

**Why Women Should Make the Abortion Decision:
Damned if you do, Damned if you don't
CHRISTINA SAN FILIPPO¹**

As a woman in today's society, a woman who has had life-altering decisions about her body made for her throughout her entire life, I want to call attention to other women who are just trying to make their own decisions about their own bodies.

With this work, I recognize that within society there is a split between those who support a woman's choice to have an abortion, and those who do not. I argue that both the decisions, to have an abortion, as well as to carry a pregnancy to term, have consequences. These consequences can be physical, sociological, and/or psychological. Therefore, the decision should be left to individual women to decide which consequences they are able to bear. For this reason, access to safe, medical care regarding reproduction and abortion should be available to all women, across all states.

Initially, I will establish the foundational background on the legalization of abortion. It will begin in the early 1800s, a time where abortion before "quickening" was legal for women in the United States. However, as women began to die from abortion inducing drugs, and Dr. Horatio Storer teamed with the American Medical Association to begin the "crusade on abortion," disdain for the procedure grew. Throughout the mid-to-late 1800s, states began passing legislation to ban the drugs used for abortions and, eventually, the procedure itself. Contraception was also federally outlawed with the Comstock Law of 1873. Almost 100 years later both became legalized again with the major Supreme Court cases *Griswold v. Connecticut*, *Eisenstadt v. Baird*, and *Roe v. Wade*.

This legalization has not come without obstacles, however. The second section of this work delves into the state barriers put on abortion. Although legal federally, state constitutions still allow for each state to put laws in place that restrict access to abortion, including zoning laws, mandatory counseling, mandatory waiting periods, and minor consent or notification. All of these barriers within states were upheld by the Supreme Court in the case of *Planned Parenthood v. Casey*. In addition to these ongoing issues in states, the current President proposed a domestic gag rule, and reinstated a global gag rule, that limits funding to abortion providers. This section will further discuss the specific details of the state laws regarding access to abortion, and the status of the issue of abortion within the current federal administration.

Thereafter, the physical, sociological, and/or psychological effects of access, or lack thereof, to abortion may have one women is considered. Reasons for having an abortion vary from financial instability to unstable relationships. Upon receiving one, there is mixed research on whether women suffer future physical, sociological, and/or psychological effects. A sad reality is that even if a woman wants an abortion and feels she is capable of handling these possible consequences, she may be unable to get one. Whether the reason be barriers related to geographic location or financial situation, being forced to carry an unwanted child may also bear physical, sociological, and/or psychological effects.

Finally, the analysis concludes that both having an abortion and not being able to have an abortion can have negative effects on a woman. These effects can be either

¹ Christina San Fillipo is a Law and Society graduate of Ramapo College of New Jersey

physical, psychological, and/or sociological. Women are capable of making their own decisions, and this should include access to abortion.

I. History of Abortion and Contraception Legalization

Today, it is easy to take certain things for granted. As people living in America, the land of the free, we do not take a second glance at some of the things we are able to do. Two of these things are the ability to receive educated medical advice on reproductive health from physicians, and the ability to get a safe and legal abortion. However, this was not always the case. At certain points in history, all things regarding contraception and abortion were outlawed in the US. Though we usually think of women's reproductive health as happening chronologically – first contraception and then abortion – the attention to women's bodies happened in the opposite order. Historically, abortion began to be regulated before contraception.

Legal Abortion Before “Quickening”

Before and during most of the 1800s, certain abortions were legal, and not uncommon. A woman was only allowed to seek an abortion before “quickening,” which was when she could feel the fetus moving. Before this, it was believed that human life did not exist. Surprisingly, even the Catholic Church shared this view, believing that abortions before quickening were “prior to ensoulment” (Ravitz, 2016). In society, early pregnancies that ended were not even considered abortions, but were rather seen as pregnancies that “slipped away” (Reagan, 2008, p. 8). At this time, conception was seen as something that created an imbalance within the body, due to the fact that it interrupted a woman's menstruation cycle (Reagan, 2008, p. 8). The way abortions usually worked was that women would take certain drugs to induce abortions. If these drugs failed, a woman could then visit a medical practitioner for an actual procedure to be rid of the fetus (Ravitz, 2016). Abortions before quickening were seen as a way to “bring the body back into balance by restoring the flow,” which meant the returning of the menstrual cycle (Reagan, 2008, p. 8). It was a practice done openly and honestly for pregnant women at this time.

Abortion Outlawed: The Beginning of the End

Although abortions done before quickening were legal, they were not entirely a safe practice. The drugs that women took to induce the abortions often ended in the death of the woman, rather than just the termination of the fetus. Due to this, states began passing statutes that controlled the sale of “abortifacient drugs” as a “poison control measures designed to protect pregnant women” (Reagan, 2008, p. 10). Each of these laws sought to punish whoever administered the drug, rather than the woman who received it (Mohr, 1979, p. 43). In 1821, Connecticut passed a statute outlawing the use of abortion inducing drugs, believing they were a threat to life by causing death by poisoning. However, the law was only applicable if the woman had already experienced quickening. It is important to note that the law was not focused on the actual act of abortion and did not even mention surgical abortions; the focus was on the drugs used for abortions. After this statute was passed in Connecticut, more states began to follow. Missouri in 1825, and then Illinois in 1827, also passed legislation outlawing the use of abortion inducing drugs in an attempt to avoid deaths by poisoning. However, both of

Why women should make the abortion decision

these states did not mention quickening, and made the use of these drugs illegal at any point during a woman's pregnancy (Mohr, 1979, pp. 22–26).

Within the next few years, several states also began passing legislation regarding abortion. However, these statutes focused more on the act of abortion, rather than the drugs that caused them. Similar to the anti-drug laws, these statutes also sought to punish the person who performed the abortion, not the woman who received it (Mohr, 1979, p. 43). In 1834, Ohio passed a law stating that “the death of either the mother or the fetus after quickening” is a felony (Mohr, 1979, p. 39). Missouri soon followed by revising their previous abortion law and making “the use of instruments to induce an abortion after quickening a crime equal to the use of poisonous substances after quickening” (Mohr, 1979, p. 40). In 1840, Maine made “attempted abortion of any woman ‘pregnant with child’ an offense, ‘whether such child be quick or not’ and regardless of what method was used” (Mohr, 1979, p. 41). This Maine offense was punishable by jailtime or a large fine. As states continued to pass anti-abortion legislation, certain groups rallied behind this new-found fight against abortion.

American Medical Association (AMA) and Horatio Storer

Despite certain states passing laws prohibiting the sale of abortion inducing drugs, the nationwide business for them continued to grow. The drugs were openly discussed, even advertised in newspapers, and were readily available (Ravitz, 2016). A woman was able to purchase the drugs from physicians, pharmacists, or order them and have them delivered by mail (Reagan, 2008, p. 10). Along with the growth in popularity of these drugs came criticism.

In 1847, the American Medical Association was founded. The establishment of this Association was the beginning of the politicization of abortion. At this time period, when a woman and a man got married, “the husband assumed virtually all legal rights for the couple” (Primrose, 2012, p. 170). This was both a law, and a patriarchal viewpoint that was accepted within society. It was seen as the duty of women to bear children to their husbands. The American Medical Association asserted that abortions not only posed health risks to women, but also prevented wives from fulfilling this role in their marriage contract. At this time women were also seeking entry into Harvard Medical School, where many sought to pursue careers in gynecology and obstetrics. These career goals threatened the role of women as subjects of their husbands, and so created a kind of push-back by the American Medical Association (Ravitz, 2016).

American Medical Association Role in Outlawing Abortion

In 1857, the American Medical Association began focusing mainly on getting abortion to be outlawed, with Dr. Horatio Storer at the head of this crusade. On top of the previously mentioned patriarchal reasons pushing for this criminalization, a couple of other factors contributed. One was the fear of immigrants in the United States. Storer was one of many Americans who shared this fear, worrying that the nation would soon become out-populated by people of other ethnicities, leaving white people outnumbered. Another was the threat that licensed physicians felt from midwives and homeopaths, who they saw as their competition in the medical field. By outlawing abortion, this threat would be neutralized, and physicians would have power and control over practicing medicine. For these reasons, physicians supported Storer and the American Medical Association in the fight to outlaw abortion (Ravitz, 2016). Overall, Storer,

backed by physicians around the nation, helped influence abortion laws by appealing to “a set of fears of white, native-born, male elites losing political power to immigrants and to women” (Reagan, 2008, p. 13). However, their anti-abortion campaign also had to try to reach women in America as well.

Dr. Horatio Storer was the son of David Humphreys Storer, a professor at Harvard Medical School in the field of Obstetrics and Medical Jurisprudence. David Storer argued that the only time an abortion was acceptable was if it was to save the life of the mother, and that a fetus becomes a human being as soon as the embryo enters the uterus. David’s son, Horatio, adopted this mentality and used it in his crusade against abortion. In 1866, he wrote a book entitled, *Why Not? A Book for Every Woman*, followed by *Why Not? A Book for Every Man*, which were widely distributed to female patients by their physicians. The books were an attempt to make women feel guilty for having abortions and convince men that they were equally guilty as the father of the unborn. Storer was smart enough to recognize that not all women may give in to arguments based on morals and guilt. For this reason, he “recommended that their physician readers appeal to women’s concerns about their own health as a way to persuade them to have their children” (Dyer, 2003). This ensured that the American Medical Association was fighting against abortion from all possible angles and viewpoints.

Anti-Abortion Laws Continue

With much help from the American Medical Association, the anti-abortion movement gained traction in the nation. This social shift towards the nonacceptance of abortion was reflected in laws passed by states at the time. Within the time period of 1860-1880, “the United States produced the most important burst of anti-abortion legislation in the nation’s history” (Mohr, 1979, p. 200). During these years, states passed “at least 40 anti-abortion [laws],” and “13 jurisdictions formally outlawed abortion for the first time” (Mohr, 1979, p. 200).

The first state to start this wave of legislation was Connecticut in 1860. The law contained four separate sections laying out all things that were now illegal regarding abortion. The first section discussed abortion in general, stating that the act was considered “a felony punishable by up to \$1000 fine and up to five years in prison” (Mohr, 1979, p. 201). The second section stated that any accomplices of the person who performs the abortion is guilty of the crime as well. The third section said that the woman who receives the abortion is also guilty of the felony, even if she attempts one on herself. The fourth section discussed abortifacient information and materials, stating that the distribution of either was punishable by fines between \$300 and \$500 (Mohr, 1979, pp. 201–202). The contents within the third and fourth sections of this statute were things that had never been mentioned before in anti-abortion laws, and signified the “evolution of abortion policy” that was about to sweep the nation (Mohr, 1979, p. 201). This Connecticut law set the stage for other states, which began passing their own more intense abortion laws. Examples include “Colorado Territory and Nevada Territory in 1861, and Arizona Territory, Idaho Territory, and Montana Territory in 1864,” which each made abortion a punishable offense (Mohr, 1979, p. 202).

