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Predictors of Abortion Counseling Receipt and Helpfulness in the United States

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A B S T R A C T

Background: Little is known about women's expectations, needs, and experiences with abortion counseling and the factors that influence their experiences.
Methods: This study sought to investigate individual- and facility-level factors that influenced women's reports of receiving abortion counseling and the helpfulness of counseling. Data were drawn from quantitative interviews with 718 patients recruited from 30 abortion facilities, and 27 interviews with facility informants in the United States.
Findings: Sixty-eight percent of participants reported receiving counseling; reports varied by facility. Almost all participants who reported receiving counseling described counseling as helpful: 40% extremely, 28% quite, 17% moderately, 10% a little, and 4% not at all. Nearly all (99%) reported that their counselor communicated support for whatever decision they made. No individual-level factors predicted counseling receipt or helpfulness. Facility informant reports that it is their role to counsel patients about emotional issues was positively associated with women's reports of counseling receipt ($p < .001$). Women at facilities subject to laws requiring provision of specific information and/or state-approved, written materials had lesser odds of finding counseling helpful, compared with women at facilities not subject to such laws ($p < .01$).
Conclusions: Legal mandates that regulate abortion counseling do not seem to be helpful to women. More research is needed to understand the effects of abortion counseling and whether policies regulating counseling have a deleterious effect on women.

Little is known about women's expectations, needs, and experiences with abortion counseling and factors that influence their experiences. Despite the lack of data about women's counseling needs and preferences, laws regulating this aspect of abortion care are increasingly common in the United States. Currently, 35 states require that women undergo pre-abortion counseling, and many of these states mandate certain aspects of counseling and informed consent, including the provision of specific, abortion-related information (27 states) and/or the provision or offering of written materials developed by a state agency (27 states). In addition, 26 states require that women wait for a specified period of time between receiving counseling and having an abortion procedure (Guttmacher Institute, 2012a, 2012b). The stated objective of these laws is to ensure that women understand the risks of and alternatives to the abortion procedure (Smith, 2012). However, there is little evidence that the laws help to achieve those goals, enhance the quality of women's decision making, or improve post-abortion well-being, including women's perception that the abortion was the right decision for them (Gold, 2009; Gold & Nash, 2007; Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009; Richardson & Nash, 2006). Further, some materials developed by state agencies have been found to contain erroneous and misleading information (Gold & Nash, 2007; Richardson & Nash, 2006).

Because it is a legal and ethical obligation for healthcare providers to obtain informed consent before performing clinical interventions, informed consent is widely considered an essential component of abortion counseling. Although there are well-developed principles and conventions for obtaining informed consent from patients, there are no universally accepted practice standards for or definitions of abortion counseling more broadly. However, providers can look to several resources for guidance (Baker, 1995; Baker & Beresford, 2009; Breitbart, 2000; Ely, 2007; Harris, 2004; Johnston, 2006, 2008; Moore, Frohwirth, & Blades,

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2011; Perrucci, 2012; Picker Institute, 1999). These resources suggest that, although counseling styles may vary, abortion counseling usually includes 1) information about the clinical visit and aftercare, 2) review of the risks, benefits, and alternatives to the abortion procedure, 3) confirmation that the abortion decision is voluntary, and 4) response to emotional needs as they arise. Providers also typically provide contraceptive education (Perrucci, 2012).

In addition to informed consent (Baker & Beresford, 2009; Berg, Appelbaum, Lidz, & Parker 2001), some providers also prioritize assessment and discussion of emotional issues (Joffe, 2013; Perrucci, 2012). Social science research suggests that post-abortion emotional health and coping are enhanced when a woman frames her decision and view of herself in a positive way (Trybulski, 2006), has positive social support and an absence of negative influences (Cozzarelli, Sumer, & Major, 1998; Major & Cozzarelli, 1992; Major, Richards, Cooper, Cozzarelli, & Zubek, 1998), and believes that she has the ability and tools to cope with her feelings post-abortion (Major et al., 1998; Mueller & Major, 1989). Some abortion facilities have developed counseling practices to specifically address these aspects of women's emotional health during and after the abortion. In a recent article in the *American Journal of Public Health*, sociologist Carole Joffe, PhD, describes the evolution of one such approach—"head and heart counseling"—as a reflection of the changing needs of abortion patients over time. She argues that the increasingly stigmatized and regulated environment motivates some providers to actively attempt to counteract the politicization and stigmatization of abortion through counseling (Joffe, 2013). Such providers draw on evidence-based practices used in emotional care for other stigmatized health issues, including self-awareness assessments, peer counseling, decision aids, and encouragement of active client participation (Upadhyay, Cockrill, & Freedman, 2010). However, not all providers emphasize emotional care. For philosophical reasons, some focus more on women's autonomy in decision making and do not believe it is the role of the facility to explore women's feelings about or reasons for abortion (Gould, Perrucci, Barar, Sinkford, & Foster, 2012; Perrucci, 2012). The fact that there is little research on women's experiences or perceptions of abortion counseling furthers these philosophical debates among providers.

