductive Events and Breast Cancer Workshop, and by Deborah Winn in her interview with me.

In addition to these differing views of science, breast cancer researchers and proponents of the link also have discordant ideas about how to collect and evaluate evidence about reproductive events and breast cancer. In 1996, most breast cancer researchers and epidemiologists had decided what would constitute a definitive study on abortion and breast cancer risk and by and large their expectations were met with the Denmark study, the Beral meta-analysis, and the prospective and cohort studies that also were published between 1997 and 2006. Of most important to this group was the issue of recall bias that could have affected the results of retrospective case control studies. Once that bias was eliminated, research results became more consistent.

Further, in many ways, these scientists are aware that the controversy over a possible link goes beyond the boundaries of scientific concerns. For example, after presenting the findings of NCI Workshop on Early Reproductive Events and Breast

Cancer, Leslie Bernstein told a reporter that “I don’t want the issue relating to induced abortion to breast cancer risk to be part of mix of the discussion of induced abortion, its legality, its continued availability. I think it should not be part of the argument” (Lowe 2003). Researchers and activists who believe in a link often point to this statement as evidence of a “cover up.” Another interpretation is that Bernstein is drawing a boundary between scientific concerns (a possible association) and political concerns (the legality and availability of induced abortion). As I will discuss later, this kind of boundary work shores up the authority of scientists and works to contain debate on this topic.

Proponents of an abortion/breast cancer link see the progression of science not as a steady march towards better methods and more reliable results, but as a history in which individual scientists make an important discovery that is counter to the dominant ideas of the time, are punished for their insight, and later revealed to have been correct. In an interview, Dr. Angela Lanfranchi explained how her position within the abortion and breast cancer research was similar to Ignaz Semmelweis, a Nineteenth Century Hungarian physician who realized that instances of post-delivery maternal infections could be greatly reduced through hand sanitization. Because his findings were at odds with dominant understandings of disease at the time, he lost his hospital position in Vienna and eventually suffered a nervous breakdown. Similarly, Dr. Joel Brind made references to Galileo and the attempts by Nazis to discredit Albert Einstein’s work. For Brind and Lanfranchi, science is corrupted and dogmatic. Angela Lanfranchi maintained that researchers recognize that abortion is associated with

breast cancer and refuse to publicly acknowledge this because of fear over losing their federal grants. She additionally claimed that a link between abortion and breast cancer is not recognized by institutions because epidemiological research moves too slowly, institutions are hesitant to incorporate new knowledge or refuse to accept findings that are counter to previous knowledge, and institutions are sexist and unwilling to put the health interests of women ahead of their desire to maintain the status quo (Interview 2011).

Since the publication of his meta-analysis in 1996, Brind has not published any original research or reanalysis of data on the topic of a possible link between induced abortion and breast cancer, but he has remained a vocal, if more marginalized, proponent of a link between abortion and breast cancer. His engagement with the new research has been limited to critiques of the research in the form of letters to editors of various journals and critiques of the research written in Catholic or conservative journals. When his letters are published the majority of his concerns are addressed in the authors' response.<sup>36</sup> The concerns Brind typically raises in his letters and published

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<sup>36</sup>For example, in 2006 the *International Journal of Cancer* published a study co-authored by multiple researchers across Europe that used the European Prospective Investigation into Cancer and nutrition (EPIC) study to determine the association between abortion and breast cancer (Reeves et al. 2006).<sup>36</sup> The study found that “the relative risk of breast cancer among women who reported ever having had an induced abortion when compared to women who reported never having had an induced abortion was 0.95 (0.87-1.03) (1744). This result is in line with other studies that have found no increase in risk of breast cancer associated with induced abortion. In a letter to the editor of the *International Journal of Cancer*, Joel Brind contended that these results are flawed and that induced abortion is actually independently associated with an increased risk of abortion. Brind made three specific critiques of the study – that the age cut-off for inclusion in the study was inappropriately high, that there was no rationale provided for excluding women with in situ breast cancer, and that there was too little follow-up time for younger women in the study. (Brind 2008: 960). The study's first author, Gillian Reeves, responded to Brind's specific critiques of her analysis in the same volume of the journal. Reeves reported that when the group reanalyzed the data in light of Brind's critiques they found similar results. For example, when the age cut-off was changed from 50 to 35 the relative risk is 0.97, when “the women who reported having an induced abortion five or more years before recruitment were compared

reviews are valid scientific critiques of the research, however, it is debatable how much these flaws actually undermine the findings of the research, especially in light of the fact that in most cases when authors reanalyze their data to address Brind's critiques they find similar or identical odds ratios.

In his publications<sup>37</sup>, Brind reveals deeper concerns over the standards for evaluating this research. Brind maintains that there is no good evidence that recall-bias is present in the earlier research and that cohort-based studies have their own methodological troubles. By refuting the claim that reporting bias led to the positive associations reported in some studies before 1996, Brind has argued that the dismissal of these results by epidemiologists is wrong (Brind 2005: 105). Though prospective data and cohort-based studies are seen as more reliable by epidemiologists, Brind claims that these types of studies are also methodologically flawed in that they are prone to cohort effects and inadequate follow-up time. Because data about reproductive history is conducted during a woman's reproductive years, rather than at the time of breast cancer diagnosis some of the initial publications from these cohorts do not have enough time between a reproductive event (namely, induced abortion) and the development of a tumor and diagnosis of breast cancer. Additionally, cohort-based

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to women who reported never having had an abortion" the relative risk was 0.96, and when the in situ cases were included the relative risk was essentially unchanged at 0.95 (Reeves 2008: 962). And finally, when all three statistical adjustment were made it changed the overall result of the study to a relative risk of 0.98 (0.89-1.08) from 0.95 (0.87-1.03) (962). Brind's critique and Reeves's response are typical of Brind's engagement with the scientific community since the NCI workshop.

<sup>37</sup> Joel Brind, Angela Lanfranchi, and Karin Michels typically publish commentaries and reviews in a variety of Catholic publications, including *The National Catholic Bioethics Quarterly* and *Linacre Quarterly*, as well as the *Journal of American Physicians and Surgeons (JPANDS)*. Despite its neutral sounding name, JPANDS is the journal of the Association of American Physicians and Surgeons, a conservative professional organization that is opposed to universal health care, nationalized health care, recertification for doctors, and abortion. While articles in the journal are subject to peer-review, JPANDS is not included in MEDLINE/PubMed list of peer-reviewed scientific publications.

studies are susceptible to particular effects that can distort results. For example, Brind has argued that many of the cohort-based studies are essentially comparing two different populations. Older women in the cohort have developed the most cases of breast cancer, but they also may have experienced many of their reproductive years during a time when abortion was not yet legal in their country. On the other hand, younger women in the cohort have experienced the most of the exposures (abortions) which means the exposures and the outcomes are not evenly distributed across the study population (Brind 2005: 106).

Beyond doubting the existence of recall bias and pointing to the flaws in cohort-based research, Brind and Lanfranchi also question the motives and methods used by other researchers. Brind's critiques of epidemiological research and his letters to editors betray a deeper mistrust of how accurately researchers are portraying their results and whether they are trying to conceal an association between abortion and breast cancer. Brind's work has shifted from demonstrating an association between induced abortion and an increase in breast cancer risk to demonstrating that various researchers and institutions are committed to covering up its association. As he put it:

Over the last 15 years, more and more of my work in this area has not really looked at the abortion breast cancer link, but more the cover up of the abortion breast cancer link as an objective scientific study and basically dissecting studies and finding just breathtaking violations of the scientific method all over the place. But yet staunchly defended by all the purveyors of official scientific information (Interview 2011).

Brind maintains that most researchers know that there is a link, but refuse to publicly acknowledge it because they are afraid that it would lead to the loss of their NCI or NIH research funding. Additionally, researchers at Oxford University and Karolinska

Institutet in Sweden are invested in supplying poorly designed research to perpetuate the idea that abortion is not associated with breast cancer risk. Institutions, like the NCI, and professional organizations, like the AMA or ACOG, are committed to suppressing information about the link either because they want to maintain the “myth” that abortion is safe or because they represent doctors who perform abortions, according to Brind (Interview 2011).

The sentiment is also reflected in prolife activism around the alleged link. In an interview with the *New York Times Magazine*, the head of Americans United for Life, Charmaine Yoest claimed that the lack of data for to support a link between abortion and breast cancer was due to the fact that “the scientific establishment ‘is under the control of the abortion lobby’” (quoted in Bazelon 2012: 25). Yoest’s organization is responsible for writing much of the informed consent legislation that has been enacted in many states, and she sees these policy interventions as necessary because established scientific authorities cannot be trusted to protect women.

The proponents of the link see science functioning in a fundamentally different way than the narrative of science presented by breast cancer researchers and epidemiologists. Additionally, there is little agreement between the two sides over which types of evidence are the most accurate and reliable. When I asked what they would consider a definitive study on the issue, both Brind and Lanfranchi pointed to a study that they are trying to implement. Their design would collect a reproductive history (and other relevant information) from women who are having their first mammogram and then following them through their results. At the time of my

interviews, the study had no funding and Lanfranchi had not secured the cooperation of breast cancer screening locations, so it is unclear whether this research will be conducted. It is clear, however, that the only evidence that Brind and Lanfranchi will trust is the evidence they produce. According to Engelhart and Caplan, these are the types of conditions under which controversies continue rather than resolve or close.

### Containing Conflict

In line with other studies of scientific controversy, breast cancer researchers and epidemiologists exerted considerable influence in containing debate about a possible link between abortion and breast cancer. Brian Martin, in his study of the fluoridation debate, found that scientists, dentists, and public health officials who advocated for fluoridation were able to stifle conflict through ignoring their opponents and by appealing to consensus among professional organizations (1991). Many of these same tools have been used by breast cancer researchers and epidemiologists to contain conflict around abortion and breast cancer.

Since the NCI workshop in 2003, mainstream researchers have spoken very little to the media about research on this topic. In the mid-1990s, scientists like Lynn Rosenberg and Louise Brinton were quoted in stories about abortion and breast cancer and provided authoritative accounts of what conclusions could (or could not) be drawn from the early research. And Brind's political connections certainly forced researchers and institutions to address this issue, but after 2003 the landscape shifted. In the years after the NCI workshop, media accounts typically cite only the results of the NCI expert review and list the medical organizations which also conclude that there is no



association between abortion and breast cancer. Leaders of prochoice organizations are quoted as defending the scientific position, but researchers who conduct these types of studies are not interviewed. In conducting my own investigation, I approached many breast cancer researchers who were involved in these events for interviews and was frequently turned down. Many indicated that the “science speaks for itself” as their reason.

Though mainstream researchers have largely avoided entering the political fray over this issue since 2003, it is important to note that they do respond within the scientific community when a journal publishes Joel Brind’s critiques of their study as a letter to the editor. This is likely an attempt to keep their involvement in the debate to the “constitutive forum” of scientific practice rather than engage with Brind and others in the larger “contingent forum” (Collins and Pinch 1979). This adversity to breaching the boundary of science and nonscience allows mainstream researchers to appear objective and bolsters the professional authority of science. It is important to note, however, that these same researchers are not opposed to engaging in political struggles over other issues. For example, Susan Love has a long history of advocating for which types of breast cancer research should be funded and Leslie Bernstein has advocated that mammography screenings should continue for women in their 40s despite consistent evidence that at that age women do not see benefits from screening (Norman et al 2007; US Preventative Services Task Force 2009).

Additionally, the NCI workshop remains a critical moment that experts and reports point to as evidence of consensus among researchers. The NCI, the American

Cancer Society, and the ACOG all have issued statements that indicate that based on current research there is no apparent association between induced abortion and breast cancer. The agreement of these organizations is most frequently referenced in media reports about a potential link. And prochoice activists mention these statements as well as the NCI workshop when disputing claims about the possible association. This appeal to consensus, which Martin identified as one of the credibility tactics used by mainstream scientists and public health officials in fluoridation debates, is also used by researchers and activists in this debate. It also serves as a type of boundary work that highlights the marginalization of the dissenter's views.

### Continuing Controversy

Scholars of contemporary scientific controversies have frequently drawn attention to the resources and tactics used by dissenters to continue debate, promote uncertainty, and enact (or stifle) policy changes. Mainstream scientists have formidable resources, institutional power, and professional authority that can be deployed to contain conflict. Dissenters, on the other hand, are able to continue conflict through appealing to invested outsiders, political maneuvering, forming mimetic institutions, and critiquing research to create doubt about the certainty of mainstream scientific positions.

In his research on the AIDS causation controversy, Steven Epstein found that influential scientists, namely Peter Duesberg, were able to continue conflict by appealing to invested outside groups (1996). Some AIDS activists and alternative gay newspapers had remained doubtful about the role of HIV in the development of AIDS

and were willing to publicize and promote Duesberg's critiques of the causal model. These activists along with Duesberg and other researchers were influential in getting mainstream researchers to address their concerns. Similarly, Brind used his political connections and activists within the prolife movement to bring about changes to the NCI fact sheet in 1998 and the expert review in 2002. Though mainstream researchers appear to be in agreement that abortion is not associated with an increased risk of breast cancer, the belief that abortion causes breast cancer is held by many antiabortion activists. Brind regularly contributes to the *National Right to Life Newsletter* and has been interviewed in smaller prolife venues like Life Matters TV as well as broader conservative publications including the *National Review*. His claims about a link between abortion and breast cancer are often contested when he is interviewed by mainstream newspapers, but in the prolife and conservative media these claims go unchallenged.

In *Merchants of Doubt*, Naomi Oreskes and Eric Conway examine the influence that industry-backed scientists had in continuing a variety of scientific controversies such as debates over the harms of smoking tobacco, the existence of a hole in the ozone layer, and the reality of global climate change (2010). These scientists, who often have connections to conservative politicians, were highly regarded specialists in fields not directly related to the scientific debates they are addressing, but were frequently appointed to expert panels and had significant influence over policy recommendations. Oreskes and Conway, like others researchers (see for example Michaels 2008) argue that dissenters do not need to disprove

dominant views of science, but only to cast doubt over the reliability of findings. In many cases this was done by pointing to minor flaws in research design or by using instances in which the finer details of a body of evidence were unsettled to call into question the certainty of the evidence as a whole. By promoting uncertainty, these scientists were able to delay political action to revise warning labels on cigarettes and hold off any real progress towards addressing climate change. Industries also helped to promote uncertainty by setting up institutions and organizations that are designed to look like research institutes or advocacy groups, but publicize industry-friendly research or policies.

The debate over a link between abortion and breast cancer mirrors many of the cases examined by Oreskes and Conway in important ways. Brind is a specialist in endocrinology, but he is not an expert in breast cancer research or epidemiology. His letters critiquing the research on breast cancer and reproductive events usually address minor methodological problems, but are characterized by him as “fatal flaws” that completely discredit findings. And his political maneuvering to revise the NCI fact sheet has resulted in making the research appear more inconsistent or uncertain. Additionally, Brind and his colleagues have set up organizations like the Coalition on Abortion/Breast Cancer and the Breast Cancer Prevention Institute, which promote research that demonstrates an association between abortion and breast cancer and criticizes research, scientists, and institutions that disagree.

By far the most powerful resource that Brind has capitalized on to continue debate has been his opponents’ relative silence on the issue. Reporting, even on

scientific work, aims to strike a balance and give equal coverage to two sides of a debate. As mentioned above, many of the scientists involved in breast cancer research have declined to enter the political fray over this issue. When the possible association is covered in newspapers, Brind is typically the only scientist interviewed and reporters only challenge his claim by pointing to the consensus reached by the NCI. This balanced style of reporting and lack of a robust challenge to Brind's claims helps to make the science seem less certain.

It is important to note that Brind and Lanfranchi do not consider themselves to be similar to the "merchants of doubt" examined by Oreskes and Conway. Though they use similar techniques, they lack any real financial backing or industry support. In fact, they see the "abortion industry" as the corrupting influence in this debate. In interviews and on the website for the Coalition on Abortion/Breast Cancer, advocates of the link compare their struggle to those of scientists who realized the harms of cigarette smoking, but whose concerns were dismissed by the tobacco-industry controlled American Medical Association and National Cancer Institute (Interview with Malec 2011). Though the tactic of following the money works well for the cases examined by Oreskes and Conway, it does not adequately capture cases in which deeply held moral beliefs or differing views of science are the motivating factor in continuing controversy.

The different narratives of science put forward by the two sides in this debate raises important questions about the study of controversies. Scholars who propose a more normative view of science (Oreskes and Conway 2010; Collins and Evans 2007)

often portray scientific practices and institutions as in need of defense from politically-motivated interlopers or industry influences. My examination of the abortion/breast cancer debate indicates that not all groups that deploy the kinds of tactics favored by “merchants of doubt” are acting solely in the interest of achieving political goals. Researchers like Brind and Lanfranchi consider mainstream scientific institutions as corrupt and scientists too fearful of losing their research funding. Rather than interfering with scientific processes to disrupt policy initiatives, Brind and Lanfranchi see themselves as vocal proponents of “the truth” about abortion. Rather than looking to industry financing or political ties as the explanation for both the motivation of dissenters and the reason why controversies continue, I contend that a broader examination of potential motivations that includes the larger critiques of science that dissenters draw upon enriches scholarship on controversies.

As a scientific consensus emerged around the possible association between abortion and breast cancer risk, researchers who are critical of abortion deployed a variety of tactics, including appealing to political allies and prolife activists, to continue debate and promote uncertainty. Epidemiologists and breast cancer researchers drew upon their own resources to perform boundary work to assert their authority, build consensus, and isolate dissenters. In the next chapter, I examine a similar controversy over a potential association between abortion and mental illness. Though many of the tactics used to either end or continue debate are similar, the social, scientific, and institutional contexts in which the debate takes place are

different. Through comparison, I explore how these different factors have impacted the trajectories of these controversies.

## CHAPTER THREE: ABORTION AND MENTAL HEALTH

Debate over a possible association between induced abortion and mental illness has a complicated history within both the scientific community and the social movements around abortion. Early research on the topic focused on whether terminating a pregnancy exacerbated an already diagnosed mental illness or whether carrying an unwanted pregnancy to term would endanger the mental health of the mother. Activists and researchers within the prolife movement claimed that the procedure had another relationship to mental health – that abortion caused mental distress. These different understandings of the possible connections between abortion and mental health have impacted how research on the topic has been designed, what types of “mental distress” are being studied, and the strategies used by various actors to bolster their credibility and define what counts as good research.

In this chapter, I analyze this history of the debate about abortion and mental health with particular attention to how psychologists, psychiatrists, and researchers who are critical of abortion have studied this relationship and how research on this subject has been evaluated. Researchers tend to agree on the methodological problems within the current body of research, but they disagree over what is considered good evidence and what that evidence indicates about abortion and mental illness. Researchers also are dissimilar in the strategies they employ to shore up their professional authority and influence the debate. Mainstream psychologists and psychiatrists appeal to the growing professional consensus that there is not increased



risk of mental illness associated with aborting an unwanted pregnancy. They also defend their position in the media and in legal proceedings around abortion as well as demonstrate the discrepancies between shared norms of scientific engagement and the actions of researchers who are critical of abortion. These strategies function as a type of boundary work to contain debate on the topic. On the other hand, researchers who are critical of abortion appeal to invested social groups (namely the prolife movement), engage in scientific research, and argue that mainstream researchers and professional organizations are not objective evaluators of research due to their ties to prochoice politics. These strategies facilitate the continuation of controversy both within the community of mental health researchers and in the public and legal arenas.

Though many of the strategies deployed by mainstream researchers and dissenters are similar to those used in the abortion/breast cancer debate, there are a few important differences that are examined in this chapter. First, unlike epidemiologists and breast cancer researchers, the researchers in this debate have been more vocal advocates of their interpretation of scientific findings both in the media and in legal disputes. And unlike advocates of the abortion/breast cancer link, researchers who are critical of abortion have continued to contribute to the literature on abortion and mental health through publishing their work in peer-reviewed journals. These differences in strategies along with the different social, scientific, and institutional contexts in which these disputes play out have shaped the trajectories of these two controversies in different ways.

### **Psychiatry and the Legalization of Abortion**

While the concept of a “post-abortion syndrome” emerged within the prolife movement during the early 1980s, there was a longer history of psychological and psychiatric research on mental health and abortion. The first review of research on the psychiatric sequelae of abortion, authored by Simon and Senturia, was published in 1966 and covered international and domestic studies published between 1935 and 1964. The authors concluded that much of the research was not conducted in any systematic fashion, and focused on how women with diagnosed mental illnesses fared after pregnancy termination (Simon and Senturia 1966: 387). During the post-war period, psychiatrists and other mental health professionals played an important role on hospital advisory committees that evaluated the medical necessity of individual women’s requests for abortion (Solinger 1992). With advances in medicine most appeals for abortion were made on the basis of preserving mental health rather than protecting the women’s physical health.

By the late 1960s, public and psychiatric opinion about abortion had changed dramatically. According to a poll of members of the American Psychiatric Association only 24 percent of members favored abortion on request in 1967, but 72 percent of members favored it just two years later in 1969 (Schwartz 1986: 324). Additionally, research on women who obtained abortions on psychiatric grounds during the late 1960s found that many women experienced no adverse psychological effects, and many experienced a therapeutic effect (Ekblad 1955; Peck and Marcus 1966, Simon et al. 1967; Patt et al. 1969; Ford et al. 1971). These studies mark a significant change in the ways that psychiatrists thought about abortion and mental health. Contrary to

previous beliefs, it seemed that the most mentally ill patients fared the worst after an abortion, and women with less severe diagnoses adjusted well after an abortion. Some experienced improvement in their conditions.

In 1970, the American Psychiatric Association adopted a position that favored legal abortion and that diminished the professional role of psychiatrists in abortion provision. The statement read: “A decision to perform an abortion should be regarded as strictly a medical decision and a medical responsibility. It should be removed entirely from the jurisdiction of criminal law” (1554). This position preserved the professional sovereignty of the medical profession (of which psychiatrists are a part) by suggesting that the entire issue of abortion be removed from the realm of criminal law. However, the role of the psychiatrist became that of a consultant in cases where a patient’s motivations are unclear or in question, rather than a central figure in deciding whether or not a woman should have an abortion.

By the early 1970s, several states had liberalized their abortion laws allowing more women to undergo the procedure for a broader variety of justifications. Two lawsuits, *Roe v. Wade* (Texas) and *Doe v. Bolton* (Georgia), challenged the constitutionality of the states’ abortion restrictions which only allowed for abortion in cases where the pregnant woman’s life was in danger. These two cases were eventually appealed to the U.S. Supreme Court. The American Psychiatric Association filed a joint *amicus curiae* brief along with the American College of Obstetricians and Gynecologists, the American Medical Women’s Association, the New York Academy of Medicine, and a group of 178 physicians on behalf of the appellants. The brief

largely framed the legal question of abortion provision as a professional concern among doctors. The laws were critiqued for being “too vague” in meaning and for their lack of clarity regarding when the procedure was allowed.<sup>38</sup>

Many of the briefs filed in defense of abortion restrictions claimed that the fetus is a distinct, separate human being in need of legal protection. Medical professionals opposed to abortion made the case that the procedure could be harmful to women. In another brief filed on behalf of “Certain Physicians, Professors and Fellows of the American College of Obstetrics and Gynecology” the case was made that abortion can have serious medical risks and long term physical and mental health consequences for women. When reviewing the evidence on psychiatric outcomes after abortion, the authors of the brief indicated that adverse reactions are only present among those who are already mentally ill, and that there were no legitimate reasons to perform an abortion on psychiatric grounds (57-58).<sup>39</sup> For these medical professionals the Texas abortion statute was not too vague – abortion should only be provided when carrying the pregnancy to term would likely result in the death of the woman.

Psychiatry, accordingly, should play no role in abortion provision.

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<sup>38</sup> It’s not surprising that the impact of abortion statutes on medical practice would be a central concern of doctors during a time when abortion laws were being liberalized. In fact, many scholars point to the involvement of doctors and medical professionals as central to the Supreme Court decision to legalize abortion (Halfmann 2011). While the text of the *Roe vs. Wade* decision frames the issues in terms of a woman’s constitutional right to privacy, the brief submitted by the American College of Obstetrics and Gynecology, the American Psychiatric Association, and other groups frame women’s privacy as a secondary concern. Their primary concern is that the Texas abortion statute violates their constitutional rights to practice their profession.

<sup>39</sup> The authors state, “Most abortion proponents not involved in public efforts to promote their cause, admit that elective removal of the fetus is without psychiatric or medical justification. The fetus has not been shown to be a direct cause of any emotional disorder, and present medical capabilities make pregnancies safe. Almost always, other means than abortion are available to handle any medical or psychiatric complications of pregnancy. Indeed, if a woman wants her child, there are no medical or psychiatric indications that ever make an abortion necessary” (57). They go on to argue that the danger of suicide among pregnant women is greatly exaggerated (58).

Ultimately the *Roe vs. Wade* decision (1973) did not take up the issue of mental health and abortion in a significant way. Instead the mental distress of carrying a pregnancy to term and caring for an unwanted child was given precedence. Rather than framing abortion as potentially harmful to women, Justice Blackmun argued that mental health problems arise from carrying an unwanted pregnancy to term and that a woman's decision to end a pregnancy through abortion should be a protected right, in part, because it preserves her mental health. Though the medical and psychological health of the woman is the primary focus of this rationale, the Court maintained that "there is also distress, for all concerned, associated with the unwanted child." The decision to terminate a pregnancy is framed here as a family decision rather than solely a personal choice.

### **The Emergence of "Post-Abortion Syndrome"**

The legalization of abortion remains one of the most contentious social issues in America. Within years of the Court's ruling, two national movements coalesced to either preserve or do away with the right to abortion. As discussed in Chapter One, Congress generated legislation to restrict access to abortion or to reverse the Court's decision by changing the Constitution to reflect the belief that life (and citizenship) begins at conception. Much of political activity around abortion focused on convincing courts and legislatures to recognize rights for the fetus. In the early 1980s, both houses of Congress began to debate a variety of legislation that would either outlaw abortion or greatly restrict some women's access to the procedure (particularly minors and poor women). Within the antiabortion movement and in these legislative

debates, new arguments emerged that called into question the safety of abortion and the potential for it to cause harm to women.

Through this research, a consensus emerged within the prolife community about what the negative aftermath of abortion looked like. Women suffering from post-abortion syndrome seemed to suffer from a panoply of maladies that included depression and guilt, and many turned to substance misuse or considered suicide to deal with their symptoms. It was also clear that some women maintained a deep denial that they were even suffering from mental distress until many years after the abortion. This denial was thought to end as a result of some other reproductive event (e.g. the anniversary date of the abortion, the projected due date for the terminated pregnancy, the birth of a child or grandchild). These reactions to abortion were also universally characterized as outside of the normal range of emotions after abortion; these women were suffering from a new mental illness. Over the course of the next few years, prolife researchers would develop detailed symptom information and diagnostic guidelines for three new mental illnesses: *post-abortion distress* (an adjustment disorder), *post-abortion syndrome* (a variant of PTSD), and *post-abortion psychosis* (a major affective disorder). While mainstream mental health organizations disputed the existence of these disorders and the American Psychological Association never recognized them or included them in the DSM, some members of the prolife movement felt that recognition of them would be essential to recriminalizing abortion.

The Koop Review and its Fallout

The idea that abortion might be psychologically harmful for women did not reemerge in government debates until the late 1980s. Due to the efforts of nascent post-abortion organizations, some preliminary research on psychological sequelae, and the publication of memoirs of women who suffered from “post abortion syndrome”, these ideas had taken hold within the prolife movement. In 1987, President Ronald Reagan, during a briefing of prolife leaders, directed Surgeon General C. Everett Koop, an outspoken opponent of abortion, to prepare a comprehensive report on the health effects of abortion on women. It was later reported that the idea for such a report came from conservative commentator and convicted felon, Dinesh D’Souza, then a White House aide (“The Federal Role ...” 1989: 3). The Reagan Administration believed that this report could provide a rationale that could be used to challenge *Roe v. Wade*. Over the course of a year and a half, Koop and his staff met with 27 different groups that had “philosophical, social, medical, or other professional interests in the abortion issue” (Koop 1989). These included political and religious organizations like the National Right to Life Committee and the U.S. Conferences of Catholic Bishops, organizations involved in abortion provision, and medical organizations such as the American Psychological Association, the American Psychiatric Association, the American Public Health Association, and the American College of Obstetricians and Gynecologists. Government officials within the Department of Health and Human Services were also consulted.

The Surgeon General’s investigation into the health consequences of abortion treated physical and psychological health as two separate areas of inquiry. The

possible physical complications from abortion were well-known and well-studied at the time that the report was being generated, with most of the data coming from the CDC or the Guttmacher Institute (then the research branch of Planned Parenthood). Koop ultimately validated the prolife groups claim that “it has been documented that after abortion there can be infertility, a damaged cervix, miscarriage, premature birth, low birth weight babies etc.” But he went on: “I further conclude that these events are difficult to quantify and difficult to prove as abortion sequelae” (Koop 1989).

The Surgeon General came to an equally ambivalent conclusion about the psychological health consequences of abortion. Representatives from the American Psychiatric Association and the American Psychological Association (APA) had met with Koop during the inquiry, and the American Psychological Association had assembled an expert panel to evaluate the current research in this area. The APA report found the studies examining psychological responses in women following an abortion to be “extremely varied” in terms of quality (Adler, prepared testimony 1989). Much of the research was based on small case studies with non-representative study populations. Additionally, there was a great deal of variation in how post-abortion responses were measured – most studies included a short follow-up time (usually just a few months post-abortion) and varied in how responses were measured (some used standardized diagnostic tests for mental illness, others used scales designed specifically for the study). Finally, studies that compared post-abortion responses to post-partum responses typically used the wrong comparison group. In order to study whether or not abortion is associated with negative psychological



responses, one has to compare women who obtained abortion with women who wanted to abort a pregnancy but were ultimately either denied the procedure or decided against it. This comparison would control for the “wantedness” of the pregnancy. The expert panel found that most comparison studies at that time compared women who aborted (and likely did not want the pregnancy) with women who carried to term (and likely did want the pregnancy).

Despite serious methodological flaws, the APA expert review advised Koop that “The best studies available on psychological responses to abortion suggest that severe negative reactions are rare and are in line with those following other normal life stresses” and that “despite methodological shortcomings of the individual studies, the fact that studies using diverse samples, different measures of post-abortion response, and different times of assessment come to very similar conclusions is persuasive evidence that abortion is usually psychologically benign” (Adler, prepared testimony, 1989). Additionally, the APA reasoned that if post-abortion trauma were a pervasive health problem, there would have been a significant rise in the number of women seeking professional help. Since this was not happening it provided further support for the claim that severe reactions were rare.<sup>40</sup>

The Association for Interdisciplinary Research in Values and Social Change (AIRVSC), an organization for prolife researchers that is affiliated with (and shares the same address as) the National Right to Life Committee, assembled a white paper

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<sup>40</sup> This evidence was also used to refute the claim that post-abortion syndrome is a form of PTSD and that women who suffer from symptoms similar to those experienced by Vietnam veterans. Adler points out in her testimony that one of the reasons that PTSD was “discovered” was because so many combat veterans were seeking help that it swamped the mental health system.

analyzing the psychological aftermath of abortion and submitted it to the Surgeon General's office during the inquiry. The authors of the white paper also found that much of the research on post-abortion sequelae was seriously flawed, but conducted a meta-analysis of eleven studies on post-abortion sequelae and argued that of those there was "one best study" that indicated that abortion was associated with increased risk of mental illness. The study compared admission rates to psychiatric hospitals among postpartum and post-abortion women in Denmark and found that while married or never married postpartum and post-abortion women had similar levels of psychiatric hospitalization one year after the end of their pregnancy, women who were separated, divorced, or widowed at the time of their abortion had significantly higher rates of psychiatric hospitalization than all other groups (David et al. 1981).<sup>41</sup> The original authors of the study claimed that the higher rates for separated, divorced, or widowed women post-abortion should be interpreted cautiously because they only made up a small portion of the study's population. In the white paper, the authors reported the higher rate of psychiatric admissions for separated, divorced, and widowed women post-abortion as the rate for all women post-abortion and claimed that this "one best study" indicated that abortion was harmful for women ("The Federal Role..." 1989: 11).

The Surgeon General's Office sent the AIRVSC white paper to several government scientists, including researchers at the CDC, the National Center for Health Statistics, and the National Institute for Child Health and Human Development

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<sup>41</sup> It is important to note that the first author of the study, Dr. Henry David, served on the American Psychological Association's expert review of psychological factors after abortion and was a well-known expert on the subject.

as well as an independent biostatistician for review. These reviews called into question the appropriateness of using meta-analysis on a group of studies with such a wide variety of designs and expressed concern that the methodological flaws of the studies might compound error rather than minimize it United States House of Representatives 1989: 150-173). The CDC review of the research concluded that “since the meta-analysis used a combination of studies with disparate results, the conclusions based on such analysis have little value,” (153) and the independent biostatistician accused the AIRVSC of “academic warfare” and claimed that the report “deserves little recognition” (United States House of Representatives 1989:173).

Ultimately, Koop was unable to produce the report that Reagan requested.<sup>42</sup> Instead, on January 10, 1989, Koop delivered a letter to President Reagan that claimed that current research was too flawed to be able to say with any certainty whether or not abortion was associated with physical or psychological health consequences. He concluded that “the scientific studies do not provide conclusive data about the health effects of abortion on women” (Koop 1989: 4). This conclusion reflects that Koop, to some extent, was persuaded by the claims of antiabortion groups that research on the topic was more uncertain than government scientists and medical professionals led on. The Surgeon General also proposed that the government allocate either \$50 million or \$100 million dollars to conduct a “prospective study on a cohort of women of child-bearing age in reference to the variable outcomes of mating” (3). This longitudinal,

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<sup>42</sup> This is not the only example of the fraught relationship between Reagan and his Surgeon General. In his response to the HIV/AIDS crisis, Koop did not align himself with the administration’s position that widespread testing and abstinence were the best methods to combat the spread of HIV. Instead Koop argued for condom distribution, more open discussions of sexual practices and an expansion of domestic welfare programs (Brier 2009).

prospective study would allow government agencies to compare the long-term physical and psychological health consequences of different pregnancy outcomes.

The release of the Koop letter set off a political firestorm. Koop and many prolife activists claim that major media outlets mischaracterized the conclusion in the letter and portrayed the letter as supporting the conclusion that abortion was safe (Koop, testimony, 1989; Burke 2002); however, major newspapers like the *Washington Post* and *USA Today* accurately reported that Koop's letter indicated that no conclusion about whether or not abortion was safe or unsafe could be drawn from the available research (Specter 1989: A1; Tinsley 1989: 3A). There were mixed reactions within the prolife, prochoice, and public health communities. Representatives from the National Organization for Women and Planned Parenthood praised the letter's objectivity while the NRLC interpreted the letter as a prochoice victory (Tinsley 1989: 3A). Some current and former CDC scientists were upset by the ambiguous statement about the long-term physical consequences of abortion, which they felt the evidence indicated was clearly safe (Leary 1989).

### **Mental Health Organizations Confront Post-Abortion Syndrome**

The debate over whether or not abortion was associated with mental illness was highly politicized by the time that mental health organizations like the American Psychological Association (APA) and the American Psychiatric Association started to sift through the research. Of course, psychologists and psychiatrists had been studying the post-abortion sequelae, but the assertion that some women's psychological reactions to abortion constituted a new mental illness came from organizations and

researchers who were opposed to the legalization of abortion. With the Surgeon General's inquiry and subsequent Congressional hearings, both had to address the claim that abortion harmed women's mental health. The debate over psychological factors in abortion moved from being debated in Congress to exchanges in academic journals and position statements of professional mental health organizations. Not surprisingly, professional mental health experts and prolife researchers articulated very different positions. The two sides differed significantly in how they defined the "problem" of post-abortion sequelae, whether or not women who experienced negative emotional responses to abortion were mentally ill, the prevalence of negative emotional responses, and what research or policies needed to be enacted to address this problem.

#### Defining the Problem

Representatives for the American Psychological Association, the American Public Health Association, and the American Psychiatric Association in Congressional testimony and subsequent publications all defined unwanted pregnancy as the central problem under investigation in scholarly research on this topic. Most U.S. women who seek abortions do so to end an unwanted pregnancy; the experience and stress of handling an unwanted pregnancy cannot be easily separated from the abortion experience. Nancy Adler, representing the APA, testified that, "In studying women following abortion, what is really being studied is the response to the entire experience of having an unwanted pregnancy which is terminated" (131). They argued that research into the psychological aftermath of abortion only makes sense in the larger

context of the pregnancy. In this framing of the problem, unwanted pregnancy is cast as a stressful life event and the research on this topic does not adequately separate out the possible negative mental health outcomes that might occur with an unwanted pregnancy from those that might occur if that pregnancy ends in abortion.

Prolife organizations and researchers, on the other hand, framed abortion as the central problem under investigation. They argued that there is something unique about the decision to terminate a pregnancy and the abortion procedure that makes women more likely to have negative emotional reactions than just the pregnancy itself (Speckhard testimony 1989; Franz testimony 1989). Based on limited clinical and anecdotal evidence, prolife researchers argued that the abortion itself was responsible for a variety of moderate and severe emotional reactions, such as depression, guilt, anxiety, and regret. Having an abortion could also be traced to behavioral changes in women including increased substance abuse and suicide. This constellation of emotional and behavioral responses was often referred to as Post Abortion Trauma or Post-Abortion Syndrome.

#### Mental Illness or Normal Reactions to Stress?

Prolife researchers were motivated by the ongoing revision of the Diagnostic and Statistical Manual of Mental Disorders (from DSM-III-R to DSM-IV) to reframe post-abortion syndrome in the language of psychiatric disorders in hopes of gaining legitimacy and recognition that PAS was a real disease. In the DSM-III-R “abortion” was listed as a potential psychosocial stressor that could lead to a stress disorder.<sup>43</sup>

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<sup>43</sup> There is some controversy over whether or not “abortion” actually appears as a psychosocial stressor in the DSM-III-R (David and Lee 2002). It is true that abortion does not appear in the adult “Severity of

Capitalizing on the diagnostic expansion of Post-Traumatic Stress Disorder, such as claims that victims of rape and domestic violence might suffer from variants of PTSD, prolife researchers argued that undergoing an abortion could similarly be a traumatic event (Lee 2003; Speckhard and Rue 1992). As was the case in the changing landscape of breast cancer funding and research, the expansion of the definition of trauma and PTSD was an intellectual opportunity (Frickel and Gross 2005; Waidzunus 2013) that prolife researchers were able to take advantage of to shape scientific debates about abortion and mental health.

In the first publication about PAS in a peer-reviewed, scientific journal, Anne Speckhard and Vincent Rue argue that clinical research indicated that abortion could lead to three distinct mental disorders: Postabortion Distress (an adjustment disorder), Postabortion Syndrome (a variant of Post-Traumatic Stress Disorder), and Postabortion Psychosis (a major affective disorder) (1992: 104-106). Each of these potential diagnoses was defined in terms of the recognized mental illness to which it was meant to be attached. For example, Postabortion Distress (PAD) was defined as “the manifestation of symptoms of discomfort following abortion” that resulted from “the perceived physical pain and emotional stress of the pregnancy and abortion”, the perception of loss following the abortion, and “the conflict in personality, roles,

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Psychological Stressors Scale” which lists examples of stressors in categories of severity from “none” to “catastrophic” (1987: 11). Miscarriage, however, is listed as a moderate psychosocial stressor. Abortion is given as an example in an instructional passage on how to complete the Axis IV component of a diagnosis, which is the evaluation of the severity of psychosocial stressors. Under types of psychosocial stressors to be considered, abortion is listed in the category “physical illness or injury” rather than in more interpersonal categories such as “conjugal” or “family factors” (1987: 18-20) It is not entirely clear what abortion meant in this context. The term includes both induced abortions and miscarriages (spontaneous abortions), and might also be included because some research at the time indicated that illegal abortions were associated with more medical complications and stress (Stotland 1991).

values, and relationships that results from the changed perception of the appropriateness of the abortion decision” (104-105). Additionally, to fit within the diagnostic criteria of affective disorders, PAD must have its onset not more than three months after the abortion and persist for no more than six months (105).

Postabortion Syndrome (PAS) was given the most specific diagnostic criteria. Following the framework of PTSD in the DSM-III-R (1987), to be diagnosed with the disorder a person must experience a markedly distressful event outside of the range of normal human experience, must “persistently reexperience” the traumatic event (e.g. through intrusive thoughts, flashbacks, nightmares), must experience “persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness”, must experience “persistent symptoms of increased arousal” (e.g. sleep disturbance, difficulty concentrating, or hypervigilance), and these symptoms must persist for a least one month. Speckhard and Rue argued that women with PAS fit these diagnostic criteria and manifested symptoms similar to those of veterans returning from war. However, some critics pointed out that legal abortion does not qualify as a trauma because it is not “outside the range of usual human experience” and does not involve a mortal or serious physical threat to one’s self, and because it is volitional (i.e. a woman must choose to have an abortion and seek it out; it is not something inflicted upon her) (Wilmoth, Bussel, and Wilcox 1992). The authors responded to these critiques by claiming that trauma is about perception – many women experience abortion as a “death event” of a fetal child, fear for their own physical safety, and view the abortion as nonnormative (107-108). Additionally, they



claimed that many women are coerced into abortion by partners, family members, and clinic staff, or are not fully informed about the procedure, so the abortion experience is not always volitional.

Prolife researchers clearly thought that negative emotional reactions to abortion were part of a spectrum of mental illness that ranged from mild (postabortion distress) to severe (postabortion psychosis). Characterizing a group of women as mentally ill can have a variety of unintended consequences. For example, Speckhard and Rue were concerned that portraying these women as “ill” could lead to victim blaming – after all, these women chose this traumatic experience. Speckhard and Rue caution against this by asserting that PAS is “an adaptive response to a maladaptive decision to have an abortion” (113). That is, PAS in their framing was a normal response to an abnormal decision to end a pregnancy.<sup>44</sup>

While prolife researchers worked to define psychological responses after abortion within a framework of psychopathology and argued that prevalence rates for post-abortion trauma were high, researchers with the American Psychological Association and the American Psychiatric Association argued that these same responses fell within a framework of normal stress and coping. In an *American Psychologist* article, the researchers on the APA expert review wrote that

an unwanted pregnancy is seen as an event that can be challenging or stressful. . . . Research on the impact of stressful life events has pointed to the importance of several variables that mediate or moderate the impact of such events on the individual. Among the key variables that have been identified are social support, attributions for the cause of

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<sup>44</sup> This appears to be a different form of victim blaming. Rather than blaming women for being mentally ill, Rue and Speckhard argue that it was the abortion decision (not the reaction) that is “maladaptive” (1992).

the event, the meaning attached to the event, and the coping strategies used for dealing with the event (Adler et al. 1992: 1197).

From this perspective unwanted pregnancy is a stressful event that is similar to the end of an important relationship or the loss of employment—events that “pose challenges and difficulties to the individual but do not necessarily lead to psychopathological outcomes” (1197). Research by psychologists indicated that the circumstances of the unwanted pregnancy and the circumstances of the abortion could explain why some women had more difficulty after abortion than others. For example, women who reported that they anticipated not coping well, women who described their pregnancy as highly meaningful, and women who attributed their unwanted pregnancy to a fault in their character (as opposed to a correctable self-behavior blame or chance) were more likely to cope poorly after the abortion (Major, Mueller, and Hildebrandt 1985). Additionally, women who characterized their pregnancy as intentional were more likely to be depressed three weeks after the abortion (Major, Mueller, and Hildebrandt 1985).

