

“Bans Off Our Bodies”:
Effects of Abortion Restrictions on Women’s Wellbeing

Cynthia Boaz, Ph.D
Department of Political Science
Sonoma State University
boazc@sonoma.edu

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Abstract

This research looks at the relationship between abortion bans and women's wellbeing in the United States. It integrates quantitative data on several objective quality-of-life indicators with interviews with twenty-seven women from ten states [California, Oregon, Washington, New York, Texas, Ohio, Mississippi, Georgia, North Carolina, and Tennessee] about their subjective abortion experiences. The primary goal is to establish whether there is a relationship between the restrictiveness of abortion laws and the wellbeing of women generally. The early analysis has rendered many interesting findings, the most striking of which is the degree to which quality of reproductive care differs across US states. In the US, a woman's ability to access an abortion is determined largely by the geographical location in which she resides. Different standards of care and degrees of access ensure that not all women in the United States enjoy reproductive rights equally. Ongoing legal challenges to existing access further threaten the long term prospects for reproductive justice in the United States.

*I am grateful to former students Kristi Strobeck for inspiring this project and Adam Bernstein for his research assistance on everything from gathering data to coding to talking through future directions of the research.

Introduction

With the introduction of S.B. 8 in Texas last May, nineteen US states passed or attempted to pass restrictive anti-abortion legislation in less than one year. In fact, the year 2021 had the dubious distinction of being the year with the most abortion bans (108) passed since the *Roe vs. Wade* decision in 1973. The restrictions introduced so far in 2022 have already surpassed the previous year. It has been clear for some time that states “have been constructing a lattice work of abortion law-codifying, regulating and limiting whether, when and under what circumstances a woman may obtain an abortion” (Guttmacher 2021). Last December, the Supreme Court heard arguments in Mississippi’s ban on abortions after 15 weeks. If they uphold that prohibition—which many observers of the court expect them to do—it will effectively unravel *Roe v. Wade* (Barnes 2021.) What does this mean for the day to day experiences of women? In order to try and understand the short and long-term consequences of imposing abortion bans in the United States, I propose here a state-centric approach that compares the experiences of women in more permissive states like Washington and New York with women in more restrictive states such as Texas and Mississippi. Because it is impossible to talk about the experience of abortion in the United States as a monolith, this approach seemed more prudent than a national-level approach. However, as I note below, I do attempt to make some generalizations across state “types” at different points in the analysis.

Literature Review

Reproductive Control and Social Outcomes

We know from looking at places like Romania and Ireland that the suffering of women under coercive abortion bans is not limited to being forced into motherhood. Mental health outcomes are worse, domestic violence is higher, job stability is lower, drug and alcohol abuse is higher, social isolation spikes, and self-reported rates of happiness plummet. Indeed, the European Court of Human Rights, the Human Rights Committee, and the Committee Against Torture have all recognized that denying or obstructing access to an abortion or compelling a woman to continue with a pregnancy against her will amounts to Cruel, Inhuman, or Degrading Treatment (CIDT) in certain contexts (Zureick 2015.)

The Romanian abortion story reads like something straight out of a dystopian novel.¹ Shortly after coming to power in December 1967, Nikoli Ceaușescu issued Decree 770, which effectively nationalized Romanian women's wombs. His objective was to quickly and brutally increase the size of the Romanian population, which he believed would make Romania a player on the European continent. Under Decree 770, abortion was criminalized for all women age 45 and under who had not borne at least four children (later increased to five.) The only exceptions were for rape and incest, high-risk pregnancies, and cases in which the fetus had inherited a disease from either parent. The state ultimately determined if pregnancies fell into these categories, which not surprisingly, they very rarely did. The secret police kept a log of all actual pregnancies and suspected pregnancies and watched the women until the birth of the child was confirmed. "Womb police" even inspected pregnant women on the job in factories in order to make sure they hadn't secretly terminated their pregnancies. "In the 1970s, young people were afraid to have sex," says Daniela Drăghici, an abortion-rights activist now in her 60s. "We never talked about pleasure. It was difficult because every single month we were thinking about getting our period. If we got our period we were very happy. If we didn't, we were very worried, and started looking for ways out" (Vladi and Bird 2019.)

Amazingly, two decades into Decree 770, Romania's birth rate had not increased. In fact, the scheme had backfired. By 1989, Romanian women had undergone nearly 7.3 million back-alley abortions – an average of three apiece – since 1967. Romania's infant-mortality rate during this period was also the highest in Europe, up to 59 times greater than that of other countries (Horga et al 2013.) Children born under a restrictive birth control regime are more likely to be unplanned, unwanted, or mis-timed (Pop-Eleches 2006), and the horror stories of Romanian state orphanages during this period still resonate in the public mind more than three decades after the Ceausescu's' deaths. Kligman (1998) uses a political demography approach to identify the effects of Ceausescu's regime of reproductive coercion. She argues that the endeavor erased all distinction between public and private realms and the intrusiveness of the state into everyday life produced a culture of duplicity and dissimulation (1998). Many observers of the Romanian state today argue that the destructive legacy of this period is still visible and that the stores of social capital that were lost under the Ceausescu era are still being replenished today.

¹ And indeed it was one of the main inspirations for the fictional regime of Gilead created by Margaret Atwood in her 1985 novel *The Handmaid's Tale*.

“The State acknowledges the right to life of the unborn”, begins the now-repealed 8th Amendment to the Irish Constitution [Bunreacht], passed via referendum in 1983. Alarmed by what they saw as a trend of liberalization of abortion laws (both the UK and US had lifted restrictions in 1967 and 1973 respectively), conservative politicians backed by the Catholic Church launched a powerful campaign to enshrine the existing ban on abortion in the republic. It passed with 67% of the vote. As in Romania, the women of Ireland learned the hard way what life under a complete abortion ban means for women’s daily existence. Mother and Baby homes were church-run institutions that opened in the early 1920s and continued through the late 1990s, where unmarried women were sent to deliver their children under a veil of secrecy and shame, and under the watchful eye of the Church. Life for both women and children in the homes was marked by trauma, malnutrition, and neglect. In some cases, infant mortality rates peaked at upwards of 80%, according to local public health records. In a comprehensive tome on the history of reproductive control in Ireland since the early 20th century, Ferriter argues that although Ireland was no more sexually repressive than Spain or Italy at certain points, what was truly unique to Ireland was the extent of the State’s reliance on religious institutions to provide institutional care to children, and more egregiously, the abusive conditions that prevailed in those institutions: “Thousands of children suffered systematic physical and sexual abuse between the 1930s and the 1970s, and lived in a climate of fear in residential institutions founded by the state and run by religious orders” (Ferriter 2010.) To this day, the Irish state is still being asked to reconcile with this history by acknowledging its responsibility to the women condemned to those institutions. In speaking about this subject to my Reproductive Rights course (POLS 487), Irish writer and activist Stephanie Lord reflected “this history has a deep effect on how you exist [in Ireland] as a woman to this day.”²