A review of 104 women's reports about their experiences at one facility found women valued a friendly atmosphere and a nonjudgmental counselor who normalized their experience, was knowledgeable about the procedure, and was capable of counteracting prior negative abortion experiences (Ely, 2007). Another study found that the overall quality of information provided to the patient, staff's attention to privacy, patients' confidence in staff, and being treated with respect and dignity were the most important influences on patient satisfaction with their abortion experience (Picker Institute, 1999). Another study of 797 women receiving abortions at two facilities in New England found that overall patient satisfaction was highly associated with staff sensitivity, quality of counseling, and quality of information provided (Zapka, Lemon, Peterson, Palmer, & Goldman, 2001). Two studies of British women's abortion counseling experiences documented primarily positive attitudes toward abortion counseling (Harden, 1999; Hunton & Spicer, 1979).

However, other studies suggest that counseling may be unnecessary or even unwanted. For example, some studies have found that many women have already made their abortion decision when they present for care and few feel coerced into having the abortion (Brown, 2013; Hunton & Spicer, 1979; Kumar, Baraitser, Morton, & Massil, 2004; Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005). Further, a recent qualitative study of 49 patients found that many women did not want to discuss their emotions with abortion counselors owing, in part, to fear of being judged and/or possibly denied care (Moore et al., 2011). This finding was echoed in a recent qualitative study of 24 British women ages 16 to 20, the majority of whom declined counseling when it was offered (Brown, 2013). More research is necessary to understand women's experiences with abortion counseling. Such an examination should take into account the specific features of the counseling, which are likely to vary significantly depending on the legal and cultural context in which it occurs. This study describes women's self-reports of their experiences receiving counseling and their perceptions of the helpfulness of counseling. This study builds on previously reported findings about the abortion counseling practices at 27 abortion facilities, all of which reported providing routine counseling to all patients. In that study, 96% of the of facilities reported "always" providing information to patients about the procedure and visit, 92% of facilities reported "always" assessing the certainty of each patient's decision, and 74% reported "always" assessing patient's feelings and providing emotional support (Gould et al., 2012). In this study, we assessed individual- and facility-level predictors of counseling receipt and helpfulness, and examine whether women felt supported by counselors in their decision to have an abortion. Last, the study examines whether counseling experiences were associated with women's feelings about whether the abortion was the right decision for them.

Methods

Data for this study were drawn from three sources. Patient data were collected through telephone interviews with participants in the Turnaway Study. The main purpose of the Turnaway Study is to investigate the mental and physical health and socioeconomic impacts of receiving or being denied an abortion. However, data pertaining to women's experiences with counseling were also collected and are used in this analysis. In the Turnaway Study, three groups of women were recruited from 30 facilities in the United States: Women denied an abortion because they presented for care just above the gestational age limit for the facility (most in the second trimester), women who received an abortion just below the gestational age limit, and women undergoing a first trimester procedure. Detailed information about Turnaway Study recruitment procedures and participant and facility characteristics, including specifics about how researchers obtained participant's written consent, is described elsewhere (Dobkin et al., under review; Gould et al., 2012). The analysis presented herein includes 718 women from the two groups who underwent abortions and answered the questions about the counseling they received. Three of the women who received abortions did not answer the questions about counseling. Facility data were drawn from the Site Practice Survey, which was used to collect information about the characteristics and counseling practices of Turnaway Study recruitment facilities. Methods of the Site Practice Survey, including procedures used to obtain verbal consent, as well as the facilities' counseling practices, have also been described in detail elsewhere (Dobkin et al., under review; Gould et al., 2012). Briefly, data were collected through interviews with facility key informants (e.g., facility or program managers, senior counselors)

from 27 of the 30 Turnaway Study recruitment facilities. Finally, we used published Guttmacher Institute policy data about state-mandated counseling policies (Guttmacher Institute, 2012a).