Contraception Outlawed: Comstock Law of 1873

Why women should make the abortion decision

In 1873, The American Medical Association gained a victory when the Comstock Law was passed. This statute, passed on March 2, 1873, banned both the importation and distribution of any information or drug that aimed towards the prevention of conception (Tone, 2000, p. 439). The law made it illegal to “mail contraceptives, any information about contraceptives, or any information about how to find contraceptives” (Primrose, 2012, p. 173). Congress was able to do this by “enacting the antiobscenity statute to end the ‘nefarious and diabolical traffic’ in ‘vile and immoral goods’ that purity reformers believed promoted sexual licentiousness” (Tone, 2000, p. 439). Simply put, the government banned birth control and any information related to birth control under the guise that both its availability and use would contribute to sexual promiscuity, making it obscene, and allowing it to fall under the purity laws. The penalty for anyone who was caught violating the Comstock Law was “one to ten years of hard labor, potentially in combination with a fine” (Primrose, 2012, pp. 173–174). After Congress enacted this law, twenty-four states passed their own state versions to affirm the federal law (Tone, 2000, p. 441). On top of these federal and state laws, the government also gave “the United States Postal Service authority to decide what was ‘lewd, lascivious, indecent, or obscene’” (Primrose, 2012, p. 174). This was based on the fact that the business of birth control relied heavily on interstate commerce (Tone, 2000, p. 441).

Despite the fact that birth control and all information regarding it was outlawed people did not stop having sexual intercourse. As expected, this resulted in unwanted pregnancies. Women in this position who still sought an abortion despite its illegality were forced to look elsewhere to receive the procedure, which many times consisted of unsafe and unsanitary conditions (Primrose, 2012, p. 175).

Contraception Legalized: Contribution of a “First Wave Feminist” Movement in the United States

Around 1915, coinciding with advocates for the right of women to vote, a large feminist movement began growing, headed by Margaret Sanger, which focused on the importance of birth control. Sanger was a nurse who visited homes and was often asked questions by women on how to prevent having more children. One of Sanger’s patients died from a self-induced abortion, which led her to become more vocal about the unjustness that comes from restricting information on birth control. Sanger believed that the only way to achieve equal rights among men and women was for society to release women from the expected role of being a childbearing wife. In 1916, she attempted to open a contraceptive clinic in Brooklyn, New York, but was shut down after ten days. Despite being open for a short amount of time, the clinic had visits from 464 women. This staggering number displays the desperate need for contraception at the time.

Sanger continued her efforts to fight for contraception, and with support growing, she created the American Birth Control League (Galvin). In 1932, after Sanger was arrested for mailing birth control products, a judge from the Second Circuit Court of Appeals “ordered a relaxation of the Comstock laws at the federal level” (Primrose, 2012, p. 182). The opinion, written by Judge Augustus Hand, stated that contraception could no longer be described as “obscene,” and that there was a great amount of damage caused by this ban. He “ruled that doctors could prescribe birth control not only to prevent disease, but for the ‘general well-being’ of their patients” (Galvin, 1998). This

was a great win for Sanger and those who also fought for the legalization of birth control.

In 1942, the American Birth Control League decided to switch their approach and portray birth control as a means of family planning rather than a way to “liberate women” (Primrose, 2012, p. 183). With this change in approach also came a name change: Planned Parenthood. Although Sanger did not approve of this shift in philosophy or name change, both helped the organization present itself as much friendlier towards both men and women, and to become socially accepted (Primrose, 2012, pp. 183–184).

As time went on, the feminist movement towards legalized contraception and abortion continued. In the 1960s, the women’s liberation movement gained much more support after many were being “inspired by the civil rights and anti-war movements” (Ravitz, 2016). This traction in the women’s movement could be seen in the years to come within court decisions.

First Comes Marriage

After the ruling by Augustus Hand in the Second Circuit Court of Appeals, there was a large move towards the social acceptance of birth control. However, a Second Circuit decision is only binding in one jurisdiction. While this was a win for those within this area, and certainly did reflect a growing social acceptance, it was not sufficient to repeal laws nationwide. At this point, disagreement among the states on the issue of abortion was rising. For this reason, the issue rose all the way to the US Supreme Court.

***Griswold v. Connecticut*, 381 U.S. 479 (1965)**

In 1965, the Supreme Court helped strike down any laws within the states that mimicked the Comstock Law in *Griswold v. Connecticut*. In this case, Estelle Griswold was the executive director of Planned Parenthood in Connecticut. Griswold was arrested for giving out information about contraception under a Connecticut law which banned this. The Supreme Court brought up the idea of privacy within homes and ruled that although the “right to privacy” is not overtly written in the Bill of Rights, it still is a fundamental right protected under the Constitution. They discussed the idea that the Bill of Rights throws “penumbras” under which certain fundamental rights lie. In this case specifically, the First, Third, Fourth, Fifth, and Ninth Amendments all cast grey areas in which the “right to privacy” stands, which is then applied against the states using the Fourteenth Amendment. The court held that the Connecticut statute was overly broad and caused more harm than needed to be done. The statute encroached on a certain area in life where privacy is essential – inside a marriage. This ruling declared that a state is unable to ban the use of contraceptives within a marriage due to the right to privacy.

Then Comes All Persons

***Eisenstadt v. Baird*, 405 U.S. 438 (1972)**

While this was a great win for birth control advocates, it only made the distribution of contraception legal for married couples. In 1972 came *Eisenstadt v. Baird*, the Supreme Court case which extended this ruling to single peoples as well. In this case, Bill Baird was arrested for selling birth control in the form of vaginal foam to

Why women should make the abortion decision

multiple women at Boston University. He was charged under a Massachusetts statute that mimicked the previous federal Comstock Law. After the ruling of *Griswold v. Connecticut*, this statute had been amended, but it was only to legalize the distribution of birth control to married couples. In the opinion of *Eisenstadt v. Baird*, Supreme Court Justice William Brennan “declared that ‘whatever the right of the individual to access to contraceptives may be, the rights must be the same for the unmarried and the married alike’” (Garrow, 2001, p. 65). The foundation of this argument stemmed from the fact that “the law violated ‘the rights of single persons under the Equal Protection Clause’ of the Fourteenth Amendment” (Garrow, 2001, p. 64). This ruling helped establish legal contraception for all individuals.

Abortion Legalized Federally

***Roe v. Wade*, 410 U.S. 113 (1973)**

In 1973, the contraception movement came to a peak when the Supreme Court ruled in the case of *Roe v. Wade*, federally legalizing abortion. In this case, a single pregnant woman in the state of Texas challenged a “criminal abortion statute which only allowed abortions ‘for the purpose of saving the life of the mother’” (Zagel, 1973). The plaintiff, named anonymously as Jane Roe to protect her identity, who was later revealed to be Norma McCorvey, asserted in the legal briefs that the statute was unconstitutional and a violation of the right to privacy, therefore the law was null and void. Texas argued that it has compelling state interests in the life of the mother, the protection of prenatal life, and in the discouragement of illicit sexual activity, making this statute constitutional. The court understood the state’s concern for the mother and unborn child but did not accept the argument regarding sexual activity. After weighing the valid points brought forward by both Roe and Texas, the Court ruled accordingly. In the first trimester, the state has no say, and all decisions are to be made between a woman and her doctor. In the second trimester, a woman is still able to receive an abortion, but the state is able to make some regulations in order to protect the mother’s life. In the third trimester, abortions are contingent upon demonstrated threats to the mother’s health, due to the fact that the life of the fetus is considered viable.

Throughout history, the idea of access to “family planning” – whether that be birth control or abortion – has been controversial. Abortion drugs were initially very common but were then banned under the Comstock Law after much lobbying by the American Medical Association. After this, feminist movements began picking up the fight for contraception. The pleas of the movements were not answered until much later, when the Supreme Court made their rulings in *Griswold v. Connecticut*, *Eisenstadt v. Baird*, and *Roe v. Wade*.

Before 1800s	Abortion before “quickening” is legal, both federally and in states
1820s	States begin passing statutes outlawing the use of abortion inducing drugs
1830-40s	A few states begin passing statutes outlawing the actual procedure of abortion (Ohio, Missouri, Maine)
1860-80s	Anti-abortion statutes continue to pass throughout the states in the nation, with 13 jurisdictions formally outlawing abortion for the first time

1965	<i>Griswold v. Connecticut</i> , 381 U.S. 479 federally declares that a state is unable to ban the use of contraceptives within a marriage due to the right to privacy
1972	<i>Eisenstadt v. Baird</i> , 405 U.S. 438 federally legalizes the use of contraceptives for all individuals
1973	<i>Roe v. Wade</i> 410 U.S. 113 federally legalizes abortion

Figure 1: Legal Historical Timeline of Abortion and Reproductive Rights

II. Current Legal Obstacles Preventing Abortion

After several federal court decisions legalized abortion and the distribution of contraception, and any information regarding it, it seemed as though the fight for reproductive rights was over. Significantly, an “undue burden” on a woman was ruled as unconstitutional. Additionally, the American Medical Association, a previously large motivator in the anti-abortion movement, moved towards a more pro-choice viewpoint and backed up from being vocal against abortion. In 1990, the AMA stated that “the issue of support or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs.” In 2013, the Association as a whole shifted further towards pro-choice, stating that “the Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion,” as long as it is done in “good medical practice” and does not violate the law (Hart, 2014, p. 292).

However, the federal court rulings only set a legislative basis for states, which were then responsible for the abortion statutes within their own borders. Despite the fact that abortion was made legal on the federal level, states were, and still are, able to enact statutes that could create certain barriers making it hard for women to obtain an abortion. These barriers include zoning laws, mandatory counseling, waiting periods, and minor consent or notification. Besides being inconvenient hurdles to overcome, these barriers also insinuate an assumption that women seeking abortions have not thoroughly contemplated their decision, and/or are not able to properly educate themselves before doing so.

Hyde Amendment of 1976

In 1976, the United States Congress passed an “amendment to a federal appropriations bill specific to [the Departments of Labor and Health and Human Services].” This amendment, titled the Hyde Amendment, “prohibits using U.S. federal funds to pay for abortions in programs administered through” the two aforementioned federal departments. One of the programs that is affected by this amendment is Medicaid, which is “a joint state-federal program for low-income people.” Under the Hyde Amendment, Medicaid programs in states are unable to access and use federal funds to help low-income people get abortions. Since its installment, the Amendment has “been altered to include exceptions for pregnancies that are the result of rape and incest” (Boston Women’s Health Book Collective, 2011, pp. 341–342, 774). This Amendment is a possible barrier for women who are unable to afford an abortion on their own, which is discussed further below.

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992)

Why women should make the abortion decision

In 1989, Pennsylvania passed the Pennsylvania Abortion Control Act, which sought to intensely restrict a woman's ability to get an abortion. Under this law:

A woman seeking an abortion must (i) be given certain state-approved information about the abortion procedure and give her informed consent; (ii) wait 24 [hours] before the abortion procedure [after receiving this information]; (iii) if the woman was a minor she had to obtain parental consent; and (iv) if the woman was married she had to notify her husband, in writing of her intended abortion (Medoff, 2009).