Making Abortion Law in the United States

An objective of this study is to look at the real world effects of laws (in this case, abortion restrictions) on women’s daily lives because presumably, the choices made by policymakers have measurable consequences on the lives of constituents. However according to a 2004 study, there is evidence that many laws, particularly those focused on social issues, have very little chance of actually producing social change, and that many laws are essentially religious practices that have little basis in rational analysis (Roots 2004.) In a paper that examines the justifications for lawmakers’

² Discussion with Stephanie Lord, POLS 487: Politics of Reproductive Rights, Sonoma State University, November 9, 2020.

positions on abortion, Woodruff and Roberts (2020) found that evidence in the form of empirical data and statistics almost never shifts their position. And there is substantial evidence to indicate that not only do abortion bans not reduce the demand for abortion, but conversely, that making abortions safe, legal, and accessible does not appreciably *increase* demand (Grimes 2006.) There is also no evidence that TRAP laws have a statistically significant independent effect on reducing abortions (Medoff 2010.) Although TRAP laws can make performing abortions too expensive and burdensome for some physicians, causing them to close their practices (Solinger 2013), Jones and Jerman (2017) actually found that fluctuations in abortion clinic numbers—whether decreases or increases—were not associated with changes in abortion rates. Similarly, restrictive abortion laws have no demonstrated effect on reducing teenage pregnancy rates (Mlawer 2017.) So what exactly are anti-abortion lawmakers seeking to do and more immediately, what are the consequences of the avalanche of restrictions if not to reduce the demand for abortion? The first question is unfortunately beyond the scope of this paper, but the second will be taken up here.³ Notably, Woodruff and Roberts also found that while evidence has no impact on lawmakers' positions on abortion, elected officials *do* tend to rely quite heavily on personal stories and will often draw broad conclusions from anecdotes (2020.) This of course is another reason to look closely at the personal narratives of women's abortion experiences.

Abortions and Stigma Culture

Although banning abortions does not reduce the demand for abortion, it does make them more difficult to obtain safely. Besides the TRAP laws that have placed excessive burdens on abortion providers in recent decades, the wave of anti-abortion extremism that began in the 1980s has contributed to a decline in the number of providers across the United States (Rose 2007.) When a medical procedure cannot be easily obtained and requires a healthy degree of resilience, resourcefulness, and secrecy just to access, there will inevitably be mental health effects. The American Psychological Association has listed stigma as a major risk factor for the mental health of women who have had abortions and suggested that stigma can create anxiety, depression, increased psychological distress, and social withdrawal (Hanschmidt 2016.) It is hardly surprising then that Shellenberg and Tsui (2016) found that 58% of women felt they needed to keep their abortion a

³ There is an entire literature in feminist and policy studies that addresses the motives of the historically male policymakers behind abortion bans and other laws limiting women's rights to reproductive and other forms of justice. See for example Reingold, Beth et al. "Anti-Abortion Policymaking and Women's Representation." *Political research quarterly* 74.2 (2021): 403–420.

secret and 33% said that other people's opinion about their abortion mattered to them. Similarly, Cockrill et al (2013) assessed the impact of internalized stigma of women who had received abortions and the majority of participants reported moderate to strong negative feelings of guilt, shame, and selfishness in the aftermath of their abortion. Among women generally, Catholic and Protestant women experienced higher levels of stigma than nonreligious women (Cockrill et al, 2015.) Where opposition to abortion is widespread, abortion-related stigma is more likely (Hanschmidt 2016), so it tracks that in geographical areas with a concentration of religious or conservatively-identified people, the internalization of shame will be more profound. We know that abortion seekers generally engage in introspection before undertaking their decision, often involving political and religious/spiritual considerations, as well as family and community relationships (Swan 2021.) It should not be surprising that an expectation of disapproval and condemnation from those realms would have a negative impact on women's experiences with abortion, though notably very few women actually change their mind after making the decision to obtain an abortion.⁴ Some of these results may also in part be due to the fact that women and abortion providers are generally treated by law and policymakers as untrustworthy and in the narratives surrounding the justification for abortion restrictions as well as mandated "informed consent" scripts in many states, the perceived interests of the fetus, rather than the needs of the woman, is centered (Johnson 2014.)⁵ Others have found that there are links between measures of women's wellbeing such as Intimate Partner Violence (IPV) rates and the distance traveled to obtain an abortion (Ely and Murshid 2021), with a likely intervening variable being stigma or shame.

Given the preceding discussion, I do expect to find a relationship between ease of access to abortion and various social indicators of women's wellbeing, including quality of life indicators, social isolation, emotional and psychological health, and self-reported levels of happiness.

⁴ In one study, less than 1% of women cited their partner or parent's attitudes as the primary motivation to seek (or not to get) an abortion (Finer et al., 2005). This decision usually rests exclusively with the woman, which evidence from my interviews confirms.

⁵ In various US states, medical providers are required by law to inform women prior to an abortion that the procedure can lead to depression, infertility, or breast cancer; that fetuses can feel pain; and/or that fetuses develop heartbeats at six weeks. There is no substantiated scientific evidence for any of these claims.