The APA expert review characterized emotional reactions after abortion as falling within the spectrum of normal human reactions to stressful events. While they did point out the methodological shortcomings of the research, the authors gestured at a particular pattern of responses. Most women had no negative reactions, but some women were at higher risk for negative reactions due to the circumstances of their pregnancy and social situation. Among the women who reported feelings of sadness, guilt, or regret after abortion these emotions were not so severe as to be labeled

psychopathological, and in most cases these negative emotions had subsided or disappeared within six months of the abortion (Adler et al. 1990; Adler et al. 1992).

The American Psychiatric Association took a firmer position on Post-Abortion Syndrome. The group issued statements to clarify the PAS was not a recognized mental disorder in the DSM (*Psychiatric Aspects of Abortion* 1991). This position would not be unexpected due to the association's role as gatekeeper of mental illness. Additionally, one prominent psychiatrist, Nada Stotland, who specialized in women's issues and would go on to be the president of the American Psychiatric Association, authored a commentary in the *Journal of the American Medical Association* titled "The Myth of the Abortion Trauma Syndrome" (1992). Like scientists with the APA, Stotland argued that the experience of abortion cannot be separated from the stress associated with having an unwanted pregnancy; she also made a sharp distinction between feelings and disease. She wrote, "A symptom or a feeling is not equivalent to a disease. Some women who undergo abortion experience transient feelings of stress and sadness, as distinguished from psychiatric illness, before and for a short time afterward. The majority experience relief after the procedure" (2079). In a handbook published by the American Psychiatric Association which provides guidance to psychiatrists on the psychiatric aspects of abortion following the Koop inquiry and the *Webster v. Reproductive Health Services* ruling, Stotland further asserted that ending an unwanted pregnancy through legal abortion is safer than the alternatives of illegal abortion, adoption, or raising an unwanted child (1991: 3-13). Like the APA, representatives from the American Psychiatric Association claimed that mental illness

following abortion was rare and that feelings of sadness in the months after an abortion were normal rather than a distinct psychiatric illness.

### Prevalence

Prolife researchers also claimed that the prevalence of post-abortion stress disorders was likely higher than the psychological and psychiatric research indicated. This underreporting, Speckhard and Rue argued, could be due to a number of factors. First, they claimed that the politicization of the abortion issue would make women who are suffering from their previous abortions less likely to seek help or discuss their difficulties. This assumes a widespread cultural belief within the medical professions that abortion is safe and “good for women,” and so complaints about abortion’s harms would be taken less seriously. Additionally, many women suffering from PAD, PAS, or PAP are in denial that their mental illness is associated with their abortions. Some research indicates that women can be relatively symptom free up to ten years after their abortions before they start to experience negative effects, according to Speckhard and Rue. This would mean that research that only followed women in the months and immediate years after their abortions would not be catching all the cases. Moreover, Speckhard and Rue claimed that women who drop out of research investigations into the psychological aftermath of abortion might be more likely to be experiencing negative reactions and are avoiding interactions that remind them of their previous abortions. Finally, because PAD, PAS, and PAP are not recognized diagnoses, Speckhard and Rue claimed that many women who do seek treatment might be misdiagnosed with some other illness. For example, secondary symptoms like

depression, substance abuse, and sleep disorders “may all too easily be misdiagnosed as primary and treated without reference to the unresolved emotions from abortion trauma” (109).

The APA experts did not give a specific rate of prevalence for severe reactions to unwanted pregnancy and abortion except to indicate that they were “rare.” However, they also argued that the existing research might overestimate the number of women who experience negative reactions. They argued that early research on post-abortion psychological reactions was conducted by researchers who indicate a strong bias against abortion, which might lead to analysis that only examines negative (and not positive) responses. This claim is supported by the fact that most research before the early 1980s did not even include measures for positive emotions like relief. Additionally, they asserted that the social context of abortion can influence how a woman feels about her decision. The stigma of abortion may make women who feel they benefited from their less likely to speak about it. Finally, they argue that even 15 years after the legalization of abortion, mental health professionals are still not seeing the increased utilization of services that would result from a widespread mental illness.

The lack of data and disagreement on the prevalence of severe post-abortion had important policy implications. Without estimates of what percentages of women who have abortions experience negative reactions, policy-makers are unable to determine whether or not a policy-relevant problem exists or how large it might be. Additionally, properly informing patients of risks associated with a surgical procedure requires medical professionals to use comparisons to determine whether or not a risk is

acceptable with respect to alternatives (Wilmoth 1992; Wilmoth, de Alteriis, and Bussel 1992).

### Further Research

Given the differences in how the two sides define the problem and how prevalent they imagine it to be, it is not surprising they proposed different ways to move forward with the research. Pro-life researchers and organizations cited research on prevalence and development of therapeutic regimes as the next step. For example, Speckhard testified:

While incidence and comparison data is lacking we have clear evidence that some women are stressed by abortion and that many develop a variant of Post Traumatic Stress Disorder, namely Post Abortion Syndrome. High stress reactions to abortion have been clearly identified and described. The questions remaining to be answered are how many women are affected, how do their experiences compare across pregnancy outcomes, and what variables act (and interact) in predicting stress and style of coping (1989: 128).

For Speckhard, the question is not whether or not Post Abortion Syndrome exists, but rather how many women are affected, how much more dangerous psychologically abortion is from childbirth, and how can we more effectively screen for women who are likely to be affected? She also proposed that the government pay to conduct a study of “the problem of post-abortion stress, by conducting retrospective interviews with participants in the National Survey of Family Growth (147).

Franz, on the other hand, discounted the value of comparative research with other pregnancy outcomes. She testified:

What we need to find out is whether abortion has a particular etiology to create specific problems. Clearly, post-birth trauma, depression, is known ... We have some ideas about how it functions. What we need

to do now is to understand how post-traumatic stress functions, and, to make the comparison with birth, while it provides some interesting findings in terms of intervention, and so forth, does not get to the issue of whether women are having these problems, what the nature of those problems are and how abortion specifically impacts on their mental health and what makes this different (145- 146).

While studies that compared rates of post-abortion trauma with post-partum depression or the mental effects of carrying an unwanted pregnancy to term would be “interesting,” for Franz, what really needs to be examined is the specific etiology by which abortion causes mental illness.

While neither the APA nor the APHA outlined an explicit research agenda for how to study the problem, the APA did provide suggestions for how research on abortion and mental health could be improved. Four central methodological flaws with the field of research were identified by the APA in their review, and each of these carried with it the assumption that if the flaw were fixed, research would be improved. First, the APA pointed out that many of the studies were not based on representative samples of women; many studies had low numbers of participants or the qualities and circumstances of the participants’ experiences were not representative of most women who have abortions. Second, the APA pointed out that there was a great deal of variety in how pre- and post- abortion mental health states were measured, and most studies did not account for measure for positive emotional responses. Additionally, many comparison studies did not use appropriate groups (i.e. comparing women who terminated an unwanted pregnancy with women who carried an unwanted pregnancy to term). And finally, the APA noted a lack of studies that had long-term follow up times; some studies measure mental health states immediately after abortion and some

also included measures a few months after the procedure, but no studies took measurements years after the procedure (Adler, prepared testimony, 140). With more representative samples, standardized measurements, appropriate comparison groups, and longitudinal research designs, the question of whether or not abortion is associated with mental illness could be answered with greater certainty. The anecdotal evidence of severe negative consequences that Franz and Speckhard argue needed to be studied more was largely dismissed by Adler and David.

### **New Directions in Abortion and Mental Health Research, 1993-2000**

With both the APA and the American Psychiatric Association positioning themselves against post-abortion syndrome and little legitimacy gained for the disease through the Surgeon General's inquiry, debate within the scientific community about abortion's potential harms died down for much of the rest of the 1990s. Additional research on the subject of the psychological aftermath of abortion was published in scientific journals, which produced a more complex picture of what women experienced during an unwanted pregnancy.

Most of the published research during this time came from a research group headed by Brenda Major. Major was a participant in the American Psychological Association's expert review of the psychological aftermath of abortion during the late 1980s and would go on to chair the Task Force on Mental Health and Abortion in 2006. Major and her co-researchers were able to study a sample of women who obtained abortions at three free-standing, private abortion clinics. Each participant was given a series of questionnaires and standardized mental health assessments, such as



the Beck Depression Index, the Diagnostic Interview Schedule, and a PTSD diagnostic tool that was modified to be abortion specific, both before the abortion and in a series of follow up assessments (Major et al. 1990; Major and Cozzarelli 1992; Cozzarelli and Major 1994; Major et al. 1997; Cozzarelli et al. 1998; Major and Gramzow 1999; Major et al. 2000; Cozzarelli et al. 2000). In these publications the researchers were able to test how well a series of factors (e.g. previous mental illness, exposure to antiabortion picketers, perception of social support, attribution of responsibility for the unwanted pregnancy) predicted how well a woman coped after abortion. In a 2000 publication, Major et al. argued that at 2 years post abortion, most women were satisfied with their decision (72%), would have the abortion again (69%), reported more benefit than harm from their abortion (72%) and were not depressed (80%) (N=442). A “prepregnancy history of depression was a risk factor for depression, lower self-esteem, and more negative abortion-specific outcomes” (2000: 777). The work of this research group provided strong evidence that while some women did experience negative emotional outcomes following abortion, very few were severe enough to be diagnosed with a mental illness, and the best predictor of post-abortion outcomes was the mental state previous to the abortion (Major et al. 2000).

During this time, there was also international research on post-abortion aftermath that used health registry information to link abortion history with maternal death (Gissler et al. 1996; Gissler et al. 1997). This research group found associations between higher rates of suicide among women who had an abortion when compared to women who had delivered. Additionally, risk of accidental death and homicide also

increased after induced abortion (Gissler et al. 1996). These studies were unable to control for previous psychiatric history and other relevant variables like history of violence exposure and wantedness of the pregnancy. Over time the authors argued that more information on covariates were needed to determine whether there was a real association between abortion and suicide or whether women seeking abortions in Finland were also more likely to have known risk factors for suicide (i.e. previous psychiatric history and exposure to violence) (Gissler et al. 2005).

Participants within the antiabortion movement were also reevaluating their engagement with science during this period. In *Making Abortion Rare*, David Reardon, founder of the prolife Elliot Institute and author of many books about negative emotional aftermath of abortion, argued that the prolife movement must “increase [its] efforts in the area of research and education relevant to the negative effects of abortion on women, men, siblings, family structures, and society at large” (121). Unlike the previous research conducted by people critical of abortion, which was largely anecdotal, based on clinical findings of women who already identified their abortions as traumatic, and appeared in Catholic publications, Reardon argued new research should be case-control and cohort based research that examined associations of mental illness, eating disorders, substance abuse, and suicide among women with different reproductive outcomes. This new research, Reardon suggested, should take advantage of large, publicly available databases such as the National Longitudinal Study of Youth (NLSY), the National Survey of Family Growth (NSFG), health registries of countries with nationalized health care systems, and

Medicare records (180). Reardon also contended that this new research should be published in peer-reviewed, academic journals in order to be taken seriously as policy-relevant research (121).

In 2000, Reardon and a group of researchers critical of abortion, including Priscilla Coleman, Jesse Cogle, Philip Ney, Vincent Rue, Catherine T. Coyle, and Martha Shuping, began publishing research in academic journals that revealed positive, significant associations between women who had abortions and a variety of mental illnesses including depression, anxiety disorders, suicide, substance abuse, instances of inpatient and outpatient psychiatric services, and death (Reardon and Ney 2000; Coleman, Reardon, and Cogle 2002; Coleman et al. 2002a; Coleman et al. 2002b; Reardon and Cogle 2002a; Reardon et al. 2002b; Cogle, Reardon and Coleman 2003; Reardon et al. 2003) . With one exception (Reardon and Ney 2000), these studies drew their data from large, publicly available databases that were not specifically designed to measure relationships between reproductive events and mental health.<sup>45</sup> In each instance the authors argued that women who had abortions experienced higher rates of depression, anxiety, substance abuse, utilization of psychiatric services, and death than women who carried a pregnancy to term.

Much of the research by these authors came under additional scrutiny and criticism due, at least in part, to the political affiliations of the authors. Further, this research has serious methodological flaws that are the result of the datasets the researchers used. For example, some databases did not include information about

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<sup>45</sup> This research uses the National Pregnancy and Health Survey, the National Longitudinal Survey of Youth, California's Medicaid records, the National Family Growth Survey, and the National Comorbidity Survey.

whether the pregnancy was wanted, unwanted, or unintended (Coleman et al. 2002a; Coleman 2002b; Reardon et al. 2003; Cogle et al. 2003). Additionally, other databases did not have accepted or reliable measures of mental health (Reardon and Cogle 2002; Cogle et al. 2003) or appropriate controls for confounding variables (Coleman et al. 2002b; Reardon et al. 2002; Reardon et al. 2003).

In letters to journals Reardon was often accused of bias, but editors of journals were often quick to defend publishing his results. In response to a 2003 study on abortion and psychiatric admission rates, Linda Capperauld, of the Planned Parenthood Federation of Canada, wrote that Reardon had a “specific and known political bias against abortion” and that publication of this research harmed the prestige of the journal (Capperauld 2003). On other occasions, letter writers noted Reardon’s affiliation with prolife groups as a potential conflict of interest that was not disclosed in the article (Blanchard 2002). The editors of the *Canadian Medical Association Journal* defended their decision to publish the study in an editorial (2003), in which they wrote that while the abortion “debate is conducted publicly in religious, ideological and political terms,” the “science offers us a more dispassionate means of analysis. To consider abortion as a health issue, indeed as a medical ‘procedure,’ is to remove it from metaphysical and moral argument and to place it in a pragmatic realm where one deals in terms such as safety, equity of access, outcomes and risk-benefit ratios” (2003: 93). Additionally, they asserted that “we must allow the gradual and honest accumulation of further evidence to confirm or contradict what we think we know” (93). The editors presented the case that even scientific research that produces

“unwanted results” helps to further our understanding of health outcomes and that the processes of dispassionate science will sort out the what knowledge is valid.

While the editors of CMAJ clearly advocated for a “pro-information” position, Brenda Major, who wrote a critical commentary of the Reardon et al. (2003) article and an additional letter to the editor, argued that “good science” needs to be distinguished from bad (Major 2003). She wrote:

It is an error, however, to assume that because researcher neutrality is difficult to achieve, what passes for ‘evidence’ on both sides of a politically charged issues is likely to be equally valid and deserve equal airing. Not all research is biased. It is possible to distinguish good science from bad. Good science is based on established scientific methods, eliminates confounders and uses appropriate control or comparison groups (2003: 103).

Major argued that Reardon et al.’s study on psychiatric admissions following abortion and childbirth does not meet the standards of “good science” and does not contribute to the “gradual and honest accumulation of evidence” that the journal’s editors value.

In addition, other researchers have tried to replicate Reardon and his colleagues’ results with little success. In 2002, Reardon and Jesse Cogle published a study in the *British Medical Journal* on associations between depression and unintended first pregnancy using the National Longitudinal Survey of Youth. Reardon and Cogle found a statistically significant increase in depression among married women who had aborted an unintended first pregnancy compared to married women who had carried their first pregnancy to term. There was no significant association among unmarried women. A study using almost the exact same data and methods was

also published a year later in *Medical Science Monitor* (Cogle, Reardon, and Coleman 2003).

In 2005, Sarah Schmiege and Nancy Russo published a reanalysis of the 2002 study (Reardon and Cogle) in which they found that much of the difference in depression rates between women who had an abortion and women who carried to term disappeared when the authors corrected for coding errors in the Reardon and Cogle study. Schmiege and Russo constructed their variables using the coding language provided by staff members of the NLSY in order to more accurately determine which women had an unwanted first pregnancy. (Reardon and Cogle had used a different variable to ascertain first pregnancy.) This new analysis indicated that there was no association between rates of depression and terminating an unwanted first pregnancy.<sup>46</sup>

Researcher error is not limited to the depression studies. Reanalysis of Cogle, Reardon, and Coleman's (2005) study on abortion and anxiety using the National Survey of Family Growth revealed that associations between ending a pregnancy and various anxiety disorders (generalized anxiety disorder, PTSD, and social anxiety) disappeared when pre-abortion mental health and history of violence were controlled for (Steinberg and Russo 2008). Reardon, Coleman, and Cogle have argued that their

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<sup>46</sup> Additionally, they were able to refute the hypothesis that women who conceal abortions are more likely to have the severest symptoms of depression. Some women who participated in the survey were asked to fill out a confidential card that contained questions about depression and abortion. When comparing depression rates between women who returned the card and women who refused, they found that a higher percentage of women who returned the card were in the high risk group for depression than women who refused. This indicates that "women who are willing to disclose an abortion may also be more willing to disclose depressive symptoms" (2005). While researchers on abortion and mental health agree that studies that rely on self-report of past abortions are flawed by a form of recall bias – that women are likely not to disclose a previous abortion, it may not be the case that these women experienced higher rates of mental distress than women who do report previous abortion.

research is sufficient to assume a causal relationship between abortion and depression, anxiety, suicide ideation, and substance abuse. Other researchers claim these associations are spurious and disappear when variables are properly constructed and pre-existing mental illness and confounding variable are controlled.

There was very little media coverage of scientific research on abortion and mental health during this time (exceptions include Brody 1997b), but a handful of newspaper articles discussed growing concern within the prolife movement about how abortion may be linked to mental distress (Toner 2004; Leland 2006). Antiabortion organizations had also made some gains in promoting informed consent laws at the state level that required doctors to tell women seeking abortions about the psychological aftereffects of abortion. In the fall of 2006, the Guttmacher Institute reported that eighteen states had passed such laws, and seven of those states included information that dealt exclusively with negative emotional reactions to abortions (Richardson and Nash 2006). In the first few months of 2005, the state legislature of South Dakota began to consider a ban on all abortions except those to preserve the life of the mother and appointed a task force to evaluate the practice of abortion in the state, including the health impact of abortion on women. An explanation of how the task force contended with scientific evidence about abortion's potential harm to women is more fully developed in Chapter Five.

### **The APA Task Force on Mental Health and Abortion**

In 2006 the APA's Council of Representatives established a task force to carry out the project of "collecting, examining, and summarizing the scientific research

addressing the mental health factors associated with abortion, including the psychological responses following abortion, and producing a report based upon a review of the most current research” (Report of the APA Task Force on Mental Health and Abortion 2008: 5-6). According to the APA the justification for forming the Task Force on Mental Health and Abortion (TFMHA) was the publication of many new studies on abortion and mental health since the previous expert review in the late 1980s and the appearance of conflicting reviews of the research, particularly the report of the South Dakota Task Force on Abortion (Report of the TFMHA: 5). The APA selected six members to serve on the TFMHA: two had done research on abortion and mental health and had served on the previous review (Brenda Major and Nancy Felipe Russo), one had done research on reproductive health (Linda Beckman), one was a specialist in methodology (Mark Appelbaum), and two members whose research focuses on interpersonal violence and trauma (Mary Ann Dutton and Carolyn West). Over the course of a year and a half, the task force members met in person and over the phone to decide how to conduct the review, how to analyze the studies, and how to formulate their evaluation of the research (Interview with Brenda Major 2012; Interview with Mark Appelbaum 2011; Interview with Linda Beckman 2011).

The TFMHA structured their review to answer four questions: “(1) Does abortion cause harm to women’s mental health? (2) How prevalent are mental health problems among women in the United States who have had an abortion? (3) What is the relative risk of mental health problems associated with abortion compared to its alternatives ...? And, (4) what predicts individual variation in women’s psychological



experiences following abortion?” (Report of the TFMHA: 3).<sup>47</sup> The first question, which addresses causation, was immediately deemed impossible to answer based on the fact that it would require a randomized experimental design similar to a clinical trial. This type of study design was deemed “neither desirable nor ethical” (Report of the TFMHA: 8). Definitive answers to questions of prevalence, relative risk, and individual variation in experiences of abortion were considered by task force members to be limited by methodological problems among the studies. For example, questions of prevalence require studies to be based on nationally representative samples of women, relatively uniform agreement of what constitutes a “mental health problem” (i.e. feelings of regret versus a professional diagnosis of a recognized mental illness) and how to measure that problem, and knowledge of the prevalence rates of that same problem among women with similar age and demographic characteristics to the women being studied (8). Most of the studies reviewed had flawed sampling methods and lacked uniform outcome measures. Because of the methodological problems of the studies and the variability in research designs, the task force members decided not to combine the results into a meta-analysis, but to evaluate the relative merit of each study and base their conclusions on the ones considered to be the “most methodologically rigorous and sound” (Report of the TFMHA: 88; Interview with

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<sup>47</sup> The review process imposed by the Task Force merits some elaboration. The members “evaluated all empirical studies published in English in peer-reviewed journals post-1989 that compared the mental health of women who had an induced abortion to the mental health of comparison groups of women or that examined factors that predict mental health among women who have had an elective abortion in the United States.” Ultimately the review contained 50 studies that included a comparison group, which could effectively answer questions of prevalence, relative risk, and individual variation of experience and 23 studies that did not include a comparison group but that could help answer questions of prevalence and individual variation of experience. Each study was reviewed by at least two task force members, with the caveat that no member reviewed their own work (Report of the TFMHA: 21; Interview with Major; Interview with Appelbaum).

Appelbaum 2011; Interview with Major 2012). The TFMHA chair, Brenda Major, recounted, “It doesn't make sense to do a meta-analysis of the data. A meta-analysis is only as good as what goes in it. And if I have 30 garbage findings and I have two well-controlled studies and I put those 32 in a meta-analysis, I'm going to produce something that's garbage. Garbage in, garbage out” (Interview 2012).

The task force identified several common methodological problems that plagued the research. First, much of the comparative research used inappropriate comparison groups by either using samples where the “wantedness” of a pregnancy was not measured or could only be inferred (15).<sup>48</sup> The only appropriate comparison groups for women who terminated an unwanted pregnancy, according to the task force, were women who sought an abortion, but were denied the procedure or women who delivered an unwanted pregnancy and raised the child or relinquished it for adoption (15). The second common methodological problem identified by the TFMHA was lack of control for co-occurring risk factors. They wrote:

Elective abortion commonly co-occurs with unwanted or unintended pregnancy, and unwanted/unintended pregnancy is often associated with adverse circumstances and characteristics that may be associated with mental health problems. Because few studies adequately controlled for these co-occurring risks, it is almost impossible from the available literature to distinguish outcomes that flow from abortion *per se* from outcomes that might appear to be associated with abortion, but in actuality have their origins in the unwanted/unintended pregnancy (or some other co-occurring risk), which is more highly represented in the abortion group than in the comparison group (16, original emphasis).

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<sup>48</sup> For example, some studies considered all pregnancies that occurred during a subject's teenage years to be unwanted or unintended (Fergusson et al. 2006; Fergusson et al. 2008) or pregnancies that occur when a subject is utilizing a state assistance program, such as Medi-Cal, to be more likely to be unintended (Coleman et al. 2002b; Reardon et al. 2003).

Without adequate control for co-occurring risk factors, it is impossible to distinguish whether there is a genuine association between abortion and a mental health problem or whether the observed association is spurious. The most pervasive methodological problem noted by the task force was problems with sampling. In many cases, samples were either too small to be representative and generalizable. In other cases, the study used a highly selected subset of a nationally representative sample and did not adequately insure that the selection procedures used to construct the original sample were not distorted when subsets were selected.

In addition to problems of comparison groups, control of co-occurring risk factors, and sampling, the TFMHA identified methodological flaws in how some studies measured reproductive history, attrition of participants, and the measurement of mental health outcomes. Most studies conducted in the U.S. relied on self-report to determine how many, if any, pregnancies a woman experienced and how each of those ended. Abortion is notoriously underreported (Jones and Forrest 1992; Jones and Kost 2007) with some studies indicating that less than half of abortions are reported in face to face interviews in large national surveys (Jones and Kost 2007).<sup>49</sup> Women who had abortions in their twenties, Catholic women, Black women, and unmarried women were all more likely to underreport their history of induced abortion (Jones and Kost 2007). Task force members reported that little research had been conducted to

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<sup>49</sup> Using data from the National Survey Family Growth (which collects reproductive history via interviews and electronic questionnaires) to national abortion rate data provided by the Guttmacher Institute, Jones and Kost found that only 47 percent of abortions were reported in interviews with the NSFG (2007). Most women provided consistent answers between the interview and questionnaire, but a notable portion of women reported having no abortions in interviews, but reported have at least one abortion in the questionnaire. This is in line with earlier research (Jones and Forrest 1992).

determine whether women experiencing mental distress would be more or less likely to report a history of abortion, similar to differential reporting in research on abortion and breast cancer (see Steinberg and Russo 2008 as an exception). While records-based studies could help address these concerns, complete records databases are rare in the United States and often only cover a portion of a women's reproductive history. For example, Medi-Cal records were used in some studies (Coleman et al. 2002b; Reardon et al. 2003), but these records only cover the time when the woman was eligible for Medi-Cal services. The task force members also noted methodological problems with attrition of participants over the course of longitudinal studies. Attrition can lead to a study's findings having reduced statistical power or can distort findings if women who leave the study are more or less likely to be distressed or mentally ill (18). Additionally, the TFMHA found problems with how studies determined what constituted a "mental health problem" as well as how and when those problems were measured. While recognized mental illnesses, like depression or generalized anxiety disorder, have agreed upon definitions and standardized tests to aid diagnosis, indicators of mental distress, like feelings of sadness, regret or shame, do not. There was wide variation in measurement of mental illness, the frequency of mental health was measured after a pregnancy, and the overall follow-up time of the study.

In many ways the methodological problems in the research identified by the TFMHA were very similar to those identified by the members of the APA's 1989 expert review of the literature. In fact the task force members noted that the problems identified in the previous review "continued to be reflected in most of the studies

reviewed by the current task force and limited conclusions that could be drawn from this literature” (Report of the TFMHA: 15). Additionally, Brenda Major, who participated in both reviews stated that the first review was much easier:

The first one was much easier because there just wasn't much out there that remotely resembled anything that we would call scientific research. So it was a pretty small body of literature. So that just made it tremendously easier, and the data that we were reading, the studies, were simple. At this time, the secondary data analysis studies where they use all kinds of co-variants and they obfuscate the way that they've selected the samples were really torturous to try to get through. So it was much harder (Interview 2012).

While the methodological issues in the literature were similar over time, the studies themselves had become more sophisticated, more numerous, and more difficult to parse out. Major also recounted that the second review posed more challenges because of the politicization of science: “To my knowledge, there weren't people who were systematically trying to stack the deck the first time around. The second time, there were” (Interview 2010).

Interviews with three members of the TFMHA indicate that there was broad consensus over how to evaluate the research, that quality of the studies, and the task force’s ultimate conclusions. Mark Appelbaum stated that task force members occasionally disagreed about the details of individual studies, “every now and then, on the edge of what was a mental health outcome – things of that nature. That was why they did pick a fairly large and diverse group of people. If we had no disagreements were would have wasted a lot of time and people’s energy if we had all just sat there and immediately mirror each other’s thoughts” but that “there were no strong disagreements there was never a point of we’re going to need to generate a minority

report” (Interview 2011). Additionally, Linda Beckman claimed, “Some people saw more problems than others and some people thought certain problems were somewhat more serious than others did. But I think it was clear. I think there was agreement about the fact that these studies had problems and there was agreement especially after we talked through all the studies about what the problems were” (Interview 2011). The interviews reflect that task force members engaged in serious debates over the qualities of the studies and what conclusions could ultimately be drawn from them, but there were generally consensus about what the problems were and the overall conclusions of the review.

However, interviews with task force members revealed that there was great disagreement over the ultimate wording of the conclusion. For example, Beckman recounted:

Although the ultimate conclusions were unanimous, there was some discussion about specific wording that went on for some length of time about how specific wording might be interpreted. There was some difference of opinion among us on that, but eventually we came to consensus or close to consensus (Interview 2011).

Similarly, Appelbaum indicated, “we were generally unanimous in the general conclusion ... It was more in the wording, the word crafting, the ‘if we say this, can that be interpreted by someone who wanted to take our words and turn them into something we didn’t mean them to be’” (Interview 2011). Appelbaum also claimed that much of the debate about the wording of the conclusions had to do with how the document might be used in political debates and policy decisions.

The ultimate wording of the TFMHA narrowly delineated the circumstances in which, and the groups to which their findings could be applied. Part of the conclusion dealing with the question of relative risk stated, “The best scientific evidence published indicates that among adult women who have an *unplanned pregnancy* the relative risk of mental health problems is not great if they have a single elective first-trimester abortion than if they deliver that pregnancy” (4, original emphasis). Here the findings are limited to adult women who have only one abortion, unplanned pregnancies, elective (rather than therapeutic) abortions, first-trimester abortions, and legal abortions.<sup>50</sup> The task force concluded that research on multiple abortions was “more equivocal” and positive associations between multiple abortions and poorer mental health “may be linked to co-occurring risks that predispose a woman to both multiple unwanted pregnancies and mental health problems” (4). Task force members indicate that this conclusion was very cautious and crafted carefully so that members would avoid criticism for speaking beyond the data. The task force chair, Brenda Major, reflected, “It’s a very circumscribed statement. ...And it’s a cautious statement because we were trying to stay close to the data” and that, “It’s meant to be reflective of what we know” (Interview 2012).

In response to the question of prevalence of women who experience mental health problems following abortion, the task force members could only draw limited

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<sup>50</sup> The distinction between elective versus therapeutic abortions is a proxy measure of “wantedness” as many women who undergo therapeutic abortions for reasons of maternal health or fetal abnormality are often terminating wanted pregnancy. The task force concluded that of the few studies on mental health experiences following therapeutic abortions “suggest that terminated a wanted pregnancy late in pregnancy due to fetal abnormality appears to be associated with negative psychological reactions equivalent to those experienced by women who miscarry a wanted pregnancy or who experience a stillbirth or death of a newborn, but less than those who deliver a child with life-threatening abnormalities” (Report of the TFMHA: 4).

conclusions because none of the studies meet all three of the criteria: having a representative and generalizable sample, “clearly defined” and “appropriately measured” mental health problem, and “knowledge of the prevalence of the same mental health problem in the general population” (90). Despite these serious flaws, the TFMHA found that “the prevalence of mental health problems observed among women in the United States who had a single, legal, first-trimester abortion for nontherapeutic reasons appeared to be consistent with normative rates of comparable mental health problems in the general population of women in the United States” (91). The task force members recognized that some women experience beneficial outcomes following abortion, some experience “sadness, grief, and feelings of loss” which are within a normal range of emotions, and some women experience “clinically significant outcomes” (91). However, there was not sufficient evidence to indicate that the clinically significant outcomes were caused by having abortion rather than other factors (91).<sup>51</sup>

In their findings, the task force members sought to strike a balance between respecting individual variation in mental health experiences of women who terminated an unwanted pregnancy and accurately representing research on potential correlations between abortion and mental illness. For example, Mark Appelbaum stated:

Our report does not say that women who are having abortions, everything is just rosy, peachy keen. What we do try to make the point

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<sup>51</sup> Based on the extant research, the TFMHA were able to identify several factors that predicted individual variation in response to abortion. These included interpersonal factors (e.g. “feelings of stigma,” “low perceived or anticipated social support of the abortion decision”) characteristics of the woman (e.g. prior history of mental illness and some personality traits like low self-esteem), and feelings of commitment to the pregnancy predicted more negative post-abortion responses (92). As was the case across multiple studies, “prior mental health emerged as the strongest predictor of postabortion mental health) (Report of the TFMHA: 92, but also Major et al. 2000 and Gilchrist 1995).



is that anyone who is going through that kind of stressful life event should be monitored and if things are getting rough there should be services provided. What we do say is that there is no evidence that suggests that the abortion itself incrementally adds anything to it (Interview).

As in the previous review, task force members argued that there was a firm boundary between mental illness and normal emotional reactions to a stressful life event. This boundary marks women who claim to have feelings of sadness, guilt, or regret as “normal” rather than “ill.”

Once the task force had drafted their initial report, the APA sent it out for an extensive review process. According to one document, the APA solicited nominations based on “expertise and expression of interest in the report;” APA boards and committees were also asked to provide names of reviewers. The initial list of reviewers included thirty-three names; twenty-six individuals agreed to review the document, and twenty-one completed the review (APA Amicus Brief 2010:11). The task force then revised the report in light of the feedback provided by the reviewers and circulated the revised report to fourteen APA boards and committees for additional review before ultimately being approved by the APA Council of Representatives in 2008 (APA Amicus Brief 2010: 12; Interview with Major 2012; Interview with Appelbaum 2011). Multiple task force members described the report as one of the most reviewed documents in which they had ever been involved (Interview with Beckman 2011; Interview with Appelbaum 2011; Interview with Major 2012). Task force members received a great deal of praise within the APA for their hard work, thoroughness, and their even-handed evaluation of the research (Interview with

Appelbaum 2011; Interview with Beckman 2011). While some members of the TFMHA were pleased with the praise they received from various committees and boards during the review process, Brenda Major indicated that in some ways the APA did not give the report the recognition it would have given to a review of a less controversial topic. She recounted, “I felt a little bit like the stepchild of the APA. We didn't get a glossy brochure, big heralding, we didn't get a news press kickoff, which on occasion they've done for some things... I think APA recognizes what a hot button this issue is and might have wished that it would have gone away for all I know” (Interview 2012). Despite the support the TFMHA received within the organization, the APA seemed hesitant to court the controversy that this review would inevitable provoke.

In the intervening years between when the TFMHA was formed in 2006 and when the report of the task force was released, the public landscape of the debate over abortion and mental health had changed. There had been additional media coverage of post-abortion organizations and healing ministries (Leland 2006; Bazelon 2007; NOW on PBS 2007; Greenhouse 2007; Toner 2007). In an often referenced *New York Times Magazine* article titled “Is There a Post-Abortion Syndrome?,” Emily Bazelon interviewed numerous activists, post-abortion counselors, and researchers about the claim by prolife groups that abortion causes mental harm to women. Additionally, the language of abortion regret and the negative emotional consequences of abortion had entered the Supreme Court’s rationale for upholding the “Partial-Birth Abortion Ban.” In the majority opinion, Justice Anthony Kennedy recognized the lack of scientific

evidence on abortion and mental health, but also stated that women may come to regret their decisions (*Carhart v. Gonzales* 2007). The use of this rationale for upholding the ban was characterized in the media as a significant victory for prolife groups (Greenhouse 2007; Toner 2007). Finally, the report was released in August in the middle of the presidential campaigns of Barack Obama and John McCain.

Abortion often becomes a hotter topic during election years.

Despite the media interest in the abortion debate around the time of the report's release, only two major American newspapers covered the story (Carey 2008; Simon 2008). These articles, appearing in the *New York Times* and *Wall Street Journal*, were both very short and only briefly summarized the report's major findings. Additionally, most mainstream prolife organizations did not acknowledge the release of the report. Neither the National Right to Life Committee nor the American Life League issued press releases relating to the task force report or its conclusions. Some post-abortion organizations responded to critique the report. Speaking on behalf of the Silent No More Awareness Campaign, Janet Morana claimed that the report is "a classic case of the abortion lobby's political and financial interests trumping the truth," and Georgette Forney argued, "The APA ignored or downplayed large, peer-reviewed studies showing a clear link between abortion and subsequent problems such as depression. Professionalism and intellectual honesty are not concepts I would associate with this report" (Silent No More Press Release, 8/14/2008).

### **Additional Reviews and the Fight over Retractions**

Since the release of the Report of the APA Task Force on Mental Health and Abortion, four other reviews of the research have been conducted and published. Three of these reviews come to similar conclusions to the APA review and one, a meta-analysis conducted by Priscilla Coleman, claims that women who undergo abortion experience more mental health problems than women who deliver pregnancies. Also, additional studies conducted by researchers critical of abortion have been published and have become the focus of a fierce debate over whether or not one of these studies should be retracted based on the allegation that Coleman misrepresented her methodology. This section provides an account of the growing scientific consensus about abortion's relationship to mental health and the attempts to marginalize prolife researchers through exposing their political ties and their sloppy research.

Shortly after the release of the APA report, three additional reviews were published that came to similar findings as the APA report. The first was published in the journal *Contraception* and was authored by a group of researchers from Johns Hopkins (Charles et al. 2008). This review sorted the studies into categories based on quality and found that “a clear trend emerges from the systematic review: the highest quality studies had findings that were mostly neutral, suggesting few, if any, differences between aborters and their respective comparison groups in terms of mental health sequelae. Conversely, studies with the most flawed methodology consistently found negative mental health sequelae of abortion” (449).<sup>52</sup> The second,

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<sup>52</sup> The Charles review categorized each study by quality – sorting each study into the categories “Excellent,” “Very Good,” “Fair,” “Poor,” or “Very Poor” based on “use of appropriate comparison

published by a group of psychiatrists, concluded “the most well controlled studies continue to demonstrate that there is no convincing evidence that induced abortion of an unwanted pregnancy is per se a significant risk factor for psychiatric illness” (Robinson et al., 2009:276) and that “to date, the published studies concluding that abortion causes psychiatric illness have numerous methodological problems; since their conclusions are questionable, they should not be used as a basis for public policy” (276). The final review was conducted by the Academy of Medical Royal Colleges and the National Collaborating Centre for Mental Health, both in the United Kingdom (NCCMH Review 2011). As in the Charles review, the research assigned each study a quality rating and a grade for each potential outcome (e.g. PTSD, depression, substance misuse, etc.). They determined that based on the best available evidence, the “most reliable predictor of post-abortion mental health problems was having a history of mental health problems before the abortion” and that “the rates of mental health problems for women with unwanted pregnancy were the same whether they had an abortion or gave birth” (8).<sup>53</sup>

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group, use of valid mental health measures, control for confounders, and whether there was comprehensive exploration of the research question” (437). Of the twenty-one studies reviewed, none were categorized as “excellent” and only four met the criteria of “very good.” Among the research conducted by Reardon, Coleman, and Cogle two studies were categorized as “fair” (Cogle et al. 2005; Reardon and Cogle 2002), and four were categorized as “poor” (Coleman et al. 2002b; Cogle et al. 2003; Reardon et al. 2002; Reardon et al. 2003). It is important to note that the two studies categorized as “fair” (Cogle et al. 2005 and Reardon and Cogle 2002) had been the subject of reanalysis (Schmeige and Russo 2005). In an commentary published along with the Charles review, Julia Steinberg and Nancy Felipe Russo argue that these two studies should have been excluded from the review based on the fact that their results have been demonstrated to be “invalid and cannot be reproduced with properly coded data” (2008: 502).

<sup>53</sup> One surprising finding that came out of the AMRC review was that “unwanted pregnancy was associated with increased risk of mental health problems” regardless of how that pregnancy ended (8). The authors recommended that clinicians “consider the need for support and care for all women who have an unwanted pregnancy because the risk of mental health problems increases whatever the

Not all of the reviews published in recent years have come to similar conclusions. In 2011, the *British Journal of Psychiatry* published a meta-analysis of the abortion and mental health research by Priscilla Coleman. By pooling the results of 22 studies, Coleman argues that “women who had undergone an abortion experienced an 81% increased risk of mental health problems, and nearly 10% of the incidence of mental health problems was shown to be attributable to abortion (2011: 180). Coleman’s selection criteria were quite broad: she included any studies published between 1995 and 2009, in English, in a peer-reviewed journal with 100 or more participants, that used a comparison groups, that had at least one mental health outcome variable, that controlled for a third variable, and that reported results in odds ratio. Unlike the all of the other reviews, there were no quality criteria taken into account and very little discussion of the methodological problems of the research or the heterogeneity of research design. Based on her finding that women who have abortions have a 81% increased risk of mental health problems, Coleman argues that clinicians should now be reassessing the putative benefits and known risks of abortion when advising patients seeking to terminate a pregnancy.

The publication of this meta-analysis received a great deal of attention from a wider variety of scholars. A few months after publication, the journal published eight letters to the editor, seven of which were critical of Coleman’s research. Two major concerns emerged from these letters. First, some authors pointed to Coleman’s connections to prolife organizations and her previous collaborations with David

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pregnancy outcome” (8). This finding positions “unwanted pregnancies” rather than “abortion” as the central risk factor for mental health problems.

Reardon as a potential conflict of interest that was not disclosed and characterized this failure to disclose as a clear violation of the journal's policies (Littell and Coyne 2012; Goldacre and Lee 2010). Additionally, some pointed out that Coleman was the author or co-author of many of the studies used in the meta-analysis. Most authors, however, pointed to numerous methodological problems with the study, including too little information about the search strategy and inclusion criteria, lack of a second assessor for whether or not studies met the inclusion criteria, improper application and reporting of the population attributable risk measure, and violating major principles of meta-analysis (Howard, et al. 2012; Abel et al. 2012; Littell and Coyne 2012; Polis et al. 2012; Goldacre and Lee 2012; and Robinson, Stotland, and Nadelson 2012). While certainly the majority of letter writers were psychiatrists, the methodology of the meta-analysis was also critiqued by epidemiologists. Finally, in the NCCMH review, which was published a few months afterwards, the Coleman meta-analysis was characterized as unreliable: "A number of methodological problems with the meta-analysis conducted in the Coleman review have been identified, which brings into question both the results and conclusions" (2011: 18).

Coleman responded to these critiques by clarifying her search strategy and inclusion criteria as well as the statistical measures that she took to assess and deal with the heterogeneity of the included studies, but she does not address the other methodological criticisms posed by the letter writers (2012a: 80). Finally, Coleman defended her position not to disclose her connection to prolife groups with this statement: "I do not hold membership in any political organizations and my work has

never been funded by any prolife group. My expertise tends to be called up by the prolife community and unfortunately I am never asked to present my research or perspective on the literature to groups committed to a prochoice political position” (80).<sup>54</sup> She also accused the critics of her work as “hurling unfounded accusations” and “attempting to undermine the credibility of an individual researcher who managed to publish in a high-profile journal” (80). Finally, she claimed that professional organizations like the APA and others “have arrogantly sought to distort the scientific literature and paternalistically deny women the information they deserve to make fully informed healthcare choices and receive necessary mental health counseling when and if an abortion decisions proves detrimental” (80). According to Coleman, the criticism of her work is motivated by individual bias against her position and the desire of professional organizations to suppress the truth about abortion’s harms.

The methodological problems in the Coleman meta-analysis were not the only questions being posed about the veracity of Coleman’s work. In 2009, the *Journal of Psychiatric Research* published a study called “Induced abortion and anxiety, mood, and substance abuse disorders” by Coleman, Catherine T. Coyle (a post-abortion counselor specializing in men’s issues), Martha Shuping (a post-abortion counselor and psychiatrist), and Vincent Rue. Using the National Comorbidity Survey (NCS), which contains reliable information and measures for mental health, Coleman and her co-authors argued that women who had abortions were at an increased risk for a wide variety of mental health problems when compared to women who carried a pregnancy to term (neither the wantedness nor the intendedness of a pregnancy is measured in the

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<sup>54</sup> It should also be noted that Coleman declined to participate in this study.



NCS). These included significant increased risk for panic disorder (111%), PTSD (59%), alcohol abuse with or without dependence (120%), drug dependence (126%), bipolar disorder (167%), and major depression without hierarch (45%) (2009: 773). In 2010, the journal *Social Science and Medicine* published a study by Julia Steinberg and Lawrence Finer that attempted to replicate the results of Coleman et al. 2009 using the same data, sample, and codes, and were unable to produce the same results (2011).<sup>55</sup> Additionally, using the same data set, Steinberg and Finer found that “abortion history was not associated with having a mood disorder” and that when prior mental health and exposure to violence were controlled for there was no association between abortion history and anxiety disorders.