Following the passing of this law, the Planned Parenthood of Southeastern Pennsylvania filed a lawsuit, claiming that the law was unconstitutional. The suit made its way to the United States Supreme Court, which ruled that "states could regulate abortions before viability as long as the regulation did not place an 'undue burden' on a woman's access to an abortion" (Medoff, 2009). However, the Court did not give an explicit definition of what an "undue burden" entails, giving states leeway to enact restrictions on the access to abortion. The Court also upheld the first three parts of Pennsylvania's statute, but struck down the fourth, requiring husband notification. By upholding the first three, the Supreme Court allowed Pennsylvania to set the stage for other states across the nation which sought to limit the access to abortion (Medoff, 2009).

Types of Abortion Barriers

Zoning Laws

One possible barrier to abortion access that states are able to implement is zoning laws. Under the Constitution, each state has a certain amount of police powers that allow for the enactment of laws and regulations that aim to protect, preserve, and promote the public safety, health, morals, and general welfare of the people (Legal Information Institute). Local governments within states are able to pass zoning laws in the community under these police powers. "Zoning laws determine what types of land uses and densities can occur on each property lot in a municipality." In some areas throughout the nation, local governments use zoning ordinances to limit the areas where abortion providers can reside (Maantay, 2002, pp. 572–575). This topic is further discussed below.

Mandatory Counseling

According to the Guttmacher Institute, as of March 1, 2019, "34 states require that women receive counseling before an abortion is performed" (Guttmacher Institute, 2019a). The legal basis of mandatory counseling laws lies upon the principle of informed consent. This principle is the idea that patients "have the right to receive accurate and unbiased medical information from their health care provider so that they can make an informed decision about their treatment" (Medoff, 2009). Mandatory counseling laws in states make it a requirement for physicians to read a "'script' to any patient seeking an abortion" (Rose, 2006, p. 105). These scripts are specific to each state, which are left to approve of the information they wish to include. While the counseling information may vary state-to-state in terms of what exactly must be included, each have the same

general idea: to warn women who are seeking an abortion of the possible complications, side effects, and other options.

To stay in accordance with the idea of providing unbiased and objective information, states must also counsel women about options other than abortion, and the possible effects associated with them. For example, North Carolina's "Woman's Right to Know Act" states that physicians must inform the woman that she "has other alternatives to abortion, including keeping the baby or placing the baby for adoption." The act also requires abortion providers to provide patients with printed materials that detail the possible complications and effects of abortion, "as well as the medical risks associated with carrying an unborn child to term" (Stam, 2012, pp. 18–20).

The issue with this counseling is that not all the information distributed is necessarily accurate and may "dissuade women from having an abortion by giving them biased medical information ... that is deliberately inaccurate and false" (Medoff, 2009).

One piece of information included in the counseling materials of several states is the idea that "abortion is detrimental to a woman's mental health" (Medoff, 2009). While this may be the case for some women who receive abortions, it is not true for all. This topic is considered further below.

Other information that is commonplace in counseling materials is that abortions are linked to future medical issues within women. In 6 out of the 34 states that include mention of medical issues, the emphasis is on the correlation between abortion and breast cancer, and 22 out of 34 include information about infertility (Guttmacher Institute, 2019a). However, research has shown that the claims being made are not necessarily accurate. Among the 6 states that discuss breast cancer, 5 "inaccurately assert a link between abortion and an increased risk of breast cancer" (Guttmacher Institute, 2019a). Furthermore, in 1996, The National Cancer Institute stated that after doing research, they found "no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion" (Medoff, 2009). Regarding infertility, there is research showing that "vacuum" abortions, which are "the most common method used in over 90% of all abortions – poses no long-term risk of infertility" (Medoff, 2009). In 4 of the 22 states that discuss infertility, the risk is inaccurately portrayed (Guttmacher Institute, 2019a). The distribution of this inaccurate information may scare women away from having an abortion, fearing they will have serious health complications in the future.

In 13 out of the 34 states, the mandatory counseling information tells women that the fetus is able to feel pain during the procedure of the abortion (Guttmacher Institute, 2019a). However, not every state provides the same facts. In South Dakota, women are told that the fetus feels pain no matter how far along the pregnancy may be. In Texas, women are told the fetus can feel pain as early as 12 weeks, while women in Arkansas and Georgia are told it is 20 weeks (Medoff, 2009). However, research has shown "that the necessary physical structures to perceive pain develop between 23 and 30 weeks' gestation" (Gold & Nash, 2007). This disagreement between states clearly shows how inaccurate the information being distributed to women may be.

Aside from possibly dissuading women from getting an abortion by providing potential complications and side effects, the counseling information can also be laced with bias language meant to do the same. For example, in 2003, Texas passed a law entitled "Woman's Right to Know Act," which required abortion patients be given a twenty-three-pages long booklet discussing all of the possible risks listed above.

However, the booklet refers to the fetus as an “unborn child,” using word choice to place personhood on the fetus (Rose, 2006, p. 106). It also “speaks at length about the euphoria of giving birth,” while barely touching on the possible issue of post-partum depression if the woman chooses to have the child (Rose, 2006, p. 106). The subtle use of language and emphasis on happy childbirth shows that the state favors the idea of carrying the fetus to term rather than letting the woman have an abortion.

Waiting Periods

Following the mandatory counseling, as of March 1, 2019, 27 out of these 34 states require that there be a waiting period of at least 24 hours until the woman can receive the abortion (Guttmacher Institute, 2019a). In these cases, women are required to visit the physician twice: once to be counseled, and second to undergo the procedure after the waiting period is complete. While this may be a minor inconvenience for some women, it can be quite major for others. For example, if a woman has traveled a far distance to receive the abortion, there are extra costs involved, whether that be money for gasoline, public transportation fees, and/or paying to stay in a hotel. By forcing these women to visit the physician twice, the money they are spending increases, whether that be by a few dollars for a couple of more gallons of gasoline in their car or by a few hundred dollars for an extra night in a hotel room. While the waiting period may be a helpful time for some women to read and further inform themselves on the procedure they are about to receive, it may be a burden for others who have already confirmed their decision and cannot afford these extra costs (Rose, 2006, p. 106).

Minor Consent or Notification

As of March 1 2019, 37 states in the nation require the involvement of a minor’s parent when deciding to have an abortion. In 11 of these 37 only require parental notification, while 21 require parental consent (Guttmacher Institute, 2019b). Among the many barriers put on access to abortion, “parental involvement laws have some of the highest public support” (Rose, 2006, p. 107). A large portion of this support comes from the idea that minor’s may be too immature to make this life-altering decision on their own and require the potentially important input of their parents (Rose, 2006, p. 107).

In an attempt to avoid the laws requiring them to involve their parent, some young girls travel across state lines to receive the procedure in a state that does not have these laws. If that is not a possibility, other girls turn to unsafe illegal procedures to terminate their pregnancy (Rose, 2006, p. 107). One specific example of this is Becky Bell, a seventeen-year-old girl from Indianapolis. In 1988, afraid to inform her parents that she was pregnant, Becky sought out an illegal abortion (Lewin, 1991). During the procedure, unsanitary instruments were used, which resulted in the young girl contracting a bodily infection. Within one week, Becky’s veins collapsed, her heart stopped, and she died (Rose, 2006, p. 107). This case became an example of the potential issues with the forced involvement of parents.

While parental involvement laws may seem rational, they pay no attention to the possible circumstances within each minor’s situation. For a young girl who has an open and close relationship with her parents, these laws may not pose an issue. Oppositely, for a young girl who has a distant, unhealthy, and/or violent relationship with her parents, such as Becky Bell, these laws may be extremely problematic. In a 1991 study

that looked at reasons why minors seeking abortions did not want to inform their parents, the most common reasons listed “were wanting to preserve their relationship with their parents and wanting to protect the parents from stress and conflict” (Henshaw & Kost, 1992). These reasons may be especially true in a household where the pregnancy is the result of a friend/family rape, which would put much stress on the family relationships. Due to these possible issues, 36 out of the 37 states with parental involvement laws “include a judicial bypass procedure, which allows a minor to obtain approval from a court” (Guttmacher Institute, 2019b). This procedure, if approved, grants a minor the ability to receive an abortion without involving a parent.

Current Federal Administration

Election of Donald Trump

Although states have been able to place these barriers limiting the access to abortion within their borders, the rights granted in *Roe v. Wade* have continued to hold steady in federal law. However, more recently, there has been fear of a perceived threat to these rights. This fear began with the election of President Donald Trump in November 2016. When elected, Trump vowed “to nominate socially conservative Supreme Court Justices, withhold federal funding from Planned Parenthood, and sign legislation banning abortion after 20 weeks of pregnancy” (Reinhard, 2016). Although Trump has not signed any legislation doing so, he has indeed followed through on the first two promises.

Nomination of Socially Conservative Supreme Court Justice Brett Kavanaugh

In 2018, President Donald Trump nominated Judge Brett Kavanaugh to become a Justice on the United States Supreme Court. Since this nomination, Kavanaugh has been elected to the Supreme Court, replacing Justice Anthony Kennedy, who “protected [*Roe v. Wade*] as the court’s swing vote on abortion” (Bassett, 2018). By replacing Kennedy, Kavanaugh creates “a solid conservative majority on the court,” which could potentially threaten *Roe*, given his standpoint on the issue of abortion (Gershman, 2018). Although Kavanaugh has not spoken directly about his views on the Supreme Court decision of *Roe v. Wade*, he has spoken about “the government’s ‘permissible interests’ in ‘favoring fetal life’ and ‘refraining from facilitating abortion,’” indicating his opinions on the subject lean toward a pro-life viewpoint (Bassett, 2018). However, despite the possible personal opinions of Kavanaugh, he has stated that he believes *Roe v. Wade* is a “settled law” (Gershman, 2018). While there was no further explanation on what exactly Kavanaugh meant by those words, a logical interpretation would mean that “he believes the precedent is too deeply embedded in the fabric of the law to be re-examined” (Gershman, 2018). This would mean that Kavanaugh himself is not even confident in the fact that the Supreme Court could overturn the landmark decision.

Trigger Laws

Although the possibility of *Roe v. Wade* being overturned is questionable, some states have “trigger laws” set up in the event that it does happen. These laws are blatant state bans put on abortion, but are presently unconstitutional, therefore, unenforceable. The point of these laws is to have statutes set in place, ready to “become enforceable

without further legislative action” the moment *Roe v. Wade* gets overturned, if ever (Rose, 2006, p. 102). The states that have put these laws in place are Mississippi, Louisiana, North Dakota, and South Dakota (Gershman, 2018).