Turnaway Study Participant Data

Data elicited through Turnaway Study interviews 1 week after the abortion and utilized in this analysis include demographic variables, including age, race/ethnicity, education, and income, as well as questions about each woman's relationship status, history of depression and anxiety, and pregnancy history. Regarding pregnancy, we solicited information about the current pregnancy and abortion, including gestational age, type of abortion, degree of social support for having the abortion, difficulty making the abortion decision, and whether or not participants felt the abortion was the right decision for them. In addition, each Turnaway Study participant was asked two quantitative questions about their experiences with counseling: "Did you get counseling from the [recruiting facility] about whether to have an abortion?" (possible response, yes or no). If they said yes, they were asked two follow-up questions:

1. Did the counselor…
    a. Encourage you to have the abortion? (Possible responses: Yes/no)
    b. Discourage you from having the abortion? (Possible responses: Yes/no)
    c. Let you know s/he would support whatever decision you made? (Possible responses: Yes/no)
2. How helpful did you find the counseling? (Possible responses: Not at all, a little bit, moderately, quite a bit, extremely)

Facility Data

All study facilities provide abortion counseling to patients, and use a variety of practices (Gould et al., 2012). Facility and counseling practice measures include 1) whether or not the facility used a triage form to identify patient's psychosocial needs (possible responses: Yes/no) and 2) whether the key informant agreed or disagreed with the statement that "It is not the facility's role to provide counseling for emotional issues" (5-point Likert scale from 1 [strongly agree] to 5 [strongly disagree]). We also considered a third measure of facility provision of emotional support as part of counseling—the frequency with which the facility reported assessing patients' feelings/providing emotional support as part of counseling. We collected information in the Site Practice Survey about the amount of time facilities spent assessing certainty and discussing emotional issues with abortion clients. However, we did not include these items in models owing to concerns about the validity and reliability of the measures.

Guttmacher Institute Policy Data

The Guttmacher Institute has analyzed a wide range of state laws that regulate the provision of abortion care, including those that govern informed consent processes. A published Guttmacher Institute state-by-state policy summary was the source for whether or not each facility was mandated to provide detailed, abortion-specific information to patients, either verbally or through written materials, the accuracy of the information contained in these written materials and/or information scripts, and whether or not providers were required to enforce a waiting period between counseling and the procedure (Guttmacher Institute, 2012a). Among the facilities in our sample, 12 (44%) were located in states that mandated provision of specific, abortion-related, information and either the offering or provision of written materials developed by a state agency, as well as impose a waiting period (typically 24 hours between counseling and the abortion procedure). Of these 12 facilities, 4 were required to offer or provide information that the Guttmacher Institute has determined to contain inaccuracies, including information about the risks of abortion on future fertility ($n = 4$), risk of breast cancer ($n = 3$), and/or information about psychological risks (i.e., post-abortion responses that include only negative emotions; $n = 4$). In addition, seven facilities were mandated to give verbal and/or written information about a fetus' ability to feel pain. For these analyses, we created a dichotomous measure, "by law," with facilities in states with these legal requirements coded as a 1 and the others as 0.

Analysis

We first examined bivariate associations between individual-level factors and reporting receiving counseling as well as counseling helpfulness. We then examined multivariate models of individual- and then facility-level predictors of counseling receipt and counseling helpfulness. Mixed-effects models that accounted for clustering by facility were used to examine bivariate and multivariate associations between individual-level factors and counseling receipt and helpfulness. Generalized estimating equations with an independent correlation structure and robust standard errors were used for multivariate analyses examining influence of facility-level predictors. Separate analyses were conducted for counseling receipt and counseling helpfulness as dependent variables. Multivariate analyses included individual- and facility-level variables we expected (described in the Introduction), based on prior research and knowledge of the field, to be associated with the dependent variables. We also compared models with two alternative measures of facility providing emotional support as part of counseling and used a quasi-likelihood approach to assess which measure was a better fit for the data (Cui, 2007). Multivariate analyses for both counseling receipt and counseling helpfulness exclude data from three recruitment facilities that did not respond to the Site Practice Survey. Analyses for counseling helpfulness exclude data from individuals ($n = 8$) who reported receiving counseling, but did not answer the counseling helpfulness question.