The conflicting results of these studies were brought to the attention of the editors of the *Journal of Psychiatric Research*, who asked Coleman and her co-authors to prepare a corrigendum to explain the discrepancy. The authors concluded that much of the discrepancy was due to an error in how they weighted their subsample of participants. With the correct weighting in place, there was no longer a statistically significant relationship between abortion and depression, and many of the other mental health disorders were associated with lower increased risk than reported in the original study (Coleman 2012b). Steinberg and Finer also noted that it was unclear which time measure was used to determine when the mental health diagnosis happened (2012). Coleman revealed that she had used the lifetime measure, which means that the mental health diagnosis could have occurred before that participant had

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<sup>55</sup> Lawrence Finer works for the Guttmacher Institute.

an unwanted pregnancy.<sup>56</sup> She justified the choice of using the lifetime measure by arguing that the average age of the abortion for women in the NCS is younger than the average age at onset of the mental disorders studied. She argued that although the results are inconsistent with other research on abortion and mental health, they are consistent with the findings of her meta-analysis (Coleman 2012b: 408).

Ultimately, the editors of the *Journal of Psychiatric Research* ended up seeing greater value in Steinberg and Finer's concerns about methodology. In a commentary, they stated, "Based on our joint review and discussion of the debate, we conclude that the Steinberg-Finer critique has considerable merit and that the Coleman et al. (2009) analysis does not support their assertions that abortions led to psychopathology in the NCS data" (Kessler and Schatzberg 2012: 410). The Coleman study was not retracted, but it is clear from this analysis that serious concerns about the method employed by researchers who are critical of abortion have been raised on numerous occasions within scientific journals.

**"Feelings aren't diseases, but they are important"<sup>57</sup>**

There appears to be a growing consensus among professional mental health organizations that women who have one abortion of an unwanted pregnancy are at no

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<sup>56</sup> The NCS codes whether or not a mental health diagnosis is "present" or "absent" over various time periods. These include the 30 days preceding the interview (also referred to as "current" or "one month"), the 12 months preceding the interview, and anytime in the participants lifetime. Steinberg and Finer argue that in order to accurately assess whether the effect (in this case a mental disorder) occurred before the relevant variable (in this case abortion or delivery of a full term pregnancy), the best measure would be the 30 day time mark; the 12 month time mark would provide a less accurate assessment and the lifetime mark would not insure that the effect did not precede the reproductive event (2012: 407). In the original article, Coleman et al. use the phrase "current" to describe the diagnosis time frame, but in the corrigendum there is no indication of what diagnosis time frame was used, and Steinberg and Finer point out that Coleman publicly stated in other arenas that the 12-month mark was used (207).

<sup>57</sup> Dr. Nada Stotland in "Abortion Trauma Syndrome Does Not Exist" (Stuart TV Production 2010).

greater risk of mental health disorders than women who carry an unwanted pregnancy to term. Additionally, there is a growing recognition that a woman may experience a variety of feelings after having an abortion, but that these feelings are not mental diseases. However, the debate over whether or not abortion is associated with mental health problems seems far from over, even within the scientific community. Since the release of the Report of the APA Task Force on Mental Health and Abortion in 2008, several additional reviews of the research have been published. Many of these reviews have developed standards for which studies are considered good and valid and which are flawed and untrustworthy. These quality standards can be seen as an attempt to enshrine the value of particular studies to draw distinctions between the results that can be trusted and the ones that cannot. There has also been an increase in attempts to replicate the results of studies conducted by researchers critical of abortion, and in some cases these researchers have been accused of abusing “the scientific process to reach conclusions that are not supported by the data” (Steinberg quoted in Dell’Antonia 2012). Like in the abortion/breast cancer debate, these attempts to highlight the political motivations and methodological errors of researchers like Priscilla Coleman can be seen as a similar type of boundary work meant to delineate “real” researchers from those motivated by a political agenda.

In addition to this growing consensus that abortion alone does not increase the risk of mental illness, new types of research have emerged on this topic that examine the emotional landscape of abortion from a sociological perspective. Researchers have found that women who struggle emotionally following abortion typically identify a

real or perceived lack of support for their decision as the central issue that caused or exacerbated their mental distress (Kimport, Foster, and Weitz 2011). The experience of social stigma that surrounds abortion is now seen as a major factor in how women feel about their experience (Cockrill and Weitz 2010; Kimport, Foster and Weitz 2011; Kimport, Perrucci, and Weitz 2012). Additionally, researchers in this group have launched a longitudinal study that compares the physical and mental health outcomes (as well as a wide variety of other measures) between women who terminated an unwanted pregnancy and women who sought abortions, but were unable to obtain them (Foster, Roberts, Mauldon 2012). The initial findings suggest that women who terminate unwanted pregnancies have similar mental health outcomes to women who continued an unwanted pregnancy (Foster, Roberts, Mauldon 2012).

### **Building Consensus?**

In many cases where scientific controversies resist closure or resolution the parties disagree over what counts as evidence and how to reason with it (Engelhardt and Caplan 1987). The dispute over abortion and mental illness is no exception. All sides are in agreement over the methodological flaws of the research. During the late 1980s and early 1990s, researchers who are critical of abortion argued that what studies needed to measure was a new type of mental illness, post-abortion syndrome. Over time those researchers came to agree with psychologists and psychiatrists that research needed to examine the possible associations between abortion and recognized mental illnesses like depression, anxiety disorder, and PTSD. Despite these areas of agreement, there are still significant differences in what each group considers the

measure of quality of research, which data sources are most appropriate for studying associations, and which are the best comparison groups.

Many of the reviews of the existing research on abortion and mental health assigned quality ratings to individual studies and based their determinations on studies that were rated higher in quality. Frequently the research published by David Reardon, Priscilla Coleman, and their colleagues are rated as “fair” or “poor” due to methodological problems. This makes those findings less likely to be factored into the conclusions of the review. Conversely, in her meta-analysis of the abortion and mental health research, Priscilla Coleman made no attempt to distinguish the quality among studies. Instead, any study that met her broad criteria was included, regardless of the heterogeneity of study designs. When others critiqued this decision in letters to the *British Journal of Psychiatry*, Coleman responded that there was “no universal agreement” about what methodological strengths made a study’s results reliable or about which weaknesses merited excluding a study (2011: 79-80).

A second point of disagreement is whether large, national databases are appropriate sources of data for these kinds of studies. Databases, like the National Comorbidity Survey, have more reliable measures of diagnosed mental illness, but do not offer much information about the circumstances of the pregnancy. For example, the NCS collects data on pregnancy outcome, but not whether a pregnancy was intended. In my interviews with members of the APA task force, many expressed concern that these databases were not designed to measure associations between abortion and mental health and were not good sources for this kind of research.

Researchers who are critical of abortion, the primary users of this data for this type of research, are less concerned about the shortcomings of databases. Given the incredible cost associated with building a *de novo* dataset and the financial limitations of researchers like Coleman and Reardon, it is likely that publically available databases are their only source.

Disagreement over what constitutes an appropriate comparison group is a final point of contention in this research. Since the first APA review in 1989, researchers have been in agreement that when measuring the mental health outcomes of women who have abortions, the proper comparison group is women who experienced an unintended pregnancy that they carried to term. As mentioned before, this rules out the possibility that the distress of an unintended pregnancy is the actual source of mental illness. Researchers who are critical of abortion have often argued that other groups could also serve as fitting comparison groups. For example, Priscilla Coleman has argued the intendedness or wantedness of a pregnancy can change over the course of time (2009; Coleman et al 2005). She has also contended the women who have never experienced a pregnancy might be an appropriate comparison group (2009; Coleman et al. 2005). The discrepancies over data sources, comparison groups, and quality reflect fundamental differences between mainstream researchers and those who are critical of abortion over what counts as evidence and how evidence is used.

It is also important to note the degree to which professional and institutional statements also reflect a lingering uncertainty about this research within the scientific community. As previously mentioned, the APA task force members described

deciding on the wording of their central conclusion to be cautious and carefully worded so as not to speak beyond the findings of the extant research. Other reviews have used similarly qualified language like “a clear trend emerges” (Charles et al 2008) or “the most well controlled studies continue to demonstrate” (Robinson et al 2009). Scientific facts are generally not described as emerging trends or the results that majority of properly designed studies find. When compared to the much more definitively worded statements about the lack of association between abortion and breast cancer (see Chapter Two), it is clear that this debate is not entirely closed within the scientific community.

### Containing Debate

Throughout the debate over abortion and mental health, mainstream researchers have used a number of strategies to limit debate, bolster their scientific authority, and isolate dissenters. These include appealing to consensus, providing a public defense of their findings, and demonstrating the discrepancies between the norms of science and the practices of the dissenters. As other research on scientific controversy has demonstrated, these strategies are often used by dominant voices to contain debate and diminish the influence of dissenters (Martin 1991; Richards 1991). The first two strategies, appealing to consensus and defending findings, are used most frequently to convince public and legal audiences that the controversy has been settled. The last strategy, highlighting violations of scientific norms, is most commonly deployed in journal publications in order to persuade an expert community.

The number of reviews of the research in recent years that have reached similar conclusions provides evidence of a growing consensus among mental health researchers that abortion is likely not associated with an increased risk of mental illness. In media reporting on the subject (Bazelon 2007; Toner 2007; Bazelon 2011) the claims by prolife groups that abortion is linked to mental illness is challenged by researchers from the APA and by referencing the reviews. Brenda Major, Nancy Russo, and Nada Stotland have all participated in interviews defending their research and asserting that there is no association between abortion and mental illness (Bazelon 2007; Major 2010). It is not uncommon for researchers to be interviewed about their work or their participation in expert reviews. This more involved defense of the research stands in contrast to the breast cancer researcher and epidemiologists in the abortion/breast cancer case. Additionally, when states pass new laws requiring doctors to inform patients of such an association, professional organizations, like the APA, have often filed briefs challenging such requirements. And researchers, like Nada Stotland, have served as expert witnesses in lawsuits about these new restrictions. There is a clear investment by these researchers and professional mental health organizations in shaping policy around abortion.<sup>58</sup>

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<sup>58</sup> This greater willingness to speak publicly about the debate over mental health may be due to a couple of factors. First, prochoice groups have more often filed lawsuits against states that require abortion providers to inform women that they may be increasing their risk of mental illness by terminating a pregnancy because they few these statements as false and misleading. Therefore, there is a great demand for researchers like Stotland and Major to be expert witnesses in this litigation. Despite the fact that five states make a similar requirement of informing women of a link between abortion and breast cancer, these informed consent laws have not be subject to legal dispute. Thus, there is not demand for breast cancer researchers to serve as expert witnesses. Another potential explanation is that researchers like Nancy Russo and Nada Stotland see themselves as committed to both gender equality and honest scientific inquiry and feel compelled to defend their research both as scientists and as people concerned that prolife groups are using scientific misinformation to restrict access to abortion.



Within the mental health community, researchers are also committed to drawing attention to the incongruities between scientific norms, like transparency in methods, reporting conflicts of interest, and ethic research practices, and the behavior of researchers who are critical of abortion. In letters to journal editors, numerous psychologists and psychiatrists have pointed out that the studies conducted by these researchers have serious methodological flaws, inaccurate reporting of methods, and findings that cannot be replicated. The letter exchanges over Reardon and Cogle (2003) and Coleman (2011) as well as the whole ordeal over Coleman et al.'s research using the National Comorbidity Survey (2009) are examples of this type of tactic. These exchanges also function as a type of boundary work in which dominant researchers signal to their colleagues that the work produced by researchers who are critical of abortion violates the shared values of their scientific community. Researchers, like Reardon and Coleman, are characterized as outsiders who are abusing the weaknesses of the peer-review system to publish politically motivated and scientifically unsound research.

### Continuing Controversy

Researchers who are critical of abortion also engage in a variety of credibility tactics that serve to legitimize their dissent to scientific consensus regarding abortion and mental health. These include appealing to an invested social group, namely the prolife movement, engaging in scientific research, and, like mainstream researchers, demonstrating the discrepancies between norms within the scientific community and the behavior of mainstream researchers. These types of tactics have also been

examined by other studies of scientific controversy (Martin 1991; Epstein 1996; Oreskes and Conway 2010).

Most researchers who are critical of abortion have long-standing ties to the antiabortion movement and the initial diagnostic criteria for PAS were developed through preliminary evidence from women within the movement who came to regret their abortion. The larger history and implications of PAS and the role of women in the prolife movement is analyzed in much greater detail in Chapter Four. For now, it is important to note that the prolife movement has been extensively involved in promoting the claim that abortion increases risk of mental illness and instituting policies that require doctors to inform women of this risk. While the work of David Reardon and Priscilla Coleman has been widely critiqued in the scientific literature, within the prolife community the work is held up as proof of abortion's harms. These researchers also regularly present their research to prolife groups. For example, Priscilla Coleman has given talks at annual conventions of both the NRLC and the AAPLOG. Coleman has also served as an expert witness for states defending their informed consent legislation in courts.

Another tactic that researchers who are critical of abortion have used to continue conflict and bolster their credibility is engaging in scientific research. By publishing in peer-reviewed scientific journals, rather than solely in Catholic or conservative publications, these researchers have made it nearly impossible for psychologists and psychiatrists to simply ignore them. In each of the reviews of this topic, researchers had to contend with the studies by Reardon and Coleman in some

fashion, even to explain why their findings are less reliable. Conducting original research has made it much more difficult for psychologists and psychiatrists to do the kind of boundary work that might portray Coleman and Reardon as complete outsiders. And, as will be explored in Chapter Five, this tactic has important implications for abortion policies. When informed consent cases are decided by courts, each side is presenting their own supporting scientific evidence and judges are put in the role of deciding who has the better evidence. This type of engagement stands in contrast to the abortion/breast cancer case, where Joel Brind produced one early review of the research and has spent the rest of the controversy as a critic of others work. Similarly, Epstein's account of HIV dissenters frames them as well respected scientists who engaged in critiquing the HIV causation theory but not contributing to original research on the topic (1996).

Finally, researchers who are critical of abortion, like their opponents, also build credibility by pointing to the various ways that mainstream psychologists and psychiatrists violated scientific norms. Most commonly, this is done by enumerating the political engagements of researchers and mental health organizations. For example, both Reardon and Coleman have pointed out that that APA task force had members that publicly supported abortion rights (Russo and Beck), but no members that were publicly against legal abortion. Further, Coleman has contended that because the APA has a history of supporting access to abortion, the organization's position on mental health and abortion is motivated by a political agenda, rather than objective science. In defense of her meta-analysis Coleman wrote:

I am opposed to professional organisations such as the APA creating a culture wherein it is perfectly acceptable for any political position (in this case pro-choice) to drive data collection efforts, restrict grants to researchers committed to a political agenda, serve as journal gatekeepers to block publication of finding that are not consonant with the political agenda, and ultimately use the biased information assembled to back policy (2012a: 80).

Like Joel Brind, Coleman asserts that professional organizations and individual researchers are not objective nor politically neutral, and that their commitment to a political position shapes scientific knowledge in a particular way. This dedication to a political agenda violates scientific norms of dispassionate inquiry and objectivity.

When researchers call into question the political commitments of Coleman and Reardon, they respond in one of two ways. First, they characterize questions about their political affiliations as *ad hominem* attacks that have nothing to do with their research design or findings and point out the political affiliations of their critics (Reardon and Cogle 2002: 1098; Reardon 2003: 102-103). While David Reardon has well-documented affiliations to prolife organizations and cannot claim political neutrality, Priscilla Coleman often does. As mentioned above, Coleman claims to have no connections to antiabortion groups and asserts that she only presents her research to prolife groups because they are interested and invite her (Coleman 2011: 80). This lack of political activism allows Coleman to claim objectivity and neutrality while also demonstrating the political connections of her detractors to organizations that support abortion rights.

### **The Cases in Comparison**

There are important differences in the scientific practices and conventions between these cases, particularly in terms of measurement, the use of international research, and professional conventions. Each of these differences resulted in making the question of whether abortion was associated with breast cancer a more “answerable” question and the process of obtaining answers more “doable.” First, in the abortion/breast cancer case both of the variables, pregnancy outcome and a breast carcinoma, are relatively easy to measure – they are both biological events and typically result in some sort of interaction with a health care profession. Of course, early research on this topic was plagued by issues of underreporting of abortion and differential reporting between control and case groups, but these problems were largely considered solved with the introduction of records-based studies. By contrast, in evaluating the evidence of abortion’s potential association with mental health problems, researchers encountered more difficulties with measurement. Though mental health researchers have expressed similar concerns about underreporting of abortion and are still unsure if there might be differential reporting, these problems have not been solved by the use of records-based research in the U.S. Researchers in this case also have to measure not just pregnancy outcome, but the “wantedness” or “intendedness” of a pregnancy. Additionally, the outcome variable, mental health problems, has posed difficulty in terms of measurement. While there may be relative agreement over how to measure mental health disorders, like depression and anxiety, which all have (highly contested) diagnostic criteria and standardized measurement tools, there is very little agreement over how accurately and reliably one can measure

mental health problems that fall short of mental illness, such as feelings of regret or sadness.

Second, there are important differences between the cases with regard to the extent to which international research could be used to answer these scientific questions. In the instance of research on abortion and breast cancer, international research, particularly research conducted in countries with nationalized healthcare systems that provide researchers with access to extensive health care records, was essential to solving the methodological problem of recall bias. This was due to the fact that the legal status of abortion in other countries did not prohibit the findings of international research to be generalized to the U.S. population. In the case of abortion and mental health research, the international variability of the procedure's legal status, its provision, and the levels of stigma associated with it makes it complicated for researchers applying international results to women in the United States. Thus, while record-based studies have been conducted outside of the U.S. (Gilchrist et al. 1995; Pederson 2008; Munk-Oleson et al. 2011), their results have to be regarded cautiously when applying them to the U.S. case.

Third, there are notable differences between professional groups with regard to conventions about whether research could even determine if an association existed. The professional group tasked with answering questions about a possible association between abortion and breast cancer, namely epidemiologists, had more tools at their disposal and expressed confidence that they could overcome methodological weaknesses. Identifying association, eliminating bias, and accounting for confounding

variables are fundamental parts of the practice of epidemiological research. Also, many of the methodological problems of the research identified in the mid-1990s had been addressed by the NCI Workshop in 2003, and today epidemiologists indicate even greater confidence in their conclusion that abortion is not independently associated with breast cancer. The task was seen as doable and the question was seen as answerable. This was not the case for mental health researchers tasked with examining the research on abortion and mental illness. Many of the methodological problems that were identified in the initial APA expert review in the late 1980s were the same as those identified in the 2006-2008 task force report. In fact, task force members even expressed doubt about the ability of future research to address this question:

Well-designed, rigorously conducted scientific research would help disentangle confounding factors and establish relative risks of abortion compared to its alternatives, as well as factors associated with variation among women in their responses following abortion. Even so, there is unlikely to be a single definitive research study that will determine the mental health implications of abortion ‘once and for all’ given the diversity and complexity of women and their circumstances (2008: 4).

The process required answer to questions of prevalence, predictors, and the relative risk of abortion for increased mental health problems is framed as a complicated and messy task. The task is characterized as less doable and the question is not easily answerable.

Though these differences in measurement, the use of international research, and professional conventions that distinguish the scientific processes in these two cases are important, they are not necessarily sufficient to explaining why the

abortion/breast cancer link has achieved greater closure. These scientific processes have also been impacted by social factors outside of the scientific communities charged with determining abortion's potential harm to women. These factors include how the controversies originated and the strategies employed by both mainstream scientists and dissenters.

In many ways, the debate over an abortion/breast cancer link was initially less politicized than the debate over abortion and mental illness. Concerns about associations between reproductive events and breast cancer were a longer-standing concern among epidemiologists and cancer researchers than among antiabortion activists. The scientific question about such associations arose first within scientific discourse and became a concern among women's health and lesbian health advocates who were more interested in the effect of childlessness on breast cancer risk. That is, the debate over abortion and breast cancer started as an endogenous concern among researchers in this field and only later was politicized by antiabortion activists. This history may have allowed researchers to maintain a greater deal of control over the debate and its potential closure. By contrast, while it is true that psychologists and psychiatrists were concerned about abortion and mental health since the pre-*Roe* era, I argue that the debate was much more politicized from the beginning. The American Psychological Association and the American Psychiatric Association had internal debates over the professional role mental health clinicians would play in abortion care provision. Additionally, both expert reviews by the APA were prompted by political concerns over an association rather than an expressed need from members of the



scientific community to evaluate the research. One might say that the debate over abortion and mental health was never not politicized. While more research is needed to make a clear determination, it is possible that where a debate originates (either within the scientific community or outside of it) can impact the degree to which scientists are able to set the terms of the conflict and exert greater influence over its outcome.

Additionally, both controversies have been influenced by researchers who are critical of abortion or who have a political investment in recriminalizing the procedure. However, these researchers have deployed different strategies. Joel Brind and Angela Lanfranchi have used strategies better fitting to their status as marginalized by the breast cancer research and epidemiology communities. Neither of them are members of the professional discipline that is responsible for conducting or evaluating this research. Aside from Brind's meta-analysis of the early research, neither has published original research or a review of this research in an academic, peer-reviewed journal. Furthermore, Brind has often turned to his political allies to intervene in this scientific debate; he used political connections to get funding for his meta-analysis. And he used his contacts with prolife members of Congress to get the NCI factsheet changed in 1998 and to prompt the 2003 workshop. Brind and Lanfranchi often characterize the professional and governmental organizations involved in this debate as corrupted and unworthy of their participation. While these strategies have been somewhat effective in continuing the abortion/breast cancer controversy outside of the scientific community, their marginalization has made it

easier for mainstream researchers to dismiss them as political actors and to exclude their concerns from scientific debates.<sup>59</sup>

By contrast, researchers like David Reardon and Priscilla Coleman have used strategies that legitimize their role as members of the scientific community. Coleman and Reardon have professional identities that are closely aligned with this area of research— Reardon has a doctorate in bioethics from a non-accredited college, but has dedicated his career to studying the emotional aftermath of abortion and Coleman has a Ph.D. in developmental psychology from West Virginia University. Like Brind and Lanfranci, both Coleman and Reardon see professional organizations as corrupted by prochoice politics, but unlike them they have chosen to participate in these communities by publishing in peer-reviewed journals, conducting original research on the topic, and authoring reviews of the research. At a point when multiple professional organizations and independent scholars were conducting reviews, the research of those critical of abortion had to be included because it met search criteria. These strategies have contributed to the continuation of these controversies because the scientific community must engage with Coleman and Reardon’s research and cannot easily dismiss their concerns as only motivated by politics.

Further, these debates differ in the extent to which each side can claim to be “politically neutral.” In both cases, researchers critical of abortion have tried to play

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<sup>59</sup> One exception to this characterization is that Brind and Lanfranchi are trying to put together an original research study on reproductive factors and breast cancer incidence, but given that they refuse to engage those outside of the prolife community in the research and to seek funding from traditional sources (like their universities or the NIH), it seems unlikely that this research will go anywhere (their current obstacles include not having someone to enter and analyze data, and they cannot get institutional permission to administer their questionnaire at multiple breast cancer screening locations).

down their own involvement in prolife politics. For example, Priscilla Coleman and Angela Lanfranci both claim that the reason they only present their research to prolife groups is that these groups are interested in their research and other groups never invite them to speak. However, their critics often characterize them as prolife activists or campaigners. While these denials might not be fooling anyone, they carried different valences in these two debates. In the debate over an abortion/breast cancer link, most of the researchers and organizations involved have few ties to prochoice groups or abortion politics. Most of the research is funded through the government, and many of the public intellectuals in these debates have shied away from publicly discussing their position on abortion. Thus, Brind and Lanfranci's claims that the National Cancer Institute is invested in protecting abortion providers and legal access to abortion are more difficult to maintain. However, in the debate over abortion and mental health, major professional organizations (both the APA and the American Psychiatric Association) have publically supported legalized abortion. Additionally, some members of the APA expert review and the TFMHA have been awarded research funds from pharmaceutical companies that manufacture abortifacients or funding agencies that support legal abortion. Therefore, when Reardon and Coleman point out how some involved in this research support prochoice politics, their claims are not unfounded.

A final difference between these cases is the degree to which mainstream scientists have been willing to speak out about the controversy. In the abortion/breast cancer debate, breast cancer researchers and epidemiologists were more successful at

marginalizing the concerns of Brind and Lanfranchi. They have also been less involved in defending the position of the NCI and epidemiological research in public. This strategy has allowed scientists to frame this controversy as beyond the boundary of scientific concern. In comparison, psychologists, psychiatrists, and their professional organizations have been more outspoken in their defense of the research on abortion and mental health. Members of the APA task force and the former president of the American Psychiatric Association have granted newspaper interviews, authored editorials, and have served as expert witnesses in lawsuits. In many ways, this engagement has prevented the kind of boundary work that contained debate in the breast cancer case. Mental health researchers are more vulnerable to being characterized as politicizing the issue or acting in the interests of their own agenda about abortion rights, rather than as objective experts on the issue.

This difference in the levels of public defense of research speaks to one of the central concerns raised by researchers of conservative engagements with science. In *Merchants of Doubt*, Oreskes and Conway chastise climate scientists for not taking a more public role in defense of their research. Similarly, in *Rethinking Expertise*, Collins and Evans call for a much greater role for certain kinds of experts and the exclusion of other kinds of voices in public debates around science. However, the cases I examined demonstrate that speaking out can have the unintended consequence of further politicizing a debate. By entering the fray, scientists also risk being seen as losing objectivity and professional authority. While more research on this topic is certainly needed, this finding is supported by anecdotal evidence from Rachel Aviv's

reporting on the case of Tyrone Hayes, a biologist at Berkley (2014). Hayes was targeted by the agribusiness, Syngenta, when he began to speak out about his experiments on the effects of the herbicide atrazine on the endocrine systems of frogs. In interviews with Aviv, Hayes's colleagues expressed admiration at his public defense of his research, but were also worried that he lost his status as an objective researcher.

### **Conclusion**

These debates over abortion's potential harm to women are unlikely to achieve a greater level of closure due to the epistemological commitments of researchers who are critical of abortion. These commitments differ significantly from those held by epidemiologists, breast cancer researchers, and mental health researchers. Both Joel Brind and David Reardon have expressed a belief that all pathways of knowledge (e.g. science, theology, philosophy) lead to the same truths. For example, in his book *The Jericho Plan*, a text whose intended audience is religious ministers, Reardon argues that religious officials shouldn't shy away from scientific arguments about abortion's harms because ultimately those are in alignment with moral arguments against abortion (1996b). He writes, "We must remember that the interests of a mother and her child are permanently intertwined. This means that the morality of abortion is built right into the psychological effects of abortion" (8) and "when we are talking about the psychological complications of abortion, we are implicitly talking about the physical and behavioral symptoms of a moral problem" (8). Additionally, he argues that "if an act is indeed against God's moral law, it will be found to be injurious to our

happiness. Thus, if our faith is true, we would expect to find compelling evidence which demonstrates that such acts as abortion, fornication, and pornography lead, in the end, not to happiness and freedom, but to sorrow and enslavement” (9). Thus, we should expect that women who have abortions will suffer mentally. Similarly, Brind in an interview recounts:

Science was always my way of pursuing the truth. And my scientific views and my religious views, my personal views don't conflict with each other, because then I couldn't sleep at night. Truth is truth. ...So my belief is certainly rooted in a philosophically consistent -- the whole basis of my scientific pursuit is no different than my philosophical outlook on everything. It all has to agree (Interview).

Brind and Reardon are clearly committed to a view of science that is deeply grounded in a particular moral and religious understanding of where the “truth” comes from.

And this puts them at odds with other researchers over how to evaluate research.

While Brind, Reardon, Coleman, and Lanfranchi are all adept at pointing out methodological and analytical flaws in the scientific research, in the end there may never be a study that would convince Brind or Reardon of a null association between abortion and either breast cancer or mental health problems because that truth is not compatible with their moral understanding of the issue. These researchers will always be committed to continuing these debates until the consensus shifts to their conclusions. Brenda Major, the chair of the APA Task Force on Mental Health and Abortion put it this way:

You could try to do a perfect longitudinal study, but you know, nothing's going to put it to rest and the reason nothing's going to put it to rest is because this isn't about science for some people... Anything that doesn't conform to a certain viewpoint is dismissed as biased. No study will lay it to rest (Interview).

## PART TWO: THE POLITICS OF ABORTION REGRET

The focus of the first half of the dissertation was the changing dynamics of the antiabortion movement and the development of scientific controversies over abortion's possible connection to breast cancer and mental health. My attention now shifts to the examination of implications of women-centered strategies and the consequences that the claim that abortion is harmful to women's health have had within the prolife movement and policy arena. In the next two chapters, I analyze the ways in which experiential evidence and lay expertise in conjunction with scientific claims about abortions harms have influenced the emergence of the victim identity within the prolife movement. I also examine the debates over abortion informed consent legislation, particularly the 2005 revision of South Dakota's informed consent law. Through this exploration, I illuminate the interconnectedness of scientific claims and the women-centered strategy as well as what the prolife movement gains by adopting this framework for understanding abortion.

The evidence of experience can be a powerful tool in both social movements and policy debates. As feminist historian Joan Scott argues, for many marginalized groups visibility and accounts of an individual's experiences become important markers of histories that have been erased or ignored (1991). We can point to countless examples of the ways in which the stories and experiences of women, racial minorities, sexual minorities, and colonized people have been "omitted or overlooked in accounts of the past" (776). Scott contends that the power of experiential evidence

is fueled in part by the way we consider it to be outside of the scope of history, as uniquely true and individual. This resistance to seeing experience within its historical context, Scott asserts, is dangerous. She writes, “The evidence of experience then becomes evidence for the fact of difference, rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see and act in the world” (777). Experiential evidence must not be treated as outside of history, but rather as historically contingent and part of a process by which difference is defined (Scott 1991; Murphy 2006).

It is difficult to overestimate the role of experience and anecdote in gender-based activism. During the women’s rights movements of the 1960s and 1970s in the United States, women were encouraged to see their own experiences of unequal treatment, sexual abuse, and violence as personal and political. Consciousness-raising and support groups helped women to see that their experiences were not individual and isolated, but shared by other women in their communities and as part of a larger system of oppression based on gender. For many women, these experiences became motivation to become involved in social action and as evidence of widespread inequality. Often individual stories that highlighted systemic inequalities became the basis upon which women as a group were able to “speak truth to power.”

In some cases, personal experiences of illness or disease have also come to be the basis of collective action that targets scientific or medical institutions. Scientific and medical knowledge have been greatly impacted by the experiences of people suffering from disease (see, for example, Rabinow and Rose 2006). Patient or patient advocacy



groups have often used personal experience with diagnosis and treatment as a way to both illustrate collective and systematic injustices and to influence research funding, the structure of clinical trials, and the ways diseases are treated (Epstein 1996; Taylor 1996; Heath, Rapp, and Taussig 2001; Murphy 2006; Klawiter 2008). Within science studies many scholars have begun to study social movements that include medical professionals, health institutions, and patients (Epstein 1996; 2007a; Brown, et al 2004; for a thorough review see Epstein 2007b). These configurations often are referred to as health movements, which are defined as “challenges to political power, professional authority and personal and collective identity” that are “centrally organized around health, and address issues including... access to, or provision of health care services; health inequality and inequity based on race, ethnicity, gender, class and/or sexuality; and or disease, illness experiences, disability, and contested illness” (Brown et al. 2004: 52).

Of particular importance in the study of health movements is the focus on the roles of patients and lay people. Scholars of these types of social movements have attended to the ways that patients develop and deploy particular kinds of expertise based on their experiences (Brown, et al. 2004; Epstein 1996; Heath 1997; Callon and Rabearisoa 2003; Clarke et al. 2003; Klawiter 2008; Heath, Rapp, and Taussig 2001; Murphy 2006). For example, patients deploy an expertise about the lived experience of a disease and what types of medical interventions or research would best serve the needs of patient groups (Heath 2007). In many instances, the activism on the part of patient groups has led to changes in the way the healthcare is practiced and medical

research is conducted (Epstein 1996 and 2007b; Callon and Rabearisoa 2003; Rapp, Heath, and Taussig 2001). In some cases, the experiences of people suffering from an unknown medical problem can be quantified and translated into evidence of a new disease (Murphy 2006). Interactions with medical experts are often fraught with tension as patients and patient advocates struggle to reconcile scientific knowledge with their own experiences and identities (Epstein 1996; Taylor 1996).

In Chapter Four, I examine the expertise networks that emerge around Post Abortion Syndrome. Like women involved in consciousness-raising groups, women struggling after abortion shared their experiences and began to see their suffering as linked to the social degradation of motherhood and the practice of abortion. The public sharing of their experiences led to greater involvement in the prolife movement and their stories were used to build criteria for a new mental illness. As stories of abortion regret were translated into quantified evidence that could be studied by experts, women worked and struggled with prolife researchers, mental health researchers, prolife leaders, and post abortion therapists to define Post Abortion Syndrome and to develop treatment for it. I trace the ways that women who regret their abortions assert their own expertise based on their experiences.

Experiential evidence has also been influential within policy-making and legal disputes. The impact of the evidence of experience is clear in the trend of writing or revising laws around the particular circumstances of an individual or group. For example, in 2009 President Obama signed the Lilly Ledbetter Fair Pay Act that changed the statute of limitations on filing a pay discrimination lawsuit. The act was

based on what was perceived as an unfair decision by the Supreme Court which ruled against Ledbetter because she had not filed her lawsuit within 180 of her employer's decision to discriminate against her based on gender, even though she did not become aware of the unequal treatment during that time. In this case, Ledbetter's experiences came to represent the collective experiences of pay discrimination among professional women. Further, even broad policy changes are often justified or opposed by using personal stories that are used as illustrative of larger trends and function as a type of evidence. In the debate over the Affordable Care Act, numerous personal anecdotes were presented by elected officials as evidence of either why the law was desperately needed or why it would limit the freedom of individuals. Narrative and using narrative as evidence are common features of public debates in the United States (Polletta 2006).

The impact of experiential evidence within legal disputes is more complicated, particularly when the testimony of affected parties conflicts with scientific information. In her analysis of litigation over silicone breast implants, Marcia Angell contends that juries were often swayed by the stories of plaintiffs who experienced medical conditions that they attributed to silicone implants, even in light of scientific findings to the contrary (1996). Francesca Polletta's analysis of the use of narrative in gender discrimination suits revealed that juries are more likely to find in favor of plaintiffs when statistical evidence of workplace discrimination and underrepresentation in the field of employment is presented in addition to testimony from victims (2006). That is, compelling narratives were not enough to persuade

juries. In legal disputes over abortion restrictions, both sides typically present experiential and scientific evidence, but not enough scholarship has been done to identify a clear pattern in what configuration of evidence is most convincing to judges.

In Chapter Five, I analyze how scientific claims about abortion's potential harm to women have been taken up within the policy arena through the examination of one particular debate over informed consent and abortion. In 2005, South Dakota passed a law to create a task force to study the physical, psychological, and social consequences of abortion and make policy recommendations based on their findings. Additionally, the state also enacted a law that revised their informed consent procedures for abortion to require doctors to tell patients that they may face an increased risk of suicide and suicide ideation if they terminated their pregnancy. The stories of women who regret their abortions were submitted to both the task force and as evidence in the legal battle over the informed consent law, but were taken up in different ways. The task force considered the experiences of women who regret their abortions to be very powerful and along with the scientific claims made by prolife experts found it to be convincing evidence that abortion should be banned in all circumstances. Within the context of the legal battle, *Rounds v. Planned Parenthood of Minnesota, North Dakota and South Dakota*, judges found the contested scientific claims of prolife experts about a possible connection between suicide and abortion to be convincing, but dismissed the experiential evidence of women as irrelevant to the case. Through this comparison, I draw attention to the possibilities and limitations of experiential evidence in policy decisions.

## CHAPTER FOUR: BROKEN WOMEN?

There is no circumstance great enough to validate an abortion. It is not a solution. It is a problem that wrecks your whole being; mind, body, soul and spirit. The amount of pain and destruction that comes from this “procedure” is irreparable. Although I have found healing and God’s love, I still suffer from post-traumatic stress and will always miss my baby!

- Alexa, Silent No More Testimonial<sup>60</sup>

We understand that abortion is evil from first-hand experience.... We are the consumers of the product and now we are here to tell you that the product is not good.

- Georgette Forney, March for Life, January 24, 2011

“...Abortion touches on three central issues of a woman’s self-concept: her sexuality, her morality, and her maternal identity. It also involves the loss of a child, or at least the loss of an opportunity to have a child. In either case, this loss must be confronted, processed, and grieved in order for the woman to resolve her experience”

- Theresa Burke, Forbidden Grief, 2002

What is Post Abortion Syndrome and who are the women that suffer from it? The above quotes hint at three different understandings. Alexa, a woman who posted her narrative to Silent No More website, the largest post abortion organization in the United States, suggests that the aftermath of her abortion negatively impacted her “whole being” and that post abortion syndrome is similar to the mental illness post-traumatic stress disorder. Georgette Forney, the co-founder of Silent No More, indicates that women (and men) who suffer after abortions are comparable to victims

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<sup>60</sup> This may be a real name. Some women who wrote the abortion regret narratives used in this chapter supplied their real names when submitting their stories to a public forum, though that is not a requirement. Because many women view the public sharing of their abortion experiences as a political act, I have decided to use the names they have used in the original forum.

of dangerous products and medical interventions that cause more harm than good.

Finally, Theresa Burke, a post abortion counselor and co-founder of one of the largest post abortion healing programs, Rachel's Vineyard, contends that post abortion syndrome occurs due to unresolved grief that results from loss and the violation of a women's femininity. Women who suffer from it are not mentally ill, but in need of guidance to help them process the loss.

In this chapter, I explore the competing definitions of Post Abortion Syndrome (PAS) put forward by women who regret their abortions, experts, and activists within post abortion organizations and the prolife movement. I argue that struggle over defining the illness shapes how women who regret their abortion think of themselves and their experiences. As in many similar cases, these women do not just wholesale adopt expert understandings of their struggles and often challenge these understanding on the basis of their own experiences.

Within the prolife movement there are organizations that collect the stories of women who regret their abortions and that provide support and healing for these women. The existence of these organizations raises several questions about collective identity, expert definitions of illness, and gendered activism within the prolife movement. What are the shared grievances and identities of women who regret their abortions? How have these grievances, identities, and goals changed over time and through interactions with the larger prolife movement and with scientific research on abortion's potential harm? And in what ways do activists within this movement see

themselves as engaging in a legacy of women's health and women's rights organizing?

In this chapter I use prolife movement documents, interviews with activists within the movement, and an analysis of women's abortion regret narratives to examine the history of what has been referred to as abortion's second victim – women who have undergone the procedure. The construction of the victim identity is accomplished not just through the experiences, stories, and shared meanings of women who regret their abortions: it also involves larger dynamics within the prolife movement, religious-based therapeutic regimes, and scientific inquiry into the possible connection between abortion and mental illness. I argue that the victim identity has been constructed, challenged, and modified through a complex interaction that has unfolded over time in a shifting network of women who regret their abortions, therapists, researchers, and leaders of the mainstream prolife movement.

Additionally, I illustrate the ways that the stories women tell about their abortion experiences are deployed within post abortion organizations and crisis pregnancy centers, within the prolife movement, and within the larger debate about abortion. Post abortion organizations function similarly to other self-help or support group movements. While some scholars of social movements have argued that these types of movements do not facilitate political activism, a large body of scholarship has found that these kinds of organizations do encourage members to enact political and institutional changes. It is important to note that narratives did not stand apart from social movement processes. Narratives often function to foster collective identity and

political engagement, but they are also promoted within a movement that shapes and reframes narratives to advance movement goals. Drawing on this tradition, I contend that abortion regret narratives are used to build group consciousness and identity. Beyond that, they are used within the larger movement as a conversion narrative that illustrates the immoral nature of abortion and the connection between personal and social sin (Young 2002). Increasingly, the narratives are used in legal and policy debates as evidence that women need additional protections when seeking abortions.

In this chapter I examine the construction of the victim identity and deployment of narratives over two time periods. First, I analyze the emergence of the first post-abortion organizations, their structures, their relationships with researchers and the prolife movement as well as the narratives of the women who joined these movements. Then I explore how ideas about what it means to be a victim of abortion changed after a series of policy failures and shifts in power dynamics within the movement in the mid-1990s. Following this period of upheaval, new post-abortion organizations and therapeutic regimes emerged and the construction of the victim identity was shaped by new movement goals, scientific research, and therapeutic understandings of what it means to struggle emotionally after an abortion. In the final section of the chapter I revisit major themes and investigate the larger implications of thinking of identity construction as taking place in a network that involves multiple actors, institutions, and organizations that all have different interests in speaking for the experiences of women who regret their abortions.



### **Identity, Expertise, and Narrative in Social Movements**

During the 1960s and 1970s new social movements began to appear that mobilized participants around a shared identity and tended to focus on “quality of life” issues rather than, or in addition to, gaining formal equality or securing rights (Taylor and Whittier 1992; Morris and Mueller 1992; Laraña et al 1994; Gamson 1995; Taylor 1996; and for a critique of the “newness” of these movements see Pichardo 2001 and Young 2002). Much of the scholarship on new social movements focuses on the nature of collective identity or the “shared definition of a group that derives from members’ common interests, experiences, and solidarity (Taylor 1996: 127). Over time these movements begin to develop through setting boundaries that define who is in the group, forming a group consciousness through the creation of new self-understandings of collective problems and experiences, and through individual political expression (Taylor and Whittier 1992). This vein of scholarship has focused on how social movements themselves are central in the construction of identity (Taylor 1996; Munson 2010). That is, rather than seeing movement participants as joining an organization based on a “pre-formed” identity category, it is important to consider the ways in which participating in social movement activism influences and shapes identity.

Rather than considering identity formation as solely a process of individual agency (i.e. a “bottom-up” process in which identity is the main driver of movement or scientific goals and strategies) or social influence (i.e. a top-down process by which movements or scientific expertise “create” the identities), identity can be seen as

created in the process of a feedback loop (Hacking 1995; Hacking 1986; Eyal et al 2010). According to Hacking, there are human kinds, by which he means kinds of people “about which we would like systematic, general and accurate knowledge; classifications that could be used to formulate general truths about people” (1995: 352). More simply put, science is often a process of identifying, categorizing, and naming that creates new potential identities for people. As Hacking states, “classifying people works on people, changes them, and can even change their past” (369). And as these classifications are taken up, rejected, or challenged by people or groups, “those changes demand revisions of the classification and theories, the causal connections, and expectations. Kinds are modified, revised classifications are formed, and the classified change again, loop upon loop” (370). This concept of looping was further elaborated in Gil Eyal and his co-authors work on diagnosing autism (2010). For instance, Eyal et al. found that what it means to be autistic has changed as psychiatric definitions of mental retardation and autism were revised, as children with mental disorders were moved out of institutions, as new types of experts on behavioral therapy emerged, and through parent and patient advocacy (2010).