Gag Rules Withholding Federal Funding from Planned Parenthood

When getting elected, President Trump also promised to withhold federal funding from Planned Parenthood. In February 2019, the Trump administration announced, “that it will bar organizations that provide abortion referrals from receiving federal family planning money” (Belluck, 2019). This new legislation is a form of a “gag rule,” which “prohibit those working in state-run health care facilities from even speaking of abortions as an option with patients” (Rose, 2006, p. 109). In this specific federal rule, “clinics will be able to talk to patients about abortion, but not where they can get one” (Belluck, 2019). This means that organizations meant to help women, such as Planned Parenthood, could potentially lose millions of dollars in funding (Belluck, 2019). As of this writing a federal court in Washington state issued a nationwide injunction that stops the rule from taking effect while various lawsuits are pending (Barbash, 2019).

Trump Reinstatement of Global Gag Rule

Aside from being present within the United States, every recent Republican Administration has enforced such gag rules internationally. “The United States is the largest donor of international family planning money, which is dispersed through the United States Agency for International Development.” This agency “funds international non-governmental organizations (NGOs) in contraceptives, training, technical assistance, and other family planning needs.” However, in 1984, the Reagan Administration instituted a global gag rule, which mandated that any NGO “that performed or promoted abortion services” were no longer “eligible for USAID funding,” even if abortion was legal in their jurisdiction. When the Clinton Administration came into power, this global gag rule was overturned. This back-and-forth has continued ever since, with the Bush Administration reinstating the global gag rule, and then the Obama Administration overturning it (Gezinski, 2012, pp. 839–840). Predictably, President Trump reinstated it – on his first day in office. This global gag rule is a large setback for many countries in the developing world, where NGOs are a primary source for women’s health care. For example, in some parts of Africa, these clinics “offer HIV/AIDS prevention and treatment, maternal health, and counseling on sexual violence like genital mutilation.” This rule also cuts funding for the International sector of Planned Parenthood (Quackenbush, 2018). By cutting funding to NGOs around the world, the global gag rule can have serious effects on a woman’s ability to get proper health care.

III. Possible Effects After Having an Abortion or Being Denied an Abortion

Before being able to fully understand the potential effects of an abortion, one should know exactly what the abortion process consists of. There are multiple different kinds of abortion procedures a woman can receive that vary in methods and depend on how far along the pregnancy is. By being fully educated on the details of the actual procedure, individuals are able to understand the issues surrounding abortion on a

more comprehensive level. The following paragraphs will go through the vital specifics of each procedure.

Receiving an Abortion: How is it Done?

First Trimester Abortions

“In the United States, most abortions (88 percent) are performed during the first trimester,” which includes the first twelve weeks of pregnancy. Currently, there are two different forms of first-trimester abortions: a medication abortion or an aspiration abortion. A woman is able to choose which one she wishes to receive. As of 2011, aspiration abortion is more commonly used than medication abortion, but the interest for the latter continues to rise. If a medication abortion fails, an aspiration abortion is necessary to abort the fetus (Boston Women’s Health Book Collective, 2011, pp. 324–328).

“In a medication abortion, the pregnancy is interrupted and expelled over the course of a few days using medicines.” While in the presence of the doctor, a woman swallows a pill containing a drug called mifepristone. Later, when at home, the woman takes another drug, misoprostol, either by inserting it vaginally or letting it dissolve inside her mouth. The abortion begins a few hours later, consisting of heavy bleeding and cramping. To ensure the abortion worked, the woman must go back to the doctor one week later for a follow-up appointment. In 95 to 98 percent of cases, this method is effective. However, if it fails, the woman must then undergo an aspiration abortion (Boston Women’s Health Book Collective, 2011, pp. 324–326).

In an aspiration abortion, also known as surgical or vacuum abortion, “suction is used to remove the pregnancy.” A thin tube, called a cannula, is “inserted into the uterus and connected to a source of suction, either an electric pump or a handheld syringe,” which then removes the fetus from the woman. Unlike medical abortions, aspiration abortions only take 5-10 minutes to complete and do not require a follow-up appointment with the doctor unless the woman is experiencing problems (Boston Women’s Health Book Collective, 2011, pp. 324–328).

Second and Third Trimester Abortions

When Do They Happen?

“In the United States, about 12 percent of all abortions take place after the first trimester” (Boston Women’s Health Book Collective, 2011, p. 332). Women enter the second trimester of pregnancy at week 12, and the third trimester at week 28 (Boston Women’s Health Book Collective, 2011, p. 332; Cha, 2015). The Centers for Disease Control and Prevention reported that in 2015, only “about 1.3 percent of abortions were performed at or greater than 21 weeks of gestation.” This means that within the aforementioned 12 percent, almost all of these abortions are done during the beginning and middle of the second trimester. In the rare cases where women seek abortions in their third trimesters, the reasons are serious and based on “an absence of fetal viability,” and/or risks to the mother’s health or life (Cha, 2015).

Procedure Details

Why women should make the abortion decision

For second and third trimester abortions, the procedures differ from those in the first trimester. Currently, there are two different methods used to abort a fetus after the first trimester: dilation and evacuation (D&E), and induction abortion (Boston Women's Health Book Collective, 2011, p. 332).

In a D&E procedure, the fetal and placental tissues are removed by using a combination of instruments and suction. This method is more commonly used, and quite similar to the aspiration abortions performed during the first trimester. However, due to the fact that the pregnancy is further along, the woman's cervix must "be opened wider to allow the larger pregnancy tissue to pass, which requires the clinician to soften and dilate the cervix ahead of time." This can take anywhere from a few hours to two days and can be done either by the use of instruments (osmotic dilators), or drugs (misoprostol). The earlier a woman is in her pregnancy, the less time this portion of the abortion takes. After the cervix is prepared, "the clinician removes the pregnancy (fetal and placental tissue) with vacuum aspiration, forceps, and a curette (a small, spoonlike instrument)" (Boston Women's Health Book Collective, 2011, pp. 332–333).

"After a certain point in pregnancy (usually around twenty-four weeks), a D&E can no longer be performed and the only option is an induction abortion." In an induced abortion, a woman is given drugs that induce labor. The drugs that are used can vary depending on the circumstances of the situation, and can either be inserted into the vagina, be given through an intravenous line, or injected into the woman's abdomen. These drugs cause contractions of the uterus, thus sending the woman into labor. The fetus and placenta are then 'delivered,' expelling the pregnancy. This method "usually takes place in specialized facilities or hospitals," and takes more time than D&E's. Due to this, and the fact that it forces women to endure the mental and physical stress of labor, induction abortion is less commonly chosen than D&E. However, in a case where the pregnancy being ended is wanted, this method allows the woman to deliver and hold the fetus, and say good-bye (Boston Women's Health Book Collective, 2011, pp. 332–334).

Reasons Why Women May Get an Abortion

Despite the possible attempts by state law to limit a woman's ability to get an abortion, the medical procedure is still performed across the nation. While the specific reasoning behind every abortion is different in each individual situation, in many cases, there are common themes of reasoning.

In 2004, a study was done by the Guttmacher Institute to explore the reasons why a woman may seek an abortion. In the study, over 1200 abortion patients at 11 providers completed a survey that asked questions regarding their reasoning. The first portion of the survey was open ended, asking the woman to briefly explain why she was choosing to get an abortion at that time. If there were multiple reasons, she was asked to give them in order from most to least important. After that, there were specific reasons listed that the woman had to confirm whether or not were applicable to her. There were three large reasons listed that then provided even more specific sub-reasons underneath. These three included: "having a baby would dramatically change my life," "can't afford a baby now," and "don't want to be a single mother or having relationship problems" (Finer et al., 2005, p. 113). Under "having a baby would dramatically change my life," the sub-reasons for why it would do so were because it would interfere with the patient's education and/or career, and/or because she already had other dependents in

her life (Finer et al., 2005, p. 113). Under “can’t afford a baby now,” a few sub-reasons for lack of funds were because the woman was unemployed, could not leave her job to care for the child, and/or could not even afford the basic necessities of life (Finer et al., 2005, p. 113). Under “don’t want to be a single mother or having relationship problems,” a couple sub-reasons were because the woman was unsure about her current relationship, or because she was not in a relationship at the moment (Finer et al., 2005, p. 113). After the breakdown of these three large reasons, there were various others listed, including: “have completed my childbearing,” “don’t want people to know I had sex,” “don’t feel mature enough to raise a child,” “victim of rape,” and “result of incest” (Finer et al., 2005, p. 113). Finally, the questionnaire provided a space where the woman could write in her own reasons that were not listed or did not qualify within the given categories. The results showed that most women identified with reasons that fell within the three large ones, with 74% of respondents feeling that “having a baby would dramatically change [their] life,” 73% saying they “[could not] afford a baby [at the moment],” and 48% “[citing] relationship problems or a desire to avoid single motherhood” (Finer et al., 2005, p. 113). This study provided many possible reasons as to why a woman may seek an abortion.

In 2013, a similar study was published by BioMed Central Women’s Health that examined the reasons why women get abortions. This study looked at the data collected during the *Turnaway Study*, which was done to evaluate “the health and socioeconomic consequences of receiving or being denied an abortion in the US” (Biggs et al., 2013, p. 1). Although the premise of the *Turnaway Study* was not to focus on the reasons why women wanted an abortion, those who participated were required to give their reasoning. This 2013 study took those women’s answers and analyzed them. The sample for this study was “954 women from 30 abortion facilities across the US,” who were questioned between 2008 and 2010 (Biggs et al., 2013, p. 1). Many of the reasons women mentioned in this study overlapped with those given during the 2004 study, falling under the general concepts of financial instability, partner-related issues, and inconvenient timing. However, some women delved into other reasons motivating their decision. Out of all the respondents, 12% had health-related reasons regarding either herself, the fetus, or both. One woman explained that the medication she had been taking for her bipolar disorder was known to cause birth defects and felt it would be considered child abuse to bring a baby into the world knowing that it may have life-altering defects. Five percent of respondents mentioned reasons that included family members. One woman was scared her family would not accept that she would be having a biracial child, while another stated that her dad wanted her to finish school before having a child (Biggs et al., 2013, pp. 7–8). The 2013 study differed from the 2004 study in the fact that the women were only given open ended questions to answer, rather than checking off possible reasons from a provided list. This emphasis on personal words helped yield answers that reflected how each woman’s reasoning is specific to her own life and situation.

It is important to note that every woman and situation is different. While these studies show a plethora of reasons why women decide to get abortions, the circumstances surrounding every single abortion are personal to the individual(s) involved. The range of reasons can include physical and mental health issues, economic needs, and/or fear of social stigma.

Potential Physical, Sociological, and Psychological Effects of Abortions

A hypothetical woman who wanted an abortion did it. She jumped through all the hoops: she was granted the fundamental right to receive one by the federal government, came to the educated and reasonable decision that she wanted one, overcame any legal barriers her state instituted on the matter, and was able to get the abortion she sought out to get. Now what? Does the life-altering procedure she just underwent truly alter her life? Or does she return to her regular weekly schedule, viewing the abortion as a minor inconvenience in her life?

The general consensus on this matter is contradicting. When speaking about physical, sociological, and psychological health, some research states that there are no effects on women who receive an abortion, while other research state that they are indeed affected. That is because “both opponents and advocates could easily prove their case by picking and choosing from a wide range of contradictory evidence” (Arthur, 1997, p. 7).