Methodology

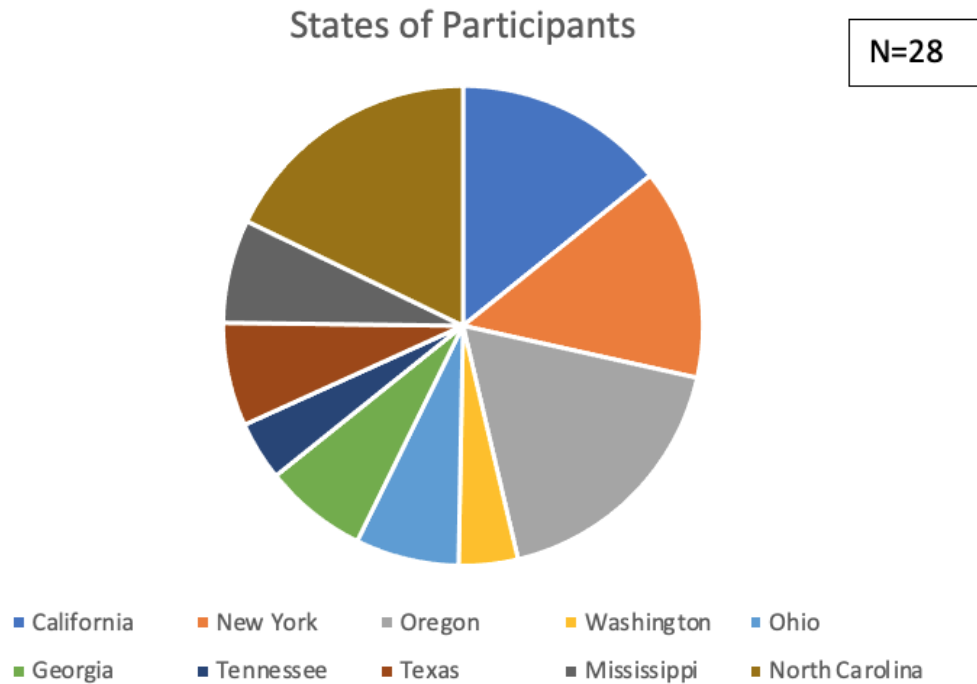
The project has unfolded in several stages. The initial stage involved gathering and coding data on each US state's level of abortion access based on an index of several criteria: parental consent requirements; exceptions in the cases of rape, incest, or health of the woman; "heartbeat" requirements; limits on later term abortions; and geographical proximity to abortion-providers. This was followed up by the gathering and recoding of relevant data on a number of measures of quality of life and wellbeing: rates of maternal mortality, domestic violence, depression and other mental health issues, employment, social isolation, and self-reported levels of happiness. This data came from state health offices, nonprofit organizations, several IGOs, and the PEW Research Center.

In the first round of qualitative research, which is my primary focus in this paper, I interviewed twenty-seven women from ten states-- Oregon, California, Washington, New York, Georgia, Mississippi, Tennessee, Ohio, North Carolina, and Texas.⁶ Each interview took approximately two hours and was conducted via Zoom between July 6th and August 13th 2021.⁷ The participants were asked for demographic information as well as questions about the medical facility where they received the abortion, the quality of care they received, the financial, legal, logistical, and emotional barriers to obtaining the abortion, any social isolation a result of seeking an abortion, their primary emotional responses to receiving the abortion, the stability of employment around the time of and after their abortion, and their self-assessment of relative happiness since the abortion. Respondents were allowed to skip any questions they did not wish to answer, and were encouraged to elaborate on their responses. The study averaged just under three participants per state of investigation, although the range was 1 (Washington and Tennessee) to 5 (Oregon and North Carolina.) The distribution of states in which participants lived at the time of abortion is detailed in Image 1:

⁶ There are a total of twenty-eight cases in the study because one of the participants had undergone two abortions in the designated time period of the study (within five years prior to summer 2021), so in that case, her state (California) was counted again. The original IRB proposal included fourteen states, however I was unsuccessful in recruiting any participants from Hawaii, Vermont, South Carolina, or Alabama at this stage.

⁷ I used a combination of snowball and convenience style sampling and recruited all participants via social media. Most of the initial participant contact took place via Instagram, followed by Facebook and Twitter. This methodological approach resulted in a self-selected participant pool that was largely white, non-religious, and of similar ages (early to mid-30s) and socioeconomic status. For the next round of interviews (to be conducted in fall and winter 2022), I will make an effort to recruit a broader and more diverse participant pool that better reflects the demographics of abortion recipients in the United States. Participants were offered \$100 remuneration for their time.

Image 1:

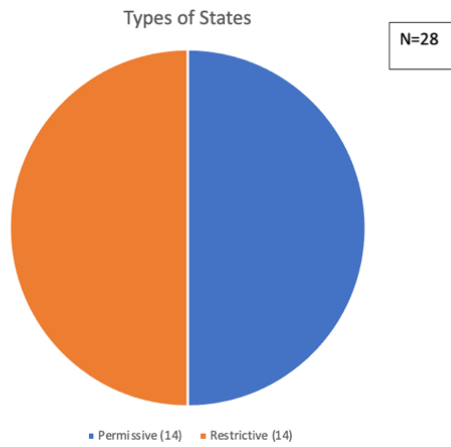


Analysis

In order to evaluate the effects of abortion restrictions around the United States, I began by separating the states of investigation into two categories: permissive and restrictive states. Permissive states are those that have few if any limitations on abortion access before twenty-four weeks and/or that enshrine the right to an abortion into their state constitution. Restrictive states are those that have strict limits to abortion access before twenty-four weeks and/or have passed TRAP laws that have resulted in the closure of abortion-providing facilities in that state.⁸ As illustrated in Image 2, there were four permissive states (California, New York, Oregon, and Washington) and six restrictive states (Georgia, Mississippi, Ohio, North Carolina, Tennessee, and Texas) included in the study at this stage of the analysis. Participants were drawn evenly from permissive and restrictive states, at fourteen each, which allows for some general comparison.

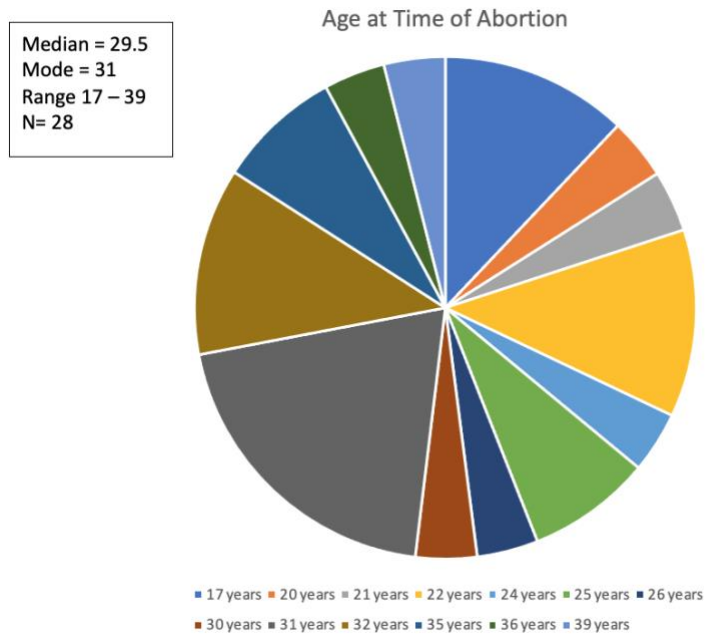
⁸ The acronym TRAP stands for “targeted regulation of abortion providers.” TRAP laws are typically considered to be medically unnecessary restrictions designed to limit or even completely close off access to abortion-providing facilities in a given geographical area

