This study involved in-depth interviews with 25 long time abortion counselors, including several who were instrumental in developing this field in the early 1970s, when the first freestanding clinics arose in Washington, DC and New York City. This study was premised on the insight of the preeminent sociologist of work, Everett Hughes, that occupations, as well as individuals, have “careers”, therefore it is fruitful to study occupations over time. Accordingly, the respondents were asked to reflect on their careers, and those of their colleagues, and discuss the evolution of the occupation of abortion counselor. In short, this research was intended as a study of the career of abortion counseling.

The majority of respondents actually started their involvement in abortion work around the time of the Roe decision in 1978, and were first asked to recollect the very beginnings of this field, and the events leading up to the creation of a special role for “counselor” on the abortion team. Many recalled a certain division within the ranks of newly hired abortion staff, especially those who emerged from the feminist health movement, whether “counseling” was even appropriate to impose on abortion patients. Some felt it paternalistic, and argued that women who came for an abortion had already thought this decision through. Yet another division that manifested itself in these early days of the field was the tension between the “advocacy” role of the counselor and the more professionalized “therapeutic” role, which necessitated a certain type of training in counseling techniques.

Though these tensions between “advocacy” and “therapy” persist to some degree to this day (with counselors typically being called on to perform both functions for patients, e.g. helping them raise funds for the procedure, and addressing the patients’ emotional reactions to her abortion decision) over time there emerged a consensus that all patients needed some amount of counseling, as the term is most conventionally understood: the counselor needs to ascertain that the abortion decision was truly the patient’s, and not coerced; she needs to be given “informed consent” about the details of the abortion procedure, including possible risks, and any other aspects of “patient education” that may be mandated by the particular state in which the abortion is taking place. Beyond this consensus however, there exist considerable variation as to how much time is allocated for counseling sessions, what are the credentials of those who are hired to do the counseling, and how are they trained, whether such counseling takes place in group sessions or in individual sessions, and so on.

A major finding of this study is the degree to which the larger political conflict surrounding abortion, and in particular the stigmatization of abortion that intensified in the years following the Roe decision, impacted the work of counselors. In particular, the 1989 Supreme Court Webster decision, which opened the doors to an unprecedented amount of regulation of abortion care, as long as these regulations did not impose an “undue burden” on women seeking the procedure, led, among other things, to numerous states imposing mandates scripts that counselors (or sometimes physicians) had to incorporate as part of counseling. In 23 states, these mandated scripts contain information that is blatantly untrue, e.g. the alleged, link between abortion and breast cancer or infertility putting abortion staff in very difficult positions.