Physical Effects

After receiving an abortion, there is research concluding that women may suffer from possible physical health effects in the future. The effects that will be discussed below are increased risk of breast cancer and future reproductive health issues.

Breast Cancer

One health risk that has been linked to abortion is an increased risk to breast cancer. According to biologist and endocrinologist Joel Brind, Ph.D., as stated in an article published in *Human Life Review*:

Breast lobules, which are the lactational apparatus of the breast, remain in their immature Type 1 and 2 states unless they are stimulated by a pregnancy. The pregnancy signals the mother’s body to send estrogen (a potential carcinogen) to her breasts, and the lobules begin to multiply. This multiplication continues until the thirty-second week of pregnancy, when the milk cells are fully mature. If a woman has an abortion or delivers prematurely before the thirty-second week, cancer is more likely to develop in the immature cells. Mature milk cells are much less prone to becoming cancerous (Adamek, 2017, p. 28).

Many other health professionals agree upon this statement and have offered further medical information. One comprehensive review that looked at the link between breast cancer and induced abortion stated that “it is only after 32 weeks’ gestation that elevated levels of pregnancy hormones allow sufficient maturation of cancer-resistant breast tissue to occur” (Lanfranchi & Fagan, 2014, p. 5). After carrying a pregnancy to full-term, “only about 10 to 30 percent of a mother’s breast tissue remains susceptible to forming cancer,” and this risk decreases another 10 percent with each subsequent pregnancy (Lanfranchi & Fagan, 2014, p. 6).

Future Reproductive Health

Another physical health risk that has been linked to abortion is the risk of future reproductive health issues. Although occurring in less than 1% of cases, after an

abortion, there is a possibility that a woman can develop an upper genital tract infection. The upper genital tract involves the pelvis and fallopian tubes, which are important parts of a woman's reproductive system. Serious infections can cause major issues to these, including chronic pelvic pain and damage to the fallopian tubes. This damage can consequentially lead to future issues, such as infertility and ectopic pregnancy (Boston Women's Health Book Collective, 2011, p. 318; Lohr et al., 2014, p. 4).

Physical Health: Opposing Views

Despite these statements, there have been dissenting opinions on the idea that induced abortions and breast cancer are linked. "In February 2003, the National Cancer Institute (NCI) convened a workshop of over 100 of the world's leading experts who study pregnancy and breast cancer risk" (National Cancer Institute, 2003). The conclusion of this workshop was that having an abortion "does not increase a woman's subsequent risk of developing breast cancer" (National Cancer Institute, 2003). The NCI is a part of the National Institutes of Health under the United States Department of Health and Human Services, and states on the website homepage that it is "the nation's leader in cancer research." Due to the fact that it is an organization under the federal government, one can assume that the research they publish is trustworthy. This disagreement upon health professionals makes it hard for women to know the true risk. The scientific facts of the development of breasts points to a clear correlation between abortion and breast cancer, but the highly respected National Cancer Institute dissents from that idea. Similarly, in regard to the possible development of an upper genital tract infection, it is difficult for women to measure the possible risk. The fact that it happens in only 1% of cases is promising, but women are left unsure of whether or not they will end up falling into that small percentage until they actually undergo the abortion procedure.

Sociological Effects

Social Norms and Stigmas

Within every society, there are certain human behaviors that become normalized over time. These behaviors, also known as "social norms," can include essentially anything about a person, such as how they speak or dress, their mannerisms, or traits of their personality. A stigma can be described as "an attribute that is deeply discrediting that negatively changes the identity of an individual to a tainted, discounted one" (Kumar et al., 2009, p. 626). Stigmas are created and reproduced through a social process. In a 2001 *Annual Review of Sociology*, Link and Phelan describe this process:

In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labelled persons to undesirable characteristics – to negative stereotypes. In the third, labelled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them'. In the fourth, labelled persons experience status loss and discrimination that lead to unequal outcomes (2001, p. 367).

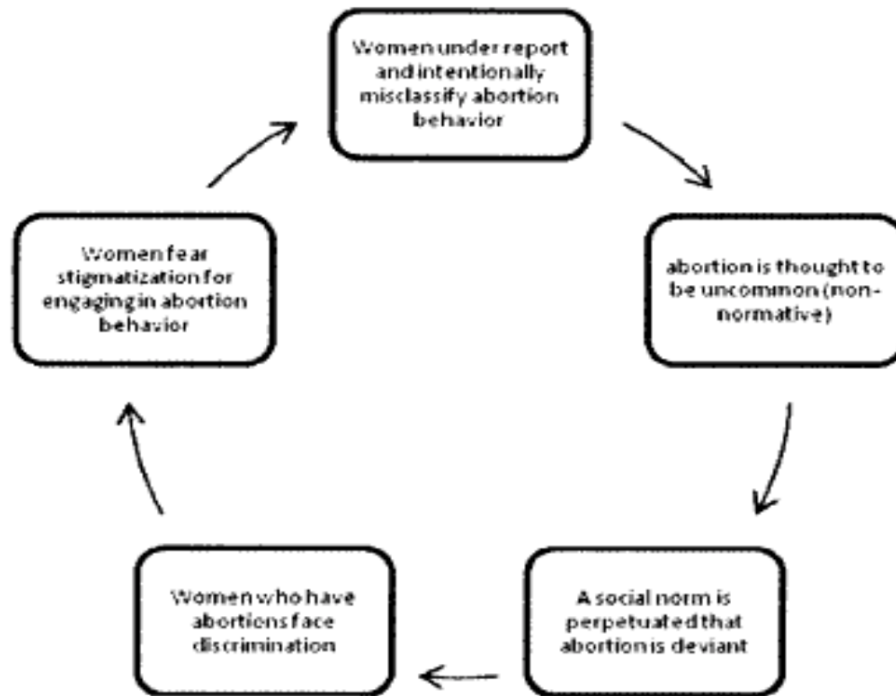
Throughout history, worldwide, societies have constructed and enforced stereotypical social norms on women as a whole. Some of the most widely held stereotypes are based around the fact that women bear children. Female sexuality can be seen "solely for

procreation,” and becoming a mother viewed as being natural and inevitable (Kumar et al., 2009, p. 628). Due to this, societal norms may expect women to be instinctually warm, kind, caring, and nurturing. Therefore, when a woman wishes to end a pregnancy by receiving an abortion, she is challenging these “assumptions about the ‘essential nature’ of women” by using “her agency to deem a potential life unwanted and then [acting] to end that potential life” (Kumar et al., 2009, p. 628). By terminating a fetus, which would eventually develop into a baby, a woman getting an abortion deviates from the assumption that she should be naturally maternal. Instead, she may be labelled with opposite stereotypes, seen as being heartless, promiscuous, and/or selfish. Consequentially, for those who accept these social norms about women, abortion can be seen as a stigmatized act (Kumar et al., 2009, pp. 628–629).

Stigma Causes Underreporting, Which Perpetuates Further Stigma

Over the past several decades, surveys have been an essential way for researchers to gather data on topics they are studying. However, “the usefulness of surveys in studying highly personal or sensitive individual characteristics” has been questioned (Jagannathan, 2001, p. 1825). This may include topics that involve things that are typically regarded as private matters, such as mental health, income, and/or sexual behavior. Personal topics like these can easily have some type of stigma attached to them if a person deviates from any type of social norm within the matter. Survey data involving these topics may be inaccurate if people refuse to participate, even if they are affected by the topic, in fear of being a social deviant. As previously mentioned, abortion is a controversial issue in society that has been stigmatized. Therefore, women who have gotten abortions may feel a social pressure to stay silent, making “it challenging to know the true prevalence of abortion in a given community” (Kumar et al., 2009, p. 629). Studies that have specifically looked at the underreporting of abortions have stated that “only 35% to 60% of abortions are reported in surveys” (Jagannathan, 2001, p. 1825). The social construction of deviance in regard to abortion creates an ongoing cycle of silence about the topic. This cycle is demonstrated in the following chart, provided by Kumar (2009, p. 629):

Figure 2: Cycle of Stigmatization in Society



This chart shows how “silence and fear of social exclusion keeps women” from speaking openly about abortion, “thus sustaining the negative stereotype” (Kumar et al., 2009, p. 630). Underreporting of the issue makes it seem uncommon, which makes it a deviant from social norms. Those who do not behave in accordance with social norms are typically outcasted or discriminated against, making women who get abortions fear stigmatization and not report it, consequentially creating inaccurate data due to underreporting. This then brings the issue back to the beginning of the cycle (Kumar et al., 2009, pp. 629–630).

Psychological Effects

Similar to the physical health effects linked with abortion, the idea that there are mental health consequences after receiving the procedure is a topic of controversy. However, the issue with psychological compared to physical is the fact that every individual is different, and every mind works in unique ways. Physical effects are a matter of science and fact, while psychological effects rely on the unpredictability of the human brain. There is research concluding that after receiving an abortion, women may suffer from possible mental health effects. The effects that will be discussed below are “post-abortion syndrome,” anxiety/panic disorders, and depression.

Post-Abortion Syndrome

The largest source of controversy within the discussion of abortion and possible mental health effects stems from the concept of “post-abortion syndrome.” The idea behind this syndrome is that abortion can cause women “severe and long-lasting guilt, depression, rage, and social and sexual dysfunction,” and can be categorized under post-

traumatic-stress-disorder (Arthur, 1997, p. 7). However, this so-called syndrome is “not recognized in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association” (Robinson et al., 2009, p. 269).

Anxiety/Panic Disorders and Depression

Over the years, studies have been done that concur with the idea that abortion is linked to post-abortion syndrome and further mental health problems. Research has stated that most panic disorders in adults form in the six months following a major stressful life event. Therefore, if women view the abortion they received as a traumatic life event, it “may trigger a psychological .. process that culminates in an anxiety disorder” (Coleman et al., 2009, p. 775). Aside from anxiety disorders, a 2009 study found:

Women who have aborted are at a higher risk for a variety of mental health problems including anxiety (panic attacks, panic disorder, agoraphobia, PTSD), mood (bipolar disorder, major depression with and without hierarchy), and substance abuse disorders when compared to women without a history of abortion (Coleman et al., 2009, p. 775).

When looking specifically at anxiety and depression, the study found that among women who had abortions, the risk for panic disorders increased by 111%, and the risk for depression increased by 45% (Coleman et al., 2009, p. 773).

Furthermore, in 2011, “a comprehensive review and analysis of 22 of the world’s best large studies of abortion’s impact on women’s mental health” concluded that “women who had undergone an abortion experienced an 81 percent greater risk of mental health problems” (Adamek, 2017, p. 32).

Psychological Effects: Opposing Views

Despite the studies claiming that women who get abortions are at a higher risk for mental health issues, there is also research that opposes this view.