Image 2: Types of States by Participant



In terms of other demographics, the age at time of abortion for participants ranged from seventeen to thirty-nine, with a median age of 31 (see Image 3).⁹

Image 3: Age at Time of Abortion

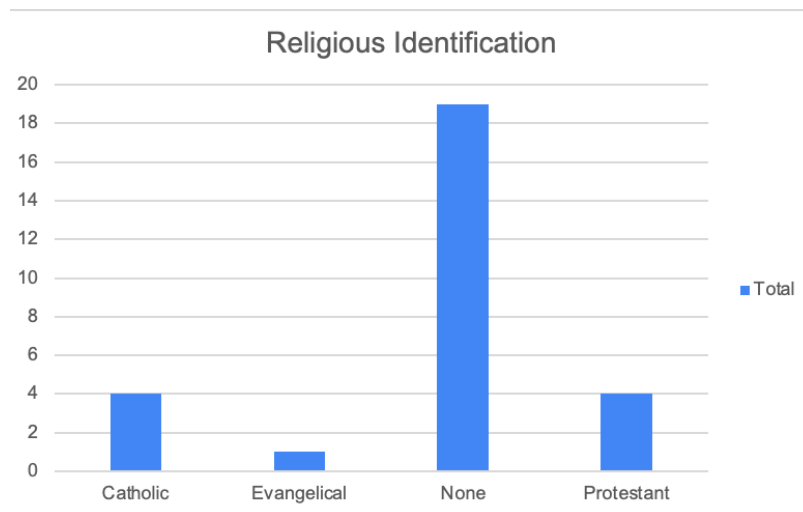


⁹ Participants had to be 18 or older in order to be interviewed, but several had undergone abortions as minors and were still within the five-year window since the procedure.

All three participants who had abortions at seventeen years were from restrictive states (Ohio and Texas), and all three had to overcome substantial hurdles in order to receive their abortion. One of the young women was able to obtain a judicial bypass in order to override parental consent laws in the state. She described spending several days and night researching the process for obtaining judicial consent, recruiting a temporary guardian and an attorney to work pro-bono, riding her bicycle to the clinic, and locating the necessary resources to obtain car rides to and from the courtroom, as well as funds to pay out of pocket for the procedure. She said about this process that “I had to be an adult” because at no point was keeping the pregnancy a serious option in her mind. She said she would have done whatever was necessary in order to obtain the abortion.

Since abortion discussions are often framed in terms of moral values, I also asked participants about their religious identification. As illustrated in Image 4, of twenty-seven participants, only nine indicated a religious preference. Of those, four identify as Catholic, four as mainline Protestant, and one as Evangelical.

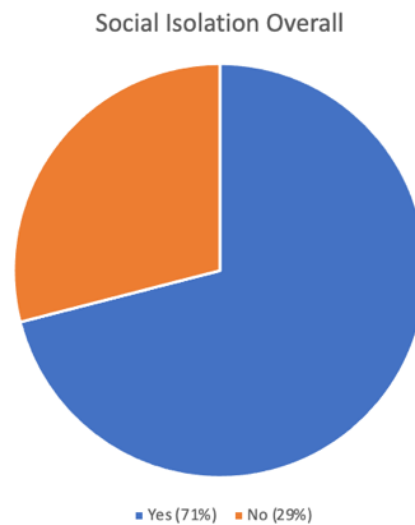
Image 4: Religious Identification of Participants



Social Isolation

Participants were also asked whether they have experienced any social isolation or political ostracization as a result of their abortion. It is important to note that across all states, 71% of women said they felt some social or political consequences (see Image 5), which is consistent with the research on stigma mentioned above. Many women said that although they were solidly pro-choice before their own abortions, they did not expect the shame and prevalence of pro-birth narratives that accompanied the experience. One women said that “being yelled at like an animal” had an effect, and another noted that she “had to pretend [in front of others] that I wasn’t grieving.”

Image 5: Social Isolation Across All States



The picture becomes much more illuminating when we look at social isolation by type of state, however. Among the fourteen participants who were from restrictive states, 86% said they felt social isolation as a result of their abortion experience, compared to 57% of women in permissive states (see Images 6 & 7). Many women spoke about family, community, or friends from whom they became estranged as a result of their decision to obtain an abortion. Many others indicated that they did not share their abortion story with people in their circles out of fear that they would be spurned or derided for their decision. This sentiment was not exclusive to women in the restrictive states, but it was more common in those places. One respondent from Oregon noted that even among

progressive, pro-choice communities, there is a special stigma associated with abortions that fall into moral gray areas, such as later-term abortions, abortions that are not the first for the woman, and elective abortions undertaken after pre-natal CVS screenings that show Downs Syndrome or other chromosomal conditions that do not threaten the life of the fetus. This respondent said that people are “not as pro-choice as they think”, but that those same people also don’t know first-hand the circumstances that would make them seek an abortion: “Unless you’ve been in this situation [facing an ethically complicated abortion scenario], you have no authority to speak on it.” Another participant from North Carolina said that it was her relative privilege (race, socioeconomic status, and full-time employment) that kept an extremely difficult situation from being a “disaster.” She commented that “if any one of the variables had been different, this would have been a horror story rather than a serious inconvenience.”

Image 6:
Social Isolation in Restrictive States

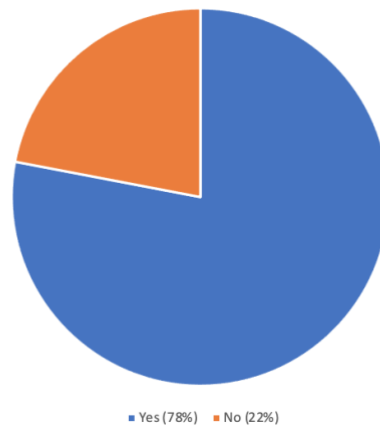


Image 7:
Social Isolation in Permissive States



Following on the discussion above, I also looked at social isolation by religious identification. Of those in the study who identified as religious (all Catholic or Protestant/Evangelical), 78% said they had experienced some social isolation, compared to the 71% of the respondents generally (see Image 8.)