There is also a long history of scholarship on illness identity both within medical sociology (Conrad 1987; Kleinman 1988; Rosenberg and Golden 1992; Frank 1995; Barker 2002; Aronowitz 2008) and feminist research on health and identity (Martin 1987; Clarke 1998; Clarke and Olesen 1999; Murphy 2006; Dubriwny 2012). This work traces how concepts of the self are shaped through diagnosis and treatment (Conrad 1987; Barker 2002; Dubriwny 2012). As medical and social understandings

of disease change, the identities of those suffering from the disease are also impacted (Rosenberg and Golden 1992; Barker 2002; Aronowitz 2008). Additionally, the public narratives of patients, which often appear in self-help literature, can become important sources for identity formation among the newly ill. For example, Kristin Barker, in her research on Fibromyalgia Syndrome, argues that the self-help literature on the disease functions as a way for sufferers to understand their symptoms and make sense of their experiences (2002). Further, these narratives help those struggling with the syndrome to see their collective experiences as valid, even though the disease is socially perceived as lacking biomedical legitimacy (2002). Illness identity is often shaped through struggles between expert definitions of disease and the experiences of patients.

Much of the STS scholarship on expertise examines instances of collaboration and resistance between traditional experts and lay experts (Wynne 1992; Epstein 1996) and the resistance of groups to expert understandings of illness and health (Treichler 1990; Murphy 2004; 2012). Recently there has been a move to consider expertise as “networks that link together objects, actors, techniques, devices, and institutional and spatial arrangements” (Eyal 2013:864). The strength of this understanding of expertise is the inclusion of the material conditions that contribute to scientific knowledge (e.g. devices, techniques, and laboratory space). Also, Eyal moves away from work that divides actors into particular categories (Collins and Evans 2007) in favor of analyzing a network that includes different kinds of actors and experts. Using the case of autism, he argues that the marked shift in the medical understanding

of autism from a rare illness composed of a few recognizable symptoms to an illness composed of a “wide spectrum of social and communicative deficits” and behaviors was due to changes in the expertise network rather than the technical superiority of behavioral therapies (2013: 894). Within the context of deinstitutionalization, behavioral therapists were considerably more effective than child psychiatrists in addressing the concerns of parents and securing their cooperation in the treatment of their autistic children (894).

My understanding of expertise is also informed by a long history of feminist scholarship on gender and health. Much of this research examines the ways in which medical and scientific knowledge, particularly around reproduction, characterizes women as bad or improper medical subjects (Martin 1987; Treichler 1990; Balsamo 1999; Haraway 1997; Casper and Clarke 1998; Clarke 1998; Clarke and Olesen 1999). This scholarship also chronicles how women resist these forms of expert knowledge or engage in uneasy alliances with medical experts (Treichler 1990; Taylor 1996; Clarke 1998; Murphy 2006; 2012; Mamo 2007). Additionally, scholars have begun to analyze the experience-based knowledge claims that emerge from feminist engagement in self-help movements as a distinct type of expertise (Murphy 2004), and to examine how feminists have used the knowledge gained through experience to construct both alternative understandings of health and disease and systems of treatment (Morgen 2002; Murphy 2012). In my analysis of women in post abortion organizations and their abortion regret narratives, I consider the knowledge claims that they make as a type of evidence and expertise based on experience. And, much like scholars of

gender, health, and expertise, I contend that this experiential evidence and expertise is constructed within a broader network that also includes prolife researchers, movement leaders, therapists, and mainstream researchers.

In this chapter, I draw on these understandings of expertise to examine how definitions of Post Abortion Syndrome changed as the network of experts shifted. I argue that over time the network transitioned from a small group of prolife researchers who built diagnostic criteria for a new mental illness by using accounts of women who faced emotional difficulties after abortion to a broader network of experts, “post abortive” women, and treatment programs that defined PAS as an issue of unresolved grief rather than a distinct mental illness. The inclusion of a larger array of actors influenced both understandings of PAS and the narratives produced by women who regret their abortions. These changes in the definition of PAS were also important for how women in post abortion organizations saw themselves and their experiences.

In addition to tracing the shifts in collective identity and networks of expertise, this chapter also examines how narratives and experiential evidence are used to achieve a variety of organizational and movement goals. I analyze post abortion organizations as self-help organizations positioned within their own stream of the larger prolife movement. Some have critiqued self-help movements as leading to individual self-transformation but as failing to address larger political concerns through social change (Kaminer 1992; Rapping 1997). However, many social movement scholars have demonstrated that these kinds of movements contribute to social and political change (Taylor and Rupp 1993; Taylor 1996). For example, in her

analysis of post-partum depression support groups Verta Taylor illustrates how women in these organizations worked to challenge medical understandings of maternal mental health, change health care practices, and modify laws in cases of fetal homicide (1996: 154-162). I follow in this tradition of research by exploring the different ways in which abortion regret narratives are used to advance many movement goals. I contend that these narratives are used to build collective understandings of the post abortion experience and identity within post abortion organizations and as “moral guides” (Polletta 2006) about the harmful nature of abortion. Additionally, these narratives are deployed to achieve institutional changes such as restricting access to abortion through more stringent informed consent procedures and to ban certain types of abortion.<sup>61</sup>

## **Methods**

My argument in this chapter is based on the written narratives of female members of post abortion organizations, an interview with Silent No More co-founder Georgette Forney, and numerous books, pamphlets, websites, and public statement by leaders of prolife organizations, post abortion organizations, post abortion healing

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<sup>61</sup> Throughout the chapter, I draw heavily on research from two other self-help movements – support groups from women experiencing post-partum depression and groups for people dealing with miscarriage and pregnancy loss. It is certainly the case that post abortion organizations share a great deal with other kinds of organizations. For example, they capitalize on the diagnostic expansion of PTSD, like organizations for victims of sexual assault. And they are organized around a medically contested diagnosis like female office workers suffering from sick building syndrome (see Murphy 2006). I chose to focus on similarities with other groups that deal with reproduction in order to contextualize the risk around reproductive decisions. Many within the prolife movement want to recriminalize abortion based on its potential to harm women emotionally. But, the decision to carry a pregnancy to term puts women at risk for post-partum depression, and women who miscarry may also struggle emotionally with their loss. As Ellie Lee demonstrates, mental health and reproduction have become thoroughly medicalized (2003).

organizations, and post abortion research organizations. The narratives come from two sources. First, I use 20 narratives written by members of Women Exploited by Abortion (WEBA) that were published in David Reardon's *Aborted Women, Silent No More* (1987). WEBA members submitted these narratives as part of Reardon's research on the negative physical and psychological aftereffects of abortion. The second source is a random sample of abortion testimonials taken from the Silent No More Website in the summer of 2011. At the time the data was collected, the ability to post a narrative was open to anyone who found the website; it did not appear to be curated to reflect a particular political view of abortion.<sup>62</sup> However, the website does have some guidance on how to structure the narrative, including that the author should address the circumstances of the unwanted pregnancy, any pressure the author felt to terminate the pregnancy, the author's emotional state in the days, months, and years after the abortion, and whether the author found healing and forgiveness. At that time, there were 1,155 testimonials written in English by women in the United States. I collected about 10% of them, or 115, and coded them using Atlas.ti to identify major themes.<sup>63</sup>

The analysis of narratives as evidence has a long history within the social sciences and science studies (Geertz 1973; Latour and Woolgar 1979; Ginsberg 1989; Riessman 1993; Haaken 1998; Lamb 1999). This scholarship emphasizes the need to

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<sup>62</sup> Now one must register with Silent No More before being able to post a testimonial on the website. In my sample there was one narrative that recounted a positive abortion experience that did not result in regret and three others that attributed both positive and negative emotional outcomes to having an abortion. This suggests that, at the time, there was little to no curation of the narratives.

<sup>63</sup> Over the course of analysis, two narratives were excluded: One was removed because it was a duplicate of a previously posted narrative, and the other was removed because it was a journalist's profile of Olivia Gans that appeared in the British newspaper.

consider narratives within their historical, social, and geographical context (Riessman 1993, among others). The construction of narratives is also based on how the authors remember past events in the context of their present lives. Narratives based on memory pose additional challenges to interpretation (Pezdek and Banks 1996; Park 1997; Haaken 1998).

Abortion regret narratives need to be understood in a particular context. As I will explain in more depth in the pages that follow, the narratives are typically constructed towards the end of abortion “recovery.” They are meant to reflect how a woman came to understand her abortion through a new lens, typically a religious (specifically Christian) or prolife lens, and found healing, forgiveness, and purpose through a new relationship with God. This is truer of the Women Exploited by Abortion narratives, which were written by women who had been involved with the organization for some time and produced their narratives at the end of a recovery process. The narratives found on the Silent No More website can be posted at any point and do not require the poster to be involved in any post abortion organization or recovery program. The experiences described in the narratives are not those of all or even most women who terminate a pregnancy, nor can they simply be generalized even to the subset of women who struggle emotionally after an abortion. Rather, they reflect a process of identity formation that highlights the tensions between dealing with the emotional aftermath of a perceived loss while also trying to advance a particular religious and political agenda. It is also important to note that most, if not



all, narratives within social movements reflect similar tensions though the individual experiences and circumstances of the women vary greatly.

### **The Emergence of the Victim Identity (1980 to mid-1990s)**

In the fall of 1974, Nancyjo Mann, a twenty year-old woman from Iowa, found herself in a difficult situation. Mann explains that she was five and half months pregnant and recently had been deserted by her second husband. With no source of income and two small children from her previous marriage, Mann turned to her family for help. According to Mann, her mother made it clear that no man would ever want to be in a relationship with a single woman with three kids and that Nancyjo would probably have to spend the rest of her life on welfare if she continued the pregnancy. Mann's family suggested that she have an abortion, she relates. Mann recounts that she accepted this advice, and her mother began the process of finding a doctor (1987).

Mann continues: because was already in the second trimester of her pregnancy, she received a saline abortion at a hospital. This procedure involves using a syringe to remove some amniotic fluid and replace it with a saline solution. The saline mixture induces uterine contractions and after several hours women are given injections to stimulate labor and expel the fetus. Mann describes feeling her child thrash around for two hours and laboring for twelve more hours before delivering a dead fetus. She explains that eight hours later she was discharged from the hospital (1987).

In the weeks, months, and years that followed, Mann describes experiencing a series of physical complications from her abortion and several symptoms of mental

distress that she attributed to the procedure. Mann's abortion was followed by numerous infections and eventually she underwent a total hysterectomy. According to Mann, she also began to engage in self-destructive behavior. She took up with a motorcycle gang and abused and sold drugs. After four years, Mann recounts that she contemplated suicide but never followed through with it. In 1978, Mann explains, she was involved in serious motorcycle accident, and during her time in hospital accepted Jesus as her Lord and Savior and started down the path to recovery from her abortion (Mann 1987: xii-xxii).

We learn from Mann's account that after recovering from her motorcycle accident, Mann moved to California and became the lead singer of the Christian heavy metal band, Barnabas. She explains that though she had found peace with her abortion experience, she felt that she needed to do something to help other women who might be suffering. In 1982, Mann recounts attending a prolife event in Iowa and was introduced to the president of the National Right to Life Committee (NRLC), Dr. John Willke. After hearing her story, Willke realized that Mann was the first woman he had encountered who had an abortion and who was willing to speak about the harm the procedure had done to her. He invited her to speak at the NRLC Conference that year in New Jersey (Colmar 2009).

At the New Jersey conference, Mann recounts, one of the featured speakers was Vincent Rue, a Los Angeles psychiatrist who had begun to study the negative aftereffects of abortion on women's mental health. Based on his interactions with patients, Rue theorized that some women experienced severe psychological distress

and self-destructive behaviors in the years following abortion. Another conference attendee, Olivia Gans, was struggling with many of the symptoms Rue described in his lecture. According to Gans had become pregnant during college, and under pressure from the father, terminated the pregnancy (1998). After the presentation, Gans recalls that she stayed to ask Rue further questions about his research and met Nancyjo Mann and two other women who had similar experiences. Mann, Gans, and the two other women spent the evening sharing the stories of their abortions and comparing the struggles they had after the procedure (1998). Out of that informal meeting, Women Exploited by Abortion (WEBA), the first post abortion support group was formed. According to Mann, within 10 months the group had chapters in 30 states and over 10,000 members (Testimony to House Subcommittee on Health and the Environment 1983).<sup>64</sup> In 1985, Gans recounts that she had decided that the message of women harmed by abortion needed to have a larger place within the mainstream prolife movement and founded American Victims of Abortion (AVA), an education and outreach program of the NRLC (Gans 1998).

These first post-abortion organizations were structured as informal support groups in which women who are struggling after abortion could share their experiences.<sup>65</sup> Many of these were associated with crisis pregnancy centers (Kelly

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<sup>64</sup> Mann does not indicate how the organization grew within those first 10 months. It is likely that WEBA was able to use the existing infrastructure of Crisis Pregnancy Centers, which were early adopters of after-abortion support groups (Kelly 2014) and the increased publicity for her organization provided through her connections to the NRLC and John Willke (Colmar 2009).

<sup>65</sup> Some scholars and activists trace the origin of “post abortion syndrome” and post abortion counseling to the work of crisis pregnancy centers in the early 1970s (Kelly 2014). According to Margaret Hartshorn, president of Heartbeat International, CPCs began developing Bible-based treatment programs for PAS shortly after legalization and promoted them through local churches (2003). These

2014). Much like support groups for women with post-partum depression (Taylor 1996) and pregnancy loss (Layne 1997), WEBA provided a forum for women who regret their abortions to come together, discuss their struggles, and find a different understanding of their abortion experience (WEBA pamphlet 1983). It is important to note that both WEBA and AVA were affiliated with the prolife movement and these support groups are guided by prolife and usually conservative religious understandings of abortion. Based on the accounts of participants, women typically came to be involved in these organizations after having a religious experience, such as renewing or beginning an affiliation with a Christian church or seeking salvation through a personal relationship with the divine (Reardon 1987). By the time women came to WEBA, they already had begun to understand abortion as the taking of a human life and a sin. Additionally, these women identified as mothers who were grieving a child that they played some role in killing.

However, this support group organization only served one of WEBA's three purposes. According to organization materials, members of WEBA were also expected to be "dedicated to advocating pro-life philosophies and legislation" as well as "educating women on the trauma of abortion" (WEBA pamphlet 1983). Similarly, AVA, through its association with the NRLC, had both advocacy for prolife legislation and education built into its mission (Gans 1998). The educational goals of these organizations typically involved members speaking publically about their

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initial efforts may have had a local or regional impact. In this chapter, I begin my analysis when claims about post abortion syndrome and counseling programs reach the level of national attention.

negative experiences with abortion and the consequences they understood as following from their decision to terminate a pregnancy.

The three purposes of these organizations – healing, advocacy, and education – were fulfilled through the writing of abortion regret narratives.<sup>66</sup> The (re)constructing of the abortion experience in narrative form is considered an important part in the post-abortion healing process. Initially, these narratives were used as powerful stories when counseling a woman at a crisis pregnancy center and as a script for speaking publicly about abortion's harms. Over time, abortion regret narratives began to be used to lobby for abortion restrictions and as evidence in courts for the need to further limit access to the procedure. Abortion regret narratives typically have the following structure: They begin with an account of the circumstances of the pregnancy and the decision to have an abortion. This is followed by a detailed account of the experience of the procedure. Then the narrative transitions into describing the physical and emotional outcomes that followed in the months or years after the abortion. Finally, the narratives end with a story of how the woman came to realize her sin, her steps towards or to recovery, and her vision for what she hopes the story of her description can do (e.g., help change the mind of a woman considering abortion, help guide women struggling after abortion to healing).

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<sup>66</sup> It should be noted that writing and speaking publicly about abortion experiences has been a strategy on both sides of the abortion debate since the drive to liberalize abortion laws in the 1960s. For example, radical feminist groups, like the Redstockings, would hold "Speak Outs" where women would describe their experiences with illegal abortions. Today, abortion narratives that represent every political position on abortion can be found in books, activist documents, and websites that are solely dedicated to accounts of abortion. I use the phrase abortion regret narrative to indicate that I am examining narratives written by women who regret their abortions.

Abortion regret narratives are part of a longer tradition of religious storytelling in the United States often referred to as conversion narratives or confessional protest narratives. In his examination of the temperance and anti-slavery movements, Michael Young argues that narratives of sinners (e.g. drunks and slave owners) were not only self-transformative for the storyteller, but also an important way to identify social problems and mobilize people for change (2002; 2006). These types of narratives which elicit empathy, identify systems of oppression, and motivate people to act were also central to the civil rights movement, women's liberation, and the gay rights movement (Polletta 2006: 114-115). For example, women's stories of illegal abortion and sexual assault were significant components in political struggles around contraception and abortion as well as campaigns to change attitudes around and enforcement of rape. Additionally, these types of narratives can be found in contemporary self-help organizations. For example, Verta Taylor demonstrates how narratives of post-partum depression are used within self-help groups to build collective identity facilitate political expression (1996). Others have argued that the narratives used in self-help settings might lead to individual change, but often did not lead to political or collective action (Rapping 1997). Further, the identification of the storyteller as, at least in part, a victim is critical to the success of these stories and can be deployed to achieve different goals. However, as Polletta contends, taking on the victim identity is not without consequences (2006). For example, narratives about victimhood may help to prove damage or injustice within a legal setting, but movement based around victimhood may have trouble recruiting new members who

are uninterested or unwilling to see themselves as victims (Polletta 2006). Beyond this, movements that form around a common injury or shared experience of victimhood run the risk of making demands to be protected from state power rather than sharing in it (Brown 1995).

In the section that follows, I analyze the abortion regret narratives submitted to David Reardon by members of WEBA for a research project on the after-effects on abortion. These narratives were published in the 1987 book, *Aborted Women, Silent No More*, and were used to illustrate the variety of circumstances that led these women to have abortions. More specifically, I analyze these narratives in terms of what these women expressed as their common grievances about issue of legalized abortions, their understandings of themselves as victims, their understandings of gender, and their expressions of what potential they saw for their stories to change the discussion of abortion in the U.S.

There are some important limitations to this data. First, these accounts are typically produced after participation in a pro-life post abortion organization. They represent, at least partially, how these women have come to think about their experiences through the lens of the pro-life movement. While I do not treat them as “objective” accounts of what abortion is like for all, or even most women, I do consider them to be truthful descriptions of what the authors thought about their abortions at the time that they wrote them. In many cases these narratives were written while the author was participating in a support group for women who felt exploited in their experience with abortion. Thus, the stories are already shaped, at least in part, by

a prolife understanding of abortion and cannot be read as existing outside of the “looping effect” I describe. Second, during this time period, abortion regret narratives were penned and distributed in a few different ways, including by pro-life organizations that submitted collections of these narratives to legislators and politicians and by researchers studying the negative after-effects of abortion. In a sense, the process of collecting these narratives and presenting some as “representative” is a process of curation. The reader should keep in mind that these narratives are the best representations of the abortion experience as decided by the person putting together the collection, in this case David Reardon. My point is not to suggest anything nefarious or sneaky on the part of curators but simply to emphasize the strengths and the limits of these data.

### Victims of Abortion Speak

The language of victimhood is ubiquitous among the first post abortion organizations and their members. It is included in the names of their organizations and regularly appears in the stories of women who regret their abortions. But what are these women victims of and who (or what) do they see as the perpetrator of their injury? Based on the narratives of their abortions, they see themselves as being persuaded (or in some case, coerced) into having abortions by their partners and families. Both Nancyjo Mann and Olivia Gans describe the lack of a supportive partner or family as a major factor in their decision to terminate their pregnancies (Mann 1987; Gans 2002) and WEBA flyers claim that the organization is “dedicated to help those women who feel they’ve been exploited by doctors, boyfriends,



husbands, and society” (1983). However, the most common grievance within these narratives is with abortion providers.

Grievances about providers fall into two categories: complaints about poor treatment and complaints about informed consent. Many of the narratives describe being treated roughly during the procedure, being chastised or made to feel guilty about the circumstances of their pregnancy, or feeling like they are part of an assembly line. One woman, Gaylene, wrote that during her abortion, the nurse “grabbed my hips roughly and pulled my body down to the end of the table and fastened the straps around my feet” (1987: 39).<sup>67</sup> Another, Carolyn, wrote, “I was given a paper gown and told to put it on. The place was cold and the people formal. No compassion, no understanding. It was like a busy assembly line” (145). Though some women describe the staff and doctors at the clinics where they obtained their abortions as kind, friendly, and supportive, others felt that the experience of being treated in a formal and clinical manner supported their view that providers don’t care about women and are simply trying to make money as efficiently as possible.

The much more common grievance about abortion providers has to do with the information they received (or did not) about the procedure and pregnancy. In all the cases I analyzed, women who came to regret their abortion had become involved with a religious organization or prolife organization prior to beginning the process of healing from abortion. At the time of writing their narratives, they saw their abortion

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<sup>67</sup> This may be an actual woman’s name. Both of my sources for abortion narratives allow the writers to use either their own or fictitious names. In *Aborted Women, Silent No More*, Reardon puts fictitious names in quotation marks; a practice that I will continue here. I have decided to use the names of the writers because their stories are all publicly available and, more importantly, because these women see the public recounting of their experiences as a political act.

as the taking of a human life or the “killing of a baby.” The use of medical terms like “fetus” and “embryo” as well as more euphemistic terms used in clinics like “a blob of tissue” are seen by these women as hiding “the truth” about what abortion does. For example, Gaylene recalled that “the aide matter-of-factly told us that they would remove a ‘pink blob.’” She said that then we would no longer be pregnant, and that it was a simple surgical procedure.... I didn’t even know what they were going to do to me or my baby” (38-39). And Alice wrote, “I asked the doctor, ‘Is the baby alive?’ He said ‘No.’ I never had prior instruction in school as to the development of a baby, so I didn’t know any better. All I had to go on was what he told me; and that’s all he said” (148). Many of these women claim that they would have never gone through with the abortion if they understood that they were “killing a baby” and see the abortion provider as engaged in an act of deception in hiding this truth from them.

The issue of consent also reflects a particular understanding of gender and the role of women in society. While many scholars have argued that the prolife movement is best understood as a backlash to feminism and a movement that values traditional gender roles (Luker 1984), the stories of these women paint a more complicated picture. To be sure, “pro-choice feminists” appear as villains within abortion regret narratives and in the public statements of post abortion leaders. More generally, however, the authors of abortion regret narratives adopt arguments that articulate how part of their exploitation or victimhood is due to their unequal place in society. Stories of women being abandoned by their partners or pressured into having abortions reflect the disproportionate responsibility that women have in reproduction. Their feelings of

being deceived by providers are a critique of paternalism within medicine. These accounts illustrate the ways that reproductive choices are limited by class and gender. Women's narratives reflect feelings of victimization by abortion providers, but do not typically present a larger context for understanding this struggle, for example, in terms of other social movements around medical paternalism or women's health. However, leaders within post abortion organizations are more likely to characterize their activism in relation to women's issues and place themselves within a legacy of struggles over women's rights.

Feelings of abandonment by "society" or "culture" during an unplanned pregnancy are a common theme throughout early abortion regret narratives. For example, Cathe wrote: "I didn't want an abortion. I didn't want all that guilt again. But all the people at the abortion clinic were real helpful and friendly and tried to help me. Everybody else would just look down their noses at me for being pregnant" (33). This sentiment is articulated more forcefully by post abortion leaders. Mann founded WEBA to shed light on the problems women face after abortion. She stated:

It was time for society to learn that abortion was no favor which women had the 'right' to enjoy. It was a trap. A curse. A cheap substitute for love and support. A tool for manipulation and exploitation of the women society has abandoned. We are its victims; the aborted women of an unwanting society (1987 xxii-xxiii).

Additionally, in a press conference with the NRLC, Olivia Gans articulated it this way:

A policy of abortion on demand does not create a compassionate society. Abortion on demand does not solve problems of poverty, neglect, or lack of opportunity for women. As a matter of fact, abortion on demand has become a reliable device for the problem solvers of our

culture to thrust on women like myself seeking real help and real alternatives at a time of crisis when we tried to cope with an unplanned pregnancy... This act of violence to women and their children cannot solve these problems because it starts from the premise that the children have no value and therefore the problems that their mothers face are not worthy of the real earnest contemplation and answers they deserve (1989).

The ideas about gender expressed in these statements both support and challenge Luker's work on the abortion debate (1984).<sup>68</sup> Like those interviewed by Luker, Gans and Mann express concern for the "cheapening of life" and devaluation of motherhood that they see as associated with abortion and feminism. They also express real concerns about women's vulnerability, the lack of support for women who want to parent but do not have a supportive partner, and the social inequalities that women experience. Contemporary post abortion organizations and CPCs often advocate for social changes typically associated with feminism, like subsidized child care and accommodations for students who are also parents in high school and college. Gans's comments suggest that feminism and the struggle for reproductive rights failed to address genuine issues of inequality and did not more evenly distribute responsibility for reproduction.

Given that issues of abortion provision and consent are the most frequently voiced grievances, it is not surprising that a large amount of the advocacy post abortion groups engaged in was around changing provider practices, particularly to require providers to tell patients about fetal development. In her account, Donna argued:

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<sup>68</sup> Luker interviewed activists within the pro-life movement in 1979. Though not a perfect match, her respondents are likely of the same generation of pro-life activists as the women I am writing about here.

I feel that women are being deceived when they go in to have an abortion because they aren't being shown pictures of what their child looks like. Women are being deceived before they get to that place in that they're being sheltered from this truth... Women should see pictures representing the child inside of them, and they should know beforehand the side effects of abortion. ... Without it, that's deception; women aren't being allowed to make a truly informed decision about their abortion (157).

In testimony before the House Subcommittee on Health and the Environment, Nancyjo Mann also argued that most women would choose not to have abortions if they were properly informed of the risks: "I believe that we women have the right to know what is going to be used on us, what is going to happen to us, and what could happen to us. I really believe that 80 percent, maybe more of the abortions would never take place if the woman truly knew how her baby had to die, what size it was" (Testimony 1983).

The narratives also offer insight into the sense of identity and the comfort women experienced from finding a group like WEBA. One woman writes, "I heard about WEBA and decided 'I want to get involved with that.' And ever since I became involved in the right-to-life movement, my whole life has changed. Now I'm able to use my own experience to help other women avoid abortion. There's a lot of hope in that" (1987:77). Another woman's testimonial reads: "I have only been involved in WEBA for the past four months, but I have learned a lot through WEBA. I've learned that there are so many victims of abortion who are sharing the same guilt and grief that I experienced" (Silent No More "Testimonials" 2011). Mann herself expressed her own surprise at the number of women who joined her group, especially considering the silence around the issue of abortion:

It is a hell that you live in, and you don't talk about it over a cup of tea and a cookie, you know. You just don't talk about how it felt. All of the sudden, there is a support group, and it is like they are crawling out the woodwork. I am glad that there is somebody that I can go and tell who really, truly understands what it was like (Testimony 1983).

Through participation in WEBA women were able to get support for their shared experiences of grief and guilt.

The sentiments of finding identity and purpose through participation are similar to those expressed by participants in other identity-based movements and even older social movements. Within the narratives, some women describe seeking counseling or medical care for their emotional distress after abortion, but found these methods of treatment to be unsatisfactory because they failed to address the grief that resulted from "losing a child." In this way WEBA members shared a common identity as "grieving mothers"--an identity that was not recognized or validated outside of the prolife movement. For example, in Linda Layne's research on pregnancy loss support groups, she found that members commonly expressed frustration over the lack of social recognition of their loss (1990; 1997). As "would-have-been parents" the participants of these groups recounted that medical professionals, family, and friends often reacted in ways that minimized their loss and continued the silence around miscarriages and stillbirths (1997).

In addition to participation in post abortion organizations, the abortion regret narratives themselves were important in the construction of the victim identity. The narratives share similar structures, grievances, and the emotional and behavioral aftermath of abortion. Many scholars have also pointed out that over time they also

began to share similar details (Diamond 1989; Siegel 2008). The most common example of this is the reported fear of household vacuum cleaners, which sound like the vacuum aspiration machine used in most first trimester abortions. This detail was commonly used in crisis pregnancy center materials, and began to appear more frequently in the narratives (Diamond 1989). As women encountered more stories of post abortion regret, their own experiences were reinterpreted and framed through the lens of activist and CPC discourse on the aftermath of abortion.

### Building the Post Abortion Syndrome Diagnosis

At the same time, some psychoanalysts and therapists began to notice and write about patients who appeared to be suffering from severe trauma related to their abortions. One of these professionals was Vincent Rue, a professor of family relations at California State University, Los Angeles, who would go on to found the prolife Institute for Pregnancy Loss. In testimony before the Senate Subcommittee on the Constitution, Rue argued that rather than helping women to achieve “their absolute procreative right to self-fulfillment,” abortion had made women more disillusioned and led to “rapid increases in female suicides, relationship disillusion, husband abuse, child abuse, and substance abuse” (1981:329). Additionally, citing the results of about 30 studies, Rue claimed that the only positive emotion women reported after abortion was relief, but a panoply of negative reactions were also reported including guilt, anxiety, depression, a feeling of being misled, deterioration of self-image, regret, and psychotic reaction. (331). Rue’s testimony marks the first instance in which post-abortion trauma entered the national debate about abortion.

Though Post Abortion Syndrome did not gain traction among mental health professionals, the concept did take root among therapists and researchers who were critical of abortion. During the mid- 1980s, several books describing the condition and potential treatment regimens were published by Christian presses. Three of the most prominent were Anne Speckhard's *Psycho-Social Stress Following Abortion*, David C. Reardon's *Aborted Women Silent No More*, and Susan M. Stanford's *Will I Cry Tomorrow?*.

Anne Speckhard's *Psycho-Social Stress Following Abortion* (1987) described her doctoral research on women who reported having high stress reactions following their abortions. Based on in-depth interviews with 30 women, Speckhard found that all of the women in her sample reported feelings of grief, sadness, regret, and loss and the vast majority reported feelings of depression, anger, and guilt (60). Abortion was also reported to be associated with behavioral changes among the women including frequent crying, flashbacks of abortion, suicide ideation, and increased alcohol use (63). Of course, Speckhard's findings are based exclusively on women who identified their abortion experiences as traumatic and, therefore, are not representative of all women who have abortions. However, the demographic data collected along with the interviews indicate that her subjects did not "deviate significantly from national norms regarding abortion patients" (38), although women in Speckhard's sample were more likely to have abortions later in the pregnancy than the average population of abortion patients.<sup>69</sup> Speckhard concluded that many women used denial and repression of the

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<sup>69</sup> In 1980, 91% of all reported abortions occurred within the first trimester, but in Speckhard's sample 69% of the women had first trimester abortions and 31% had abortions in either the second or third



grief that they were experiencing as a result of their abortions, which would mean that it could take years or even decades for women to realize they were suffering from their abortions (101-104).

In *Aborted Women, Silent No More* (1987), David Reardon presented descriptive statistics of 252 WEBA members from across 42 states; the book also included narratives from some WEBA members about their abortion experience and their lives after the procedure. As was the case with Speckhard's research, the sample is not representative of all abortion patients – Reardon only surveyed women who had joined a post abortion support group. And like the women in Speckhard's sample, Reardon's subjects were more likely to have a second or third trimester abortion than the typical abortion patient. Reardon reported that 94% of all his participants reported that they had experienced “negative psychological effects” that they attributed to their abortions (22). Of these women, 73% characterized their reactions as severe (22). The most commonly reported reactions were guilt, depression, a lowered sense of self-worth, and self-hatred (22). Additionally, 63% of women reported that they became suicidal after their abortions and 20% claimed to have attempted suicide (22-23). Many women also indicated that they increased their use of alcohol and other drugs, and a small percent characterized themselves as becoming drug addicts (23). These psychological problems were characterized as long lasting –most of the women

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trimester (38). Having a later term abortion might be a risk factor for having a negative reaction to abortion because delaying the procedure into the second or third trimester suggests ambivalence about the pregnancy or the possibility that the pregnancy may have initially been wanted (Adler et al 1992). Additionally, Speckhard surveyed only white women, and while white women have the majority of abortions in the United States, they are underrepresented in terms of race and abortion rate. That is, African American women and Latinas have abortions at higher rates than White women.

reported that they lasted for 3 or more years – though it was unclear in the survey how many of them had sought out counseling for their distress.

Finally, in *Will I Cry Tomorrow?* (1986), Stanford, a professional therapist, recounted her experience of having an abortion after becoming pregnant during an extramarital affair. After the procedure, she experienced severe depression and suicide ideation until she began a healing journey through forging a new relationship with Jesus Christ. After her recovery, Stanford left her academic position to start a counseling practice and develop a treatment program for women who were also suffering from post-abortion trauma. Her twelve step treatment includes helping the client realize that their current mental health problems may be linked to their past abortion and a general catharsis about the abortion decision, experience, and aftermath. The therapy concludes with a healing meditation in which the client seeks and receives the forgiveness of Jesus, reconnects with the aborted fetus, and commits the child to the care of Jesus until they can be reunited in heaven (161-171). The reliance on the Divine to perform a great deal of the therapeutic work places this treatment outside of the boundaries of mainstream counseling practices, and Stanford argued that the tools of modern psychotherapy alone are insufficient to treat post-abortion trauma (139). This model of treatment is similar to other Christian-based models of treatment for PAS used by groups like Rachel's Vineyard.

The narratives of women who had come to regret their abortions were also shaped by their involvement in prolife organizations and through their role as participants in research. Questionnaires and interview guides were produced to capture

the details of the women's abortion experiences as well as the emotional and behavioral aftermath of the decision to terminate the pregnancy. These forms were typically extensive – Speckhard's interview guide asked respondents to assess the duration, intensity, and trigger of 38 different affective reactions and 28 behavioral symptoms (1987:108-131), and a questionnaire developed by the Elliot Institute and used by the post abortion group Victims of Choice asked women to rate their experience after abortion for 42 affective and 20 behavioral measures on a five-point Likert scale (1988). These open-ended measurements often led to participants indicating that they experienced a wide variety of affective and behavioral difficulties. In some cases this even resulted in contradictory symptoms being brought together under the same diagnosis. For example, symptoms included increased promiscuity as well as frigidity and decreased interest in sex, and an inability to properly bond with children as well as a tendency to over-parent. Surveys and questionnaires can function as a means to translate personal experiences into quantifiable evidence that can be used by scientists and experts (Murphy 2006; Eyal 2013).

Based on clinical evidence and the abortion trauma testimonials, researchers like Rue, Speckhard, and Reardon, who all have ties to the prolife movement, began to argue that these women were suffering from a new mental illness, Post Abortion Syndrome. They argued that the depression, heightened anxiety, substance abuse, and flashbacks reported by women in their testimonials were characteristic of Post-Traumatic Stress Disorder, and claimed that Post Abortion Syndrome was a variant of PTSD. At the same time, other health movements were similarly capitalizing on the

diagnostic expansion of PTSD to include groups like victims of domestic violence and rape (Lee 2003).

During this time women in post abortion organizations and researchers fostered a relationship that was central to the development of the PAS diagnosis and the victim identity. Women participated in this research by supplying narratives and survey data so that researchers could describe post abortion syndrome and design criteria for diagnosing it. In turn, women read this research and came to contend with the new, more medicalized meaning of their experiences. Further, what it meant to be a victim of abortion was transformed from general shared experiences of trauma and grief into a list of emotions and behaviors. Almost all of the initial prolife research on the emotional aftermath of abortion was published by small Christian presses with the intended audience being prolife activists and women struggling after abortion. For example, the descriptive statistics produced as part of Reardon's *Aborted Women*, *Silent No More* were used in his subsequent books as well as in Theresa Burke's *Forbidden Grief*, a staple of post abortion healing programs. Many of these books are also organized by the initial categories of symptoms (e.g. difficulty parenting, sexual issues, eating disorders, substance abuse) (Speckhard 1987; Burke 2002). It is likely that for many women, one of their first encounters with information about PAS came through these books, which mix prolife research with abortion regret narratives. Kristin Barker describes a similar phenomenon in her work on the role Fibromyalgia Syndrome self-help literature in constructing illness identity (2002).

This type of relationship between people suffering from a disease and researchers is not uncommon (Epstein 1996; Heath, Rapp, and Taussig 2001; Murphy 2006; Eyal et al. 2010). For example, when Bernard Rimland, an important figure in modern autism research, included a checklist of symptoms at the end of his book *Infantile Autism*, parents of children were eager to fill it out and return it to Rimland for analysis (Eyal 2013: 885). These completed checklists, according to Gil Eyal, were significant to our contemporary understandings of what constitutes autism and the centrality of using applied behavioral analysis therapies to address it (2013). Further, this new engagement of parents in diagnosis and treatment marked an important transition in the network of expertise that shifted control of diagnosis and treatment from child psychologists to a broader spectrum of clinicians, therapists, parents, and patients (2013). Like the parents in Eyal's case, women who came to regret their abortions provided crucial data to researchers of PAS and, in turn, were able to benefit from the insights of the researchers.

#### A Place in the Movement

After his meeting with Nancyjo Mann, John Willke quickly realized that women who regretted their abortions could be an important asset within the prolife movement. In addition to arranging for Mann to speak at the NRLC Conference in 1982, Willke began to talk about Mann in his own speeches on behalf of the prolife cause (Colmar 2009). Willke recounted that over time, it became more common and then routine to have women speaking to prolife groups about their experiences and that these women's stories provided a "second argument" against abortion. Prolife

leaders could argue that abortion should be recriminalized because it killed an innocent human life *and* because it hurt women (Colmar 2009). Within the mainstream movement the language of two victims was also taken up. As Willke put it, “We see two victims. We see the baby who is killed, and the mother who is only too frequently badly hurt” (C-SPAN 1989). As Reva Siegel has argued, during this time the argument that abortion is harmful to women was largely an internal framework used within the movement to generate empathy for women who had abortions and to recruit new members, particularly women (2008). Abortion regret narratives and the women who produced them were used towards achieving these goals within the movement.

The women of post abortion organizations largely came to serve the outreach and educational missions of the prolife movement. As previously mentioned, AVA cultivated members to serve as speakers at movement events. Through educational outreach, leaders of post abortion organizations claimed that they added a new perspective to the abortion debate. According to a WEBA pamphlet:

the members of WEBA feel that what we have to say about our experiences will be a tremendous benefit in turning the tide of opinion towards legislation prohibiting abortion. WEBA members add a totally different dimension to the abortion debate...a dimension that no one can refute because we are the organized voice of experience. **We know** what it is all about. In a debate all too often obscured by complex philosophical views, the real heart of the issues, dead babies and grieving women, seems to get lost (1983: original emphasis).

During this time, abortion regret narratives were also used to convince members of the validity of the second argument. As David Reardon contends, initially the prolife movement had to become more accepting of women who got pregnant out of wedlock

and to women who had terminated pregnancies (1996a). Narratives that demonstrate suffering and contrition for past sins, historically, have been used to demonstrate authenticity of the conversion experience and create sympathy among listeners (Polletta 2006:115). Abortion regret narratives also serve this dual purpose of legitimizing the storyteller as a “true believer” in the antiabortion cause and as worthy of the empathy of movement members who have not had abortions.

Additionally, many women who came to regret their abortions found a place within crisis pregnancies centers and considered using their stories to persuade women against having an abortion as a key part of their recovery. Of the 20 abortion regret narratives in *Aborted Women, Silent No More*, seven women wrote about becoming involved with the mainstream prolife movement either before or after joining WEBA and of these three wrote about counseling women at crisis pregnancy centers and outside of abortion clinics. Given that many post abortion support groups had disbanded during the 1990s, without a formal structure there were likely fewer opportunities for women to speak publicly about their stories.<sup>70</sup>

By the early 1990s, three distinct understandings of Post Abortion Syndrome and those who suffered from it had emerged. First, through CPCs and post abortion organizations, women who had come to regret their abortions understood themselves as victims of undue pressure and misinformation that lead to their participation in

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<sup>70</sup>It is not entirely clear why so many organizations disbanded during this time. One possibility is that groups just died out after their members felt that they had adequately dealt with their suffering and moved on to other streams of the prolife movement or out of the movement entirely. Many post abortion healing programs were developed in the mid-1990s, which means that women struggling after abortion may have ended up in these treatment programs rather than in the organizations that focused on publicizing abortion regret narrative.

ending a pregnancy. The narratives they produced detail poor treatment by providers and indicate a lack of information about fetal development and the abortion procedure. Further, these narratives describe a variety of emotional and behavioral aftereffects that are attributed to feelings of immense guilt over what they have come to understand as their role in the murder of their child. Second, prolife researchers, like Vincent Rue, Anne Speckhard, and David Reardon, saw these women as suffering from a unique mental illness and worked to develop diagnostic criteria and treatment regimes. These researchers claimed that a panoply of psychological and behavioral symptoms, often contradictory and emerging years after the abortion, composed this new mental illness. Finally, mainstream mental health professionals had rejected the PAS as a new mental illness; it did not appear in the DSM – IV (1994). Expert reviews by the American Psychological Association and the American Psychiatric Association found no evidence that terminating an unwanted pregnancy would lead to mental illness. Further, a federal inquiry into the physical and psychological consequences of abortion conducted by Surgeon General C. Everett Koop failed to produce any firm conclusion.

As discussed more extensively in the previous chapter, experts within the professional mental health community disputed the existence of PAS and pointed to research that demonstrated that a woman's psychological state previous to her abortion was the best predictor of her post-abortion psychological state. Many within the post-abortion movement felt that this served as further evidence that the APA and the American Psychiatric Association were biased in favor of legal abortion and were



offended that experts associated with these organizations dismissed their suffering as resulting from the fact that these women “were crazy before they got their abortions” (Gans 1989). It is clear that the methods deployed by mental health experts failed to capture or misrecognized the concerns of these women. For example, abortion regret narratives often describe the complicated series of events that follow an unplanned pregnancy and the decision to end a pregnancy making it impossible to draw a neat causal line from an abortion to the psychological distress that may follow. Though women in post abortion groups were confident that their abortions had caused them psychological harm, for a researcher it would be difficult to ascertain how much of that distress was the result of the medical procedure and how much was the result of an unsupportive partner, pressure to abort a wanted pregnancy, or just general life circumstances. Furthermore, the narratives reveal that, at least in retrospect, most of the women who came to regret their abortions recounted that they terminated a wanted pregnancy or felt ambivalent about getting an abortion. Most researchers of psychological aftermath of abortion recognize that these conditions are associated with increased distress (Adler et al 1990).

Through both professional and prolife research on the after-effects of abortion on mental health, the “post-abortive woman” emerged as a “human kind,” to use Hacking’s term. The American Psychological Association and the American Psychiatric Association considered the classification of women who suffer mental illness after abortion to be a small group whose mental health status was inseparable from the circumstances of their pregnancy and the degree to which the pregnancy was

wanted. Rather than classifying the outcomes described by post-abortive women as evidence of an emerging mental illness, psychologists and psychiatrists found these experiences to be normal reactions to a stressful life event. By contrast, for prolife researchers and groups, these women were suffering from a variant of PTSD and their experiences were indicative of mental illness. Despite the new category created for members of post abortion organizations to occupy, there is little evidence that they were interested in taking up this diagnosis. The narratives penned by WEBA members do not use the phrase Post Abortion Syndrome, nor is there any indication that these women consider themselves to be mentally ill.