One study examined 442 women over a two-year period to assess their mental health after receiving an abortion. Those who participated were evaluated one hour before the abortion, and then one hour, one month, and two years after. The study assessed the women for “preabortion and postabortion depression and self-esteem, postabortion emotions, decision satisfaction, perceived harm and benefit, and posttraumatic stress disorder.” The results concluded that two years after receiving their abortion, 72% of the women were satisfied with the decision they made, and 69% would make the same decision again. From pre-abortion to post-abortion, depression decreased, self-esteem increased, and some women reported feeling a sense of relief more than any negative emotions (Major et al., 2000). Further research has agreed with this, stating that “although there may be sensations of regret, sadness, or guilt,” more frequently, women “report feeling relief and happiness” following their abortion (Adler et al., 1990, p. 41). It is important to note that “feelings” do not translate into true psychological issues. For example, a woman may feel a sense of sadness following the procedure, but that does not imply she is clinically depressed.

Link Between Socio- and Psycho-

When looking at whether abortion has a psychological effect on women, it is important to note the intersectionality between sociology and psychology. As discussed above, culturally developed societal norms and stigmas influence individuals to behave and think certain ways. Therefore, the way abortion is socially accepted within a certain group may have an impact on the psychological effects a woman experiences after getting the procedure. If a woman belongs to a community where there are stereotypes put on women, and stigma surrounding abortion, she may have a poor view of herself afterwards. “Women may feel that they are selfish or immoral because they perceive themselves to be defying familial expectations, cultural norms or ideas of motherhood” (Kumar et al., 2009, p. 633). In comparison, if women are part of a community that shows support for their personal decision, they “may experience less grief and anxiety than those who were unsupported by their communities or the larger environment” (Kumar et al., 2009, p. 632). This interrelationship shows how important it is to be socially accepted within society, and how being outcasted may cause real psychological issues within human beings.

Trauma from Unwanted Pregnancy

When looking at the possible realness of “post-abortion syndrome,” it is essential to look more deeply at the root of the issue. This syndrome claims that abortion is an event so traumatic that it may lead to serious psychological effects for women. However, this poses the question: is the abortion the traumatic life event triggering psychological issues, or is it the unwanted pregnancy?

In 2008, the American Psychological Association’s Task Force on Mental Health and Abortion published a report that “concluded ‘that among women who have a single, legal, first-trimester abortion of an unplanned pregnancy ... the relative risks of mental health problems are no greater than risks among women who deliver an unplanned pregnancy’” (Kaplan, 2009). Furthermore, one study concluded that abortion patients who “had no intention to become pregnant” were significantly less depressed than women whose pregnancy was wanted and “viewed as personally meaningful by the woman” (Adler et al., 1990, p. 42). These research findings indicate the possibility that it is the unplanned/unwanted pregnancy that raises the risk of psychological issues, rather than the actual abortion.

Abortion is Not Always an Option

Making the choice to get an abortion is a huge decision. Women are forced to decide whether they want to alter their lives by going through pregnancy and bringing a child into the world, or if they want to terminate the fetus and risk the possible side effects. However, for some women, the burden of this choice is not the only difficult part about the situation. Depending on circumstances, even if a woman wants to get an abortion, the likelihood of getting one may be close to impossible. As discussed above, states have been able to pass statutes within their borders that make it difficult for a woman to get an abortion. These legislative barriers include zoning laws, mandatory counseling, waiting periods, and minor consent or notification. On top of these legal obstacles put in place by the state, there may be additional conditions that cause prevention of the procedure. Two large circumstances that may play into a woman’s decision are her geographical location and her financial situation.

Reasons Why Women May Not Be Able to Get an Abortion

Zoning Laws and Access to Abortion Providers

Zoning Laws

One large obstacle for women who wish to receive an abortion is the ability to access a provider. As discussed above, some local governments attempt to block abortion providers from residing in an area by using zoning laws, applicable under the police powers given to each state. The use of these zoning ordinances to limit providers can make it extremely difficult for women who want to get an abortion to be able to find a place to receive the procedure within a reasonable geographical range.

A couple current examples of the use of these zoning laws to limit access to abortion providers can be seen in Manassas, Virginia, and San Antonio, Texas. In 2015, both the city's made amendments to their zoning codes that consequentially affected the access to abortion providers.

In Manassas, Virginia, the amendment "[requires] medical care facilities, including abortion clinics, to obtain a special use permit that would be granted only after a period of public comment and City Council approval." This means that any new clinics trying to open in Manassas would need to obtain the permit, as well as any current clinics that want to relocate or make expanding renovations. Due to the fact that the city's council is predominantly Republican, the need for their approval may cause a possible barrier for abortion providers (Stein, 2015).

In San Antonio, Texas, a bill was passed in 2013 that required "all facilities that provide abortion services [to] meet the standards of an [ambulatory surgical center] in order to remain in operation." Then, in 2015, a zoning code amendment was passed that put restrictions on where these centers can be built. Under the new amendment, ASC's cannot be built in C-1 areas – a level of classified area for commercial use – "without permission from the Zoning Committee and the City Council, both of which will then have to vote on each individual case." Similar to the amendment made in Manassas, Virginia, these San Antonio zoning laws "effectively [target] any future abortion providers in the city (Cato, 2015).

Access to Abortion Providers

"Most abortions are provided by freestanding clinics," and "fewer than 5 percent of abortions are performed in hospitals" (Boston Women's Health Book Collective, 2011, p. 317). As of 2008, only 610 hospitals in the US perform abortions, and 87% of counties do not have an abortion provider. This means that for the women who want an abortion but do not live in that small thirteen-percent that have providers, they must travel outside of their local community to get one. Large organizations such as Planned Parenthood and The National Abortion Federation provide resources for women to help find the closest abortion providers (Boston Women's Health Book Collective, 2011, pp. 317–318).

Financial Situation and Cost of Abortion

Just like anything in life, the abortion procedure has a cost. According to Planned Parenthood, an abortion can cost anywhere between zero and almost a thousand dollars. Whether it is performed in a clinic or hospital, and is paid for by the patient, insurance,

or government funding, someone is paying for it in the end. However, the price tag of the procedure is not one-size-fits-all. The cost of an abortion varies on many factors, including where the procedure is taking place or how far along a woman's pregnancy is.

Another factor is the type of abortion a woman decides to get, as discussed above. Due to the fact that these abortions include various differences: where they take place (home vs. doctor's office), what is used (medication vs. instruments), and follow-up care, the cost of the type a woman gets may vary. Further, if a woman has to get an aspiration abortion after the failure of a medication abortion, she is forced to pay for both.

A few final factors that involve the cost of an abortion are whether or not a woman has health insurance and her overall financial situation, which will be further discussed below (Emily @ Planned Parenthood, 2014).

Cost of Abortion: Health Insurance, Income, and Funding

A large factor that plays into the cost of the procedure is whether or not the patient has health insurance. This factor is different from the rest because it does not determine the actual cost of the procedure, but rather how the procedure will be paid for. If she does have health insurance, it may cover some or all of the costs of the abortion. The patient must call her insurance provider to find out about her coverage. If she does not have health insurance, or chooses not to use it to maintain privacy, the patient must pay out of pocket (Emily @ Planned Parenthood, 2014). Depending on her income and/or financial situation, this factor may be debilitating to the woman seeking the abortion and completely prevent her ability to get one. Simply put, if you cannot pay for a service, you cannot receive a service.

One source, The National Network of Abortion Funds, provides a website where women can search their location and find different organizations that may help them with the costs of their abortion (Boston Women's Health Book Collective, 2011, p. 320). On the "About" page of their website, the NNAF states that some of their member organizations "work with clinics to help pay for [women's] abortions[s]." Other member organizations offer to help with different factors that may cost the woman, such as childcare, transportation, and/or a place to stay if they had to travel for the abortion (*About: What are Abortion Funds*, n.d.).

In some states, the government may offer financial assistance to women through "Medicaid programs [that] use state funds to provide abortion coverage." However, "twenty state Medicaid programs do not fund abortion under any circumstances." As mentioned above, the Hyde Amendment prohibits state Medicaid programs to use federal funds to help pay for abortions. This barrier contributes to a lack of funding, which in turn hurts poor women who are desperately searching for a way to pay for the procedure (Boston Women's Health Book Collective, 2011, pp. 341–342).

Furthermore, if the domestic gag rule takes effect, this will affect the range of choices for women without other health insurance. As discussed above, the Trump Administration announced in February 2019 "that it will bar organizations that provide abortion referrals from receiving federal family planning money" (Belluck, 2019). This gag rule affects places such as Planned Parenthood, which provides many reproductive health services to women who cannot afford health insurance.

Relation Between Geographical Location and Financial Situation

Why women should make the abortion decision

Individually, the possible geographical and financial obstacles of receiving an abortion are difficult to deal with. However, for some women, the issues may intersect. Take for example a woman who is financially struggling and must travel over 30 miles to reach the nearest clinic that performs abortions. Not only must this woman travel a far distance to undergo the procedure, but she is also forced to worry about all the costs associated with it. First, there is the cost of the actual abortion. Then, there are the travel costs to get to the clinic and back home, whether it be gas money or public transportation fees. If she has children and does not want to bring them with her, there is the possible cost of childcare while absent. If her state has a mandatory waiting period, she is forced to pay these transportation and childcare fees a second time when going back to the clinic to get the procedure. If she gets a medication abortion and requires a follow-up appointment a week later, she has to pay them a third time. On top of all of this, there is the cost of her time. The time it takes for her to travel the far distance, possibly multiple times, is time she could have spent at her job making the money she desperately needs.

Physical, Sociological, and Psychological Effects on Women Denied Abortions

For women who seek an abortion but cannot receive one due to factors mentioned above, there may be certain physical, sociological, and/or psychological effects.

Physical Effects

Pregnancy

For women who are unable to get an abortion, the physical effect is obvious: pregnancy. If cannot abort the fetus inside of her, she is forced to continue the pregnancy, and carry the child inside of her until it is delivered. According to a website powered by the American Academy of Family Physicians, being pregnant comes with many physical effects. These effects include, but are not limited to, tiredness, nausea, frequent urination, lightheadedness, heartburn, and vaginal discharge and bleeding (*Changes in Your Body During Pregnancy*, 2009). Two of the largest, and most obvious, physical changes with pregnancy are belly and breast growth. As the fetus develops into a fully functioning baby, it grows, causing a woman's uterus and belly to grow in size as well. Breasts also physically change during pregnancy to allow a woman to breastfeed her child once born, as discussed earlier.

Episiotomies

In addition to pregnancy, the actual delivery of a child may bear its own physical effects on a woman's body. One of the most common of these effects is the use of an episiotomy during childbirth. "An episiotomy is a surgical enlargement of the vagina by means of an incision in the perineum, the skin and muscles between the rectum and vagina." This is done "as the baby's head is crowning," in order to "enlarge the vagina so that forceps [can] be inserted high into the pelvis, thereby assisting in the birth of the baby." Aside from the physical incision made to the body, episiotomies may lead to further physical effects, such as postpartum pain, infection at the site of the incision, problems with having intercourse, and vaginal swelling. One article published in 1995

stated that “The American College of Obstetricians and Gynecologists (ACOG) estimates that as many as 90 percent of women giving birth to their first child in a hospital will have an episiotomy.” Although this number may have changed throughout the years, this statistic shows how significant episiotomies have been within the last twenty years (Griffin, 1995).