Image 8: Social Isolation and Religious Identity



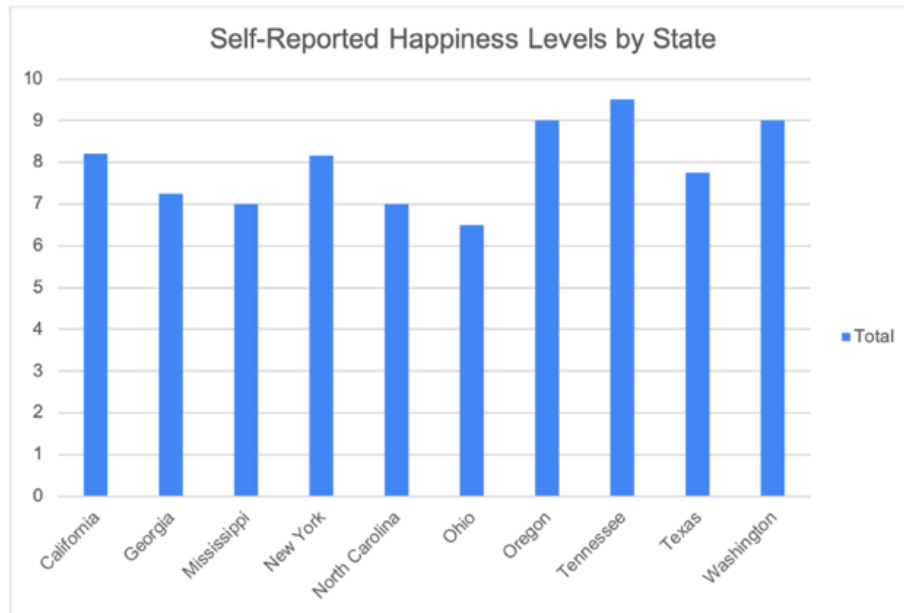
Happiness

Respondents were also asked about their level of relative happiness, as compared to other women they know. While on one hand the majority of women in the study felt socially isolated, but less so in permissive states, women also reported feeling generally happy overall (an average of 7.79 out of 10), though consistently less so in restrictive states (see Image 9) on the other hand.¹⁰ One reason that many women gave for being less happy than they wanted was the culture of silence and shame around abortion generally. This was true regardless of age, whether the women were themselves pro-choice or pro-life before their abortion, and whether they came from a restrictive or permissive state. One woman, who had a strongly conservative upbringing in one of the restrictive states (Ohio) said “I felt really mad at our policymakers. They made me feel bad about my decision.” Another participant from Georgia commented that the “taboo” around abortion “made her feel shameful.” At the same time, despite the burden of internalized shame and stigma, one respondent from North Carolina drove home the overall benefit of abortion to many women’s lives. While she assessed her

¹⁰ Tennessee was the one exception. Of course there are many reasons why a woman might evaluate her own happiness as higher or lower than others around her beyond just having had an abortion. I tried to emphasize in the question that respondents should consider their abortion experience in their decision-making. Additionally, there is no way of knowing whether all of the women assessed the concept of happiness similarly, which is why I relied upon a self-reported measure. If we trust women to generally know whether they are happy or not, their relative self-assessments can be considered good guides.

relative happiness as only a 4, she provided the caveat “but it would be a 1 if I had a five-year old right now.”

Image 9: Happiness by State

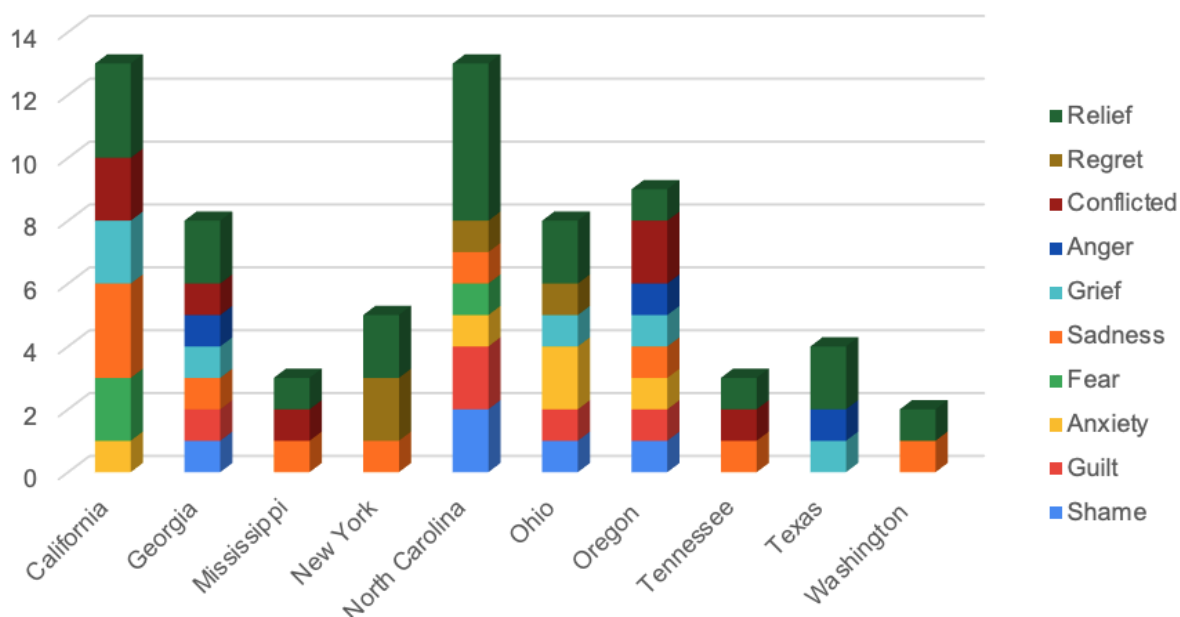


Emotions

In order to assess how the women felt in response to their abortion experiences, I asked each about their predominant emotions following completion of the procedure. The question was open-ended and there was no minimum or maximum number of emotions they could name. Some women gave just one response while others provided multiple reactions. When aggregated, the responses fell into ten categories: relief, shame, grief, anxiety, guilt, fear, sadness, regret, anger, and “conflicted.”

Participants also had the opportunity to elaborate on their responses if they wanted. The prevailing emotional response among respondents was “relief”; in fact, that word was used by 20 of 27 participants. Other common emotions were sadness, grief, and a conflicted feeling (see Image 10).