From the mid-1970s until the mid-1990s, a particular expertise network emerged around the emotional aftermath of abortion for women. Women who regretted their abortions worked in collaboration with prolife researchers to provide information about their experiences to help build the diagnosis of PAS. The lack of recognition of the disease by mainstream mental health organizations meant that its diagnosis and treatment were relegated to counselors and treatment programs within the prolife movement. Post abortion and prolife organizations both characterized mental health professionals as untrained and unable to meet the unique needs of women struggling emotionally after abortion (Burke and Reardon 2002: 60-62). Women were instructed to contact a prolife group or a crisis pregnancy center to be directed to a counselor who could assist them. By the mid-1990s, PAS was only recognized as a mental illness within the prolife community and among prolife mental health researchers, and the central source of assistance for women who were

struggling with their abortion experience were organizations and counselors who had a particular political view about the legality of abortion.<sup>71</sup>

### **Integration into the Prolife Movement (mid-1990s to present day)**

The mid-1990s were a time of great change within the antiabortion movement. As discussed more extensively in Chapter One, a series of legislative events and Supreme Court decisions facilitated a transition to incrementalist strategies that sought to end abortion through restricting access. Framing abortion in terms of the sacredness of fetal life had also failed to change the hearts and minds of Americans in the “mushy middle.” Prolife leaders saw a greater promise in the argument that abortion is harmful to women. During this period of soul-searching, the NRLC committee conducted market research to evaluate their slogans and to test new directions for the movement. The research demonstrated that

while three-fourths or more of the people in the United States now admitted this was a child who was killed, two-thirds of the same people felt that it was all right to give the woman the right to kill. We found out that the basic problem in the minds of the general public was that, by their own evaluation, most were undecided on this issue. They felt that pro-life people were not compassionate to women and that we were only ‘fetus lovers’ who abandoned the mother after the birth. They felt that we were violent, that we burned down clinics and shot abortionists. We were viewed as religious zealots who were not too well educated (Willke 2001).

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<sup>71</sup> It should be noted that I am considering PAS at this point as relatively separate from larger debates of abortion and mental health. For example, contests over abortion’s potential association with depression, substance abuse, etc. continue to engage both professional mental health communities, but the narrow diagnosis of PAS is quite limited to the pro-life movement.

Though Willke considered it success that the pro-life movement had convinced about three-fourths of people that abortion was the killing of a child, this belief failed to translate into moral outrage against abortion.

Noting that the pro-choice movement had been successful in making “choice” the predominant frame of the abortion debate, Willke sought to develop a new campaign that would effectively sway those in the “mushy middle” to favor the pro-life position (Willke and Willke 1997: 16).<sup>72</sup> The “choice” framework highlighted personal freedom and the ability to make decisions about one’s life without the government intervention. It also made women’s choice the center of the abortion debate. As the market research conducted by the NRLC discovered, the right of the woman to choose trumped the “fact” that the fetus was killed. In developing a new campaign to counter the “choice” frame, the NRLC found that emphasizing the pro-life movement’s compassion towards women resonated within their market research and came up with slogan “Love Them Both” (Willke 2001). This new slogan was used in a new campaign to address the role of women and a general compassion for women within the pro-life movement. According to Willke:

Pro-lifers needed to showcase just how compassionate the movement is to women. We emphasized that there are more pro-life pregnancy help centers than there are Right to Life chapters. We've stressed the fact that there are far more women involved in the pro-life movement than men. We underscored that three-fifths of the total effort of the pro-life movement is devoted to helping women with unexpected pregnancies (2001).

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<sup>72</sup> It is important to note that this was meant to be a strategy to sway public opinion, not to mobilize new members.

As opposed to previous campaigns that characterized women as the “second victim” of abortion that can provide a “second argument” for why abortion should be recriminalized, Willke at this time was proposing a more central (rather than complementary) role of women’s concerns. As Siegel (2008) notes, this marks a change from using the argument that abortion is harmful to women as an internal framework among prolife organizations to an external framework to shape the debate around abortion and to build support for increased restrictions on access to the procedure.

This sentiment was also shared by David Reardon, who had spent much of the 1980s using the stories of WEBA members to build a case for PAS and the recriminalization of abortion. He wrote, “...when hearts are closed, pounding heads with proof of the unborn child’s humanity is ineffective. The truth must enter in a roundabout way, through the testimony of women who grieve over their lost children....In this very really way, the issue of the unborn child’s human rights is not replaced by a focus on post-abortion issues, it is subsumed into it” (1996a:9). Again, this position makes the concerns of post abortive women more central to the debate and suggests a smaller emphasis on the “human rights of the unborn child.” Further, the new strategy also opened up the possibility that abortion regret narratives could be used to convince the general public of the immoral nature of abortion.

Of course, discussion of strategies and slogan often differ when that strategy is implemented in the movement. This emphasis on “loving them both” certainly had critics within the prolife movement, but this strategy also opened up new opportunities

to restrict access to abortion and revitalized older ones. Specifically, the narratives of women who regret their abortions and the research on abortion's potential harm have been used to pass state-level restrictions on access to abortion, to grow crisis pregnancy centers, and to put a female face on the prolife critique of "choice." Each of these strategies relies, at least in part, on abortion regret narratives and in turn these narratives have been shaped to meet the needs of these strategies.

The shift to incrementalism and the growing importance of women-centered strategies within the movement lead to changes in how abortion regret narratives were deployed and the expertise network concerned with abortion and mental health. As researchers moved from studies based on data provided by women who regret their abortions to studies that utilized large, national databases, new types of expertise emerged on PAS – post abortion healing programs. These healing programs presented alternative conceptions of what it means to be a victim of abortion and to suffer from PAS. And as women who regret their abortions became more aligned with these treatment programs, their regret narratives came to be deployed not in the service of bolstering scientific claims about abortion and mental health, but in providing legal evidence of abortion's harm.

#### The New Shape of Post Abortion Research and Treatment

The use of abortion regret narratives, questionnaires, and clinical anecdotes were central to the development of the diagnostic criteria for Post Abortion Syndrome. However, once that diagnosis was rejected by the professional mental health community, the research on post abortion psychological sequelae changed. As

discussed in much greater detail in the previous chapter, this research shifted from using “post abortive women” as subjects in studies to the use of national databases such as the National Comorbidity Survey and the National Longitudinal Survey of Youth. Furthermore, the emphasis of the research moved from describing and instituting a new mental illness to establishing correlations between abortion and a variety of already recognized mental illnesses, such as depression, generalized anxiety disorder, and substance abuse. This new research on the psychological aftermath is published in peer-review academic journals, rather than through Christian and pro-life books and materials. This transition gave researchers who are critical of abortion more credibility within the scientific community, but it fundamentally changed their relationship with the women who supplied the data for their previous work.

Though the research moved further away from the experiences of women who regret their abortion, during the mid-1990s there was a noticeable increase in the number of post abortion healing programs. These programs are religious-based therapies that have redefined Post Abortion Syndrome as a problem of unresolved grief and guilt that result from a traumatic experience rather than a stress reaction to a traumatic experience. This indicates an expansion of the definition of PAS and perhaps a response to the lack of women interested in taking up the diagnosis. While some of these therapy programs continue to understand PAS as a variant of PTSD, others see PAS as a manifestation of unresolved grief, and all programs characterize their therapeutic goal as dealing with grief. These therapeutic regimes have played a

large role in reshaping abortion regret narratives and understandings of what it means to be a post abortive woman.

Post-abortion healing takes place in three types of programs: one-on-one counseling, support groups, and weekend retreats. There are many women who go through post abortion counseling with a trained peer counselor, a clergy member, or a licensed therapist. Project Rachel, is a post abortion organization that refers women to trained counselors and clergy members, and Post Abortion Counseling and Education (PACE) is a program run through CareNet and its affiliated CPCs that matches women with peer counselors. Additionally, there are several multi-week group therapy programs that are offered through CPCs and churches. Examples of these programs include the 10-week My Abortion Grief, Guilt and Shame Is Ending Soon [sic], the 12-week *Forgiven and Set Free* Bible Study, and the 15-week Rachel's Vineyard Group Therapy Model. Finally, Rachel's Vineyard offers weekend long retreats focused on post-abortion healing. It is not uncommon for women to go through multiple therapy programs. For instance, a woman might elect to attend a Rachel's Vineyard weekend retreat to supplement peer-based counseling. In 2006, Rachel's Vineyard hosted 450 retreats in the United States and the organization estimated that at least 60,000 men and women had gone through either a weekend retreat or the support group program since its founding (2007).<sup>73</sup>

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<sup>73</sup>Post abortion healing programs are predominantly based on Catholic and Evangelical Protestant beliefs about life and abortion. The Jewish Pro-Life Foundation offers a post abortion healing program called Tikvat Rachel, which is a multi-week group therapy conducted via teleconference (2014). To the best of my knowledge, there is no post abortion healing program designed for Muslim women. There are secular programs for women who struggle emotionally after abortion such as Exhale, Connect & Breathe, and Pregnancy Options.



Despite the differences between these types of therapies, the structure of the multi-week support groups and the Rachel's Vineyard retreats are very similar. In all cases, women spend the first week or so contemplating their life circumstances, relationships, and values before the pregnancy, then they spend a couple of sessions working through issues related to the pregnancy, the decision to have an abortion, and the abortion itself. The next step typically involves dealing with unresolved grief over the loss of the child and identifying relationships that were damaged by the abortion. Lastly, women accept God's forgiveness for their sins and memorialize the aborted child(ren). In two of most popular programs, *Forgiven and Set Free* and Rachel's Vineyard, the sessions are structured around open-ended questions, passages from the Bible, prayer, and discussion (Cochran 1996; Burke 1995).<sup>74</sup> Often these programs ask participants to complete particular rituals to illustrate abortion's effect on them. According to the Rachel's Vineyard support group manual, in the second week participants are asked to draw a self-portrait that depicts them "as a beautiful creation of God" and "perfect, without blemish" (39). Each week, participants are told to draw in different ways that they have been damaged through sin, bad relationships, and abortion. Each of these programs also concludes with a memorial service. According to the Rachel's Vineyard website, "the Memorial Service is a special ceremony where you can give dignity to the eternal life and memory of your child in heaven. It is a time

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<sup>74</sup> According the Abortion Recovery InterNational (ARIN), over 60% of their affiliates used the *Forgiven and Set Free* Bible Study, and about 15% used Rachel's Vineyard materials. Rachel's Vineyard is targeted specifically toward Catholics, and *Forgiven and Set Free* is the most popular program among non-Catholic Christians.

to bring a precious bereavement doll and placing this symbol of your child to rest in a cradle. It is also an act of entrusting the soul of your lost child to God” (2014).

Each of these programs has a particular definition of Post Abortion Syndrome. Rachel’s Vineyard uses the term Post Abortion Trauma and markets the therapy as an effective treatment for PTSD.<sup>75</sup> Abortion is described as a “life-changing traumatic event” with repercussions that can include “eating disorders, relationship difficulties, reenactments in the form of repeat abortions or other damaging and painful behaviors, substance abuse, chronic or acute depression, suicidal thoughts and behaviors, and parenting difficulties” (Rachel’s Vineyard Ministries 2007:6). Theresa Karminski Burke, the founder of Rachel’s Vineyard, argues that the major symptoms of PAS are similar to the broad symptoms of PTSD: hyperarousal, intrusion, and constriction (2002:109). For example, PAS symptoms of anxiety are associated with hyperarousal, the flashbacks, nightmares, and intense grief reactions around the anniversary date of the abortion are examples of intrusion, and the substance abuse is an indication of constriction (109-110). The therapeutic regime set forth by Rachel’s Vineyard is intended to “facilitate grief work” and to teach “healthy ways to stay connected with and honor the aborted child, rather than continual connections with their child through self-punishment” (33). The symptoms of PAS are considered to be the manifestation of a desire to connect with the aborted child, and often take the form of self-destructive behavior or grief. It is treated through developing healthy ways to grieve and connect with the child. The rituals and Scripture meditations structure treatment

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<sup>75</sup> Burke writes about PAS differently in different settings. The quote that appears at the opening of this chapter frames PAS as an issue of unresolved grief, but the Rachel’s Vineyard website characterizes it more as a variant of PTSD.

because “research has shown that trauma victims respond to a sensory-based treatment model” (Rachel’s Vineyard Ministries 2007: 20).

The *Forgiven and Set Free* therapeutic model is grounded in grieving a major loss rather than in trauma recovery. Modeling her program on Elizabeth Kubler-Ross’s *Five Stages of Grief*, Linda Cochrane, the author of the *Forgiven and Set Free* workbook, argues that women often experience relief, denial, anger, depression, and acceptance following an abortion (1996: 15-17).<sup>76</sup> The symptoms of PAS are associated with different stages of the grief process. For example, Cochrane contends that women in the depression stage of grief are most prone to substance abuse and that nightmares are associated with the denial stage (15-16). The therapeutic regime proposed in *Forgiven and Set Free* is designed to recognize that women are grieving from a past abortion, to facilitate their movement towards acceptance, and to help them come to terms with their loss. By and large, Cochrane sees women who struggle after an abortion as similar to women who struggle after a miscarriage or to other individuals who have suffered a major loss (15). Unlike Rachel’s Vineyard, which maintains that women are suffering from a recognized mental illness, *Forgiven and Set Free* draws on a different psychological tradition that normalizes the emotional aftermath of loss.

The process of healing after abortion is in many ways similar to therapies designed to help women and men who have experienced pregnancy loss. As Linda Layne notes, there is an “absence of accepted cultural scripts for how to behave” when

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<sup>76</sup>Kubler-Ross proposed that terminally ill patients typically go through five stages of grief following the news that they will be dying. These stages are denial, anger, bargaining, depression, and acceptance (1969). In the *Forgiven and Set Free* model, bargaining is removed and relief is added.

one experiences a miscarriage or knows someone who has lost a pregnancy (1997). As in post abortion healing programs, the suffering that women experience is thought to result from a lack of social recognition of legitimate loss and the social sanctioning of grief. This grief, according to Burke, is compounded by the fact that society does not recognize abortion as a loss or the “motherhood” of these women. However, the creators of these therapeutic regimes see miscarriage as different than the termination of a pregnancy through abortion. Women suffer from PAS because of the guilt they feel in being complicit with the death of their child. For example, Cochrane argues the grief experienced by post abortive women is different from the grief experienced by a woman who has a miscarriage: “Women who had a miscarriage feel guilty because they don’t know what role they played in their child’s death. Women who choose abortion feel guilty because they do know what part they played in their child’s death” (15).

These two therapeutic regimens also advance particular understandings of why women struggle emotionally after abortion that are based in essentialist ideas about gender. Burke contends that “abortion touches on three central issues of a woman’s self-concept: her sexuality, her morality, and her maternal identity. It also involves the loss of a child, or at least the loss of an opportunity of have a child” (32-33). Post abortion healing programs, in addition to promoting essentialist ideas about women as mothers, also see a return to traditional gender roles as an important step towards recovery. Women are instructed to forgive the partners and family members who may have pressured them to terminate the pregnancy, even those who have not asked for

forgiveness (Kelly 2014). Abortion, according to these programs, is wrong because it causes women to act against their “natural instincts” to create and nurture life. In order to heal, women must come to embrace their intrinsic virtues. This is further highlighted by the way these program encourage men to heal after abortion. Men, too, are instructed to take control of their lives by fulfilling their natural role as providers and protectors of women and children (Kelly 2014).<sup>77</sup>

In summary, two of the most popular post abortion therapies offer different understandings of PAS. Though both Rachel’s Vineyard and *Forgiven and Set Free* see unresolved or disenfranchised grief as a major contributor to Post Abortion Syndrome, *Forgiven and Set Free* characterizes grief as the central component of the psychological aftermath of abortion and Rachel’s Vineyard draws on previous understandings of Post Abortion Syndrome as a variant of PTSD. Rachel’s Vineyard continues to see PAS in a much more medicalized way; women are suffering from a mental illness. In many ways the course of treatment for both of these organizations is quite similar despite these differences. Women who go through these programs are asked to come to terms with their involvement in the death of their child and to seek forgiveness from God for this sin. As PAS syndrome became a disease only recognized within the prolife community, these treatment regimes have been a central influence on post abortion narratives and the identities of women who have come to regret their abortion.

### Re-emergence of Post Abortion Organizations

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<sup>77</sup> This treatment regime is also found in reparative therapy programs for homosexuality in which men and women are taught to behave in accordance with traditional gender roles in order to overcome same-sex attraction (Robinson and Spivey 2007)

In the fall of 1976, Georgette Forney, a Michigan teenager, had an abortion at a Detroit clinic. Because her parents did not know about her pregnancy, Georgette spent her recovery time at her sister's house. She recounted, "And as soon as my abortion occurred, I basically went into denial and shut down about it. And I lived like that for 19 years" (Interview 2011). In 1994, Georgette was cleaning out boxes in her basement and came across the yearbook from her junior year in high school. As she put it:

I picked it up, thinking I'd take a quick stroll down memory lane, but something strange happened. Instead of opening the book and seeing the kids' faces, the yearbook felt like a baby, my baby. I knew instantly it was my child that I had aborted. I knew she was a little girl. I could feel her resting in my hands. And I knew that I had missed out on parenting a wonderful person, who would have brought a lot of joy into the world (SNM website).

Georgette began to grieve for the child she aborted and went through the *Forgiven and Set Free* Bible Study. She recounted, "As I went through the program I began to understand what forgiveness and repentance is all about. For the first time I knew God loved me and that through Jesus' death and resurrection, He forgave me, and I was able to forgive myself. I also understood that my child was in Heaven with God, and she forgave me too" (SNM "Campaign Videos" 2014). After her recovery, Georgette began to share her story in church and to work as the Executive Director of Anglicans for Life (then NOEL).

Her job put her in contact with many women who were struggling with their past abortions. She recounted that

These experiences changed my opinion about a woman's right to choose abortion. What I have learned from personal experience - and

from thousands of other women - is that abortion does not solve problems; abortion just creates different problems... Women may have the right to choose abortion, but I know abortion is not right for women (“Campaign Videos” 2014).

Her work with Anglicans for Life brought her to Washington, D.C. every January for the March for Life. In 2002, Georgette made a sign that read “I regret choosing abortion” that she carried at the March and held at the steps of the Supreme Court while women from pro-choice groups held a vigil in the same location. During this vigil by pro-choice organizations Georgette held her sign because she wanted to see if they would engage her.

Was there compassion from their side once a woman expressed pain? One woman said, ‘I’m sorry you feel that way.’ The rest of them looked at me like I was a jerk, like I was an idiot, like I was some sort of freak. And that pissed me off because I had bought the Kool-Aid. I had believed that this was a good thing and I could do this and it was no big deal. But it had become a big deal. And not only for me, but for all these other women. And I just really felt like we were duped” (Interview 2011).

Upset that pro-choice groups refused to acknowledge her pain and the pain of many other women, Georgette teamed up with Janet Morana from Priests for Life to launch the Silent No More Awareness Campaign in order to give a voice to women who regret their abortions.

Many of the early post abortion organizations that began in the 1980s had disbanded by the late 1990s. For example, both WEBA and Victims of Choice are no longer viable movement organizations. AVA has continued in affiliation with NRLC, but it functions mostly as a public awareness campaign. In many ways the support group work that these organizations were doing has been subsumed by crisis

pregnancy centers and post abortion healing groups. However, in the mid-00s two new post abortion organizations were founded to collect testimonials and represent the concerns of post abortive women.

Silent No More (SNM), founded in 2002 as a campaign in which “Christians make the public aware of the devastation abortion brings to women and men. The campaign seeks to expose and heal the secrecy and silence surrounding the emotional and physical pain of abortion” (SNM “About Us” 2014).<sup>78</sup> SNM organizes public events where members tell the stories of their abortion and its consequences and collects testimonials from women and men who regret their abortions. The organization has regional coordinators in most states who hold local events. As of July 2012, SMN had held over 1,000 gatherings in 48 states and 10 countries, and over 5,500 men and women have shared their abortion testimonials publicly. The SMN website is also currently home to a database of over 1,600 abortion narratives (“About Us” 2014).

Like previous post abortion organizations, Silent No More identifies three central goals of their campaign – to facilitate healing, educate the public on the harms of abortion, and use the stories of women and men who regret their abortions to dissuade others from having abortions (“About Us” 2014). SNM fulfills these goals by referring out to post abortion healing groups, holding public events where members tell their stories, and making the stories of members publicly available. Additionally, SNM sees advocating for women as a central part of the organization’s mission:

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<sup>78</sup> Silent No More and Rachel’s Vineyard are both affiliated with Priests for Life, a major pro-life organization. Silent No More is a joint project between Priests for Life and Anglicans for Life.



Through their work in abortion recovery and personal abortion experience, the co-founders saw the ongoing need to let the public hear from the many women who regret their abortion and do not believe abortion is a good thing for women. They wanted to show that NOW and NARAL do not represent all women on this issue (“About Us” 2014).

Part of the mission of SNM is to provide a counter-narrative about abortion’s impact on women that challenges NOW and NARAL’s authority to speak for all women on the topic.

Operation Outcry, a project of The Justice Foundation, was founded in 2005 to collect the testimonials of women who regret their abortions in order to use them in legal proceedings. Like Silent No More, Operation Outcry includes post abortion healing in its mission and refers women to various programs that conduct post abortion healing. However, Operation Outcry asks women who submit their stories to declare the details of their narratives to be true under penalty of perjury. This additional authentication allows Operation Outcry to use the testimonials as evidence in court proceedings. In June 2010, Operation Outcry submitted an amicus brief to the Eighth Circuit Court of Appeals that included the testimonials of over 2,000 “women injured by abortion.” Though anyone can submit a Declaration, additional involvement in Operation Outcry (for example, as a state leader) requires the completion of post abortion healing (“Who We Are” 2014).

Both Operation Outcry and Silent No More gather narratives using an online form. The forms collect basic information about the writer (such as name, contact information, etc.) and about the abortion (e.g. the year it occurred, age at the time of the abortion, the state the procedure occurred in, and the type of abortion, etc.). Both

forms also solicit information about the informed consent procedure, inquiring whether the writer felt adequately informed about the nature of abortion and the consequences of the procedure. The Operation Outcry form also asks for information about whether or not the writer was informed of the link between abortion and breast cancer and whether the writer has had breast cancer. Additionally, both forms request information about who was involved in the abortion decision and whether the writer was pressured or influenced into choosing abortion. Finally, both forms provide a structure for the narrative. SNM asks the writer to address why they had the abortion, the experience during the procedure, how the writer felt immediately after the abortion, how those feelings changed as time went on, and how the writer found “help and forgiveness” (SNM “Join Us” 2013). Similarly, the Operation Outcry form requests that the writer describe how she has been affected personally by abortion, how it affected others in her life, what she would tell a woman considering abortion, and what she would “tell a court that believes abortion should be legal” (Operation Outcry “Declaration” 2011).

### Silent No More

Since 2003, the Silent No More Awareness Campaign has collected over 1,600 abortion narratives from men and women from eleven different countries. In 2011, I took a random sample of 113 from those written by women in the United States (N=1,355). Those narratives were then coded for major themes. In comparison to the earlier abortion regret narratives written by members of WEBA, this sample shares many similarities, but also some striking differences. In general, grievances about

providers, informed consent, and pressure to have an abortion remain the same, as do the common visions for redressing these problems. However, the Silent No More sample clearly illustrates the impact that therapy regimes have had on the concept of the aborted child, the solidification of the “grieving mother” identity, and involvement in the prolife movement.

The abortion regret narratives on the Silent No More website share many of the same grievances about the “abortion industry” as the members of WEBA. For example, there are still many descriptions of the abortion experience as an assembly line. One woman writes, “I felt like I was in a herd of cattle being shuttled in and out.” Additionally, many women reported that they were not given information about fetal development and were shocked to learn later that they aborted a child and not a “blob of tissue.” For example, another woman writes, “There was no talk of a baby. I was shocked when I found out a baby was fully formed at 10 weeks.” Because informed consent legislation is a central component of the incrementalist strategy and women are asked about it in the form to submit their narrative, what women knew or were told when they had abortions features prominently in many of the narratives. It is clear that many women continue to feel that they were not given enough information about fetal development (namely, when a fetus is “fully formed”) and the emotional aftermath of abortion to make an informed decision.<sup>79</sup>

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<sup>79</sup> As an analyst, it is difficult to determine what to make of the claim that women in post abortion organizations continue to report that they were not given enough information. It is safe to assume that most women who seek abortion care understand that they are pregnant and that if they did nothing, they would likely give birth to an infant. However, how much information women are given about fetal development varies by state. This is not the real issue though. Based on my reading of these narratives, the deeper issue seems to be that women who regret their abortions have come to a different understanding of what it means to end a pregnancy (that is, to kill a child) and are rejecting biomedical

Additionally, the narratives from Silent No More are similar to earlier narratives in that many women indicated that they were pressured or influenced by their partners and families to have abortions. In studies conducted by the Guttmacher Institute the most common reasons women give for having abortions are that having a child would interfere with educational goals, that a child would conflict with work or care for existing children, or that they cannot afford to have a child now. Very few women outside of post abortion organizations report that their families' or partners' desire for them to terminate the pregnancy was the most important reason (Finer et al 2005). Within abortion regret narratives, however, a partner's desire for abortion, pressure from family members, or an absent partner are recounted as reasons for abortion by over half of the women in the sample. In over half of the narratives I analyzed the women recount being pressured or, in the case of some women who had abortions as teens, forced to get an abortion by a partner or a family. The online guide for constructing narratives and many treatment programs, encourage women to express whether they experienced pressure to abort. This trend within the narratives continues to raise questions about the degree to which these women were terminating wanted pregnancies and the extent to which their accounts mirror those of women outside of the prolife movement.

Though issues of consent in abortion provision are still prominent within abortion regret narratives, the purpose that many women identify in speaking out about their abortion has shifted from changing abortion practices to using one's story

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understandings of that experience (the removal of embryonic or fetal material from the uterus). A more cynical interpretation might see the claim of "I didn't know it was a baby" as a mechanism for reducing blame.

as a cautionary tale. For example, women see their accounts as having an impact on women who might be considering abortion to choose another option or as helping women who might be struggling after abortion to find healing. Stacy writes, “I hope that my story will help convince other women out there that their baby is a blessing, not a curse, and to give that little life inside of them a chance to live. They won't regret it.” Another woman, Patti, writes, “I am here in hopes that my testimony will encourage others to find healing and speak out.” This shift in the purported goal of the narrative might be due to two factors. First, many of the forms that guide the construction of the abortion narrative ask women what they would tell a woman considering abortion (as is the case in the Operation Outcry form). And second, some post abortion leaders are concerned about women sharing their stories for “the right reasons,” which primarily is to “help other women” (Interview with Forney2011). These factors might encourage writers to see their potential influence in terms of changing hearts and minds about abortion rather than more overtly political goals of regulating abortion access.<sup>80</sup>

Furthermore, many of the women who regret their abortions and contribute narratives are also involved in prolife activism. The act of writing a publicly available story of one's experiences could be considered a form of activism that all of these women have participated in. Many also describe being involved in more traditional forms of activism. In over a quarter of the narratives in my sample, the writer mentions getting involved with some aspect of the prolife movement. Almost half of

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<sup>80</sup> This finding might be due to the fact that I analyzed the Silent No More testimonials. Given that Operation Outcry testimonials are used specifically to establish injury from abortion, it is likely that those testimonials are more likely to be framed in terms of changing regulation.

those mention volunteering at a crisis pregnancy center. For example, Margaret writes, “The healing I have received and the knowledge and understanding of abortion and its effects have led me into training as a post abortion/crisis pregnancy counselor. Women need to know that abortion is not the only answer to their crisis pregnancy. They and their babies deserve better.” Most women become involved in either counseling pregnant women against abortion or leading post abortion healing groups in their churches or at a CPC. This avenue for activism reflects the ethic of helping other women by using the story of their own abortion experience as a cautionary tale.

The existence of treatment regimes has had a noticeable impact on abortion regret narratives. Of the narratives in my sample, more than a third of the women mention going through a specific post abortion healing program. Of these, P.A.C.E., Rachel’s Vineyard, and *Forgiven and Set Free* are the most common. The influence of these therapies can be seen in a noticeable amount of women referencing their aborted child as being in the hands of God. One woman writes, “After volunteering at my local Crisis Program Center I agreed to attend the post-abortion Bible Study. I was relieved to know that my child is in heaven with his maker and I will meet him someday.”

Another reflects on the relief that she experiences by knowing that her child is with the Lord:

The one and only thing that has really given me comfort over the years is to know that that baby will never suffer and that it is in the arms of Jesus. I have 5 other children and they have to go through trials and hardships but that baby will never feel anything but the perfect love of Christ ... I think about Jesus holding my baby and the pain isn’t quite so bad.

These expressions of aborted children being cared for by Jesus reflects the understandings about PAS and the recovery process of post abortion therapeutic regimes. Expressions about children in Heaven were much less common in earlier abortion regret narratives.

### Women's Understandings of PAS

Despite the prevalence of post abortion therapies in women's narratives, PAS and PTSD do not feature prominently in the testimonials. Though most women recount emotional problems like depression, substance abuse, and promiscuity that are listed as symptoms of PAS, very few use the diagnosis in their narratives. In my sample only six women referred to PAS or to PTSD. Many women also recounted feeling that their emotional responses were "normal" or "typical" of women after abortion. For example, Nina writes, "For many years, I thought that there must be something dreadfully wrong with ME, because I was so sorry for what I'd done, but as I talked to more and more post-abortive women, I realized that almost everyone regrets that choice." Rather than seeing themselves as afflicted with a distinct mental illness, most of the women in the sample write about experiencing a variety of problems in the months and years following their abortion that stem from guilt over abortion. This indicates that women who struggle after abortion are not particularly interested in receiving a medical diagnosis or considering themselves to be sick or unusual.

Post abortion support groups differ from other reproductive support groups in their relative lack of engagement with medical professions and institutions. For

example, considerable tensions arise in many post-partum support groups over the extent to which members should accept medical understandings and interventions of maternal depression. As Taylor recounts some women were eager to understand post-partum depression in terms of biomedicine and saw great promise in pharmaceutical treatments while others favored social explanations for their difficulty and wanted to avoid medical interventions (1996). Why would women suffering from PAS feel differently? One possible explanation is that there is no dispute about the etiology of PAS that divides experts. Since PAS is not recognized as a mental illness, there is no group of psychologists or psychiatrists that argue about whether it is caused by hormonal or biochemical imbalances versus stress brought on by the procedure and the social stigma surrounding it. In many ways, women in post abortion organizations have had more control over the meaning of their “disease”. Another possible reason is that there is not a strong desire among women suffering from PAS for medical intervention. By and large, these women contend that their emotional well-being has been improved through treatment in post abortion healing programs, so they do not need doctors or psychologists to treat them.

There is also some evidence that part of the message of the prolife movement has been incorporated into the identities of post abortive women, particularly that they killed their child. Many of the women refer to themselves as murderers and see themselves as complicit in the killing of their child. For example, Stacie writes, “I still wish I could go back and have my babies. I know they're in heaven with their Heavenly Father and I hope one day I will be able to see them again. It is rare for a



day to go by without me thinking about the babies that I helped murder. That's what abortion is....murder." Another recounts that "Six months after I gave birth I became a Christian and the Lord began to reveal that I had murdered my own child and I sought His forgiveness." Within the narratives, some women immediately realize they have "killed a child" and experience guilt, whereas other women only realize that they have "killed a child" after hearing a sermon about abortion, coming into contact with a prolife organization, or after the live birth of a child. While the narratives are certainly shaped by prolife understandings of abortion, these different moments of understanding the immorality of abortion do not provide much evidence that prolife rhetoric causes these emotions. However, the prevalence of women who see themselves as murderers suggests that acknowledging and repenting for the sin of abortion is a central component of the victim identity.

Finally, while leaders of post abortion organizations have indicated that the stories of women who regret their abortions provide a counter-narrative to the claim that prochoice organizations represent the interests of women, the narratives only bear this out partially. And, despite leadership claims that post abortion organizations represent the "true" voice of feminism and protection of women, the narratives demonstrate that members are not particularly interested in "taking back" feminism. Many of the writers rely on essentialist understandings of femininity to explain why abortion is harmful to women. Margaret writes, "I decided to have my abortions because of shame, fear, ignorance and panic [,] not a sensible basis to make any life changing decision. No human being, especially a woman, can make such a choice

without nature hitting back.” And Nina writes, “Any mother in the animal kingdom has more maternal feeling than I had. Mother birds risk their lives luring cats away from their nest, a mother fox will fight to the death for her kits, but I just couldn’t be bothered.” Additionally, many of the post abortion recovery programs claim that a woman’s pain after abortion stems from going against her maternal instinct and harming, rather than protecting, her child. These understandings of gender and motherhood are also present in the abortion regret narratives.

In some instances, women do write critiques of pro-choice arguments and feminism. This is mostly to illustrate how abortion providers take advantage of women by not disclosing information about fetal development and the potential emotional aftermath of abortion. One woman, Debbie, offers this critique: “Today, I cannot understand WHY the pro-women advocates will not take a serious look at abortion. Abortion is not the answer. Women truly do deserve better than abortion. We deserve to be taken serious when we say abortion leaves scars. Women deserve to know the truth.” Another woman challenges the claim that abortion providers are concerned with women’s well-being:

Silence has been our enemy. Because of silence, so much remains hidden in the abortion industry. Abortion clinics claim to be concerned for the woman's well being but it is women whom the abortion industry exploits! Cashing in on the opportunity, these abortion clinics prey on women and young girls in a crisis situation. They focus in on the woman's fears and hide the true development of the baby. The real risks of the abortion are not shared about the procedure.

Like earlier abortion regret narratives, the challenge to abortion is largely one of critique of medical paternalism and the lack of informed consent. These women feel

that they were not given enough information to make a proper decision or they feel that they were preyed upon by unscrupulous providers.

### From Victims to Victors?

As research on the emotional aftereffects of abortion moved from being based on experiential evidence provided by women to relying on large databases, the shape of the expertise network around PAS also shifted. Researchers who are critical of abortion continued to examine the psychological sequelae of abortion, but did so in a manner that was further removed from the lived experiences of women in post abortion organizations. As examined in much greater detail in the other chapters, this shift in methods and data allowed these researchers to gain more credibility within scientific and policy debates. Additionally, another type of expert, the post abortion counselor, grew in numbers and prominence. Post abortion healing programs use the experiential evidence of women to build and illustrate their theories of PAS. In turn, women who go through these programs begin to see their experiences with abortion through that lens.

As new types and configurations of experts emerged, definitions of PAS and the victim identity also evolved. Early prolife research on PAS had characterized it as a distinct mental illness, related to PTSD, but composed of a wide variety of emotions and behaviors. Some of the new treatment programs continue in this vein, but others characterize PAS as response to unresolved grief. This understanding of PAS is much less medicalized than previous iterations and more in line with the articulations of emotional difficulties expressed by women in post abortion organizations. Women

who suffer emotionally after abortion are characterized as “grieving mothers” whose pain is compounded by the lack of social recognition of their loss. The treatment for PAS is based in conservative, religious understandings of abortion, gender, and motherhood. The language of these treatment programs has largely been taken up in abortion regret narratives, indicating that these therapeutic regimes have come to play an important role in shaping the victim identity.

The reshaped expertise network and new understandings of PAS also contributed to deploying abortion regret narratives in new ways. Up until the mid-1990s, the argument that abortion is harmful was used primarily as an internal frame to recruit members (Siegel 2008), and abortion regret narratives were deployed to illustrate the immorality of abortion and to counsel women facing unplanned pregnancies against the procedure. As prolife leaders began to see the potential of women-centered strategies to gain public support for more restrictions on abortion, the narratives began to be deployed in new ways and gave post abortive women a greater role in the movement. According to Georgette Forney, leaders within the movement have come to embrace organizations like Silent No More. As she recounts:

The leaders in the movement, especially like Family Research Council, Americans United for Life, National Right to Life, they have firmly endorsed and encouraged and partnered with the campaign...And in 2007, we were all meeting in Washington and they were talking about the women’s message being incorporated into anything and everything we would do. And it dawned on me at that point that we had gotten their attention. And the fact that I don’t go to a meeting, I don’t work with people in which I don’t 98% of the time have them reference how are we meeting women’s needs, not just the babies’ needs (Interview 2011).

The proliferation of women-centered strategies and campaigns focused on the concerns of women in the abortion debate suggest that the mainstream prolife movement is invested in promoting the image that they care about women as well as fetuses.

The incorporation of the concerns of post abortive women also led to new deployment of these narratives to change policy to restrict abortion on the basis of protecting women. For example, the organization Americans United for Life, which writes sample legislation and distributes it to the states, has developed sample bills like “Women’s Right to Know Act,” “Women’s Ultrasound Right to Know Act,” and “Abortion Patients’ Enhanced Safety Act.” All of these bills imposed informed consent measures or regulate abortion procedures at the behest of protecting women. Currently, 32 states require some sort of enhanced informed consent procedure for women seeking abortions. Additionally, abortion regret narratives, particularly those collected by Operation Outcry, have been cited as justification by the Supreme Court for banning a late-term abortion procedure and by numerous state legislatures as evidence that access to abortion should be limited on the grounds that it injures women (*Carhart v. Gonzales* 2007). The deployment of these narratives is explored more fully in the next chapter.

## **Conclusion**

The identities of women who come to regret their abortions are formed through involvement in post abortion organizations, and challenged and revised within

particular networks of expertise that surround Post Abortion Syndrome. The narratives produced by these women indicate that they found meaningful and new understandings of their abortion experiences through hearing the stories of other women and through participation in healing programs. In the first post abortion organizations, women were additionally encouraged to share their stories with prolife researchers who, in turn, used their narratives and survey responses to define PAS, build diagnostic criteria for the disorder, and develop treatment programs to help these women find healing. Ultimately, PAS was rejected as a diagnosis by mainstream mental health professionals who viewed the emotional struggles of women following abortion as a normal reaction to a stressful event or, in more extreme cases, as a result of a pre-existing mental illness. Post abortive women were also largely uninterested or unwilling to take up the diagnosis, seeing themselves as struggling through unresolved grief and guilt rather than a distinct mental illness. And as post abortion healing programs began to proliferate, their definitions of PAS and what it means to be a victim of abortion reshaped how post abortive women came to understand their experiences.

This analysis relies on an understanding of identity that is iterative, or in Hacking's terms, looping (1995). Through the interactions of women who have had abortions with various types of experts and systems of classification, what it means to suffer from PAS is formed and reshaped. While prolife researchers and post abortion therapists certainly have significant power as experts to assert their understandings of PAS, in many cases the women who were being classified took up or resisted these

classifications in different ways. In many cases, the same women who acknowledged suffering from depression or substance abuse following their abortion did not understand themselves as “sick.” This resistance to expert definitions and the failure of PAS to be recognized by experts outside of the movement has allowed women to assert more control over the meaning of PAS.

Beyond the iterative nature of the victim identity, my analysis also demonstrates how identity is formed within particular networks of expertise. Drawing on the work of Eyal (2013), I contend that expertise around PAS is made up of linked “agents, devices, concepts, and institutional and spatial arrangements” (863). As this network changed, so did definitions of PAS. For instance, as post abortion healing programs rose in prominence, PAS shifted from being understood as a novel mental illness to a response to unresolved grief. This new understanding recognized important aspects of the abortion experience for post abortive women (that they were grieving mothers) and also placed diagnosis and treatment of PAS within the jurisdiction of post abortion counselors, rather than mainstream mental health professionals.

This understanding of identity as iterative and co-constructed within networks of expertise expands scholarship on collective identity within social movements and scholarship on patient and health movements. Scholars of social movements have thoroughly demonstrated how collective identity is shaped through participation in social movements (Taylor 1996; Munson 2010; Armstrong 2002) rather than simply being the motivating factor for joining a movement (Blee 1991; 2003). The prolife movement, due to its longstanding existence in American politics, provides a way to

study how identities change over time. And as the movement has begun to make both scientific and moral arguments about abortion, a variety of different experts have emerged that have also influenced how some members understand their identity. Additionally, scholars of health movements have examined the influence of different types of expertise, particularly the expertise of people suffering from illness, in the shape of scientific research (Epstein 1996; 2007; Brown, et al. 2004; Callon and Rabeharisoa 2003; Clarke et al. 2003; Klawiter 2008; Heath, Rapp, and Taussig 2001; Heath 2007). Less attention has been paid to how networks of expertise shape social movements that are not specifically about a disease or illness. Moreover, within the study of social movements the role of various kinds of experts and expertise has not been fully explored. My examination of expertise as a part of social movement processes, such as framing, identity construction, and mobilization, illuminates how experiential and scientific claims can have an impact on the shape and trajectory of the movement.

The abortion regret narratives created by women who come to regret their abortions have also been deployed in different ways as movement strategies and expertise networks have changed. In the early days of the movement, abortion regret narratives were used within post abortion organizations and crisis pregnancy centers to build collective identity and to warn women experiencing unplanned pregnancies of the dangers of abortion. Also, the narratives set an agenda for collective action. The narratives describe the pressures put on women to end the pregnancy and the lack of information about abortion and its aftereffects. The identification of these grievances



and systems of oppression led, in some cases, to concrete action that some within the movement argued would improve the conditions under which women get abortions. More elaborate informed consent procedures, monitoring patients for signs of coercion, and many of the TRAP laws currently being enacted are examples of how prolife organizations address these types of grievances. This deployment has become more prominent as these narratives enter into policy and legal debates over abortion restrictions in the form of evidence. As will be examined in the next chapter, in certain contexts these forms of experiential evidence can be particularly persuasive.

Additionally, I contend that within the larger movement, these narratives of victimhood can be understood as moral guides against abortion (Young 2002), which is also the intended goal of both post-abortion and prolife organizations. Even as prolife organizations adopt incrementalist strategies, they still consider recriminalizing abortion to be their ultimate goal. As victimhood narratives, the stories of women who regret their abortions gesture to the inherent immoral nature of abortion and a call to protect women by ending all access to the procedure. By adopting the victim identity, post abortive women are able to fashion themselves into experts on the immorality of abortion within a movement that under other circumstances would see them as murders. As in the cases of earlier social movements, like the temperance movement, the stories of sinners who have come to see the light can be particularly powerful in convincing a larger audience to support a movement's agenda (Young 2002). Abortion regret narratives function as evidence of conversion within the movement and as

moral guides about the dangers of abortion to a movement audience and to a larger public audience.

Taking up the victim identity is not without consequence. As Francesca Polletta has argued, sometimes victims are seen as lacking agency and as inviting overprotection and paternalism, rather than autonomy and rights (2006). Further, critics of self-help based movements contend that while they can further self-transformation, they do not lead to engagement in changing political institutions (Rapping 1997; Lamb 1999; for greater discussion see Taylor 1996). And political theorists have raised concerns about victimhood movements that aim to achieve protection from state power rather than attempt to have greater access to it (Brown 1995). The women of post abortion organizations certainly run these risks. Leaders of post abortion organizations often assert that through telling their stories, women become empowered and experience a feeling of taking control of their experience rather than remaining a victim of it (Interview with Forney 2011). In many of the narratives, women recount feeling more in control of their lives and assert that post abortion healing programs have greatly improved their mental well-being. And, as I have discussed, abortion regret narratives are used to achieve different goals that span both individual transformation and political action. It remains unclear how much of these personal feelings of empowerment have translated into how these women are viewed within the larger prolife movement. Finally, basing a movement around victimhood can have significant consequences for mobilization. As Polletta argues (2006), recruiting new members to a movement based around a shared victimhood is

difficult as some potential members may not consider themselves to be victims or may not desire to take up the victim identity. Further, a narrative of victimhood may be at odds with a belief that collective action can change things. My examination of the case of post abortion organizations brings into sharp relief the need to attend to the ways that movements might mitigate this effect. For example, the emphasis on healing and empowerment promoted by movement leaders may make mobilization easier, or at least make victimhood a lesser barrier to mobilization than Polletta finds.