Sociological Effects

Financial Instability

One factor that may motivate a woman to seek an abortion is her current financial situation. In a 2004 study discussed above, 73% of participants listed “can’t afford a baby now” as their reason for abortion, with sub-reasons including that the woman was unemployed, could not leave her job to care for the child, and/or could not even afford the basic necessities of life (Finer et al., 2005, p. 113). While many women identify with these reasons, not all are able to receive the abortion they want. In these cases, the intense burden of financial instability becomes a possible reality, with the newly added cost of raising a child. While there is the option of giving the child up for adoption, that is not the right choice for every woman.

One study published in 2018 looked at the socioeconomic outcomes of women who were denied wanted abortions compared to women who were able to get them. Similar to the study discussed earlier, done by BioMed Central Women’s Health, this study looked at data collected during the *Turnaway Study*. After analyzing the collected data, it was determined that women who were unable to get the abortion they sought were more likely to “experience economic hardship and insecurity lasting years” (Foster et al., 2018, p. 407). More specifically, compared to women who were able to receive a wanted abortion, women who were unable were “more likely to be in poverty for 4 years after denial,” and “less likely to be employed full time” six months after denial (Foster et al., 2018, p. 407). These results are an example of how following through with an unintended pregnancy as a result of being unable to receive an abortion can have a negative sociological impact a woman, pushing them into severe financial struggle.

Welfare Stigma

As discussed earlier, when something deviates from the widely accepted social norms and stereotypes within society, it is stigmatized, creating further stereotypes. One of the generally accepted ideas about America is that it is a land full of equal opportunity for everyone. “Most Americans believe that anyone can succeed [through] hard work, and that those at the bottom of the social heap have not tried enough to make it.” Due to this, being impoverished and receiving help from public assistance programs has become a stigmatized act. This is especially true in the case of women who face financial struggles as a result of unintended pregnancy. People who are impoverished due to a physical or mental disability are less stigmatized than those whose financial dependency on the government results from something that is perceived as a “personal failure, such as [being an] unwed mother.” These stigmas further perpetuate stereotypes on poor people and women as whole groups (Goodban, 1985, pp. 403–404).

One study aimed to further examine this social stigma, interviewing one hundred black single mothers who were getting assistance from public programs. The women were asked a variety of questions about being on welfare, such as why they were on it

and their feelings surrounding it. Many of the women “believed that they were on welfare for temporary, uncontrollable reasons having to do with their situation, rather than personal characteristics.” Out of the one hundred women, “sixty-one said they were sometimes ashamed of their welfare status” (Goodban, 1985, pp. 414–418). The results of this study exemplify the severity of stigma and stereotypes within society.

Psychological Effects

Postpartum Depression

One of the most well-known psychological effects of giving birth to a child is postpartum depression. This form of depression is experienced by women in “the postpartum period, which is increasingly viewed as up to 1 year after childbirth” (O’Hara, 2009, p. 1258). Furthermore, women who give birth to a child resulting from an unintended pregnancy have a possible higher risk of developing postpartum depression compared to women who gave birth to a child that was planned and wanted. One study in North Carolina analyzed a group of 550 women who were 12 months postpartum for the possibility of depression. This group included a mixture of women whose pregnancies were intended (64%) and women whose pregnancies were unintended (36%). The results concluded that “depression was more common among women with unintended pregnancy [12%] than women with intended pregnancy [3%]” (Mercier et al., 2013, pp. 1116–1118). Although every individual is different, the possibility of developing postpartum depression is a real consequence that may affect women who give birth to a child. These results imply that this fact may be especially true for women whose pregnancies were unwanted and/or unintended, which can include women who wanted to get an abortion but were unable to. Postpartum depression has also been linked to further psychological, such as suicidal ideation and self-harm (Coker et al., 2017).

Link Between Socio- and Psycho-

When looking at whether being unable to get an abortion has a psychological effect on women, it is important to note the intersectionality between sociology and psychology. Social norms and stereotypes within society can cause people to become outcasted if they do not act in accordance.

As discussed above, being impoverished and receiving help from government programs is stigmatized in American society. In the study that examined one hundred black single mothers on welfare, over half of the participants admitted to sometimes being ashamed of their status. This shame stemmed from the feeling that “they could not seem to succeed no matter how hard they tried, and [were] stigmatized by a society that devalues the poor.” Consequentially, this shame and guilt resulted in a handful of the participants experiencing low self-esteem (Goodban, 1985, p. 418). All of these feelings circle back to the socially normative belief in America that poor people do not work hard and accept government handouts, and that is why they are poor. Aside from guilt and low self-esteem, low socioeconomic status has also been linked as a risk factor for postpartum depression in women who gave birth (O’Hara, 2009, p. 1261).

When comparing women who receive a wanted abortion to women who do not receive a wanted abortion, it is important to note that both may suffer from physical,

sociological, and psychological effects. A summary of the effects that were discussed can be found below.

	Possible Physical Effects	Possible Sociological Effects	Possible Psychological Effects
Women Who Receive a Wanted Abortion	-Increased risk of developing breast cancer -Future reproductive health issues	-Stigmatized for deviating from the social norm that women should be maternal	Developing: -Post-Traumatic Stress Disorder (Post-Abortion Syndrome) -Anxiety/panic disorders -Depression
Women Who Do Not Receive a Wanted Abortion	-Must endure all bodily changes that come with pregnancy (belly growth, breast growth, nausea, frequent urination, etc.)	-Being financially unstable/living under poverty line -Stigmatized for being on welfare	-Postpartum Depression

Figure 3: Possible Effects of Receiving and Not Receiving a Wanted Abortion

IV. Conclusion

Abortion is an issue that has been relevant for over two hundred years. Before and during most of the 1800s, certain abortions were legal, and not uncommon. However, a woman was only allowed to seek an abortion before “quickening,” which was when she could feel the fetus moving. Before this, a fetus was not equated with a human life. Women who wished to abort their fetus were given certain drugs that would induce the process, and if those failed, a woman could visit a medical practitioner to remove the fetus.

Although abortions done before quickening were legal, they were not an entirely safe practice, and often ended in women dying. As a result, in the 1820s-40s, states began passing various laws in an attempt to control the procedure, which included outlawing the abortion inducing drugs (Connecticut, Missouri, and Illinois), the instruments used in the procedure (Missouri), or the actual procedure itself (Maine).

Within the late 1840s-50s, the American Medical Association was founded and began a crusade against abortion, headed by Dr. Horatio Storer. The Association, made up of licensed physicians, aimed to tarnish society’s view of abortion by painting it as a dangerous and immoral procedure. This anti-abortion movement gained traction, and the social shift towards the nonacceptance of abortion began to reflect in state laws. Beginning in the 1860s, states began passing legislation to criminalize the procedure of abortion and continued to do so throughout the early-to-mid-1900s.

In 1873, Congress went even deeper into the issue of women’s reproductive health and outlawed the importation and distribution of any information or drug that

Why women should make the abortion decision

aimed to prevent conception with the passing of the Comstock Law. However, with much help from the feminist movements fighting for contraception, this was later declared unconstitutional by the Supreme Court in *Griswold v. Connecticut* in 1965 (married persons), and then *Eisenstadt v. Baird* in 1972 (single persons).

In 1973, the Supreme Court struck down all state laws criminalizing abortion with the landmark case of *Roe v. Wade*, which made the procedure federally legal. Despite seeming like a victory for reproductive health, this federal ruling only set a legislative basis for states. Within their own borders, states are responsible for the abortion statutes, and can create certain barriers making it hard for women to obtain an abortion. These barriers include zoning laws to limit the areas where abortion providers can reside, mandatory counseling and/or waiting periods for women who want an abortion, and parental consent or notification requirements for minors. These state barriers are all federally legal under the 1989 ruling of *Planned Parenthood of Southeastern Pennsylvania v. Casey*. Some states even went as far as to implement “trigger laws” that will automatically ban abortion if *Roe v. Wade* ever gets overturned.

On top of these state-by-state barriers, there are also federal barriers that prevent women easy access to an abortion. In 1976, the Hyde Amendment was passed to prevent federal funds from being used by state Medicaid programs to help low-income people get abortions, and it is still in effect today. When President Trump took office, he re-implemented a global “gag rule” that prevents any international non-governmental organizations that perform or promote abortion services from receiving funding from the United States Agency for International Development. In 2019, the Trump Administration implemented a “gag rule” within the US, barring organizations that provide abortion referrals from receiving federal funds. However, despite the possible attempts by state and federal law to limit a woman’s ability to get an abortion, the medical procedure is still performed across the nation.

In the end, each individual's story is different. Your circumstances are different, your reasoning is different, your journey is different, and your aftermath is different. All of the research in the world cannot predict how a woman is going to be affected by either receiving an abortion or being unable to receive an abortion. The most common reasons and effects of these two situations can be summarized in the tables below.

Common Reasons Why a Woman May Want to Receive an Abortion	Reasons Why a Woman May Not Be Able to Receive a Wanted Abortion
<ul style="list-style-type: none">• Having a baby would dramatically change her life (Further reasons: would interfere with her education and/or career; she already has other dependents in her life)• Cannot afford a baby right now (Further reasons: she is unemployed; she cannot leave her job to care for the child; she cannot even afford the basic necessities of life)• Do not want to be a single mother or having relationship problems (Further reasons: she is unsure about her current relationship; she is not in a relationship at the moment)	<ul style="list-style-type: none">• Zoning Laws- Local governments attempt to block abortion providers from residing in an area by using zoning laws• Personal Geographical Location- As of 2008, 87% of counties in the U.S. do not have an abortion provider, forcing many women to travel outside of their local community to receive one• Personal Financial Situation- An abortion can cost anywhere between zero and almost a thousand dollars. A few factors that affect the cost include: where the procedure is taking place, how far along the pregnancy is, what type of abortion the woman gets, and/or if the woman has health insurance• Further Barriers- Mandatory counseling, mandatory waiting periods, minor consent or notification

Figure 4: Common Reasons Why a Woman May Want to Receive an Abortion vs. Common Reasons Why a Woman May Not Be Able to Receive an Abortion

Why women should make the abortion decision

	Possible Physical Effects	Possible Sociological Effects	Possible Psychological Effects
Women Who Receive a Wanted Abortion	-Increased risk of developing breast cancer -Future reproductive health issues	-Stigmatized for deviating from the social norm that women should be maternal	Developing: -Post-Traumatic Stress Disorder (Post-Abortion Syndrome) -Anxiety/panic disorders -Depression
Women Who Do Not Receive a Wanted Abortion	-Must endure all bodily changes that come with pregnancy (belly growth, breast growth, nausea, frequent urination, etc.) -Episiotomy	-Being financially unstable/living under poverty line -Stigmatized for being on welfare	-Postpartum Depression

Figure 3: Possible Effects of Receiving and Not Receiving a Wanted Abortion

Cases Cites:

Eisenstadt v. Baird, 405 U.S. 438 (1972).