Image 10: Emotions by State



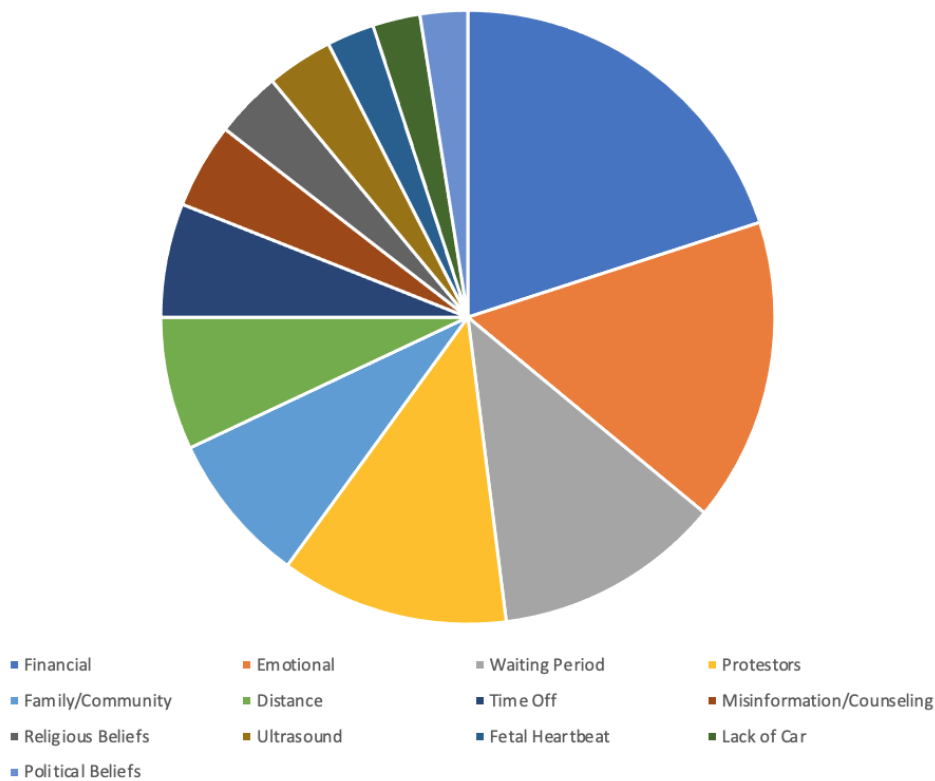
Several participants who said they were conflicted clarified that they were not conflicted about the decision to obtain an abortion, but rather that they had gotten themselves into that situation in the first place. For example, one participant from a restrictive state who came from a deeply Catholic family and underwent a third-trimester abortion after returning from overseas in a country where abortion was completely banned said “I regret it, but I also would not change my decision.” Many others expressed similar sentiments, one saying that she was glad for her abortion, but the “daunting” nature of the process in her state led her to feel “true adversity” for the first time in her life. Others expressed emotions that ranged from gratitude: “My abortion saved my life. I’m so thankful to have the option to be in control of my life,” to anger. One respondent from Texas who sought an abortion after being raped said she was furious that the “joy of being a mother [had been] taken from [her] in this way.”

Barriers

In order to get more directly at the question of how different levels of reproductive access affected women differently from state to state, I also asked participants to discuss the main barriers they encountered in obtaining an abortion. Barriers are not necessarily the same as bans or legal

restrictions. Barriers can also extend to concerns like lack of financial resources or insurance, no access to transportation to medical facility, inability to take time off from work or school, or religious, emotional and psychological burdens felt by the participant. As with the previous question on emotions, this was open-ended. Some respondents named only one barrier while others cited up to five. As illustrated in Image 11, a total of thirteen categories of barrier were mentioned by participants. By far the most common was financial, which was mentioned by 63% of respondents. The second most frequent category was an emotional barrier (which most women specified as internalized shame or guilt), named by 52% of women. Finally, a waiting period and the presence of protestors outside the facility were each mentioned by 37% of respondents. Pressure from family or community and distance from the clinic were also cited by a large number of participants.¹¹

Image 11: Most Common Barriers



¹¹ Two of the participants had to leave their state to obtain their abortions. A resident of North Carolina went to Washington DC, and a resident of Mississippi went to Alabama.

I also calculated the average number of barriers by state (see Image 12). At one end of the spectrum were Washington, New York, and California, with an average of 1.0, 1.3 and 1.8 barriers. At the other end are Texas, Mississippi, and Georgia, with an average of 5.0, 5.5, and 6.0 barriers respectively. It is not surprising that women in restrictive states noted a higher frequency of barriers tied to the legal restrictions in those states, but it is intriguing that the rates of non-legal barriers, such as logistical issues, emotional costs, family and community pressure, and religious beliefs were higher as well. This seems to be additional evidence for the claim that the women being targeted by abortion restrictions across the United States are the ones already the most overburdened by lack of access.

Image 12: Barriers by State

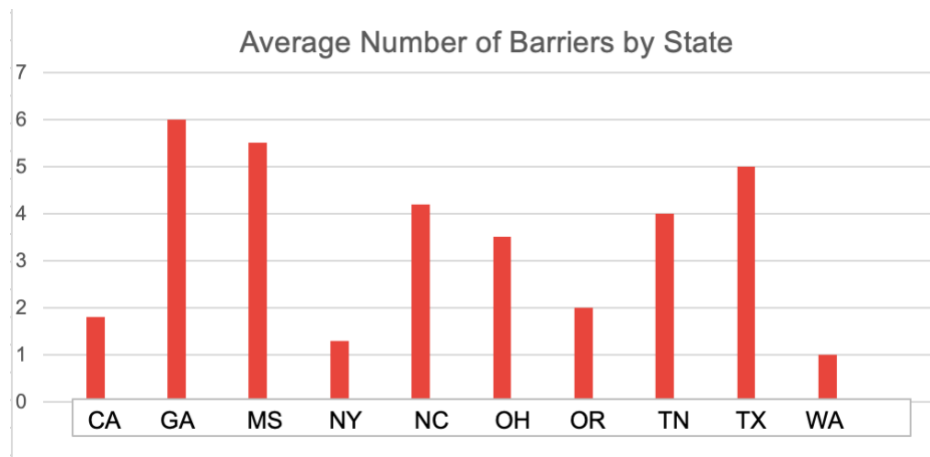
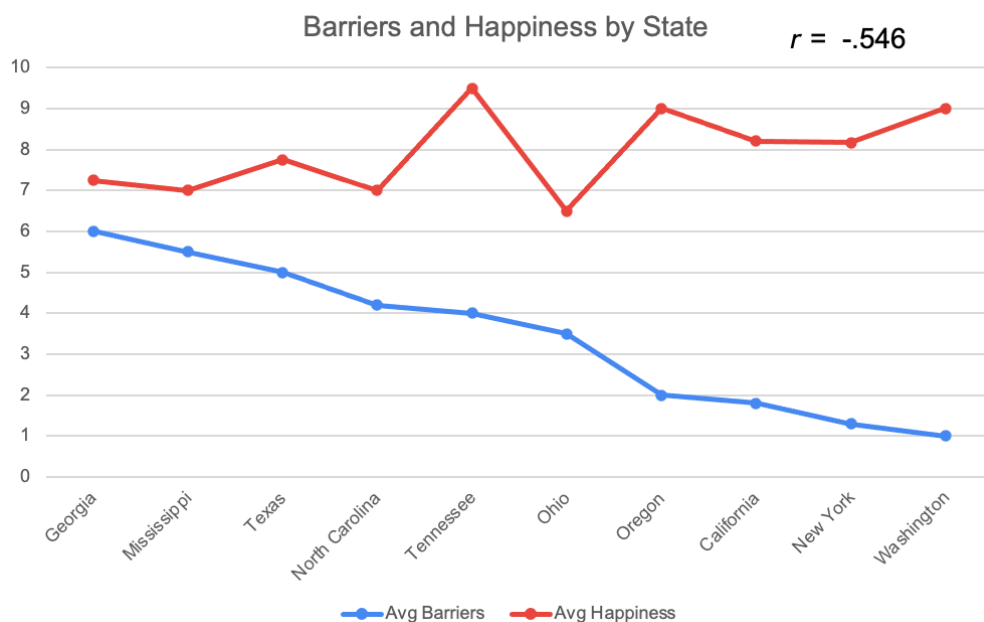