Further, the victim identity has significant consequences for abortion policy and regulation. The laws and policies enacted in the name of women who regret their abortions are justified based on the need to protect women from interfering partners and family members as well as clinic staff. In many cases, these types of protection do not make abortion safer for women nor do they protect especially vulnerable women from unscrupulous providers. As I examine in the next chapter, often these policies are based in a belief that women are particularly incapable of making decisions and in need of special protections under the law.

## CHAPTER FIVE: (MIS)INFORMED CONSENT

Between 2011 and 2013 more abortion restrictions were enacted at the state level than in the previous decade. In September 2013 the Center for Reproductive Rights and Justice at the University of California Berkeley School of Law hosted a one day symposium for reproductive rights attorneys, scholars, and activists. The topic of the symposium was the undue burden standard in *Casey*, but it also served as a forum for those concerned with this sharp rise in new laws to take stock and discuss strategy. Of concern for this group was how the legal battle over some of these restrictions (as well as those passed before 2011) had been decided within the federal court system. It seemed that older legal arguments that had been successful for reproductive rights groups in the past were no longer having the same impact and that medical and scientific evidence were not carrying the weight that they had in the past. Specifically, lawyers, activists and scholars were shocked by the way the Eight Circuit Court of Appeals had ignored much of the scientific evidence presented by Planned Parenthood in the decision about a South Dakota law that required abortion providers to inform women that the procedure is associated with an increased risk of suicide and suicide ideation.

Previous chapters have analyzed the scientific controversy surrounding a potential association between abortion and mental illness and the construction of the victim identity among women in post-abortion organizations. While major scientific organizations have concluded that terminating an unwanted pregnancy through a legal

abortion in the first trimester is not associated with an increased risk of mental illness, including suicide, these organizations are not the only arbiters of fact within American society. Access to abortion is largely determined by state-level policies that dictate what kinds of facilities can perform abortion, how abortion for low income women is funded (or not), what kinds of information women must receive before being able to consent, and how long they must wait between consent and the procedure. This chapter explores how one state sought to modify its informed consent procedure in the mid-2000s and to shape future legislation on the basis of an expert review of the practice of abortion.

This chapter examines two different entanglements of science, law, and policy. Drawing on two South Dakota bills passed during the 2005 legislative session, I analyze how scientific arguments about abortion's potential harm to women have shaped informed consent laws and reproductive health policy. One of these bills, HB 1233, established a task force to study abortion practice in the state from 1973 to the present day and to use this information to make recommendations for future legislation. The other bill, HB 1166, modified the state's informed consent law to, among other things, require that women seeking abortions be told that they may be at increased risk for suicide ideation and suicide. HB 1166 resulted in a federal lawsuit that required judges on the 8<sup>th</sup> Circuit Court of Appeals to weigh evidence about these potential risks and determine if the scientific research merited informing women of this risk even if the correlation between suicide and abortion was indirect and possibly due to other factors.

My analysis reveals that both the Task Force to Study Abortion and the federal courts that heard arguments about the informed consent law struggled to define who is an expert, to weigh contested scientific information, and to reach conclusions about how abortion care should be modified to reflect changing understandings about abortion's potential harm to women. In both cases the arguments for and against abortion restriction were presented, at least in part, through the use of scientific evidence and the testimony of medical experts. I contend that by framing their arguments against abortion in terms of health, prolife organizations were able to have a greater impact in policy-making and in having abortion restrictions upheld by courts. In the case of the South Dakota Task Force to Study Abortion, I argue that the inability of the task force members to adhere to any standards of evidence or definition of expertise ultimately resulted in the prolife committee members using the proceedings to legitimate their political goals. Further, the use of the health frame by the prolife representatives in conjunction with the experiential evidence provided by a large quantity of abortion regret narratives submitted as evidence allowed the task force to frame their policy recommendations as both scientifically sound and as in the service of a vulnerable group of citizens.

In the legal dispute of *Rounds v. Planned Parenthood of Minnesota, North Dakota, and South Dakota*, the use of scientific evidence by prolife groups and witnesses had a slightly different impact.<sup>81</sup> In court proceedings and decisions, judges

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<sup>81</sup> Within scholarly literature on this legal dispute, the initial ruling of the three judge panel of the Eighth Circuit Court of Appeals is referred to as *Rounds I* and the full panel ruling on the suicide advisory is known as *Rounds II*. In this chapter, I use the phrase the *Rounds* cases to denote both *Rounds I* and *II*.

were tasked with sifting through conflicting findings concerning a somewhat unresolved scientific controversy over abortion and mental health. The judges were frequently unable to or uninterested in evaluating the relative merits of each side's scientific claims. I found that the conflicting scientific arguments resonated with two distinct views of science and governance. Some justices contended that in the case of scientific uncertainty elected officials and legislatures were the best judges of what laws and regulations were necessary. Other justices asserted that evidence of emerging scientific consensus around abortion and mental health should be the guide for determining which restrictions on the procedure are needed.

The chapter begins with a discussion of relevant literatures including scholarship on social movement impact and framing, science and technology studies work on expertise in policymaking, and a history of informed consent. Then I move into the legislative process that generated HB 1233 and HB 1166 as well as their outcomes and consequences. The evidence presented in this chapter is based on an analysis of government documents, legislative hearings, legal decisions, and local newspaper reports about these two laws enacted in the state of South Dakota.

### **Social Movement Impact and Framing**

Scholars of social movements have paid a great deal of attention to issues of mobilization and collective identity formation, but less scholarship has focused on movement “success” or the impact movements have on the media, institutions, or political systems (for exceptions, see Giugni, McAdam, and Tilly 1999; Moore 2008;

Amenta et al 2010). Social movement success is difficult to define. Measuring whether or not a movement achieves its stated goals does not reflect the unintentional change that a particular movement might cause or address how goals shift over time (Giugni 1999). One measure of social movement success is how much the movement is able to change or influence policy (Giugni 1999; Amenta 2014). Others have pointed out that the focus on policy impact ignores some of the other ways social movements succeed, for example in collective identity formation, raising awareness, or shifting cultural values (Epstein 2007b). In the case of the antiabortion movement, focusing on policy influence is an important, though not singular, measure of the movement's success. As a movement that has sustained itself for over forty years and become increasingly professionalized, organizations within the movement like Americans United for Life and the NRLC focus on writing legislation and shaping policy in order to ensure that movement goals are enshrined in law and have a lasting institutional effect.

Simply writing legislation that is adopted in various states does not adequately explain how social movements impact political processes. The ways in which social movements frame their arguments can have a significant impact in convincing policy makers and changing larger cultural understandings (Benford and Snow 2000; Cress and Snow 2000; Reese and Newcombe 2003; McCammon et al. 2007; Amenta et al 2010; Amenta 2014). However, much of the literature on framing in social movements has focused on initial framing of grievance and goals, getting movement members to buy into particular frames, and on mobilizing participation in movements (Snow et al



1986). The role of framing in social movement impact as well as how framing shifts to address countermovement tactics are less studied (Cress and Snow 2000; Reese and Newcombe 2003; McCammon et al. 2007; Amenta et al 2010).

Studies that examine the relationship between social movement framing and outcomes have found that articulate and precise framings of grievances and goals are central to successful policy outcomes (Cress and Snow 2000). Additionally, movements develop frames that are not only instrumental in the sense that they are designed to fit into the sociocultural context of debates and the landscape of political opportunities but also expressive of the movements core values and beliefs (Reese and Newcombe 2003). As Holly McCammon and her colleagues have argued, “movement frames and the political and cultural environment in which they are expressed *work in combination* to produce a movement’s desired political outcome” (2007: 726 original emphasis). The authors also found that frames that draw on hegemonic discourses like legal principles and traditional gender beliefs were more likely to be associated with successful outcomes.

Beyond the importance of social and cultural context in which frames are deployed, there are also movement and countermovement dynamics that effect how social movements construct frames. During the early years of the abortion debate, it was understood that the prolife movement framed their opposition to abortion in religious or moral terms and prochoice organizations often used legal and medical arguments to frame their support of abortion rights (Condit 1990). In her analysis of the “partial-birth” abortion debate, Anne Esacove argues that while both sides

maintained their expected style of reasoning, the debate over how to frame partial-birth abortion was dialogical or evolving through interaction between proponents and opponents (2004). While it is clear that the prolife and prochoice movements alter strategies and frames in response to political opportunities, changing movement dynamics, and each other, I have argued throughout this dissertation that the prolife movement has increasingly begun to frame their opposition to abortion through arguments about abortion's impact on women health that are largely based on contested scientific claims. I build on Esacove's concept of dialogical framing by illuminating how prolife organizations have attempted to co-opt the health framework favored by the prochoice movement. That is, both sides of the debate are framing their opposition to or support of abortion rights using arguments about health.

Within debates about abortion restrictions, both the prolife and prochoice movements must develop frames within a particular discursive opportunity structure (Ferree 2003) that includes beliefs about gender, cultural ideas about abortion, and longstanding legal principles. Though both sides use a women's health framework, the larger discourses that these arguments draw on are quite different. Prochoice groups tap into legal principles of freedom of speech and privacy while prolife groups frame their arguments in terms of state's rights. Additionally, prolife organizations tend to characterize women in more conservative terms that depict women as inherently maternal and as unreliable decision makers who need protection. In contrast, prochoice groups describe women in more liberal terms and argue that women need greater freedom from state interference with their medical decision making. Moreover,

these arguments about abortion take place in a cultural context in which abortion is highly stigmatized (Joffe 2010). Finally, the women's health framework is also supported by scientific claims and experts from both prolife and prochoice organizations. Prochoice groups emphasize the large body of research that indicates that abortion is generally safe and not associated with increased risk of mental illness, breast cancer, or infertility. They draw attention to scientific consensus about these issues and the official positions of both government institutions and professional organizations. Prolife organizations call into question the certainty of these scientific findings and support their claims with highly contested scientific research. The inclusion of the role of scientific claims and expertise into the study of social movement framing and impacts expands on previous research on social movement framing and impact.

In this chapter, I examine how the co-opting of the health framework has a significant influence on how well the prolife movement is able to persuade key decision-makers, namely judges and policy-makers to support greater restrictions on abortion. I contend that this strategy allows the prolife movement to have a greater impact on policy in three distinct ways. First, it forces judges and legislators, who are often untrained in medical research, to confront complicated scientific findings and make decisions based on uncertain medical evidence. Often judges and elected officials lack specialized training in scientific reasoning and struggle to determine which results are reliable and can be trusted. Within the context of abortion litigation, medical experts hired to testify on behalf of abortion providers have been seen by

courts as more credible because, unlike medical experts for prolife organizations, they have experience in abortion provision. The legal battle over the federal ban on “partial-birth abortion” marks one of the first occasions in which the Supreme Court discounted the expertise of abortion providers in favor of medical arguments presented by doctors associated with the prolife movement. Second, it resonates with larger discourses of governance, particularly public health and women’s health issues, that policymakers are invested in. When scientific evidence is presented as uncertain, elected representatives and judges may see increased regulation of an industry as either part of their duty to protect citizens or, in the case of judges, may consider democratic institutions to be better suited for representing the interests of the public. And finally, it works with the experiential evidence provided by post-abortion organizations to frame abortion restrictions as not just general protections for women’s health, but also as helping a particular group of victims. Anecdotal or experiential evidence provided by women who regret their abortions can tip the scales in favor of less accepted scientific knowledge, particularly when the experiential evidence confirms deeply gendered understandings of what women should feel like after an abortion.

### **Science, Law, and Policy**

Within STS, many scholars have focused on the entanglement of science, law, and policy, especially around the issues of expertise and evidence. Both law and science are powerful, authoritative, and generally respected arbiters of fact and truth in

our society. Sheila Jasanoff argues that both law and science claim “an authoritative capacity to sift evidence and derive rational and persuasive conclusions from it” (1995:8). And while both are governed by rules for evaluating evidence and making decisions based on these evaluations, those rules are quite different. We tend to view scientific inquiry and fact-finding as ostensibly governed by the scientific method which values testability, impartial analysis, and critical review of results. Fact-finding within courts is based on the Federal Rules for Evidence which guide judges in deciding which evidence is relevant. Courts also weigh evidence through the adversarial system of cross-examination, which challenges the testimony and credibility of expert witnesses. However, scientific practices and legal proceedings are much more complicated.

Though the concept of a unified science can be politically or ideologically convenient, in practice what we think of as science is composed of an array of different methods, theories, and disciplines (Galison 1996). Karen Knorr Cetina has demonstrated that disciplines can have their own epistemic cultures that are distinct from other scientific disciplines’ practices and ways of knowing (1999). Law, too, is made up of different branches and areas of specialization (e.g. criminal, civil, intellectual property) that are guided by specific practices and standards. While there are shared rules for evidence, the implementation of those rules can vary widely by specialization and region (Jasanoff 2004).

The scientific questions and evidence that courts must contend with are also dependent on context. For example, in criminal proceedings, scientific questions are

typically focused on the reliability of certain technologies and practices, such as fingerprinting, DNA comparison, and lie detecting (Cole 2001; Lynch 2003; Lynch et al 2008; Adler 2007). The task of establishing causality are often at the heart of civil law proceedings (Angell 1996). Determining whether a pharmaceutical drug or medical technology is responsible for the adverse effect experienced by a plaintiff is just one example of this. In these types of cases, legal determinations often have to be resolved before scientific evidence about causation has been conducted and evaluated. Courts are left to make these decisions based on uncertain science (Jasanoff 1995 and 2001). This can lead to problematic outcomes. For example, in the case of silicone breast implants, Marcia Angell contends that juries awarded monetary damages to plaintiffs even though scientific research eventually determined that these implants were safe and not causally linked to adverse outcomes (1996). Legal disputes over abortion restrictions in the United States are argued within the context of constitutional law due to the unique history of the procedure's legalization. This means that scientific arguments about abortion's potential harms are made alongside other powerful arguments about privacy, speech, and governance. As I demonstrate in this chapter, in the *Rounds* cases scientific research was often used by judges to support particular understandings of science and governance.

Scholarship on the role of expertise in science, law, and policy has largely focused on expert witnesses. Tracing the history of experts in the courtroom, Tal Golan, argues that our modern conception of the expert witness derives from the proliferation of civil litigation under the rule of the Stuarts in England (2004: 21).

During this time period, the credibility of expert witnesses was tied to their status as gentlemen and the code of honor that assured their honesty and unbiased opinions in the eyes of the Court (50). Over time, Golan asserts, this credibility was undermined through the adversarial judicial process which pitted experts on one side against experts on the other as well as financial compensation of expert witnesses. In the United States, the decision in *Frye v. United States* set the first guidelines for the use of scientific evidence. The *Frye* decision held that expert testimony presented in court must be generally accepted within the scientific community (Golan 2004). Later the Supreme Court's ruling in *Daubert v. Merrell Dow Pharmaceutical* (1993) established our contemporary standards for scientific evidence allowed in the courtroom and permitted to be presented by expert witnesses. The factors that trial judges are asked to consider when determining the quality and admissibility of scientific evidence are: testability, peer review, error rate, standardization, and general acceptance within the scientific community (263). Sheila Jasanoff writes that with the *Daubert* decision "the judge's objective in all cases should be to hold scientific evidence to the kinds of standards that scientists themselves would apply under the circumstances" (2001: 29). However, Jasanoff also notes that this gives judges considerable discretion (and very little accountability) in determining who is an expert and what scientific evidence is admissible (2001). Judges may have experiential biases for or against particular scientific findings that can influence what evidence presented to a jury. Or a judge may overestimate the power of cross-examination to establish credibility, thus allowing unqualified experts to testify.

Beyond issues of admissibility of evidence, scholars of science and the law note that there is considerable variation of how judges and lay juries evaluate scientific evidence (Jasanoff 2001; Angell 1996; Foster and Huber 1997). Some scholars have contended that juries are especially ill-equipped to understand and weigh scientific evidence, particularly against the testimony of sympathetic plaintiffs (Angell 1996). Others have argued that judges are often equally unsuited for determining which scientific findings are most reliable and relevant to the case (Jasanoff 2001; Foster and Huber 1997). These concerns are even more pronounced when courts must make decisions about uncertain or unsettled science. In my analysis of the *Rounds* cases, I contend that even when dealing with relatively certain scientific information, the Eight Circuit Court of Appeals struggled to determine whether the regulations on abortion passed in South Dakota contained truthful and non-misleading information. I argue that ultimately the Circuit Court was divided by different views of science and governance. The majority in *Rounds II* argued that in the face of uncertainty in the scientific community, legislatures and elected representatives were the best judges of what regulations were necessary. Conversely, the dissent in the case asserted that expert opinions and the positions of scientific institutions should be granted more weight when considering what information doctors can be compelled to give their patients.

### **Informed Consent**



Much of the debate in about South Dakota's abortion laws is centered on what information a medical provider must give women about abortion and its effects for the procedure to be considered voluntary and informed. Informed consent within medical research and practice has a history that dates back to ancient Greece, but our contemporary understanding of consent was primarily developed after World War II (Rothman 1991). In light of Nazi atrocities in Europe and instances of abuse of research subjects in the United States, formal federal guidelines for medical and scientific research involving humans were developed that requiring that participation in research be voluntary and based on adequate information (Rothman 1991; Belmont Report 1979). Within medical practice, standards for informed consent have been largely grounded in professional codes of ethics (such as those outlined in the American Medical Association's Code of Medical Ethics) and in state statutes and case law. Professional standards require doctors to tell patients, when possible, their diagnosis, information on the proposed treatment including the risks of benefits, alternative to the proposed treatment including the risk and benefits of the alternative treatment, and the risks and benefits of not receiving treatment (AMA Guidelines for Informed Consent). State laws regarding informed consent typically adopt one of two standards, the reasonable physician standard or the reasonable patient standard. The first requires doctors to give patients information that a "reasonable physician" would find relevant and important, the second requires that the patient be given information that a "reasonable patient" would find relevant and important to making decisions about their own health. In many cases, the specific information disclosed to patients is

not the subject of legislation, rather it is determined by professional guidelines, the doctor's judgment, and, increasingly, the mechanics of preparing informed consent forms which patients sign to limit the physician's liability.

In certain cases, states have introduced legislation that regulates the informed consent procedure further. For example, during the 1980s, twenty-two states introduced legislation that specified a particular informed consent procedure of breast cancer patients (Montini 1996). These laws, which were enacted in sixteen states, required physicians to give a woman diagnosed with breast cancer information about the various treatments that were available and to gain her specific consent before treatment began (1996:9). This type of legislation was seen as necessary by breast cancer activists and former breast cancer patients who were pressured to undergo a very aggressive form of cancer treatment - typically, a double mastectomy – without discussion of alternative treatments that may have been equally effective, but less invasive (1996). Similarly, informed consent for sterilization procedures funded through Medicaid are federally regulated and require a thirty day waiting period between giving written consent and having the procedure (Health Consumer Alliance 2007). These types of regulations were designed in response to past (and ongoing<sup>82</sup>) sterilization abuse of the poor, the institutionalized, and minorities, particularly women. As these two cases illustrate, legislatures intervene into informed consent procedures to guarantee protection for groups considered to be vulnerable to pressure

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<sup>82</sup> According to a report by the Center for Investigative Reporting, 148 female inmates in California prisons were sterilized without proper state approvals between 2006 and 2010. Many of the women claim that they pressured or coerced into getting the procedure (Johnson 2013)

or coercion. Women, especially in regards to their reproductive health, have often been included within this group.

Abortion informed consent laws are also typically justified on the basis that women seeking the procedure are vulnerable and the state has an obligation to ensure that their decisions are informed. In *Casey v. Planned Parenthood of Southeastern Pennsylvania* the Supreme Court upheld most of Pennsylvania's restrictions on abortion, including a law that required a woman seeking abortion to give her informed consent and be provided with certain information at least 24 hours before the procedure (1992). The Court argued that this restriction did not present an "undue burden"<sup>83</sup> upon the woman seeking the procedure, and was a legitimate use of state power to "ensure that this choice is thoughtful and informed" (1992: 872). Further states "are free to enact laws to provide reasonable framework for a woman to make a decision that has such a profound and lasting meaning" (872). As in the examples of breast cancer treatment and sterilization, the decision to undergo abortion is seen as having "profound and lasting meaning" that provides a basis for state regulation of informed consent procedures to protect women. However, unlike those examples, abortion restrictions are generally not enacted to address the damage of previous ethical transgressions by doctors and institutions. While prolife activists contend that

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<sup>83</sup>The Court developed the "undue burden" standard in *Casey* and it remains a vague legal concept that lower courts struggle to apply. An undue burden is defined as a law that's "purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability" (1992: 880). In *Casey*, the requirement that a married woman obtain her husband's consent before undergoing an abortion was ruled to be an undue burden, but the requirement that a minor obtain her parent's consent was not.

women often report being forced or coerced to undergo abortion (The Elliot Institute 2010), there has not been evidence of systematic abuse.

The Court also addressed issues of informed consent and regret when deciding the constitutionality of a federal law banning a specific medical procedure, the intact dilation and extraction in *Carhart v. Gonzales* (2007). Citing only an amicus brief submitted by The Justice Foundation on behalf of Susan Cano (Doe in *Doe v. Bolton*), Justice Kennedy argued that

Respect for human life finds an ultimate expression in the bond of love the mother has for her child.... Whether to have an abortion requires a difficult and painful moral decision. While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow... The state has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form (2007: 159-160).

In this decision, the Court moves from considering informed consent to be necessary to ensure that the decision to terminate a pregnancy is “thoughtful and informed” to viewing informed consent as a mechanism to protect women from making a decision they may later come to regret.

In fact, legal scholars argued that the *Casey* and *Carhart* decisions represent a shift in how the Court understands women as patients (Siegel 2008; Tobin 2008; Turner 2008; Manian 2009). Unlike previous decisions about abortion informed consent laws, in which courts struck down laws that contained information designed to

dissuade a woman from choosing abortion, in *Casey* the Court ruled that such information was allowed to help women make more thoughtful and informed choices (Manian 2009). Maya Manian argues that this shift marks a departure from the Court seeing women as similar to other patients who need informed consent laws to protect and preserve their decision-making autonomy to seeing them as “irrational” decision-makers who need to be protected from making decisions they may come to regret (2009). Also, these decisions preserve sexist understandings of women as particularly naïve about reproductive and medical issues.

Following the *Casey* ruling, many states began to enact law that outlined the requirements for consenting to an abortion. Initial laws typically specified scientifically and medically uncontested information such as medical risks associated with the procedure, gestational age of the fetus, and information about alternatives to abortion such as adoption and parenting. In many cases these law required women to be offered or to receive state prepared materials and included a 24-hour waiting period between consent and the procedure. Over time state informed consent laws began to include scientifically and medically contested information, like information about the potential for the fetus to feel pain and possible associations between abortion and mental illness and breast cancer. Often states passed informed consent laws that required state-produced written materials to be given or made available to women considering abortion. In Kansas, North Carolina, Texas, and West Virginia, these materials contain medically inaccurate information linking abortion to future infertility, increased risk of breast cancer, and increased risk of mental illness

(Guttmacher Institute 2014a). Using written materials allows restrictive states to deliver an antiabortion message to women, while not requiring physicians to give women medically inaccurate information during a discussion of the procedure.

In addition to greater inclusion of medically and scientifically contested information, states have also begun to impose more obstacles for women seeking abortions. Both Utah and South Dakota recently passed laws requiring a 72-hour waiting period between the giving of consent for an abortion and being able to obtain the procedure (Guttmacher Institute 2014a). Texas passed a law mandating that women attend a course on adoption before being able to consent to an abortion (Guttmacher Institute 2014a). And South Dakota is currently defending a state requirement that women receive counseling at an antiabortion pregnancy help center before having an abortion (Guttmacher 2014a). Each of these new laws is currently being contested in courts.

An examination of the informed consent laws is important because it represents an arena of contestation among both sides of the abortion debate, researchers and scientists, policymakers, and legal authorities. These laws highlight tensions between the authority of physicians and the desire of the state to “protect” women, patient autonomy and paternalism, and science and the law. The 2005 revision of the South Dakota informed consent law and the state’s task force not only are illustrative of these tensions, but also provide an opportunity to examine how policymakers and courts balance these tensions and apply the “undue burden” standard to a new law. Additionally, this case provides an opportunity to examine how

determinations about scientific knowledge and gendered understandings of women as decision-makers and mothers work to justify restricting access to abortion.

### **Why South Dakota?**

South Dakota is an ideal case to study the entanglement of science, law, and policy within the contemporary abortion debate. As discussed in a previous chapter, during the first part of the century many states with conservative governors and legislatures began to push through increasingly restrictive abortion laws. By the opening of the 2005 legislative session, South Dakota had already instituted a parental consent law, reporting requirements for medical facilities performing abortions, a record of each abortion performed in the state, and an informed consent law that mandated a 24-hour waiting period between being given the state's consent information and when the abortion could be performed (South Dakota Codified Law Chapter 34 2014). These restrictions all fall within the boundaries set in *Casey*, which indicates that South Dakota was in league with other conservative states, but not the most restrictive.

Additionally, the legal skirmishes over abortion in South Dakota mirror a central tension within the larger abortion debate between purists and incrementalists, which was discussed in more detail in Chapter One. Using South Dakota as a case allows me to illuminate how these divisions affect state-level abortion restrictions and how incrementalist victories are often parlayed into more purist attempts to ban all abortions. In other parts of the United States, incrementalist strategies dominated

abortion policy between the mid-1990s and the present day. However, in South Dakota purist strategies were pursued alongside incrementalist legislation. For example, in 2004, 2006, and 2007 the state legislature voted to ban almost all abortions in the state, a policy strategy favored by purists that presents a challenge to the Supreme Court to overturn *Roe v. Wade*. These bans were ultimately unsuccessful. One was vetoed by the Governor and the latter two were overturned in voter referendums. But they were enacted during the same period in which the state legislature was also revising the informed consent laws and assembling a task force to study abortion in the state. Ultimately, the incrementalist legislation was more successful, but antiabortion politics in South Dakota represents the larger U.S. antiabortion movement more accurately than states that abandoned purist strategies during this same time period.

Finally, the debate over abortion restrictions in South Dakota in the mid-2000s allows for an analysis of two types of entanglements among science, law, and policy. In 2005, the South Dakota enacted a law that revised the state's informed consent law to require doctors to inform women seeking abortions that they faced an increased risk of suicide ideation and suicide as well as a bill that formed a task force to study abortion, including issues of informed consent, and make recommendations for future laws and policies. The task force's struggles to define expertise, adopt standards for evaluating evidence, and come to policy recommendations highlight the tension between science and politics and the challenges of citizen participation in health policy decisions. The revision to the state's informed consent law was the subject of a



seven-year legal struggle that compelled federal courts to make decisions about the evolving scientific and medical understandings about abortion's potential connection to mental health struggles. The legal debate about informed consent illuminates the complicated ways in which courts evaluate scientific evidence and make decisions about laws in the face of scientific uncertainty. By examining both the dealings of the task force and the law suit over the informed consent revision, I am able to analyze the role of the health frame and the consideration of experiential evidence in two important forums of policymaking and law.

### **South Dakota Legislation**

In January 2005, conservative legislators in the South Dakota House of Representatives began preparing a series of bills that would restrict access to abortion in the state. In the previous legislative session both the South Dakota House and Senate had passed a bill that would outlaw all abortions in the state except those that were necessary to save the life of the pregnant woman. Legislators had intended the bill to be a direct challenge to *Roe v. Wade* and hoped that its passage would trigger a lawsuit that would require the Supreme Court to revisit the *Roe* decision. This bill had been returned to the legislature by the Republican governor to address some technical details and the revised version failed to pass. Rather than attempting to pass another ban, antiabortion legislators directed their attention at four measures aimed at more strictly regulating abortion providers and limiting access to the procedure. This included an amendment to the parental notification law, a "trigger law" that would

outlaw most abortions if the Supreme Court were to overturn *Roe v. Wade*, an amendment to the state's informed consent law, and a bill that would establish a task force to evaluate the practice of abortion and make policy recommendations. In the following pages, I examine the social and legal trajectory of two of these laws: HB 1166, which amended the state's informed consent law, and HB 1233, which established a task force to review scientific evidence about embryonic development, abortion's potential harm to women, and the socio-economic consequences of abortion in South Dakota. These two bills both prompted scientific experts, concerned lay people, and court officials to engage with contested scientific evidence about abortion's potential harms.

During the legislative process HB 1166 and HB 1233 moved through committee hearing together, were debated together, and ultimately were passed together as sister bills. The purpose of HB 1233 was to establish a seventeen-member task force that would review the practice of abortion since the *Roe v. Wade* ruling in 1973 (2005).<sup>84</sup> The bill charged the task force with studying eight different areas of concern about abortion including new knowledge about fetal development and behavior, whether a fetus experiences pain, and the societal, economic, and ethical impact of legalized abortion. With regard to concerns about abortion and women, the task force was asked to determine whether the decision to undergo an abortion is “voluntary and informed,” the effects and health risks associated with abortion

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<sup>84</sup>When introduced the bill proposed a 15 member task force with six members selected by the Speaker of the House, four selected by the President Pro Tempore of the Senate, and five selected by the governor. The bill was amended by the Senate to give the leaders of the House and Senate six appointees each (Senate State Affairs Hearing 2005).

including “delayed onset of cancer” and “consequent life and socioeconomic experiences,” the nature of the relationship between the pregnant woman and her unborn child as well as if abortion was a “workable method” for waiving the pregnant woman’s right to that relationship, and whether pregnant women who are contemplating abortion are in need of additional protection of their rights. Finally, the task force was also asked to make recommendations about how state laws could be changed to better serve the interest of the state, the mother, and the child.

The task force bill did not generate much debate during legislative hearings. Representatives from Planned Parenthood and the ACLU raised concerns about insuring that the task force would be made up of people from different political parties and people with differing views on abortion. During the initial hearing of the bill in the House State Affairs committee, one representative proposed amending the bill to address this concern by requiring that “those making the appointments shall appoint individuals to the task force who are objective, fair, and balanced in their research, and they shall also coordinate their efforts to ensure that the task force membership includes at least one professional or expert from each of the following fields: obstetrics, neonatology, psychiatry, medical ethics, abortion practice, and sociology” (House State Affairs Hearing 2005). This proposed amendment was defeated because members felt that assuming that the governor and state congressional leaders would not select “objective and fair” individuals was insulting and that including experts from the six proposed fields would take up too many of the task force appointments (2005).

The stated purpose of HB 1166 was to bring the process of consent for abortion to a similar standard as adoption and to reinforce the state’s “reasonable patient” standard for informed consent. South Dakota had an existing informed consent law that required physicians to inform women seeking abortions of “the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, danger to subsequent pregnancies, and infertility” at least 24 hours before the abortion is performed (SD Codified Law 2014). Additionally, the existing law required that women be informed of the approximate gestational age of the fetus, the availability of medical assistance for prenatal care, childbirth, and postnatal care, and the father’s liability for financial support for the child should she choose to carry to term.

HB 1166 changed this existing law in a number of ways. First, it required physicians to inform women seeking abortions that “the abortion will terminate the life of a whole, separate, unique, living human being” in addition to providing them with the probable gestational age of the fetus. Second, the law introduced the language of adoption into the informed consent process by requiring a physician to tell a woman that she “has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota and “that by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated.”<sup>85</sup>

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<sup>85</sup>The bill included a new strategy of bringing the language of adoption into laws about abortion. This strategy was pioneered by Harold Cassidy, an attorney who spent his career representing birth mothers in adoption proceedings, and who helped write HB 1166, and would eventually be part of the legal team to defend it (Blustain 2011). Throughout legislative hearings one of the bill’s sponsors, Representative

Finally, the law outlines additional areas of medical risk associated with abortion about which women must be informed. This includes a description of:

all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected, including: Depression and related psychological distress; Increased risk of suicide ideation and suicide; A statement setting forth an accurate rate of deaths due to abortions, including all deaths in which the abortion procedure was a substantial contributing factor (HB 1166 2005).

Risks such as infection, hemorrhage, danger to subsequent pregnancies, and infertility, which appeared in the earlier version of the bill, also remained in HB 1166.

This revision to the existing informed consent laws illustrates a number of policy strategies within the prolife movement. The bill contains language to establish the “human being-ness” of the fetus as a “whole, separate, unique, living” entity. In recent years, some within the antiabortion movement have moved away from describing the fetus as a “person” and have begun to favor that term “human being.” This represents part of the changing strategies within the movement. While “person” remains a term that is primarily defined within legal and moral terms, the term “human being” has a particular scientific definition. To establish something as a “human being” relies on DNA evidence that the blastocyst, embryo, or fetus belongs to the species *Homo sapiens* rather than some other species. Thus, antiabortion activists are able to demonstrate that the human being-ness begins at the moment of fertilization

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Roger Hunt, claimed that women in adoption proceedings had to appear in “open court” to declare their intent to relinquish custody of a child and assure a judge that they understood the decision. Hunt pointed out that if we require so much to give up custody, surely we should require something similar to be allowed to “kill a child” (House State Affairs 2005).

rather than build arguments around personhood, which is typically not legally granted until after birth.

The bill also outlines specific known and “statistically significant” risk factors associated with abortion including death and mental illness. While the risk of depression appeared in other state’s informed consent laws at the time, the risk of suicide and suicide ideation was unique to South Dakota. This represents a shift in policy strategy to move beyond the parameters of the undue burden standard outlined in *Casey*. One likely explanation for this shift is addition of two new conservative Justices to the Supreme Court in the aftermath of the retirement of Justice Sandra Day O’Connor and the death of Chief Justice William Rehnquist. This new composition of the high court made it more likely for the prolife movement to have legal success with restricting access to abortion.

During Senate and House hearings on HB 1166, legislators mainly heard testimony in support of the bill from South Dakota women who had come to regret their abortion decision. For example, during the House State Affairs hearing, of the eight citizen proponents of the bill, six were women who had abortions, suffered mental distress afterward, and had joined the prolife movement. One was a woman who decided against having an abortion after visiting The Alpha Center, a crisis pregnancy center in Sioux Falls. A local ob/gyn spoke in favor of the bill’s declaration that abortion terminates the life of a “whole, separate, unique, living, human being” based on advances in DNA technology, fetal surgery, and the professional understanding that doctors treating pregnant women are treating “two patients.” There

were no proponents who addressed the veracity of the scientific claims that abortion is associated with mental illness and suicide (House State Affairs 2005). Two weeks later when HB 1166 was debated in front of the Senate State Affairs Committee, proponents of the bill had mobilized a greater number of citizens to address the science of abortion and mental illness. Dr. Elizabeth Shadigian, an ob/gyn and associate professor at the University of Michigan and the former President of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), told the committee that the mental health claims in the bill were true, and provided a review of the published scientific evidence on depression and suicide attempts. Additionally, a post-abortion counselor from The Alpha Center informed the committee that, among the women who go through their program, over half report suicide ideation and over three-quarters admit to “self-punishing” behavior.

Representatives from Planned Parenthood and the ACLU raised concerns about the science behind these claims as well as questions about whether forcing doctors to tell women something they believed to be false was a violation of their rights under the First Amendment (House State Affairs 2005). During the Senate State Affairs hearing, opponents of the bill used three arguments to voice their opposition. First, opponents asserted that the bill restricted doctors too much and required doctors to give patients “scientifically inaccurate” information about abortion’s risks. Second, opponents argued that the law was offensive to women by impugning their decision making abilities. Kate Looby, a representative from Planned Parenthood claimed that it was insulting to assume that women seeking abortions would not understand “what

going on with their fetus” or understand that if they continued the pregnancy they would give birth to a child (Senate State Affairs 2005). Finally, other opponents argued that restricting access to abortion could lead to harmful social consequences such as an increase to South Dakota’s already high rate of childhood poverty.

By the end of February 2005, HB 1166 and HB 1233 had passed in both the South Dakota House and Senate; by the end of March they had been signed by Governor Marion “Mike” Rounds. Planned Parenthood of Minnesota, North Dakota, and South Dakota and Dr. Carol E. Ball filed a lawsuit against the state on the grounds that the informed consent regulations set forth in HB 1166 were unconstitutional, and they were granted a preliminary injunction in June 2005 to prevent the law from going into effect. In August 2005, the South Dakota Task Force to Study Abortion (SDTFSA or “task force”) held its first meeting. By January 2006, the task force recommendations would be used to justify a law that banned abortions in South Dakota except those performed to save the life of the pregnant woman.

### **South Dakota Task Force to Study Abortion**

#### Composition and Format of the Task Force

As outlined in HB 1233, the Senate President Pro Tempore, Speaker of the House, and Governor Mike Rounds made their appointments to the 17-member Task Force to Study Abortion. The membership of this group was unevenly divided between proponents and opponents of abortion rights. Within the “prochoice group” was Kate Looby of Planned Parenthood of Minnesota, North Dakota, and South



Dakota; state Senator Stanford Adelstein, a Republican legislator; Dr. Maria Bell, a gynecologic oncologist and vice-chair of the task force; and Linda Holcomb, a social worker and therapist. Making up the rest of the committee was Dr. Marty Allison, a self-identified prolife pediatrician who served as chair of the task force; state Senator Julie Bartling, co-sponsor of HB 1166 and 1233; Travis Benson of the Sioux Falls Diocese of the Roman Catholic Church; state Senator Jay Duenwald, a long-time member of the NRLC who served as vice chair of NRLC Board of Directors; state Senator Brock Greenfield, Director of South Dakota Right to Life; state Representative Roger Hunt, co-sponsor of HB 1166 and 1233; state Representative Elizabeth Kraus, a prolife Republican; state Representative Kathy Miles, a prolife Democrat; Dr. John Stransky, who was affiliated with South Dakota Right to Life and Center for Bio-Ethical Reform; Dr. Allen Unruh, a chiropractor who founded The Alpha Center with his wife; and Dr. David Wachs, a member of an Aberdeen prolife group. Mr. David Day, a law professor at the University of South Dakota, and state Senator Theresa Two Bulls were also appointed to the task force, but did not attend any of the meetings and did not vote on any of the motions.

The first meeting of the task force was held on August 1, 2005. After reviewing the history and current state of abortion laws in South Dakota, the members turned to establishing a format and procedure to complete the tasks assigned by the legislation. Representative Hunt, the bill's co-sponsor, argued that the intent of the legislation was to "have the Task Force act as a fact finding body" (Task Force Minutes, Aug. 2005). How to go about finding facts, choosing expert witnesses, and

getting feedback from the public was immediately an issue of contention among the members. For example, the bill gave no guidelines to restrict who could be asked to testify as an expert nor did it provide any budgetary allocation to pay for experts to travel to South Dakota to testify. Reuben Bezpaletz, Chief of Research and Legal Services, suggested that a number of advocacy groups involved with abortion would likely be willing to fund travel expenses for expert witnesses. Allen Unruh remarked that many organizations would want to present their position to the task force and would be “willing to pay for that opportunity” (Task Force Minutes, Aug. 2005). That the task force could seek out experts with no ties to either prolife or prochoice organizations was unlikely given the lack of funding and the overwhelming interest by advocacy groups that were willing to pay.

A second point of contention with the fact finding goal was how to evaluate the expert testimony. Linda Holcomb proposed a motion to require that when experts testified about studies and statistics they provide “peer review information with disclosure of financial backing” (Task Force Minutes, Aug. 2005). This would help to ensure that the information was scientifically valid and further the goal of fact finding. Another task force member, Dr. Maria Bell, suggested that “peer reviewed journals, Centers for Disease Control statistics, governmental vital statistics, and the Department of Health” would all be good starting places for “acquiring objective, factual, and scientific information concerning abortion” (Task Force Minutes, Aug. 2005). The motion was defeated because it would limit the amount of testimony that was based on a person’s ideology (Minutes Aug. 2005). Instead the task force

nominated a three-member subcommittee to decide which experts to invite to testify and agreed that for each area of assigned study proposed in the original bill, an expert from each side of the debate would be invited and both would be given equal amounts of time. The task force would also accept unlimited amounts of written declarations/affidavits and information from advocates on either side of the issue.

The decision-making by the task force over how to go about gathering and evaluating evidence and deciding on expert testimony mirrors the adversarial format of expert testimony that has become commonplace within the U.S. legal system (Golan 2004). In this system expert witnesses appear in support of one side within a legal dispute. Their credibility and expertise are examined and challenged through a process of questioning and cross-examination. This is somewhat different from task force hearings or expert reviews discussed in previous chapters, which attempted to gather neutral experts and adhere to scientific standards for gathering and assessing evidence. In those cases, an expert's credibility is primarily established prior to involvement in the review. Additionally, this dispute over peer reviewed evidence sets the task force apart from other adversarial legal proceedings which require courts to adhere to rules of evidence established in the law (Jasanoff 1995). In these ways, the South Dakota Task Force to Study Abortion cuts across conventional categories or organizational types— its goal is to be a fact finding entity, but it adheres to neither scientific nor legal rules of evidence to determine what constitutes a fact.

A third point of contention among the members with regards to the fact finding mission of the task force was how to determine who constituted an “expert.” The task

force distinguished between invited testimony in which the invitee's name appears on the agenda and public testimony that could include members of the public whose names do not appear on the written agenda. However, there was much contention over who among the invitees were experts. This issue was particularly salient as the task force debated how to handle the testimony of women who regret their abortions. While all committee members agreed that women who have experienced abortion should be heard by the task force, there was disagreement over whether to include them as "expert witnesses." Members of the prochoice minorities argued that these women were sharing personal stories and anecdotes, which is different from expert testimony (Task Force Minutes Sept. 2005). However, Dr. Unruh expressed a broader definition of "expert" as "someone who has experienced something" (Task Force Minutes Sept. 2005). During the proceedings, women testified about their personal experiences with abortion during both the "expert" and "public" portions of hearings.

This contention over who is an expert highlights a central tension throughout the task force proceedings about how to weigh the evidence of women's experiences with abortion in comparison to scientific evidence about mental health after abortions. This issue will be discussed in more depth in the following pages. It also raises important questions about the democratization of expertise within politically charged debates. What does it mean when "someone who has experienced something" counts as an expert? Research on lay expertise has found that the evidence of experience from patient movements has forced scientists to think about research and treatment in new ways and to address concerns raised by patients (Epstein 1996; Klawiter 2010). In the

case of AIDS treatment activists, Epstein argues that activists blended experiential claims with claims based on research of the scientific literature in ways that created a *hybrid expertise* (1996). However, the women's accounts of their abortion experiences are not being used in this context to raise awareness about an understudied problem, to provide perspective to health providers or researchers about what it is like to have a particular disease, or to advocate for more or faster treatment research. Experience-based expertise is being used here to further the agenda of one of two political positions.

On September 21 and 22, 2005, the task force heard testimony from national experts on five different subject areas that were derived from the original areas of study outlined by the South Dakota legislature in HB 1233. For each subject area one expert from the prolife side and one from the prochoice side were scheduled to present. Each expert was asked to present their case for 50 or 70 minutes, and once both experts presented there was 30 or 50 minutes for joint questioning. Representing the prolife position was Dr. John Willke, Dr. Priscilla Coleman, Dr. Byron Calhoun, the president of the AAPLOG, Dr. Vincent Rue, and Dr. Martha Shuping. The prochoice position on these issues was represented by Dr. Stanley Henshaw of the Alan Guttmacher Institute, Dr. Marie Harvey, Chair of Population, Family Planning and Reproductive Health within the APHA, Lynn Paltrow, Executive Director of National Advocates for Pregnant Women, Dr. Mark Rosen, an obstetrician anesthesiologist at UCSF, and Dr. Philip D. Darney, Chief of Obstetrics, Gynecology and Reproductive Services at San Francisco General Hospital. Additionally, the task

force accepted written testimony and reports from other national experts and advocacy organizations including leading advocate of the abortion/breast cancer link Dr. Joel Brind (see Chapter Two) and prolife researcher of the negative emotional outcomes that can follow abortion David Reardon (see Chapters Three and Four).