Griswold v. Connecticut, 381 U.S. 479 (1965).

Roe v. Wade, 410 U.S. 113 (1973)

References:

About: What are Abortion Funds. (n.d.). National Network of Abortion Funds. Retrieved February 10, 2020, from <https://abortionfunds.org/about/>

Adamek, R. J. (2017). Legal Abortion Threatens Health and Fertility: Why Aren't Women Informed? *Human Life Review*, 43(4), 27–37.

Adler, N. E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F., & Wyatt, G. E. (1990). Psychological Responses After Abortion. *Science*, 248(4951), 41–44. JSTOR.

Arthur, J. (1997). Psychological Aftereffects of Abortion: The Rest of the Story. *The Humanist*, 57(2), 7–9.

Barbash, F. (2019, April 25). Trump Abortion “gag” Rule Blocked by Federal Judge. *The Washington Post*. https://www.washingtonpost.com/national/health-science/trump-abortion-gag-rule-blocked-by-federal-judge/2019/04/25/c147359a-67ac-11e9-a1b6-b29b90efa879_story.html

Bassett, L. (2018, December 1). 5 Men Could Overturn Legal Abortion In America. *HuffPost*. https://www.huffpost.com/entry/5-men-supreme-court-abortion_n_5b44c558e4b0c523e2632f62

Belluck, P. (2019, February 22). Trump Administration Blocks Funds for Planned Parenthood and Others Over Abortion Referrals. *The New York Times*. <https://www.nytimes.com/2019/02/22/health/trump-defunds-planned-parenthood.html>

Biggs, M. A., Gould, H., & Foster, D. G. (2013). Understanding why women seek abortions in the US. *BMC Women’s Health*, 13(29), 1–13. <https://doi.org/10.1186/1472-6874-13-29>

Boston Women’s Health Book Collective. (2011). *Our Bodies, Ourselves: A Book by and for Women*. Simon and Schuster. <https://www.simonandschuster.com/books/Our-Bodies-Ourselves/Boston-Womens-Health-Book-Collective/9781439190661>

Cato, G. (2015, December 21). Abortion Restrictions Go Local in San Antonio. *Burnt Orange Report*. <http://www.burntorangereport.com/diary/31549/abortion-restrictions-go-local-in-san-antonio>

Cha, A. E. (2015, December 21). *Tough questions—And answers—On ‘late-term’ abortions, the law and the women who get them*. Washington Post. <https://www.washingtonpost.com/us-policy/2019/02/06/tough-questions-answers-late-term-abortion-law-women-who-get-them/>

Changes in Your Body During Pregnancy: First Trimester. (2009, October 1). Familydoctor.Org. <https://familydoctor.org/changes-in-your-body-during-pregnancy-first-trimester/>

Coker, J. L., Tripathi, S. P., Knight, B. T., Pennell, P. B., Magann, E. F., Newport, D. J., & Stowe, Z. N. (2017). Rating scale item assessment of self-harm in postpartum women: A cross-sectional analysis. *Archives of Women’s Mental Health*, 20(5), 687–694. <https://doi.org/10.1007/s00737-017-0749-2>

Coleman, P. K., Coyle, C. T., Shuping, M., & Rue, V. M. (2009). Induced abortion and anxiety, mood, and substance abuse disorders: Isolating the effects of abortion in the

Why women should make the abortion decision

national comorbidity survey. *Journal of Psychiatric Research*, 43(8), 770–776.
<https://doi.org/10.1016/j.jpsychires.2008.10.009>

Dyer, F. N. (2003). The Physicians' Crusade for the Unborn. *The Human Life Review*, 29(1), 34–43.

Emily @ Planned Parenthood. (2014, December 30). *How much does an abortion cost?* Planned Parenthood. <https://www.plannedparenthood.org/learn/teens/ask-experts/how-much-does-an-abortion-cost>

Finer, L. B., Frohworth, L. F., Dauphinee, L. A., Singh, S., & Moore, A. M. (2005). Reasons U.S. women have abortions: Quantitative and qualitative perspectives. *Perspectives on Sexual and Reproductive Health*, 37(3), 110–118.
<https://doi.org/10.1363/psrh.37.110.05>

Foster, D. G., Biggs, M. A., Ralph, L., Gerdt, C., Roberts, S., & Glymour, M. M. (2018). Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States. *American Journal of Public Health*, 108(3), 407–413. <https://doi.org/10.2105/AJPH.2017.304247>

Galvin, R. (1998). Margaret Sanger's "Deeds of Terrible Virtue." *Humanities*, 19(5), 8–11.

Garrow, D. J. (2001). Privacy and the American Constitution. *Social Research*, 68(1), 55–82. JSTOR.

Gershman, J. (2018, September 4). Roe v. Wade Likely to Play Starring Role at Kavanaugh Hearings. *Wall Street Journal*. <https://www.wsj.com/articles/roe-v-wade-likely-to-play-starring-role-at-kavanaugh-hearings-1536058800>

Gezinski, L. B. (2012). The Global Gag Rule: Impacts of conservative ideology on women's health. *International Social Work*, 55(6), 837–849.
<https://doi.org/10.1177/0020872811421619>

Gold, R., & Nash, E. (2007). *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent* (Guttmacher Institute Policy Review). Guttmacher Institute. <https://www.guttmacher.org/gpr/2007/11/state-abortion-counseling-policies-and-fundamental-principles-informed-consent>

Goodban, N. (1985). The Psychological Impact of Being on Welfare. *Social Service Review*, 59(3), 403–422. JSTOR.

Griffin, N. (1995). Avoiding an Episiotomy. *Mothering*, 56.

Guttmacher Institute. (2019a). *Counseling and Waiting Periods for Abortion* (State Laws and Policies). Guttmacher Institute.

Guttmacher Institute. (2019b). *Parental Involvement in Minor's Abortions* (State Laws and Policies). Guttmacher Institute.

Hart, J. (2014). The American Medical Association: Former Defender of Unborn Babies. *Social Science Review*, 19, 287–294.

Henshaw, S. K., & Kost, K. (1992). Parental involvement in minors' abortion decisions. *Family Planning Perspectives*, 24(5), 196–207, 213.

Jagannathan, R. (2001). Relying on Surveys to Understand Abortion Behavior: Some Cautionary Evidence. *American Journal of Public Health*, 91(11), 1825–1831.

Kaplan, A. (2009). Abortion Trauma Syndrome. *Psychiatric Times*, 26(9).
<https://www.psychiatrictimes.com/%E2%80%9Cabortion-trauma-syndrome%E2%80%9D>

Kumar, A., Hessini, L., & Mitchell, E. M. H. (2009). Conceptualising Abortion Stigma. *Culture, Health & Sexuality*, 11(6), 625–639.
<https://doi.org/10.1080/13691050902842741>

Lanfranchi, A. E., & Fagan, P. (2014). Breast Cancer and Induced Abortion: A comprehensive review of breast development and pathophysiology, the epidemiologic literature, and proposal for creation of databanks to elucidate all breast cancer risk factors. *Issues in Law & Medicine*, 29(1), 3–133.

Lewin, T. (1991, October 27). In Debate on Abortion, 2 Girls Make It Real. *The New York Times*. <https://www.nytimes.com/1991/10/27/us/in-debate-on-abortion-2-girls-make-it-real.html>

Link, B., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, 27, 363–385.

Lohr, P. A., Fjerstad, M., DeSilva, U., & Lyus, R. (2014). Abortion. *BMJ: British Medical Journal*, 348. JSTOR. <https://www.jstor.org/stable/26511467>

Maantay, J. (2002). Zoning Law, Health, and Environmental Justice: What's the Connection? *The Journal of Law, Medicine & Ethics*, 30(4), 572–593.

Major, B., Cozzarelli, C., Cooper, M. L., Zubek, J., Richards, C., Wilhite, M., & Gramzow, R. H. (2000). Psychological responses of women after first-trimester abortion. *Archives of General Psychiatry*, 57(8), 777–784. <https://doi.org/10.1001/archpsyc.57.8.777>

Medoff, M. H. (2009). Biased abortion counseling laws and abortion demand. *The Social Science Journal*, 46(4), 632–643. <https://doi.org/10.1016/j.sosci.2009.05.001>

Mercier, R. J., Garrett, J., Thorp, J., & Siega-Riz, A. M. (2013). Pregnancy intention and postpartum depression: Secondary data analysis from a prospective cohort. *BJOG: An*

International Journal of Obstetrics and Gynaecology, 120(9), 1116–1122.
<https://doi.org/10.1111/1471-0528.12255>

Mohr, J. C. (1979). *Abortion in America: The Origins and Evolution of National Policy, 1800-1900*. Oxford University Press.

National Cancer Institute. (2003, February 20). *Abortion, Miscarriage, and Breast Cancer Risk: 2003 Workshop* [CgvArticle]. National Cancer Institute.
<https://www.cancer.gov/types/breast/abortion-miscarriage-risk>

O'Hara, M. W. (2009). Postpartum depression: What we know. *Journal of Clinical Psychology*, 65(12), 1258–1269. <https://doi.org/10.1002/jclp.20644>
Primrose, S. (2012). The Attack on Planned Parenthood: A Historical Analysis. *UCLA Women's Law Journal*, 19(2), 165–211.

Quackenbush, C. (2018, February 4). *The Impact of President Trump's "Global Gag Rule" on Women's Health is Becoming Clear*. Time. <https://time.com/5115887/donald-trump-global-gag-rule-women/>

Ravitz, J. (2016, June 27). *The Surprising History of Abortion in the United States*. CNN. <https://www.cnn.com/2016/06/23/health/abortion-history-in-united-states/index.html>

Reagan, L. J. (2008). *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973*. University of California Press.

Reinhard, B. (2016, November 20). Donald Trump's Victory Looks Set to Renew Battle Over Abortion Rights. *Wall Street Journal*. <https://www.wsj.com/articles/donald-trumps-victory-looks-set-to-renew-battle-over-abortion-rights-1479671454>

Robinson, G. E., Stotland, N. L., Russo, N. F., Lang, J. A., & Occhiogrosso, M. (2009). Is There an "Abortion Trauma Syndrome"? Critiquing the Evidence. *Harvard Review of Psychiatry*, 17(4), 268–290. <https://doi.org/10.1080/10673220903149119>

Rose, M. (2006). *Safe, legal, and unavailable?: Abortion politics in the United States*. CQ Press.

Stam, P. (2012). Woman's Right to Know Act: A legislative history. *Issues in Law & Medicine*, 28(1), 3–67.

Stein, P. (2015, April 28). Manassas vote called threat to abortion clinic. *The Washington Post*.
<https://search.proquest.com/docview/1676032179/595C1B5459464F3FPQ/1?accountid=1342>