Results

Overall, 68% of participants reported receiving counseling about the decision to have an abortion. The proportion of women reporting receiving counseling varied by facility (range, 8%–100%; median, 69%). Ninety-nine percent of those receiving counseling reported that the counselor let them know that she or he would support whatever decision they made. Three percent reported that the counselor encouraged them to have an abortion and fewer than 1% reported that the counselor discouraged them from having an abortion. One week after the procedure, almost all (95%) reported that the decision to have an abortion was the right decision for them. Most women who reported receiving counseling found the counseling helpful. Overall, only

4% did not find the counseling helpful at all, whereas 10% found it a little bit helpful, 17% moderately helpful, 29% quite a bit helpful, and 40% extremely helpful.

On bivariate analyses, only poverty and nulliparity were associated with counseling receipt. A greater percentage of women above 200% of the federal poverty level (FPL) and nulliparous women reported counseling receipt than women below 100% of FPL and parous women (74% vs. 64% [$p < .05$]; and 72% vs. 66% [$p < .05$]; respectively; Table 1). In multivariate analyses assessing the influence of individual-level factors, poverty and nulliparity were no longer significant (Table 2). There were no differences in reports of receiving counseling by trimester, previous abortion history, or difficulty deciding to have an abortion in either bivariate or multivariate models. In multivariate analyses assessing the influence of facility-level characteristics, women receiving care at facilities that agreed

Table 1
Demographic, Reproductive Health, and Psychosocial Characteristics by Counseling Receipt and Counseling Helpfulness

	Distribution of the Sample ($n = 718$), %	Percentage Who Reported Receiving Counseling ($n = 488$), %	p Value[†]	Percentage Who Reported Finding Counseling "Quite" or "Extremely" Helpful ($n = 329$), %	p Value[‡]
Age (y)					
15–19[*]	15	73	.805	76	.617
20–24	36	64	.364	68	.749
25–34	41	69	.947	65	.466
35–46	8	69	ref	72	ref
Race/ethnicity					
White	38	66	ref	67	ref
Black	29	71	.836	66	.733
Hispanic/Latina	21	70	.795	71	.912
Other	13	63	.761	77	.272
Trimester					
First	51	65	.876	66	.395
After first	49	71		71	
Education					
<High school	18	65	ref	65	ref
High school	34	68	.453	72	.244
>High school but <college	40	69	.184	69	.353
College	8	68	.340	63	.918
% FPL					
<100	33	64	ref	64	ref
100–200	23	71	.080	72	.135
≥200	14	74	.026	69	.374
Missing	29	67	.671	71	.298
Union status					
Married	9	64	ref	64	ref
Not married, cohabitating	19	65	.704	69	.607
Never married, not cohabitating	60	70	.256	69	.530
Previously married, not cohabitating	12	64	.951	69	.525
Previous abortions					
0	53	69	.814	70	.237
≥1	47	67		66	
Parity					
Nulliparous	34	72	.034	75	.050
≥1	66	66		65	
Mental health					
Not depressed/anxious	72	70	.249	71	.178
Depression/anxiety	28	63		63	
Type of abortion					
Surgical	92	69	.524	69	.976
Medical	8	65		69	
Social support					
Told no one	30	67	ref	66	ref
Negative support	7	66	.792	85	.065
All support	63	68	.723	68	.842
Pregnancy test counseling					
None	75	67	.24	67	.173
Previous	25	72		74	
Difficulty deciding					
Very difficult	28	69	ref	73	ref
Somewhat difficult	27	64	.942	67	.867
Neither easy nor difficult	15	66	.372	59	.231
Somewhat easy	18	71	.316	70	.670
Very easy	12	72	.949	71	.734
Gestational age[§]	14.81	15.00	.994	15.35	.102

Abbreviations: FPL, federal poverty level; ref, reference.

[*] This age category includes one participant aged 14 who was recruited early in the study before the minimum enrollment age was changed to 15.

[†] p value comparison for counseling versus no counseling.

[‡] p value comparison for counseling helpful versus not helpful.

[§] Mean.