A final point of contention among task force members was the degree to which abortion in South Dakota would be the focus of hearings, as opposed to abortion in the United States as a whole. This would have a particular impact on invited and public testimony. The planned schedule for the meetings was to hear out-of-state expert testimony during the second task force meeting on September 21 and 22, 2005. task force members submitted names of experts whom they wanted to invite and then the three person subcommittee arranged invitations and balanced the number of experts and the duration of their testimony between the “two sides” of the issue. For the third meeting on October 20 and 21, 2005, the members decided to focus on South Dakota experts and public testimony. Experts testifying on the first day of this meeting would either need to be residents of South Dakota or have particular expertise about abortion in South Dakota. The second day of the meeting would be open to public testimony from South Dakota residents. Another three person subcommittee took recommendations, arranged invitations, and balanced the testimony, and a motion was passed requiring that these experts be from South Dakota.

However, these agreements were not carried through by the subcommittee members. Kate Looby, the representative from Planned Parenthood, submitted a request to include Dr. Carol Ball, who provides abortions in Sioux Falls and could

provide expertise specific to South Dakota, but resides in a different state. The subcommittee also decided to invite and allow testimony from five out-of-state prolife witnesses, including two representatives from Operation Outcry who submitted as part of their testimony over 1,500 declarations from women who regretted their abortions (Task Force Minutes Oct. 2005). According to a minority report submitted by the four prochoice members, none of the out-of-state witnesses for this meeting were able to speak specifically about abortion or abortion restrictions in South Dakota.

Additionally, during the meeting on October 21, the afternoon of which was reserved for public comment by South Dakota residents, four women from other states gave comments about their negative experiences following an abortion.

On October 20 and 21, 2005, the task force heard testimony from “South Dakota” experts and received public input from “South Dakota” residents; both groups included many people who did not reside in South Dakota or speak to the issue of abortion in South Dakota. Both sides presented health professionals, social workers, and lawyers who all presented evidence about either the need to maintain access to abortion and expand coverage to contraception or to the need to end abortion in the state. During the session that included public testimony, the task force heard from women who suffered after having abortions and from many women who characterized their experience with abortion as positive.

#### Task Force Proceedings

By all accounts the task force meetings were contentious. Decisions about the format of the hearings and whose testimony to include were almost always divided

between the prochoice and prolife contingents, with Chair Marty Allison often siding with the prochoice members. A reporter covering the hearings described “angry words being exchanged” and accusations of one prolife member “abusing” Kate Looby during the October meeting (Kafka 2005). Looby was quoted as characterizing the task force as “an extremely hostile group” (Kafka 2005). These hostilities also erupted around requests by the prolife members to watch a video of an abortion being performed, listen to recordings of the informed consent message used by Planned Parenthood in South Dakota, review written informed consent materials that patients can request from the Planned Parenthood clinic, and tour the Sioux Falls Planned Parenthood facility (Task Force Minutes August 2005; Task Force Minutes September 2005; Task Force Minutes October 2005). When Kate Looby was unable to secure permission for a tour from Planned Parenthood of South Dakota’s executive board, other members of the task force accused her employer of “having something to hide” (Recording of the SDTFSA 2005).

During the final meeting of the task force, these frustrations and hostilities reached a boiling point over the issue of how to produce a final report to submit to the state legislature. At the end of the third meeting, the task force agreed to begin preparing motions and recommendations that they would like to see included in the final report. These motions would be distributed to members for consideration at the next meeting on December 9<sup>th</sup>. On the morning of the final meeting three documents were distributed to the task force. One was a description of two resolutions authored by Chair Marty Allison: one that proposed to ban abortions in South Dakota except in



cases of rape, incest, where the life or health of the pregnant women was at risk, and where the fetus is not expected to survive early infancy, and another that called for the teaching of comprehensive sexual education in public schools with the goal of reducing unintended pregnancy. The second document was a collection of twenty-one findings and recommendations authored by Sen. Adelstein, Ms. Looby, Ms. Holcomb, and Dr. Bell. The final document was a 72-page report entitled “Report of the South Dakota Task Force to Study Abortion Submitted to the Governor and Legislature of South Dakota.” This report was distributed by Mr. Benson, who clarified that he was not the author.

After failure of a motion to accept the findings and recommendations proposed by the four prochoice members as the final report, the task force spent the afternoon deliberating whether to accept the entire 72-page document as the final report. Kate Looby proposed including the twenty-one findings and recommendations as a minority report. While Dr. Allison argued that this would give weight to the task force’s findings because it would be evidence of a robust and thoughtful debate, other task force members argued that it would lead to greater uncertainty among legislatures over which recommendations to adopt. Ultimately, the proposal to include a minority report was rejected. Kate Looby and other prochoice task force members proceeded to offer proposals to amend the 72-page report or adopt some of findings they had proposed. In the majority of the cases, these proposed amendments were rejected with very little deliberation.

Throughout the proceedings, the issue of how to evaluate the scientific findings provided in expert testimony and written submissions was particularly contentious. Each side accused the other of ignoring scientific evidence that did not match their ideology or of manipulating findings to fit their political positions. Given that the task force was unable to agree on a definition of expertise or a set of guidelines for evaluating evidence, this is unsurprising. During deliberations, Kate Looby proposed that the task force incorporate the following language into the final report to address how to evaluate evidence:

The Task Force finds that the most reliable information is produced by recognized, respected professional organizations which adhere to a strict standard of objective, peer-reviewed scientific study and which represent the consensus of the scientific community. The Task Force finds that the most reliable information is produced through prospective studies, which have significantly fewer potential sources of bias and error than retrospective studies. The Task Force recommends that findings and motions passed by the Task Force be consistent with current medical science and based on findings from the most rigorous and objective studies that are accepted by respected organizations such as the American Medical Association, American Psychological Association, American Psychiatric Association, American College of Obstetrics and Gynecology (Task Force Minutes December 2005; Adelstein et al. 2006).

The proposal to consider peer-reviewed, prospective, and professionally accepted scientific findings as more reliable than others was rejected during a task force vote. Pro-life members of the task force repeatedly defended themselves against accusations that they selected only evidence that supported their ideology, discounted the credibility of experts selected by pro-choice members, and ignored scientific findings that challenged pro-life ideas.

At the end of an afternoon of deliberation, it became clear that no amendments or additions to the 72-page document were going to be accepted or even given significant discussion. When a motion by Kate Looby to revise the language on a potential link between abortion and breast cancer to reflect the findings of the National Cancer Institute, the American College of Obstetricians and Gynecologists, and the Collaborative Group on Hormonal Factors in Breast Cancer was tabled without debate, Dr. Bell, Kate Looby, Sen. Adelstein, and Linda Holcomb left the meeting. Upon exiting, Senator Adelstein said, “What you’ve done is you’ve rejected scientific evidence, you’ve rejected free speech and religion, [and] you’ve called an established, state-wide organization liars” (Recording of the SDTFSA 2005). With the prochoice contingent gone, the remaining members voted to accept the 72-pagedocument as the final report. The task force chair, Dr. Allison, was the sole vote against this motion. Allison refused to support the report because it lacked recommendations for sexuality education and contraception. Additionally, she stated, “The final report was authored by a few people on the task force, and it is less than completely objective and factual. It is biased and opinionated. She added: “The process through which we came to the final report, through our meetings we had, I was disappointed with that. It's not reflective of all the information we spent so much time gathering” (Brokaw 2005).

#### Report of the South Dakota Task Force to Study Abortion

During the hearings and deliberations, the task force was unable to come to any consensus on what counted as good evidence or who was an expert. However, the final report written by some of the prolife task force members presents a clearer

picture on this subject. By and large, the evidence presented by “prochoice” experts was ignored or dismissed, and those witnesses were characterized in the report as lacking credibility due to conflicts of interest. On the other hand, experts representing the prolife position were universally characterized as credible and their political beliefs about abortion were not presented as influencing the evidence they presented to the task force. This particular construction of conflict of interest, in the absence of any functional definition of “expert” or standards for evaluating the quality of evidence, facilitates the creation of certainty about the dangers of abortion for fetuses, women, and society.

For the purposes of this section, I am discussing a construction of evidence, expertise, and conflict of interest that occur throughout the report, but focusing on the section that deals with abortion’s potential harms to women’s health and wellbeing. In fulfilling the task force goal of studying “the effect and health risks that undergoing abortions has on the women, including the effects of the woman’s physical and mental health, including the delayed onset of cancer and her subsequent life and socioeconomic experiences,” the task force considered testimony provided in person or in writing from Dr. Elizabeth Shadigan, Dr. Martha Shuping (sometimes referred to in the report as Shupping), Dr. David Reardon, Dr. Priscilla Coleman, Dr. Vincent Rue, and Dr. Joel Brind from the prolife side and Dr. Stanley Henshaw (of the Alan Guttmacher Institute) and Dr. Marie Harvey (of Oregon State University and the University of Oregon) for the prochoice side. Shuping, Coleman, Rue, Henshaw, and

Harvey all provided expert testimony in person to the task force and Shadigan, Reardon, and Brind all supplied written testimony that was entered into the record.

In determining what testimony is considered credible, the authors of the task force relied on whether the person delivering the testimony is credible and whether that person's testimony is influenced by a financial tie to abortion provision or a political belief that abortion should remain legal. Citing research and publications that were supportive of the expert's testimony was taken as a particularly salient marker of credible expertise. For example, the authors introduce Priscilla Coleman as a "nationally and internationally recognized expert in mental health risks of induced abortion, having conducted numerous scientific studies on the issue. The Task Force finds the testimony she provided informative, comprehensive, and credible" (Task Force Report 2005: 41). The bulk of Coleman's testimony makes reference to her own research and that of David Reardon to make the case that abortion is associated with an increase in a variety of mental health issues. There is no discussion of the published critiques or known methodological problems of this research or of misrepresentation of other research. The taskforce made no distinction between peer-reviewed research, larger reviews or meta-analyses, and non-peer-reviewed research; well cited research is a central maker of credibility.

Credibility is also enhanced by agreement among different experts. In the discussion of Martha Shuping's testimony, the authors wrote that "The Task Force finds her testimony persuasive due to her training, psychiatric practice, and research. Her experiences are consistent with the broad range of adverse psychological

symptoms described by Dr. Coleman in her review of the literature” (47). Shuping was a credible witness because her testimony based on her experiences falls in line with the testimony provided by another credible witness.

However, not all of the witnesses were deemed to be credible. Throughout the report there was an uneven disclosure of witness’s connection to the abortion debate. Some witnesses for the prolife side, such as John Willke and Dr. Byron Calhoun, were identified with prolife politics, other experts were not. For instance, no mention was made of the connections between Priscilla Coleman, Vincent Rue, Martha Shuping, David Reardon, and Joel Brind and prolife organizations. However, experts for the prochoice side were almost universally tied to prochoice politics and these connections were used to characterize the witnesses as not credible. For example, Stanley Henshaw was introduced as “an advocate for reproductive choice. He has been Deputy Director of Research for the Alan Guttmacher Institute, a Planned Parenthood special affiliate which is partially funded by Planned Parenthood Federation of America” (50). Similarly, Marie Harvey was identified by her academic position and as someone who “has worked in the area of reproductive health for women for over 25 years, including providing abortion counseling. Dr. Harvey is an active proponent of the view that abortion does not cause psychological harm in women” (46). Although Coleman, Shuping, and Rue could well be characterized as an active proponents of the view that abortion is associated with psychological harm, their testimony was granted credibility and objectivity, while the testimony of Henshaw and Harvey was immediately suspect. In the report, Henshaw and Harvey were continuously characterized as citing studies

and research that “support [their] beliefs” and the prolife experts were presented as citing or noting findings using language that indicates this process is not mediated by beliefs.

Additionally, the findings of government agencies and professional organizations were dismissed when they did not fit into a particular view of abortion. For example, Harvey testified that the American Psychological Association found that “abortion has no lasting or significant health risks” and this claim is important because it was “made by an objective scientific organization of psychologists” (46). However the Task Force found this not to be credible because of the APA’s submission of amicus beliefs in support of abortion rights and because the APA “has also advocated and supported other controversial positions on homosexuality” and redefining child sexual abuse (48). Similarly, the ACOG statement that careful evaluation of the medical literature demonstrated “no significant impact” of long-term risks of reproductive functions, cancer incidence, and psychological sequelae associated with abortion was dismissed because “the Task Force disagrees with the statement due to other testimony and materials” (48). Finally, statistics from the CDC about the relative safety of abortion when compared to childbirth were not credible because while “the fact that it is a department of the federal government implies an aura of authenticity, the CDC is not funded, or under any mandate, to obtain comprehensive and accurate data on deaths due to abortion” (49).

Located conveniently in an intermediate space between science and law and therefore bound by the roles of evidence of neither domain, the task force often

characterized certain experts, organizations and institutions as lacking credibility due to conflicts of interest. Within scientific research, financial conflicts of interest cast doubt of the objectivity of the researcher and call into question the validity of results. Many peer-reviewed journals require authors to disclose the funders of their research. In legal proceedings, conflicts of interest do not necessarily damage the validity of testimony because it is assumed that an expert is advocating for a particular party within a legal dispute is in many cases is being financially compensated for their labor. However, jurors and judges have their own criteria for evaluating the credibility of these paid experts based on an adversarial system that includes both the presentation of evidence and cross-examination. The task force lacked a consistent standard for assessing conflicts of interest. Testimony provided by individuals or organizations with financial ties to abortion providers had a conflict of interest, but those with financial ties to organizations working to end the legalization of abortion did not. For example, Kate Looby, Dr. Carol Ball, and Dr. Stanley Henshaw were all characterized as not being credible experts because of their employment at Planned Parenthood or at an organization that is partially funded by Planned Parenthood. Testimony by employees of crisis pregnancy centers, however, was “particularly credible because they are free of any conflict of interest. The pregnancy help centers do not provide abortions and they do not take payment from the women they serve” (19). Similarly organizations that support legal access to abortion, like the APA and the ACOG, were represented as having a political conflict of interest that casts doubt on their position about abortion’s potential harm, while organizations that oppose legal access to



abortion, like the AAPLOG or Life Institute, were presented as objective and unbiased.

Through the systematic dismissal of experts for the prochoice side and unquestioning acceptance of testimony from experts from the prolife side, the authors of the report declare a number of uncertain scientific findings to be “facts.” Based on testimony from Dr. David Fu-Chi Mark, a molecular biologist, Dr. Bruce Carlson, a human embryologist, and Dr. Calhoun, a specialist in internal fetal medicine, the authors find “that the new recombinant DNA technologies indisputably prove that the unborn child is a whole human being from the moment of fertilization, that all abortions terminate the life of a living human being” (31). Similarly, the task force determined that there is a causal relationship between abortion and mental illness. The authors write:

The Task Force finds that it is simply unrealistic to expect that a pregnant mother is capable of being involved in the termination of the life of her own child without risk of suffering significant psychological trauma and distress. To do so is beyond the normal, natural, and healthy capability of a woman whose natural instincts are to protect and nurture her child (47).

Further, the task force declared much of the scientifically accepted information used in the informed consent procedure at the Planned Parenthood clinic to be “misrepresentations.” This included information about the safety of vacuum aspiration abortions and early abortions in general as well as the relative safety of abortion in comparison to childbirth (40-41). The task force concluded that no abortions in the state can be considered “voluntary and informed” based on these “misrepresentations”

and the fact that Planned Parenthood does not disclose that abortion terminates a “whole separate unique living human being” to women seeking abortions (37-41).

In addition to finding the scientific arguments presented by prolife experts to be far more credible than the evidence provided by other experts, the prolife task force members were particularly struck by the narratives of women who regret their abortion. These narratives were submitted both by individual women during public meetings and over 1,500 narratives entered into the proceedings by Operation Outcry. In the report, task force members wrote that of all the evidence presented “The most powerful... was the vast amount of testimony received into the record from post-abortive women who were willing to publicly share their experiences” (41). Moreover, the taskforce expressed feeling moved to act on this evidence. For example, they wrote, “The sad and compelling testimonies of women who have informed us of the reality of their experiences must not be ignored. Their courage in stepping forward to educate us on their suffering must be given meaning” (66). Though the task force heard testimony from women who regret their abortions, women who do not regret their abortions, and women who faced conditions that made it medically necessary to end their pregnancy, the preponderance of the evidence entered into the record was from women who regret their abortions. Within the report the experiences of women who do not regret their abortions was completely ignored.

Beyond the stark differences in the quantity of abortion regret narratives presented to the committee, there were also variations in the content of the narratives. By and large, the abortion regret narratives followed the typical pattern of becoming

pregnant, feeling pressured to abort, and experiencing a variety of emotional and physical difficulties in the months or years following the procedure. (For more detail, see Chapter Four.) The narratives about abortion presented by women who did not regret their decision were more likely to engage in the “hard cases” about the legality of abortion. That is, these women often had to terminate a wanted pregnancy due to a medical condition, ended a pregnancy that was the result of rape, or would have faced financial hardship if they continued the pregnancy. As other scholars have noted, this divide in the content of the experiences is frequently seen within debates about abortion (Esacove 2004). One consequence of this divide is that it makes the “prochoice” narratives seem like extreme cases (which they are) and the “prolife” narratives are seen as representing the normal or typical experience.

Armed with new determinations about fetal life and the certainty that abortion causes mental and physical harm to women, the task force made a series of recommendations to support banning abortion in South Dakota. In the report submitted to the South Dakota legislature and governor, the task force recommended banning abortion in the state because “it is clear to us that abortion terminates the life of a child and the relationship with his or her mother and is an unsafe procedure that places women at significant risk for psychological and physical harm” (69). Also, the task force recommended a slew of additional prolife legislation such as a Human Life Amendment to the state constitution and more informed consent regulations, including requiring a physician to handle all of the informed consent procedures, requiring the woman to view an ultrasound of her embryo or fetus, and requiring women seeking

abortions to receive counseling at a crisis pregnancy center before the procedure can be scheduled (69-70).<sup>86</sup>

Given the highly political nature of this task force and its heavy-handed tactics, it would be easy to dismiss this report as a product of ideological struggle rather than scientific engagement. However, the significance of this report lies in how the task force dealt with competing frames of abortion and health. Within the realm of state government, a variety of types of evidence could be used to justify banning or restricting access to abortion, yet the task force authors choose to make a *scientific* argument about abortion. The report claims that as scientific fact that human life begins at conception and that abortion *causes* mental illness among women who undergo the procedure as scientific facts rather than contested claims. The new facts are then given a political legitimacy and used to justify legislation that would ban all abortions in South Dakota.

The task force report was submitted in December 2005, and the twenty-one findings and recommendations by the four members who walked out of the final task force meeting as well as the two resolutions proposed by Marty Allison were submitted as a Minority Report in January 2006. At the beginning of the 2006 legislative session, Representative Roger Hunt introduced a bill to ban all abortions in South Dakota except those to protect the life of the pregnant woman. This bill was largely justified by the task force findings:

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<sup>86</sup> South Dakota enacted an ultrasound requirement in 2008 and a law requiring a 72 hour waiting period during which the pregnant woman must go to a CPC during the 2011 legislative session. The required CPC visit is currently being challenged in the courts (Ertelt 2011).

The Legislature accepts and concurs with the conclusion of the South Dakota Task Force to Study Abortion, based upon written materials, scientific studies, and testimony of witnesses presented to the task force, that life begins at the time of conception, a conclusion confirmed by scientific advances since the 1973 decision of *Roe v. Wade*, including the fact that each human being is totally unique immediately at fertilization. Moreover, the Legislature finds, based upon the conclusions of the South Dakota Task Force to Study Abortion, and in recognition of the technological advances and medical experience and body of knowledge about abortions produced and made available since the 1973 decision of *Roe v. Wade*, that to fully protect the rights, interests, and health of the pregnant mother, the rights, interest, and life of her unborn child, and the mother's fundamental natural intrinsic right to a relationship with her child, abortions in South Dakota should be prohibited. (HB 1215 2006).

The South Dakota Legislature passed this bill and Governor Mike Rounds signed it into law. However, the bill was ultimately defeated through a ballot initiative rather than a court battle.

The task force hearings, reports, and aftermath raise important questions about how to think about political and policy processes that require an engagement with scientific knowledge. Some critics have argued that the South Dakota Task Force to Study Abortion was just an act of political theater designed to provide the evidence the conservative legislature needed to pass a ban on all abortions (Bans 2006). While the task force was formed with the goal of objectively evaluating evidence about abortion, it is clear that unresolved disagreements over what counts as credible evidence and who is an expert greatly hindered that process. As an ad hoc committee that adhered to the standards neither of a scientific inquiry nor of legal proceedings, prolife task force members were able to invent their own rationales for which evidence is credible and rely on the scientific framing of experts aligned with the prolife cause to produce a

report that furthered their own political agenda. In this case it seems that the proceedings of the task force were centered on ideological struggle rather than scientific engagement.

### **Legal Challenges to South Dakota's Informed Consent Law**

Soon after the passage of HB 1166, Planned Parenthood of Minnesota, North Dakota and South Dakota (hereafter referred to as Planned Parenthood) and Dr. Carol E. Ball (a physician who provides abortions in South Dakota) began legal action to get an immediate injunction to prevent the implementation of the law and towards having the law ruled unconstitutional. Planned Parenthood and Ball argued that the law violated the First and Fourteenth Amendment rights of physicians by compelling them to deliver the state's antiabortion message to patients and by requiring them to give "untrue and misleading information" to patients (Planned Parenthood v Rounds 2006: 5). They also asserted that the new informed consent procedures also violate the patient's rights by forcing them to listen to the state's antiabortion message (5-6). Further, Planned Parenthood and Ball contended that requiring patients to read and understand "untrue and misleading information" about abortion poses an "undue burden" which is the legal standard for abortion restrictions set by the Supreme Court in *Casey* (6). Finally, the plaintiffs argued that much of the law was "impermissibly vague," and that the health exception was inadequate (6).

These challenges were directed at four aspects of the law that required doctors to deliver particular information, eventually referred to as advisories by the court. The

first advisory in contention was the requirement for the doctor to inform the patient that “abortion will terminate the life of a whole, separate, unique, living human being” (*the human being advisory*). Human being is defined in the bill as “individual living member of the species of *Homo sapiens*, including the unborn human being during the entire embryonic and fetal ages from fertilization to full gestation” (HB 1166). The second advisory in question required doctors to inform a patient that she “has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota (HB 1166), which is referred to as *the relationship advisory*. The third advisory, or *the risk advisory*, instructs doctors to inform patients seeking abortions of “all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected” (HB 1166). Of importance here are how the legislature and the Courts would define terms like “known medical risks,” “statistically significant” and “risk factors,” which each have common meanings as well as more specialized definitions. The final advisory of the law that was challenged by Planned Parenthood and Ball was *the suicide advisory* that requires doctors to inform patients that one of the known medical risks and statistically significant risk factors they would be subjected to is “increased risk of suicide ideation and suicide” (HB 1166). Of importance here are the final two advisories, the risk advisory and the suicide advisory.

Legal arguments both for and against HB 1166 rely on determining whether the four advisories represent truthful and non-misleading information. If the advisory

is based on truthful and non-misleading information then it is constitutional and a doctor can be compelled inform patients of this information. Further advisories that are truthful do not pose an undue burden on the patient. Lawyers for South Dakota defended the law on the basis that the sections of the law about fetal life, medical risks of abortion, and suicide ideation were grounded in scientific fact and not “untrue and misleading.” Further representatives for the state argued that it can compel medical professions to disclose information relevant to a patient’s decision and that the state has an interest in protecting the health of its citizens through informed consent laws. The central issues of the case would ultimately come down to how much the state can compel the speech of doctors providing abortions. How to sort through different types of evidence and claims about the truth is not clear from the outset.

In June 2006, Judge Karen E. Schreier of the United States District Court granted a preliminary injunction that prevented the informed consent law from going into effect. Schreier’s decision was based primarily on the compelled speech issue and not the veracity of suicide and risk claims. Citing *Casey* as appropriate precedent, Schreier argued that the state does have the ability to require doctors to provide certain information, make certain information available, or include their own assessment of the information in the consultation, but that the South Dakota law goes beyond other state’s laws. She wrote, “Unlike the truthful, non-misleading medical and legal information doctors were required to disclose in *Casey*, the South Dakota statute requires abortion doctors to enunciate the State’s viewpoint on an unsettled medical, philosophical, theological, and scientific issue, that is, whether a fetus is a human



being” (10). Further, the state’s requirement that a woman be told that abortion terminates the life of a whole, separate, unique, living human being and that the provider ensure that the patient understands this information further impinges on the free speech of doctors because it does not allow them to disassociate themselves from the state’s ideological message (12).<sup>87</sup>

With a preliminary injunction in place, the state began the appeals process to remove the injunction and have the case heard by the Eighth Circuit Court of Appeals. In 2008, the Eighth Circuit panel ruled that the District Court had incorrectly applied the criteria for granting the injunction and vacated the District Court’s decision (*Planned Parenthood v. Rounds* 2008). The case was sent back to have the District Court rule on the constitutionality of the informed consent law. Both Planned Parenthood and South Dakota filed motions for summary judgment from the District Court. Judge Schreier began the process of shifting through the evidence and arguments presented by each side.

It is important to note that between 2005 (when the law was passed) and 2008 (when the District Court began to consider the constitutionality of the law), the scientific landscape about abortion’s potential relationship to mental illness had changed significantly. As discussed previously, the American Psychological Association’s Task Force on Mental Health and Abortion had found that based on the

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<sup>87</sup>Based on previous court rulings, states can produce their own materials that contain scientifically questionable information and require doctors and other health professions to make these materials available to patients (*Casey* 1992; *Rounds* 2006). However, in other states doctors are able to explain that the information is scientifically inaccurate and patients are able to ignore the printed or verbally delivered information. The South Dakota law’s emphasis on the doctor being required to be certain that the patient understood the information is a marked difference from the requirements of other states.

extant research there was no increased risk of mental illness associated with a single, legal, first trimester abortion (Major et al 2008). Additionally, much of the Finnish research that supported a potential association between abortion and suicide had been more thoroughly critiqued (Gissler, et al 1996; Major, et al 2008). Finally, researchers who are critical of abortion had published additional studies with peer-reviewed journals and developed their own critiques of the APA's findings (Coleman 2006; Coleman, et al 2009; Reardon and Coleman 2006).

In summary judgment the U.S. District Court ruled in favor of the state in terms of the human being advisory and aspects of the risk advisory, and in favor of Planned Parenthood in terms of the relationship advisory, aspects of the risk advisory, and the suicide advisory. The human being advisory was ruled constitutional because the informed consent statute defines "human being" using a biological definition (i.e. a member of the species *Homo sapiens*) rather than an ideological definition. The relationship advisory was ruled unconstitutional because the legal definition of a "relationship" as "the nature and association between **two or more people**" (*Planned Parenthood v. Rounds* 2009: 977; emphasis in original). Because embryos and fetuses are not legally considered people until they are born - though they are human beings - the relationship advisory was untruthful and misleading. This is an indication of the potential power of shifting to a scientific argument about an embryo being a human being from a moral or legal argument about the personhood of the embryo or fetus.

The ruling on the risk advisory required the court to distinguish between common and more specialized definitions for the phrases "all known medical risks"

and “statistically significant risk factors.” Based on South Dakota’s extant informed consent for abortion which requires doctors to inform patients of all “medically accurate risks” and the professional standard for informed consent, the new phrasing of “all known medical risks” was “not too uncertain that an individual could not ascertain the meaning of it in order to comply with it” (980). The informed consent statute contains at least three different uses of the concept of risk. “Risk factors” implies a precondition that might influence the potential danger or harm that might come from a undergoing a medical procedure. “All known medical risks... to which the pregnant woman would be subjected” suggests a causal relationship between a medical risk and a particular outcome. And “increased risk” can be interpreted to mean a relative risk or “a relatively higher probability of an adverse outcome in one group compared to other groups” (*Planned Parenthood v. Rounds* 2012: 7). The phrasing of “statistically significant risk factors” was deemed to be too vague for physicians and laypersons to understand. According to the District Court, this was due to the use of the phrase “risk factors” which is medically defined as “a predisposing condition that a patient may have before a procedure,” rather than “something a patient is subject to during or after the procedure” (981).

Finally, the suicide advisory was deemed to be untruthful and misleading due to the District Court’s understanding of whether the informed consent statute sets out a correlative or causative relationship between abortion and suicide. The law requires the physician to inform the patient of “all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected,

including: ... Increased risk of suicide ideation and suicide” (HB 1166). The language of risks a women would be “subjected” was considered to indicate a causal relationship. Additionally, the phrase of “all known medical risks” requires that “increased risk of suicide ideation and suicide” to be a **known** medical risk (982-983). The District Court ruled that because the American College of Obstetricians and Gynecologists and the American Psychological Association do not consider suicide ideation or suicide to be known risks associated with abortion this advisory was untruthful and misleading. Additionally the court supported this decision with evidence from the Food and Drug Administration, which granted approval for the drug mifepristone (RU 486) without a suicide warning, and evidence from the state’s own witness, Dr. Elizabeth Shadigian, who testified that “it would not be accurate to advise an elective abortion patient that abortion causes suicide” (983). In the District Court ruling on the risk and suicide advisories, it is clear that that the court gave more weight to scientific evidence that was generally accepted (i.e. the opinions of the ACOG, the APA, and the FDA) than to evidence from researchers critical of abortion that met the rest of the Daubert criteria, but was not generally accepted.

After the summary judgment was issued by the District Court, both parties appealed the ruling to the Eighth Circuit Court of Appeals. In 2011 a three-judge panel of the Eight Circuit Court of Appeals considered the arguments about the informed consent law put forward by Planned Parenthood and the state of South Dakota. This panel’s ruling upheld parts of the District Court’s position and reversed other parts. While the earlier rulings on the human being advisory, the risk advisory and the

suicide advisory were all upheld, the Circuit Court did reverse the ruling on the relationship advisory, deeming it to be truthful and non-misleading, and therefore, not posing an undue burden on women seeking abortions.

The Circuit Court did expand upon the District Court's ruling in terms of the suicide advisory. In particular the judges disagreed over the appropriate definition of risk and the degree to which advising patients that they face an increased risk of suicide ideation and suicide was truthful. Writing for the majority, Justice Diane Murphy concurred with Planned Parenthood and the District Court that the definition of "risk" was too vague, that it implied a causal relationship, and that there was no evidence of a causal relationship between abortion and suicide. Citing the positions of the APA and the ACOG, Murphy argued that a causal connection between abortion and suicide was not considered a "known" medical risk. Drawing on the Supreme Court decision on the "partial birth abortion ban" in *Gonzales*, she wrote:

Legislatures have 'wide discretion to pass legislation in areas where there is medical and scientific uncertainty,' (citing *Gonzales* 2007: 163) but *the suicide advisory* asserts certainty on the issues of medical and scientific knowledge where none exists. The advisory thus 'very likely ... require[s] physicians to disclose information that is false' (citing Post 2007:961) (*Planned Parenthood v. Rounds* 2011).

While courts and legislatures are constantly tasked with making decisions and policy in areas where the science is uncertain (Jasanoff 1995: 10), Murphy ruled that the suicide advisory created an undue burden, in part, because it asserted certainty in a scientific debate that was still contested. Like the District Court, the majority in the Eight Circuit panel placed a greater importance on scientific evidence that was generally accepted even if was contested.

Of additional importance in regards to the suicide advisory are two issues: how the Circuit Court used the FDA approval guidelines for pharmaceutical drug to determine whether a relationship between abortion and suicide is “known,” and how the court handled the testimony of women who claimed to have been harmed by their abortions. Drawing on evidence presented by Planned Parenthood on the FDA approval process for RU 486, Justice Murphy argued that if clinical trials for the drug had demonstrated an increased risk of suicide ideation or suicide the FDA would have required that to be identified on the drug labeling. Since it is not, the Court can assume that suicide is not a known risk that follows abortion (*Planned Parenthood v. Rounds* 2011: 14). Even in an uncertain medical debate, the FDA guidelines were used as a maker of that is known and generally accepted within the scientific community. Murphy also contended that the evidence provided by professional organizations like the APA and the ACOG should be given more weight than the peer-reviewed studies done by researchers critical of abortion and the experiential evidence of women who claim to be harmed by their abortions. “Testimony by individual women reporting emotion problems after abortion has also been offered by South Dakota and the interveners; all of these women had abortions either outside of South Dakota or before passage of the state’s earlier informed consent provisions” (15). The stories of women were considered to be not relevant to the current experience of abortion provision in the state of South Dakota. Though the experiences of women who regret their abortions was considered highly relevant in the report of the South Dakota Task Force to Study Abortion and in some other court cases (for example, Gonzales), in this case

Justice Murphy contended that it did not speak to the specifics of abortion in South Dakota.

Writing a dissent for the part of the ruling on the suicide advisory, Justice Raymond Gruender disagreed that the statute described a causal relationship between suicide and abortion to be required for the informed consent law to be constitutional. Gruender argued that evidence of an association or correlation between the two would be sufficient to allow the suicide advisory to pass the undue burden test. Relying heavily on a declaration submitted by Priscilla Coleman, Gruender asserted that there is plenty of evidence to support the conclusion that there is a “significant, known statistical correlation between abortion and suicide” (17). Further, he contended that the burden should fall on Planned Parenthood to provide evidence that abortion had been eliminated as a cause of suicide or suicide ideation. Until that burden of proof was met the suicide advisory could not be labeled misleading. In contrast to the majority opinion which was cautious about imposing certainty upon a scientific and medical uncertainty for fear of misinforming patients, Gruender argued that until the debate over the potential harms of abortion has reached certainty, the state should err on the side of caution even if this meant informing patients about risks that do not exist.

Ultimately, the state of South Dakota appealed the ruling on the suicide advisory to the Eighth Circuit Court of Appeals, where it was heard by the full court. Writing the majority decision this time, Justice Gruender found that the suicide advisory did not pose an undue burden on patients seeking abortions and did not

violate the free speech rights of physicians. Relying on a distinction between correlation and causation, Gruender argued that the language of the statute only requires patients to be informed of a correlation between suicide and abortion. Gruender argued that the legislature intended for “increased risk” to be the same as the scientific definition of relative risk and that the phrase “increased risk” was the most central to the suicide advisory than the concept of “known risk.” It is this definition that Gruender asserted the legislature meant when drafting the informed consent legislation, and thus lawmakers only intended for patients to be informed of an association between abortion and suicide ideation and suicide (7).

By changing the standard from a causal to correlative relationship, Gruender argued that the burden fell on Planned Parenthood to prove that abortion had been ruled out as a causal factor in suicide. He wrote:

the truthful disclosure regarding increased risk cannot be unconstitutionally misleading or irrelevant simply because of some degree of ‘medical and scientific uncertainty’ ... as to whether abortion plays a causal role in the observed correlation between abortion and suicide.... [I]n order to render *the suicide advisory* unconstitutionally misleading or irrelevant, Planned Parenthood would have to show that abortion has been ruled out, to a degree of scientifically accepted certainty, as a statistically significant causal factor in post-abortion suicides (16-17).

The evidence presented by Planned Parenthood demonstrated a growing consensus that there is no correlation between abortion and suicide. However, research that explicitly disproves a causal relationship does not exist.

This decision also marks a misunderstanding by Justice Gruender of the state of scientific research on abortion and mental illness at the time. The Gissler study had



been widely critiqued; the research was based off of Finnish birth, abortion, and death registries which did not include full information on social class or the level of social support for all participants. The authors indicate that they were unable to determine whether the increased risk of suicide associated with abortion and miscarriage was due to the pregnancy outcome or some additional factor that increased a woman's risk for both abortion and suicide (1996). The only other evidence of an association between abortion and suicide was published by Reardon et al. (2002). The Reardon study had also been criticized for its flawed methodology and for not controlling for confounding factors. Gruender did not account for distinctions between robust associations that persist when known confounding factors are controlled for and spurious correlations that disappear when confounding factors are controlled for. Additionally, researchers are unlikely to pursue either proving or disproving a causal relationship when there is significant agreement that the two variables are not correlated.

Justice Gruender highlighted the uncertainty about a possible association between abortion and suicide to argue that the suicide advisory is truthful and non-misleading. Using the Gissler, Fergusson, Reardon, and Coleman studies as well as Coleman's critiques of the APA Task Force and other studies, Gruender argued that there are many experts who disagree with assessments and reviews of the research done by the APA, the ACOG, and the Royal College of Obstetricians and Gynecologists. In light of this uncertainty, Gruender argued that the state is in the best position to determine what information should be disclosed to patients. He wrote, "We

express no opinion as to whether some of the studies are more reliable than others; instead, we hold only that the state legislature, rather than a federal court, is in the best position to weigh the divergent results and come to a conclusion about the best way to protect its populace” (2012: 24). Gruender also made reference to the findings of the Task Force to Study Abortion as an indicator that the legislature has weighed the divergent results of the research and come to a conclusion that is more valid than those of the federal courts. This marks an unwillingness on the part of the court to make judgments about the reliability of scientific research. Further, Justice Gruender contended that in cases where the science is uncertain, legislatures should be trusted to determine what would be in citizen’s best interests.

The majority capitalizes on uncertainty and continued debate within the scientific and medical community to shift policy-making expertise and authority to legislatures. However, in the dissenting opinion, Murphy argues that the court is out of step with the growing consensus within the scientific and medical communities that there is no association or causal relationship between abortion and suicide. Murphy pointed again to the APA and the ACOG as standard-bearers for dominant medical opinions, but also addressed new research and reviews that further support the claim that suicide and adverse psychological sequelae are not associated with abortion (National Collaborating Center for Mental Health 2011; Munk-Olsen et al 2011; Robinson 2009; Steinberg and Finer 2011). This, Murphy argued, is evidence of a consensus within the medical community rather than a continued uncertainty. She wrote:

The quality of the cited studies has been recognized by leading professional associations. This research also formed the basis for the opinions of these bodies that the induced abortion of an unwanted pregnancy does not cause an increased risk of mental health problems. Rather than recognizing this emerging consensus based on the scientific research in the record ... the majority theorizes about the nature of an advisory (34-35).

The suicide advisory, contended Murphy, requires doctors to inform patients of a risk that most within the medical and scientific community do not consider to exist. Unlike Justice Gruender, Murphy argues that scientific experts and organizations, rather than legislatures, are the best guides for determining what constitutes reliable research.

As further evidence that the majority is interpreting the scientific findings incorrectly, Murphy pointed to the most recent revision of the South Dakota informed consent law, which removed the suicide advisory and now requires physicians to meet with patients to determine if they have known “preexisting risk factors associated with adverse psychological outcomes following an abortion” including coercion, a history of mental illness, and youth (37). Given that a central flaw within the research on mental health and abortion is the inability to determine whether associations are related to the abortion or a series of potential risk factors that contribute to experiencing an unwanted pregnancy **and** to mental health difficulties, Murphy asserted that this new law brings the statute in step with current scientific findings.

The Eighth Circuit Court of Appeals ruled that each of that each of the advisories in the informed consent bill were constitutional. This marked the first instance in which a doctor could be required to tell a patient that having an abortion might increase her risk of suicide ideation and suicide. Though the ruling could be

appealed to the Supreme Court, at this point South Dakota has already revised informed consent law as well as new abortion restrictions that are being challenged in court. For example, in 2012 the state enacted a bill that requires women to wait 72 hours between scheduling an abortion and having the procedure and mandates that she receive counseling at a prolife crisis pregnancy center. Regardless of these new laws, the legal fight over HB 1166 raises important questions about how courts consider evidence of correlation and causation, the construction of expertise and certainty in legal decisions, and the role of experiential evidence in abortion policy.

#### Science in the Rounds Cases

One of the central legal issues at the heart of this debate was whether a doctor could be required to inform a patient of a possible association between a medical procedure and a negative health outcome, regardless of how spurious that association might be. The Eighth Circuit was divided over what standard had to be met. The majority argued that evidence of a correlation, without regard to the reliability of that evidence, was sufficient for the suicide advisory to be considered truthful and non-misleading. Without disproof of a causal relationship between abortion and suicide, the state's interest in protecting patients was more important than a doctor's protection against compelled speech. The dissent contended that a probable correlation was not enough to compel doctors' speech; for the suicide advisory to be considered truthful there needed to be evidence of a scientific consensus that such a risk was real.

Additionally, the uncertainty around correlative relationships posed a new set of complications. In the majority decision in *Planned Parenthood v. Rounds*, Gruender

used the example of research that demonstrates an increased risk of death associated with prolonged television viewing. He argued, “We would not demand proof that television viewing itself directly caused the adverse outcome...before acknowledging that a prolonged television viewer is ‘subjected’ to the increased risk of mortality” (2012: footnote 3). While this may be true, at what point could the state require television manufacturers to include a warning label that prolonged viewing is associated with death, mandate that networks inform viewers every hour that they are increasing their risk of mortality by continuing to watch, or demand that electronic salespeople counsel their customers about the risk associated with watching television? What standard does a correlation need to meet in order for a warning about it to be considered non-misleading? The Eighth Circuit left that standard undetermined.

Another of the central issues of this case is the construction of expertise and the challenge of making a legal decision about uncertain scientific knowledge. Throughout the different stages of the proceedings, there were no major conflicts over what scientific evidence to admit and which experts should be allowed to testify or submit declarations. However, the courts did struggle to evaluate scientific evidence and determine which individuals and organizations carried more authority. Justices who considered the suicide advisory to be unconstitutional were also the ones who granted greater authority to the testimony of professional organizations and expert review and who considered the debate to be more settled or closer to consensus. By contrast, justices who considered the suicide advisory to be constitutional also granted

greater authority to critics of professional organizations and considered the debate to be less settled and more uncertain. Though organizations like the APA and the ACOG command a great deal of respect and authority, in this case it was Priscilla Coleman's declaration and her account of the scientific research that was used to justify the upholding of the suicide advisory. Further, justices who considered the suicide advisory to be constitutional also argued that legislatures were the most appropriate venue for determining how to enact policy in the face of scientific uncertainty.

Scholars of the use of scientific evidence in the courts have often focused on *Daubert* decisions as the moment of controversy, but this particular decision highlights a different tension within the courts – how to weigh scientific evidence when both party's evidence meets the *Daubert* criteria. While the *Daubert* ruling does provide a standard for what types of expert testimony should be admissible, this case further illustrates that courts have little standardized guidance to deal with scientific debates where both sides meet the basic criteria laid out in the *Daubert* standard. There is little disagreement that the evidence presented on behalf of Planned Parenthood and on behalf of South Dakota met the criteria for testability, peer review, error rate, and standardization, while only evidence submitted by Planned Parenthood met the final criterion of general acceptance. In some hearings of the case, general acceptance was considered an important factor, but in the final decision challengers of scientific institutions were seen as more credible in the eyes of the Court. This case illustrates why it is important for scholars to examine how scientific evidence is deployed throughout the trial, rather than just focusing on issues of admissibility.