Image 13: Barriers and Happiness by State



Finally, with the caveat that I am currently working with a small number of cases, I wanted to check whether there was preliminary evidence to suggest a relationship between the number of barriers to abortion access in a given state and women's self-assessment of their own happiness in that state. Image 13 plots the data points for average barriers and average happiness for each state in the study. When I include the outlier of Tennessee, the correlation coefficient between barriers and happiness is $-.546$. When Tennessee is removed, the coefficient increases to $-.727$, suggesting that barriers to abortion access correspond with women's overall happiness.¹²

Discussion and Conclusion

A first pass at this data suggests that there is a relationship between the implementation of abortion restrictions in a given state and the overall wellbeing of women in that state. In particular, women who seek abortions in restrictive states report encountering higher numbers of barriers, higher degrees of social isolation, and lower levels of overall happiness. So it seems that passage of abortion restrictions does have an impact, it is just not the impact lawmakers claim to be seeking when justifying support for new laws.

The culture of stigma and shame around abortion is toxic for women even in the most permissive of places and with the most progressive pro-choice upbringings. One conclusion that emerged from the data is that no woman treats the decision to get an abortion as cavalier. Some women find it much harder psychologically than others (it often depends on the circumstances under which she is seeking the abortion), but the caricature of abortion-seeking women as radical misandrist feminists who regard abortion as a form of birth control does not align with reality. Largely due to the seriousness with which women tend to undertake this decision, few women say they regret getting an abortion. In this study that looked at the experiences of twenty-eight different cases of abortion that took place for a spectrum of reasons from profound fetal abnormalities or threats to the mother's life on one hand to simply not wanting to become a parent (yet or with her current partner), not one woman told me that she wishes she had not had the abortion. This held for wanted pregnancies as well as unwanted ones, and across all ages, races, religious identities, socioeconomic statuses, and states of residence. One woman from California who is happily married and wants to

¹² The next stage of the study is to add an additional 50-75 interviews to the data, which will provide a much more rigorous picture of this and other relationships.

be a mother eventually said that when she hears anti-abortion, pro-birth, and fetus-centered rhetoric from her extended family members and neighbors (none of whom know about her abortion), she wants to shout “We lost a pregnancy, not a baby!”

Another lesson gleaned from this research is that despite the fact the abortion is technically still legal in every part of the United States, the barriers are such that it is effectively illegal in many states. What will happen if *Roe vs. Wade* is overturned is difficult to ponder. We know that as of now, at least twenty-six states are poised to completely ban abortion immediately after *Roe* is overturned, which would instantly make it all but inaccessible to approximately half of the women of the United States. Beyond that, if a Republican-majority House, Senate, and President go as far as to pass an abortion ban at the national level (which seems to be the objective of many in the party), the United States would enter an unprecedented era in our history, and it’s not unlikely that we would see outcomes similar to Romania and Ireland in the 20th century—skyrocketing rates of underground abortions, spikes in maternal deaths, widespread medical tourism, masses of unwanted children placed in state institutions for care, and a generation of women dealing with the social and political costs of losing their procreative autonomy.

This preliminary data also suggests that women in the United States are getting very different standards of reproductive care depending solely on the state they happen to live in. Why should a woman who happens to reside in Texas be required to show resilience and perseverance so far above and beyond what is required of a woman who had the good luck to be living in Oregon at the time her abortion became necessary? It is hard to imagine that when put under the microscope, these widely varying experiences do not represent a violation of the equal protection clause and the spirit of the *Planned Parenthood vs. Casey* (1992) ruling, which determined that states cannot place an “undue burden” on women seeking abortion.

While it may be possible for states to limit abortion demand very briefly by introducing a dramatic new ban or set of restrictions to abortion access, it is becoming clear that a) doing so will result in a widened circle of suffering and reduced quality of life for women generally, and b) the demand will inevitably go back up. Women who want an abortion will find a way to get one regardless of the law and other barriers. However, how easily a woman can do that depends on a number of variables like access to funds and transportation, an emotional support system, and other markers of privilege

such as access to internet. It is the women and girls who are already the most disadvantaged who will bear the brunt of coercive reproductive laws.

One of the women I spoke with, an extremely impressive young woman from Texas ended our interview by wanting to reassure others who find themselves in a situation like hers that there is a “guild of people” out there to assist in the process if a woman finds herself without support or access. Another woman who had a precarious run in with anti-abortion protesters outside a clinic in Ohio wanted women seeking abortions to know that clinic escorts are “angels on earth.” Many women I spoke with expressed profound gratitude for the volunteers and others who work tirelessly under the radar to fill in the gaps in reproductive care created by abortion restrictions. One participant from Oregon even told me that the kindness and support of the volunteers and health care workers “saved her life.” It is clear that pregnant women who do not want to be pregnant will find a way to take care of their needs, as they always have. But it would be prudent for lawmakers to consider the long-term costs of imposing draconian laws that have no proven social benefit.

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Appendix I: Interview Script

Hello, I am going to ask you a series of nineteen questions. The first eleven are demographic questions that help me better understand the population of people seeking abortions in your state, and the last eight questions ask you to reflect a bit more deeply on some of your experiences and perceptions.