Finally, the legal debate over HB 1166 illustrates the limits of experiential evidence within certain settings and gendered understandings of women as decision-makers. In previous chapters, I have argued that the stories of women who have come to regret their abortions have been transformative within the prolife movement and the larger debate over abortion. This type of evidence has also been influential in policy and legal decisions. For example, the South Dakota Task Force to Study Abortion cited the declarations submitted by Operation Outcry as the “most powerful” testimony they reviewed. Additionally, in the Supreme Court cases *Gonzales v. Carhart*, Justice Kennedy referenced the Operation Outcry amicus brief only when arguing that depression and loss of esteem can follow from having an abortion (2007:159). Operation Outcry also submitted a brief in support of the South Dakota informed consent bill, but in this case the experiences of women who regret their abortions were mentioned only briefly to remark on their irrelevance to this case. In the final Eighth Circuit ruling, this type of evidence was not mentioned at all. Its absence makes it difficult to determine why the courts did not find it compelling in this case. In contrast to the previous example, it does illustrate the contingent nature of the influence of this type of evidence.

Though the Operation Outcry affidavits were not used in the HB 1166 rulings, the Eighth Circuit continued to adhere to a model of informed consent that treats women as questionable or irrational decision-makers. The *human being* and *relationship advisories* appeal to a particular understanding of women as inherently nurturing and motherly, but also ignorant of their reproductive capabilities. Rather

than giving women relevant medical information that is necessary for rational decision-making, the law requires doctors to deliver the state's opinion on abortion in hopes that the patient will choose to continue the pregnancy. Unlike other informed consent laws that are meant to protect women from abuses by medical professionals and ensure time and knowledge to make decisions, laws like HB 1166 are meant to persuade patients against a particular decision and protect women from themselves.

### **Conclusion**

Since its formation the central goal of the prolife movement has been to recriminalize abortion in the United States, which is a straight-forward policy goal. In other chapters, I have examined how the movement has impacted cultural attitudes about abortion, the formation of the victim identity within post abortion organizations, and scientific research on abortion and women's health. This chapter analyzed how framing arguments about restricting access to abortion as a health issue has helped the prolife movement to achieve some policy goals while also co-opting one of the preferred frames of the movement for abortion rights. In the case of the South Dakota Task Force to Study Abortion, framing opposition to abortion in terms of health allowed prolife members of the task force to create policy recommendations based on contested medical knowledge, but that still gave those recommendations legitimacy among the elective officials who pursued them. Additionally, the confluence of scientific claims about abortions harms and the experiential evidence provided by women who regret their abortions gave the recommendations the appearance of being



motivated by the need to protect a vulnerable population and to right previous abuses by abortion providers described in the narratives. In the case of the legal battle over South Dakota's informed consent revision, framing support for the additional advisories in terms of health forced federal judges to engage with scientific knowledge that is contested and somewhat unsettled. The judges struggled to determine how to weigh the reliability of different studies and whether to trust the findings of expert reviews performed by professional organizations and government institutions. Ultimately, two different understandings of how the court should proceed emerged. The majority in *Rounds II* found that in cases of unsettled science the legislature of South Dakota should determine what restrictions to abortion were necessary, while the dissent argued that scientific institutions should be trusted to determine which regulations were medically appropriate.

Much of the scholarship on social movement framing has emphasized initial framing, frame alignment processes, and the role of framing in mobilization. However, framing has an important role in social movement impact. Getting key decision-makers to buy into a particular frame can lead to greater success in implementing policy. Further, abortion regulations are frequently contested in the federal court system. Even if a frame resonates with legislators, it is imperative that the frame also resonate with judges who ultimately decide if a regulation is constitutional. This highlights the importance of examining how frames might be more successful with particular targets and the ways in which movements may modify frames in order to persuade actors in varying institutions. Additionally, while scholars have noted that

movements can engage in a dialogical framing strategy in response to a countermovement (Esacove 2004), less attention has been paid to how social movements might co-opt the frame of a countermovement. In this case, prolife organizations have, in some instances, framed their opposition to abortion in terms of health, which has long been a preferred form of the prochoice movement. More research may reveal other social movement contests in which this strategy has also been deployed.

Secondly, I have examined how courts and a lay review panel have engaged with contested scientific information about abortion and its potential harms. The task force failed to establish any standards for how to weigh scientific evidence and had significant disagreements over who counted as an expert. Though task force members could have adopted standards of evidence that are used in scientific reviews or legal proceedings, they ended up cobbling together inconsistent standards for credibility and expertise in order to further a political goal. In the *Rounds* cases, the judges struggled to determine which scientific results were reliable and whether to trust the positions of professional organizations and government institutions. In the end, the majority decided that it was not the role of the Court to evaluate the merit of the scientific findings. They contended that the task was better left to elected officials.

Though much of the scholarship on science, law and policy has focused on the standards judges employ for admitting scientific evidence and expert testimony, many researchers have argued that both juries and judges are often ill-equipped to evaluate scientific evidence and reasoning. This proved true in the *Rounds* cases as well. More

research is needed to determine if there are patterns in how judges deal with scientific arguments. Examining cases in which the scientific disagreement is highly politicized may help to shed light on this phenomenon. In forthcoming work, researchers from *Advancing New Standards in Reproductive Health* found that courts are largely inconsistent in how they handle scientific findings about abortion and that “overwhelmingly what we do see is political ideology substituted for objective standards in adjudicating scientific claims” (Tracy Weitz quoted in Martin 2014). Given the preponderance of evidence of how poorly the courts handle scientific evidence, it may be time to more thoroughly develop an analysis of science in the courts that moves beyond the sole issue of the *Daubert* standard.

Finally, in this chapter I explored how the task force and the courts handled experiential evidence about abortion regret. The task force considered the stories from women who regret their abortions to be particularly powerful and a central motivating factor to further restricting access to the procedure. In the *Rounds* cases, much of the same experiential evidence was submitted into the record, but the judges contended that it lack relevancy to the South Dakota case. However, in other legal disputes the stories of women who regret their abortions has been cited as sole evidence that abortion should be restricted, even in light of scientific evidence to the contrary (*Carhart v. Gonzales* 2007). Rather than leading to greater autonomy for women, abortion restrictions are often upheld within the courts based on sexist beliefs about women’s decision-making capabilities and paternalistic impulses to protect women from themselves (Manian 2009). Abortion regret narratives, in which the authors

describe themselves as being naïve about reproduction, only further reinforce the belief that women are not intelligent enough to make decisions about their health care. These frames are also deployed within a context of abortion stigma. As McCammon and her colleagues argue, social movement frames that draw on hegemonic discourses are associated with successful outcomes (2007). More systematic evidence is needed, but it is possible that the juxtaposition of scientific and experiential claims about abortion's harm to women have a distinct advantage because they tap into dominant understandings of gender and abortion. That is, these claims are more likely to resonate because they conform to what we believe women *should* feel like after an abortion.

## CONCLUSION

The emergence and growing prominence of women-centered strategies within the antiabortion movement have had a number of important consequences for abortion policy, scientific institutions, and the movement itself. The argument that abortion harms women has a long history in parts of the mainstream prolife movement, particularly within crisis pregnancy centers and post abortion organizations. Over time the nature of that argument changed as prolife groups began to collect and publicize stories of women who came to regret their abortions and as researchers who were critical of abortion began to engage in scientific debates over the potential health consequences of abortion. During the 1990s, the changing legal and political landscape shifted dramatically for the movement. New political, intellectual, and discursive opportunities allowed the movement to direct their efforts at restricting access to and recriminalizing abortion by framing its demands in terms of harm to women. As I have shown women-centered strategies and scientific arguments about abortion's harms have been taken up by nearly every stream of the contemporary prolife movement.

Women-centered arguments about the harms of abortion are grounded, in part, in scientific claims that abortion is associated with breast cancer and with mental illness. Though questions about abortion's long term impact on breast cancer and mental health originated within scientific communities of epidemiologists, breast cancer researchers, psychologists, and psychiatrists, the engagement of prolife

researchers has shaped the evolution of these debates. In the case of a possible association between abortion and breast cancer, researchers like Joel Brind and Angela Lanfranchi were able to use political connections to get the National Cancer Institute to reevaluate the Institute's position on the possible link on two separate occasions. As research on the topic improved, epidemiologists and breast cancer researchers came to the conclusion that there is no association between abortion and an increased risk of breast cancer, and they have been relatively successful at portraying Brind and other researchers as outsiders who are driven by politics rather than scientific curiosity. In the case of a potential link between abortion and mental illness, researchers critical of abortion deployed a different set of credibility tactics to continue debate and promote uncertainty. In this instance, researchers like David Reardon and Priscilla Coleman analyzed associations between abortion and a variety of mental health outcomes in large national databases. They have also had their work published in important peer-reviewed journals. Both the American Psychological Association and the American Psychiatric Association have concluded that they are wrong: a single, first trimester, legal abortion of an unwanted pregnancy leaves women at no greater risk for mental illness than if they had carried the pregnancy to term. However, mainstream mental health researchers have been less successful at performing the boundary work that could isolate Reardon and Coleman and bring about closure to the controversy.

In addition to scientific arguments about abortion's potential harms, the pro-life movement has also benefited from a long history of experiential evidence of abortion's effect on women through abortion regret narratives. These narratives are

often presented alongside scientific claims, which results in a close juxtaposition of issues of expertise and experience. These narratives, along with shifting understandings of what it meant to be a victim of abortion, played an important role in the development prolife claims about Post Abortion Syndrome, which prolife researchers initially argued was a variant of Post-Traumatic Stress Disorder. Interactions between women in post abortion organizations, prolife researchers, movement leaders, mental health researchers, and post abortion recovery therapists shaped and reshaped the definition of PAS over time. As prolife researchers began to pursue new lines of research on abortion and mental health, women's regret narratives and post abortion healing regimes began to have a much greater influence on the antiabortion movement's understandings of PAS.

The narratives produced by women who regret their abortions were not just powerful experiential evidence that influenced prolife understandings. They have also been used outside of the movement in concert with the movement's scientific claims to advance policy goals and restrict access to abortion. As I have shown in my examination of abortion policy in South Dakota, political and legal institutions weigh the value of experiential and scientific evidence differently depending on the context. The South Dakota Task Force to Study Abortion found the experiential evidence particularly compelling, but the judges in the Eight Circuit Court of Appeals largely dismissed it as irrelevant to the case. However, both the task force and the court struggled to determine how to evaluate the scientific evidence about abortion and its aftermath. Both ultimately decided that the claims put forward by prolife experts were

more credible than those of the American Psychological Association and the American College of Obstetrics and Gynecology. This case illustrates the ongoing difficulty of sorting out scientific controversies within the legal and policy spheres and the impact that framing opposition to abortion in terms of protecting women's health has had on abortion policy. In the remainder of the conclusion, I turn to the contributions this work makes to the sociology of social movements and science and technology studies. Additionally, I examine the gendered implications of the stories we tell about abortion and the implications of women-centered strategies for the future of the abortion debate.

### **Framing and Impact**

The adoption of women-centered strategies and the claim that abortion is harmful to women has grown in prominence within the antiabortion movement as new political, intellectual, and discursive opportunities emerged. The "abortion harms women" frame has been deployed by the antiabortion movement in an attempt to persuade a number of movement targets to enact restrictions on abortion. By framing their concerns about the impact of abortion on women's well-being in scientific terms, prolife activists and researchers were able to engage with the scientific community in novel ways. As epidemiologists and breast cancer researchers began to grapple with the influence of reproductive events on breast cancer risk, researchers who were critical of abortion were able to push for greater evaluation of the possible association between induced abortion and breast cancer. Similarly, prolife researchers were able to



intervene in psychological research on abortion and mental health and became prolific contributors to the peer-reviewed literature on the topic. Despite the flaws of this research, the work of Priscilla Coleman, David Reardon, and their co-authors has been included in many scientific reviews on the topic and is cited by legislators and policy-makers who seek to limit access to abortion.

Changes within the political and legal environments also led to the proliferation of movement's scientific claims that abortion is harmful to women. Legal decisions, like *Casey*, that allow greater regulation of abortion, the election of conservatives to state and federal offices, and public distaste for protest at clinics were all changes that facilitated more incrementalist and women-centered strategies. Further the language of *Roe* and *Casey*, which emphasized the interests of the state to intervene in provision of abortion to protect the health of pregnant women, provided a discursive opportunity structure that made restrictions framed in those terms more likely to resonate with judges and policy-makers. It is important to note that advocates for abortion rights had long utilized this same discursive opportunity by framing their argument for increased access and opposition to regulation in terms of protecting women's health. As in the *Rounds* cases, legal fights over abortion restrictions are now often fought between two sides that both claim to be invested in protecting women's health and using scientific evidence that supports their claim.

In addition to the changing landscape of opportunity structures, the prolife movement has also evolved in response to the prochoice movement. Many prolife activists in the mid-1990s were willing to concede that "choice" had become the

dominant framework for understanding abortion. Internal research by the NRLC found that many people believed that abortion was the end of distinct human life, but were unwilling to support laws that would deprive others of making the “choice” to terminate a pregnancy. This research also revealed that the prolife movement was seen as not supportive of pregnant women and caring only about saving the fetus. In response to these movement/countermovement dynamics, prolife organizations began to highlight the role of CPCs and post abortion organizations within the movement as well as to transition the argument that abortion harms women from an internal frame to an external frame (Willke 2001; Siegel 2008).

The rise of women-centered strategies raises important questions about how we study social movements and, particularly, the role of framing in social movement outcomes. This dissertation shows how the argument that abortion harms women has been used to advance movement goals in a number of different institutional settings. While political and legal intuitions have been the central targets of the prolife movement, scientific institutions, professional organizations, women who visit CPCs, and the public’s beliefs about abortion have also become targets for the movement. Scholars of social movements have found that social movements often have targets other than the state (Armstrong and Bernstein 2008). For example, some movements target businesses (Soule 2012), scientific practices (Moore 2008), schools (Binder 2002) or religious organizations (for example, organizations for victims of sexual abuse by religious officials). My dissertation reminds us that social movements may have multiple targets and pursue changes within multiple institutions at the same time.

Additionally, the tactics used by movements to achieve their outcomes may be quite different depending on the target. What brings success within a legal dispute may not get the same result when directed at legislators. More research on long-standing, professionalized movements, like the prolife movement, might reveal important information about how movements allocate resources, mobilize, and achieve different outcomes through targeting multiple institutions.

Most of the research on social movement framing has focused on internal dynamics in which movements decide upon how to frame grievances and goals. Less attention has been paid to why and how these frames resonate with movement targets (for exceptions see Reese and Newcombe 1996; Cress and Snow 2001; and McCammon et al 2007). The ability to determine how frames resonate and persuade their targets is an important aspect of determining the impact of social movements (McCammon et al 2007). As Holly McCammon and her co-authors argue, the persuasiveness of a particular frame is not just dependent on the frame itself, but also the cultural context in which the frame is deployed. The systematic, quantitative approach employed by McCammon et al. offers a means to measure the impact of particular frames within in certain cultural contexts in the legal system, but examining the impact of framing across a greater variety of types of targets may provide more clarity about how cultural context influences the impact of frames.

My research demonstrates that impact of a frame is also influenced by the professional rules and practices of the intended target. The claim that abortion is associated with breast cancer and mental illness has been more persuasive in legal and

political settings, but has had less success in scientific communities. Additionally, the argument that abortion harms women has been a powerful frame within the prolife movement and has proliferated to most antiabortion organizations, however, more research is needed to ascertain how much this frame resonates with the public's beliefs about abortion. Examining social movements that target multiple institutions can also generate comparisons of organizational culture and its effect on social movement influence. Research that focuses on the organizational and institutional cultures of social movement targets may bring new insights into whether certain kinds of organizations are more receptive to social movement claims (Zald, Morrill, and Rao 2006). For example, it may be the case that policy making institutions are more likely to address the demands of social movements because these kinds of institutions are accustomed to being lobbied by special interests and targeted by movements. Research institutions, courts, and professional organizations may be less receptive to social movement demands.

Moreover, how a grievance is framed and in what cultural or organizational context only represents part of the story of the influence of social movements. The way different kinds of expertise are deployed affects the impact of a social movement because each context has its own definitions of expertise and credibility. In some cases, the argument that abortion harms women is made using mostly or exclusively the experiential evidence provided by women who regret their abortions. This deployment of experiential expertise has been a persuasive internal frame for changing the way antiabortion activists think about women who get abortions and have been

cited in some legal cases, most notably *Carhart v. Gonzales*, to justify greater regulation of abortion practice. In other instances, the argument that abortion harms women was made primarily using scientific evidence, as in the *Rounds* cases. More research it needed to determine exactly how conscious prolife leaders were about the strategic advantages of aligning experiential and scientific claims. Nonetheless, the benefits of combining these two types of evidence are clear. Though this scientific argument is highly contested by scientists and many professional organizations, researchers who are critical of abortion have been able to persuade federal and state lawmakers as well as some federal judges that their interpretation of the evidence is correct. And, of course, there are numerous instances in which the scientific claims of prolife researchers are used in conjunction with the experiential evidence of post-abortion women, such as in the proceedings of the South Dakota Task Force to Study Abortion. This research draws attention to the need for social movement scholars to examine the ways various kinds of expertise get deployed and the potential influence these experts have over the outcome of policy debates and legal disputes.

### **Expertise and Credibility**

The disputes over possible associations between abortion and breast cancer and between abortion and mental illness illuminate the changing role of expertise and credibility in contemporary scientific controversies. Though many scientists and critics are quick to dismiss the claims of researchers like Brind, Lanfranchi, Coleman, and Reardon as pseudoscience or junk science, it cannot be denied that these researchers have made a significant impact in continuing these controversies through

the promotion of uncertainty. My analysis demonstrates that in both controversies, researchers who are critical of abortion employed credibility tactics from the constitutive and contingent forums (Collins and Pinch 1979); they used the tools of both science and politics to bolster their own credibility and to further their claims about abortion's impact on women's health. In the abortion/breast cancer controversy, they lost the battle over credibility: the statements of researchers and the position of the NCI became more certain and less qualified over time, and epidemiologists and breast cancer researchers were successful in performing boundary work that painted Brind and Lanfranchi as politically motivated outsiders. In contrast, the statements of researchers and professional mental health organizations dealing with abortion's relationship to mental health remained less certain and more qualified. These controversies involved scientific communities that were quite different. For example, epidemiologists and breast cancer researchers were able to adequately measure associations between reproductive events and risk of breast cancer, to use international research to overcome methodological problems, and to draw on professional tools for analyzing potential associations. Mental health researchers faced different challenges in these areas. Beyond these differences, researchers who are critical of abortion deployed different strategies for continuing controversy. For example, Brind and Lanfranchi embraced their outsider status in the debate and used political connections to demand reviews of the research. They also published their research and commentary in conservative journals and periodicals. In contrast, researchers like Reardon and Coleman continued to publish their research in peer-reviewed, academic

venues, and this made it more difficult for mainstream researchers to dismiss their work or maintain boundaries between science and nonscience.

These controversies are illustrative of those identified by STS scholars as particularly vexing (Latour 2004; Oreskes and Conway 2010). Like climate change, tobacco control, or concerns about the safety of vaccines, they highlight the ways in which scientific consensus or majority opinion can be subverted by an industry or even a few vocal, well-connected individuals. In conducting this research, the most common question I encountered in casual conversations with friends, family members, and relative strangers was whether the claims of prolife researchers are true. And, to me, that is the least interesting question about these controversies. Questions that reveal larger social issues are: Under what circumstances are these claims considered to be true and in what instances does it not matter whether they are true? What does it say about the status of scientific authority in U.S. society when it is commonplace to have unending controversies in which the science is relatively clear?

Rather than seeing science as “politics pursued by other means” (Latour 1993: 111) or as singular arbiter of truth whose practices must be defended from profit-motivated, regulation adverse industries (Oreskes and Conway 2010), we should strive for analyzes of controversies that see the theories and practices of scientific inquiry as one arbiter of truth among many. The controversy over abortion’s potential harms to women draw attention to the multiple institutions and discourses that can become involved in a scientific controversy. In addition to the state and the scientific community, these controversies involve religious organizations, social movements,

reproductive health policy, and legal standards of evidence. They are embedded in discourses about protecting women's health, gendered understandings of women as decision makers, and a clash over sexual values. As this dissertation has shown, different social arenas have different standards for determining who counts as an expert and what counts as good evidence. By continuing to analyze how scientific controversies are shaped as they cross the boundaries of different social arenas, STS scholars might be better equipped to understand the developments that Latour (2004), Oreskes and Conway (2010), and Collins and Evans (2007) identify, namely the diminished authority of scientists and their capacity to influence policy. Controversies involving sexuality and reproduction, in particular, provide rich ground to develop more complex understandings of the relationships among science, expertise, and policy (Epstein and Huff 2010). The debate about abortion and women's health, and others around sexual health, are influenced not just by technical disputes on one hand and politics on the other. Instead these debates are shaped by scientific knowledge, physician practices, the rights of patients, law and regulation, and religion and morality.

Beyond examining how expertise and credibility are constructed in different social context, we also should consider new conceptions of expertise. For example, the analysis of networks of actors, devices, and intuitions developed by Eyal (2013) provides a new way to explore how disease categories and different types of experts influence each other and how these networks may shift over time. In my examination of PAS, I demonstrated how the expertise network changed over time. As the



relationships between prolife researchers, women in post abortion organizations, movement leaders, therapists, and mainstream scientists changed, so did understandings of PAS and what it meant to be a victim of abortion. Earlier work on expertise had focused more on expanding the definition of expertise to include invested lay persons (Epstein 1996; Wynne 1992), acknowledging the uneasy tensions between experts and activists (Murphy 2006), or categorizing types of experts (Collins and Evans 2007). Seeing expertise as a network better allows scholars to examine interactions between different kinds of experts, to see how expertise changes over time, and to investigate the relationships among experts, social movements, and scientific understandings of disease. In addition to examining the ways that social movement influence expert understandings of disease, my work also highlights the role that experts have in shaping movement processes, particularly framing. The work of researchers who are critical of abortion was essential to the development and deployment of the claim that abortion harms women.

### **Abortion Stories**

“The only people who would listen to me say I had any emotions were people who wanted me to fall down on my knees and ask for forgiveness.”

-Mayah, New York Magazine 2013

Public narratives play an important role in how we view abortion and its continued legality. Stories about abortion have been central to the movements for and against abortion access since the late 1960s. Feminist groups, like the Redstockings, held public events in which women spoke about their experiences with illegal abortion

in order to illustrate the need to make the procedure legal and safe. Prolife and post abortion organizations have showcased the narratives of women who regret their abortions to demonstrate the need to do just the opposite – to further regulate and recriminalize abortion. And in debates over banning certain abortion procedures or abortion after 20-weeks, prochoice organizations frequently promote stories of women who terminated wanted pregnancies due to maternal or fetal health issues. In this case, the narratives are deployed to further the argument that abortions later in the pregnancy are rare, but medically necessary and often safer than carrying the pregnancy to term.

The stories we tell about abortion have particular gendered consequences. Abortion regret narratives developed by women in post abortion organizations portray women as possessing inherent qualities associated with nurturance and motherhood. Terminating a pregnancy violates the natural role of women as protectors of the young and helpless. At the same time that women are characterized as inherently maternal, they are also seen as uniquely naïve about reproduction. Many women write that if they had just known that abortion was “killing a baby” they would have never gone through with the procedure. In these stories, women are in need of additional protection from the state to insure that they are informed and that more knowledge of fetal development would cause women to realize how contrary abortion is to their nature.

On the other hand, narratives produced by women in the service of advocating for abortion’s continued legality tend to focus on the “hard cases” in which women

face dire circumstances and abortion becomes the best option. For example, in June of 2013 the *New York Times* published Judy Nicastro's account of her decision to have an abortion at 23 weeks after discovering that one of the fetuses she was carrying had significant abnormalities. Nicastro describes herself as already a mother to the twins she was carrying, and sees her decision to terminate the pregnancy as loving and nurturing. She writes, "We made sure our son was not born only to suffer. He died in a warm and loving place, inside me." These kinds of narratives don't explicitly rely on an essentialist understanding of femininity and motherhood, but draw on those tropes to characterize abortion as a decision a woman might make in the best interests of her potential or existing child(ren). In these narratives abortion is an act of responsible motherhood, not a failure to be maternal.

Further, the predominant prolife and prochoice narratives often play into our fears about women's decision-making and abortion. We regularly hear politicians declaring that women should not use abortion as birth control and liberals often repeat the mantra that abortion should be safe, legal, and rare. Among the general public, it is common to hear a person describe their stance on abortion as a choice they would never personally make, but that they do not want to prevent other people from making. Legislators justify restricting access to abortion on the belief that women are not fully capable of making decisions without additional regulation. At the heart of these sentiments is the fear that women do not make thoughtful and informed decisions about abortion; that they end pregnancies that are merely inconvenient. The women who write abortion regret narratives often recount that they were largely uninformed

about abortion and that with more information they would not have chosen to end their pregnancies. The stories of women who have abortions in extreme cases represent women “deserving” of utilizing abortion care services. Their decisions are characterized as thoughtful and informed. There are few public stories about women facing unwanted pregnancies who make the decision to have an abortion based on good information and careful consideration.

Narratives about abortion also support certain understandings of abortion and the typical abortion experience. Abortion regret narratives are designed to highlight the negative emotional and physical consequences of abortion as a normal response to an abnormal decision. When interconnected with scientific claims about abortion’s potential harm, these narratives depict what prolife organizations see as the typical experience of abortion. In contrast, the most common stories presented by prochoice organizations are of extreme cases that demonstrate the medical necessity of abortion. These are paired with scientific evidence that women who terminated an unwanted pregnancy are at no more risk than women who carry an unwanted pregnancy to term. Within the policy sphere, this often cedes the “normal experience” to opponents of abortion. It creates the impression that abortion is safe for most women, but its accessibility is particularly important for extreme cases.

Finally, these narratives exclude other kinds of stories about abortion that are more common. First, many women make the decision to terminate a pregnancy and do not experience negative emotional consequences. Between one-quarter and one-third of all women in the United States will have an abortion at some point in their

reproductive years (Guttmacher 2014a). If the assertions about abortion and mental health made by the prolife movement were accurate, there would be a large public health crisis as a result. Additionally, current research on women who sought out counseling after abortion finds that they attribute their emotional struggles to a lack of support from their partner, their family and their friends.(Kimport, Foster, Weitz 2011).This highlights a central tension within research on abortion and mental health – it may be the case that the negative emotional aftermath some women experience may be related to the success of the antiabortion movement in stigmatizing abortion and cutting women off from social support. Finally, the most prominent prolife and prochoice abortion narratives obscure the larger social structures that impact reproductive decision-making. Abortion regret narratives usually identify abortion providers, pressure from partners, and lack of support from family as the central influences in the author’s decision to end a pregnancy. These are certainly important, but many women also choose to terminate pregnancies due to financial reasons as well as to pre-existing commitments to education, work, or care for others. The focus on these individual factors precludes a discussion about the impact on reproductive decisions of poverty and a lack of support for motherhood in schools or the workplace. This lack of attention to the relationship between these social constraints and abortion further excludes the voices and experiences of poor women and women of color.

In recent years, there has been more journalistic attention paid to the abortion experiences of women. In 2005, Jennifer Baumgardner and Gillian Aldrich produced the film *I Had an Abortion*, which featured eleven women telling the stories of their

abortion. This was followed by Baumgardner's book *Abortion and Life* that explored what she identified as the pro-voice position, which emphasize the importance of expressing abortion experiences without promoting a particular political or religious view of the procedure (2008). And in the fall of 2013, *New York Magazine* published the stories of 26 women who had abortions, including Mayah's, a 23 year-old who had an abortion in Oregon in 2009 and whose quote opened this section. These types of accounts create a much different portrait of abortion in the United States than those presented by either the prolife or prochoice movements. The authors of these stories characterize abortion as a difficult decision, but one that is carefully considered. More importantly, they place the experience of having an unwanted pregnancy and the abortion decision within a larger social context of gender and social inequality as well as stigma. As Jeannie Ludlow has argued, these kinds of stories add complexity and nuance that has the potential to deconstruct the dichotomies within the abortion debate between "life" and "choice" (2008).

Narratives have significant power in public debates (Polletta 2006). Narratives about victimhood may be persuasive in policy debates and legal proceedings, but they can also negatively impact social movement recruitment (Polletta 2006). As Polletta argues, these kinds of movements may be unattractive to potential members who do not see themselves as victims or that are unwilling to take on the victim identity. My analysis of post-abortion organizations indicates that some movements either do not face this challenge or are able to mitigate its impact. Additionally, Wendy Brown has argued that political claims based in a shared injury or victim identity can lead to

demands of protection from state power that only perpetuates injury (1995).

Movements built around injury, which includes feminist movements in Brown's account, often fail to pursue political power. The inclusion of more kinds of narratives within public discourse around abortion may not only work to destigmatize the procedure but also move mobilization around abortion away from victimization.

### **The Impact of Women-Centered Strategies and the Future of Abortion Politics**

The shifts the prolife movement has undergone within the past two decades led to numerous policy victories that have reshaped the practice of abortion in the United States. By adopting an incrementalist approach and by leveraging the claim that abortion harms women, prolife organizations have made gains in the policy sphere, have seen their policies upheld in court decisions, and have addressed a major criticism of the movement – that it does not represent the interests of women. As previously mentioned, between 2011 and 2013, 160 new abortion restrictions were enacted in the states (Guttmacher 2014b). Women seeking abortions are now much more likely to have to wait at least 24 hours between their initial counseling appointment and their procedure, to receive state-mandated information about the risks of abortion and abortion alternatives, to be given state-mandated materials that inaccurately describe the potential complications they may face, and to have an ultrasound before their abortion as the result of state-level policies.<sup>88</sup> Further, women

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<sup>88</sup> The use of ultrasound in abortion has become much more common place due to two factors. First, many states have enacted laws that require doctors to perform an ultrasound prior to abortion and some states require women to view it. Other states require that women be offered the chance to view their ultrasound. Second, and more importantly, ultrasound is now seen as the most reliable way to assess

are less likely to have access to state funds via Medicaid to cover the cost of their abortion. To be sure, the increased number of states in which Republicans have control over both houses of state legislatures and the governorship is a contributing factor to this rise in policy successes. Still, my research demonstrates that the prolife movement was particularly well positioned to take advantage of the changing landscape of political opportunities.

Beyond the policy context, the claim that abortion harms women has also helped the prolife movement to make less obvious gains. First, the mobilization of disputed scientific evidence of abortion's associations with breast cancer and mental illness has given greater credibility to prolife researchers, particularly outside of the scientific community. While these claims are disputed by many scientists, during expert reviews by government institutions and professional organizations the work of prolife researchers is included and evaluated alongside other studies. Moreover, these researchers play a role in science and policy. During the administration of George W. Bush, Joel Brind was selected to be a member of the CDC's Breast and Cervical Cancer Early Detection and Control Advisory Committee from 2003 to 2005. And Vincent Rue and Priscilla Coleman have been expert witnesses in legal cases about abortion and mental health. Their claims may be dismissed by the larger scientific community, but researchers who are critical of abortion have gotten a place at the political table to be able to influence health policy.

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gestational age and providers consider it an important component of good abortion care. Over 90% of women seeking abortion will have an ultrasound prior to the procedure.



Additionally, the argument that abortion harms women has given the prolife movement a platform to claim to be representatives of women's interests. By highlighting the work of CPCs and showcasing women who regret their abortions, prolife organizations have made the case that they, rather than prochoice organizations, are the real voices for women's reproductive interests. Most of the legal defense around abortion restrictions is based on the claim that greater regulations are needed to protect women's health and to ensure that their health care decisions are thoughtful and informed. Finally, some prolife organizations have begun to portray their opposition to abortion as grounded in the legacy of feminism and women's rights (particularly the movement for women's suffrage) rather than in the antifeminist sentiments that characterized the early prolife movement.

While the prolife movement has had substantial legal and policy victories over the past decade, the prochoice movement has largely been going through a period of rebuilding. Only a handful of prochoice policies have been enacted. These include California's expansion of abortion access to allow advanced care professionals to administer medical abortions and to perform first trimester vacuum aspiration abortions. Additionally, Vermont repealed its pre-*Roe* ban on abortion. Additionally, the lawsuits generated by new abortion restrictions are making their way through the federal court system. It is possible that prochoice groups will experience some success in having these laws overturned. Within the policy arena, prochoice organizations are in a much more defensive position, essentially weathering the onslaught of new abortion restrictions. This is mainly a process of legal strategy in which organizations

like Planned Parenthood, the Center for Reproductive Rights, and the ACLU decide which restrictions to challenge in which states to minimize cost and overall and maximize the chances of appearing in a federal or circuit court that is receptive to their argument.

Beyond policy debates, the proponents of access to abortion have been responding to the rise of women-centered strategies in new ways. These include focusing more on women's experiences of abortion, developing new services, engaging more with cultural representations of abortion, and rethinking the use of the term "prochoice" to describe the movement. First, in response to the growing prominence of abortion regret narratives, supporters of abortion rights have begun to develop avenues to women to talk about their experiences with abortion. As mentioned previously, these efforts include books, magazine articles, and a documentary in which women narrate their own abortion story without having to take a political stand for or against abortion. These types of stories typically add nuance and complexity to how we see the experience of terminating a pregnancy. Additionally, there are staunchly prochoice websites, like Thanks, Abortion! and I'm Not Sorry, that encourage women to post their positive stories about abortion and the good outcomes they experienced as a result. For example, Cass writes on Thanks, Abortion!, "I knew that I was making the right decision. That doesn't mean it wasn't a ridiculously hard and painful decision to make, but I knew and still know that it was the right decision for me. I have never regretted it, not even for a moment" (Thanks, Abortion 2012). These types of narratives provide a counterpoint to the prolife claim

that women make decisions about abortion without being fully informed and that they come to regret them. Among supports of reproductive rights, these kinds of stories provide one way to reduce the silence and stigma surrounding abortion. These stories also expand representations of a “normal” abortion experience beyond those presented by the prolife movement.

These attempts to expand public narratives about “normal” experiences with abortion face significant obstacles. Scholarship on the role of framing in social movement outcomes contend that frames that draw on hegemonic discourses like legal principles and traditional beliefs about gender are more likely to resonate with and persuade policy makers (McCammon et al 2007). My analysis of the women’s health frame developed by the prolife movement demonstrates that this frame taps into powerful discourses about science, governance, and traditional beliefs about women. This frame is also deployed within a sociocultural context in which abortion is highly stigmatized. I contend that the antiabortion movement’s scientific claims about abortion’s harm paired with experiential evidence from women who regret their abortions is particularly persuasive because it confirms how we think women should feel after an abortion. More research is needed, but these stories of women who do not regret their abortions may not resonate with policy makers because they challenge both traditional gender beliefs and abortion stigma.

Secondly, reproductive rights activists have also begun to develop new services that mirror prolife services (which are themselves mirrors of earlier prochoice services). One of the critiques that has been made against some abortion providers and

the prochoice movement more generally is that there is a lack of abortion aftercare. Abortion providers rarely offer counseling for women after the abortion. Exhale, an Oakland, CA based organization, offers counseling via a national talkline and is an alternative to the post abortion counseling services offered by CPCs and post abortion therapy programs. The organization promotes a pro-choice position and does not take a stance on the legality of abortion. The Exhale website also has a blog in which some women share their stories about abortion alongside posts by the organization's leaders and volunteers. According to the organization's website, Exhale has placed over 250,000 brochures for their services in abortion clinics around the country. Additionally, Backline, another Oakland-based organization, runs an "all options" talkline to offer "unconditional and judgment-free support for people in all their decisions, feelings and experiences with pregnancy, parenting, adoption and abortion" ("About Us" 2014) and plans to open a pregnancy resource center in Bloomington, Indiana in the near future. Backline is a non-religious, non-political alternative to prolife crisis pregnancy centers, but with more expanded services, including offering support for women facing fertility issues as well as those who are dealing with parenting challenges. Organizations like Exhale and Backline provide services somewhat similar to those offered by prolife organizations, but structured on a feminist ideology of allowing women to tell their own stories without judgment. These services are important because they both address critiques of the prochoice movement made by prolife organizations and compete directly with similar prolife services.

Third, prochoice and reproductive rights organizations have worked on critiquing and changing cultural representations of abortion. The 2014 film, “Obvious Child,” is just one example of this phenomenon. Though the film was independently conceived and written, organizations like Planned Parenthood and NARAL hosted screenings in many cities. Additionally, in 2010 Exhale worked with MTV to produce an hour long documentary, “No Easy Decision,” which depicted a teenage couple’s struggle with pregnancy and the decision to have an abortion. The documentary is part of MTV’s larger series of teenage pregnancy shows, “16 & Pregnant” and “Teen Mom 1 & 2.” (Exhale “About Us” 2014). Research on film and television depictions of abortion has demonstrated that abortion is much more likely to be represented as resulting in medical complications and death in film and television than in real life (Sisson and Kimport 2014). Engaging in how the procedure and its aftermath are represented can have an impact on abortion stigma. By changing media representations of abortion, activists hope to reduce silence and stigma while also depicting abortion as a normal outcome of an unwanted or unplanned pregnancy. These attempts to destigmatize abortion are crucial for future policy success. By changing the sociocultural context about abortion, the frames presented by proponents of reproductive rights are more likely to resonate with and persuade key decision makers.

Fourth, there has been talk among some mainstream prochoice organizations about moving away from the words “prochoice” and “choice” and towards terms that are more inclusive of concepts like reproductive rights, reproductive justice, and

autonomy. In July, the *New York Times* reported that Planned Parenthood has been discussing moving to a broader term for a few years, in part because polling has shown that the term prochoice does not resonate with younger voters (Calmes 2014). representatives from Planned Parenthood and Emily's List favor more inclusive terms that highlight the relationships among contraception, abortion, economic issues, and women's health (2014). As is evident from organizations like Exhale and Backline, which identify as provoice, there is considerable support among activists to rethink the "choice" framework and to focus on the larger social context in which reproductive decisions get made.

Further, it is important to note that the prochoice movement is responding to not just changing opportunity structures and the prolife movement. Since its inception, the movement to liberalize and legalize abortion has faced criticism from reproductive justice organizations. Women of color have rightly argued that the prochoice movement has focused almost exclusively on the reproductive concerns of white, middle-class women, namely contraception and abortion, and have ignored issues that affect marginalized groups. For example, reproductive justice organizations are much more likely to see connections among reproductive health, environmental justice, incarceration of mothers, and access to adequate health care. LGBT organizations have also critiqued the prochoice movement for dismissing the reproductive concerns of lesbian, bisexual, and transgender women. The influence of reproductive justice organizations will likely result in a broader framing of reproductive rights that

identifies access to contraception and abortion as part of the larger movement for women's health.

As organizations that support abortion rights are broadening their arguments, so too are prolife organizations. The future of the abortion debate will likely see the continuation of two distinct trends: abortion creep and isolating abortion and contraception from other health care services. By abortion creep, I am referring to the expansion of abortion related arguments into other areas of reproductive health while also isolating these areas from larger debates over health care. The most recent example of this is the current debate over religious exemptions for contraceptive coverage in the Affordable Care Act. While some religious employers only oppose covering emergency contraceptives and IUDs because of the belief that these forms of birth control are abortifacients, other religious groups see all forms of hormonal birth control as causing abortions.<sup>89</sup> However, efforts to unite opposition to abortion with opposition to contraception have a longer history within the prolife movement. Concerns about emergency contraception acting as an abortifacient also played a prominent role in the FDA's process of evaluating whether to allow Plan B to be sold over-the-counter use (Epstein and Huff 2010). Concerns about contraception have also begun to impact post abortion organizations. For example, Rachel Vineyard cofounder, Theresa Burke, offers healing programs for women who have used

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<sup>89</sup> Until recently it was not known exactly how hormonal birth control worked to prevent pregnancy. Research has shown the contraceptive pills, emergency contraception, and the Mirena IUD prevent pregnancy by preventing ovulation. The Paragard IUD prevents pregnancy by making the uterine environment unwelcoming to sperm and to a fertilized egg. Using the medical definition of pregnancy (i.e. the implantation of a fertilized egg in the uterine wall) none of these forms of contraception act as abortifacients. However, Catholics and some evangelical Protestants believe that life begins at the moment of conception and thus any drug that prevents a fertilized egg from implanting is the equivalent of abortion.

hormonal contraception in the past and have come to regret the “abortions” they may have had while on the pill (2005). The antiabortion movement considered the Supreme Court’s ruling in *Burwell v. Hobby Lobby* (2014) to be a significant victory and will likely continue efforts to frame birth control and abortion as distinct from other forms of health care. In the coming years, we will likely see more cases in which reproductive health care is pitted against religious freedom.

Finally, the antiabortion movement is likely to continue to push legislation that works to frame abortion as distinct from other forms of health care and that portrays doctors who perform abortions as in need of heightened regulation. This is particularly true of Targeted Regulations of Abortion Providers, or TRAP laws, which single out abortion for unique medical regulation. These laws have been enacted in a growing number of states. For example, 25 states have some sort of regulation of abortion care that go beyond what is necessary to ensure patient safety, and 23 states require facilities that perform abortion to meet the standards for ambulatory surgical centers (Guttmacher Institute 2014f). They are often justified on the basis of protecting women’s health, but also work to regulate abortion differently from comparable medical procedures. Doctors have historically been important allies of the prochoice movement (Halfmann 2011), and even those who do not offer abortion services have often seen the benefit of opposing unnecessary regulations on their profession. For example, the AMA and ACOG have both filed briefs on behalf of Planned Parenthood in the legal action over requiring doctors who perform abortions to have admitting privileges. However, some abortion restrictions are designed to benefit some groups of



doctors and health care professionals while simultaneously making contraception and abortion seem separate from normal health care. Conscience clauses, which allow medical professionals to opt-out of providing medical care that they deem a violation of their religious freedom (typically abortion provision and the dispensing of contraceptives), are one example. Another instance of this are laws that ban “wrongful birth” lawsuits, which protect doctors from malpractice laws filed when they fail to disclose fetal abnormality detected during ultrasound and prenatal testing. Advocates of these laws claim that they protect doctors from unnecessary malpractice lawsuits, but supporters of reproductive rights claim that the laws allow doctors to lie to women, particularly if s/he believes that the information might result in the decision to end a pregnancy. Laws that allow some health professionals to refuse to provide specific reproductive health care services are another example of this. Currently, 43 states allow medical professionals to refuse to provide abortions and 13 allow some to refuse to provide services related to contraception (Guttmacher Institute 2014e). Conscience clauses not only limit the health care options of women, they also serve to make reproductive health care distinct from other types of care. As previously mentioned, one of the effects of abortion stigma is that doctors who perform abortions experience a “legitimacy paradox” in which abortion providers are stereotyped in negative ways (Harris et al 2013). Laws that are designed exclude contraception and abortion from regular medical care and to isolate abortion providers from their colleagues capitalize on abortion stigma.

In the upcoming months, federal courts will hear cases that challenge the constitutionality of recently passed abortion restrictions. These cases include new requirements that doctors have admitting privileges at local hospitals (a restriction that has been passed in 5 states), bans on abortions after 20 weeks (passed in 9 states), and laws requiring abortions to be performed as ambulatory surgical centers (passed in 23 states) (Guttmacher Institute 2014b and 2014f). Research has shown that first trimester abortions are extremely safe. In one study it was found that complications from this procedure occur in less than 2% of the cases (Weitz et al 2013). Advocates of reproductive rights have argued that these laws pose an unnecessary burden on doctors and are designed to close abortion clinics. As these battles unfold in the courtroom, judges will not be hearing arguments from the state's lawyers about the sacredness of fetal life. Instead these lawyers will make the case that these restrictions are necessary to protect the health and safety of women. The prochoice movement has succeeded in changing the agenda of abortion policy debates to focus on women's health and safety, but as this dissertation demonstrates, that has not been without consequences.

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