You may elaborate on any of your responses; please do not feel as though you must just give a quick answer and then move on. The point is to learn as much as possible about the experiences of women who are seeking abortions in your state.

Please ask for clarification of any question you do not understand. I completely understand that abortion is a sensitive topic and that some people do not feel comfortable discussing it with others. Therefore, if you do not wish to answer a question, you may tell me to skip it, and I will move on. If you become too uncomfortable to continue the interview, you can request to end it at any time, no questions asked.

Thank you again for your assistance on this project, your insights will provide invaluable data for helping to understand the links between reproductive laws and general wellbeing in your state.

1. What is your state of residency?
- 2a. Please confirm that you had an abortion in the last five years. [2b. What is the state where the abortion took place?]
3. What is your age?
4. What is your race?
5. What is your gender identification/pronouns?
6. What was your age at time of abortion?
7. How many prior abortions have you had?
8. How many children do you have?
9. What is your religious identification?
- 10a. Are you currently employed? [10b. If yes, FT or PT?]
11. What is your relationship status?

Now moving on to the deeper questions:

12a. Please tell me about any barriers you experienced to seeking an abortion (such as inability to afford the procedure, inability to travel, or inability to take time off from work). [12b. If you did not have the abortion, was it because of one of the barriers you listed? 12c. Do you believe other women in your state generally face similar barriers or no?]

13. What would you say was/were your main emotional response or responses to receiving an abortion?

14a. Was there anyone else who was involved in your decision to seek an abortion? [14b. If yes, would you mind telling me who else participated in the decision—e.g. friend, spouse, therapist, spiritual advisor, etc.?)]

15a. Have you been employed consistently since seeking the abortion? [15b. If not, was this by choice?]

16. Please tell me about any social isolation or political ostracization you experienced as a result of seeking or obtaining the abortion.

17. To what degree do you feel that you had access to good reproductive health care in your state during the process of seeking the abortion?

18. To what degree did you feel supported and respected by health care professionals in your state during the process of seeking the abortion?

19. Overall, on a scale of 1-10, one being least happy and ten being most happy, where would you say you fall as compared to other women you know?

That concludes our interview. Please reach out to me using the contact information I provided if you have any questions or concerns in the coming weeks. Do you have any questions or final comments for me before we conclude the interview?

Appendix II: Informed Consent Script

Hello, I am Cynthia Boaz, Professor of Political Science at Sonoma State University. I am conducting interviews about the relationship between abortion laws and quality of life for women as part of a larger research project I am working on called *“Bans Off Our Bodies”: Abortion Restrictions and Women’s Wellbeing*. First off, please know that your participation is voluntary and your identity will be kept confidential at all stages of the research.

I’m inviting you to do a one-on-one Zoom interview with me that will take approximately two hours. I will ask you questions about your experience before, during, and after the process of seeking an abortion. I will take handwritten notes to record your answers, as well as using an audio recorder to make sure I don’t miss what you say. I will not be recording the Zoom session itself.

It is not likely that there will be any harms or discomforts associated with taking part in this study. You may feel a little uncomfortable with some of the questions related to your experiences seeking and obtaining an abortion. If you should experience any adverse effects from these questions, please let me know immediately and we can skip that question or stop the interview altogether.

I am engaging in this research because by better understanding the larger link between abortion law in the United States and women’s quality of life in general, researchers may be able to provide relevant information to policymakers who are working on issues of reproductive health.

Confidentiality

Your responses will remain confidential, and your name will be removed from the transcript. An anonymous code will be used to link the background questions and interview transcript. The record of your consent to participate in the study will be stored separately from both the background questions and the transcript of our conversation so that it cannot be associated with your responses.

Only the researcher (myself) and the research assistant working on this project will have access to the information that you provide.

The information you provide may be presented at professional conferences or published in academic journals. Information that could potentially identify you will never be published or shared beyond the research team. Any data from this research which will be shared or published will be the combined data of all participants. That means it will be reported for the whole group, not for individual persons. If we use a quotation that you provided, your identity will be kept anonymous.

Remuneration/Compensation

You will receive \$100 (one hundred dollars) as a thank you for your participation. If you withdraw from the study or decide not to answer some questions, you may still receive a portion of that amount.

Contact for questions or concerns about the study or about the rights of research participants

If you have any questions or desire further information with respect to this study, you may contact me at boazc@sonoma.edu or 707-799-1204 (personal cell number.)

If you have any concerns about your treatment or rights as a research participant, you may contact the Sonoma State University Institutional Research Board Chair, Dr. Heather Smith at smithh@sonoma.edu or 707-664-2587.

If you have a question about your rights as a human subject contact irb@sonoma.edu or phone 707.664.2066.

Consent Statement

Your participation in this study is entirely voluntary. You can decide to stop at any time, even partway through the interview for whatever reason.

If you choose to participate, you may skip any questions you do not wish to answer.

If you decide not to participate in the study or choose to withdraw, please let me know at any point during our conversation, or contact me if you decide to withdraw after we have had our conversation.

If you decide to stop, I will ask you how you would like us to handle the data collected. This could include destroying it or using the data collected up to that point.

If any of the questions or the interview generally causes you emotional or psychological distress, we will stop the interview at your request. I will also provide a list of resources if you would like to speak to someone about any emotional or psychological distress you are feeling. Your comfort and security are the most important considerations here.

Consent questions:

- Do you have any questions or would like any additional details?
- Are you at least 18 years of age?
- Do you agree to participate in this study knowing that you can withdraw at any point with no consequences to you?
- Do you agree to waive written consent?

[If yes to the last three questions, begin the interview.]

[If no to any of the last three questions, thank the participant for their time.]

Appendix III: Sample Recruitment Scripts (from Instagram)

 cynthia707 ...



Have you had an abortion in the past five years?

I'm looking for volunteers from 14 states to talk to me confidentially about their experiences, as part of a study looking at reproductive access and quality of life in the US. Small compensation for qualified participants.

Please consider being part of this important study!

Criteria and contact info in link in bio.

 cynthia707 ...



STILL NEED PARTICIPANTS FOR STUDY ON EFFECTS OF ABORTION BANS

IF YOU'VE HAD AN ABORTION SINCE 2017 & LIVE IN AL,GA,MS,SC,TX, HI,VT, OR WA, PLEASE SEE LINK IN BIO

EMAIL: BOAZC@SONOMA.EDU

CONFIDENTIAL AND \$100 COMPENSATION FOR ONE HOUR INTERVIEW