Table 2
Multivariate Model Examining Individual-Level Predictors of Counseling Receipt

	Odds Ratio	*p* Value	95% Confidence Interval
Age (y)			
15–19	0.92	.848	0.37–2.24
20–24	0.66	.267	0.31–1.38
25–34	0.97	.926	0.49–1.91
35–46	Reference		
Race/ethnicity			
White	Reference		
Black	0.92	.740	0.55–1.53
Hispanic/Latina	0.96	.898	0.55–1.68
Other	0.97	.908	0.55–1.71
Education			
<High school	Reference		
High school	1.06	.836	0.63–1.78
>High school but <college	1.23	.444	0.72–2.11
College	0.92	.845	0.40–2.13
Gestational age	1.00	.809	0.97–1.03
% FPL			
<100	Reference		
100–200	1.46	.126	0.90–2.37
≥200	1.75	.081	0.93–3.27
Missing	0.95	.825	0.59–1.52
No previous abortion	0.87	.492	0.60–1.28
Union status			
Married	Reference		
Not married, cohabitating	1.12	.748	0.56–2.22
Never married, not cohabitating	1.59	.156	0.84–3.01
Previously married, not cohabitating	1.01	.975	0.48–2.15
Nulliparous	1.44	.118	0.91–2.26
Depression/anxiety	0.85	.435	0.56–1.28
Social support			
Told no one	Reference		
Negative support	0.96	.908	0.45–2.03
All support	1.09	.661	0.73–1.63
No pregnancy test counseling	0.76	.200	0.50–1.16
Difficulty deciding			
Very easy	Reference		
Somewhat easy	0.93	.813	0.48–1.79
Neither easy nor difficult	0.69	.290	0.35–1.37
Somewhat difficult	0.69	.230	0.37–1.27
Very difficult	1.03	.938	0.55–1.91

Abbreviation: FPL, federal poverty level.

with the statement that it was not their role to provide counseling for emotional issues had lesser odds of reporting having received counseling (odds ratio, 0.46; $p < .001$; Table 3). The model with facility reporting always providing emotional support produced similar findings, although the model with the perception of the facility's role was a better fit for the data (results not shown).

The proportion of women reporting the counseling they received was helpful varied by facility (0%–100%; median, 67%).

Table 3
Facility-Level Predictors of Counseling Receipt and Helpfulness

	Odds Ratio	*p* Value	95% Confidence Interval
Counseling receipt			
Not our role	0.46	<.001	0.34–0.63
Triage form	1.31	.461	0.63–2.72
By law	1.10	.747	0.63–1.90
Counseling helpfulness			
Not our role	1.11	.496	0.82–1.50
Triage form	1.21	.490	0.71–2.05
By law	0.53	.002	0.36–0.80

Controlling for age, race/ethnicity, education, gestational age, poverty, previous abortion, union status, parity, depression/anxiety, social support, pregnancy test counseling, and difficulty deciding.

There were no significant bivariate or multivariate associations between individual-level variables and counseling helpfulness (Tables 1 and 4). On multivariate analyses assessing the influence of facility-level characteristics, women receiving care at facilities where aspects of counseling were state-mandated had lesser odds of finding counseling helpful (odds ratio, = 0.53; $p < .01$; Table 3).

Discussion

Many women receiving abortions reported that they received counseling about the decision to have an abortion and nearly all found counseling helpful. We found no evidence that women felt pressured by providers to have abortions. Because all of the women who received counseling had expressed a desire to have an abortion, we interpret the 3% of women who reported that the counselor "encouraged" them to have the abortion as being supportive of their choice, and not exerting pressure. Women in facilities where specific verbal and/or written information was state-mandated had lower odds of perceiving the counseling they received as helpful. These results call into question the utility of laws that regulate the timing and content of counseling

Table 4
Multivariate Model Examining Individual-Level Predictors of Counseling Helpfulness

	Odds Ratio	*p* Value	95% Confidence Interval
Age (y)			
15–19	1.03	.958	0.35–3.05
20–24	0.77	.586	0.31–1.95
25–34	0.81	.630	0.35–1.88
35–46	Reference		
Race/ethnicity			
White	Reference		
Black	0.91	.730	0.52–1.57
Hispanic/Latina	1.12	.719	0.59–2.14
Other	1.58	.238	0.74–3.40
Education			
<High school	Reference		
High school	1.41	.282	0.75–2.64
>High school but <College	1.30	.422	0.69–2.46
College	0.70	.477	0.27–1.86
Gestational age	1.02	.197	0.99–1.06
% FPL			
<100	Reference		
100–200	1.60	.108	0.90–2.84
≥200	1.53	.250	0.74–3.13
Missing	1.13	.678	0.64–2.00
No previous abortion	1.15	.540	0.73–1.80
Union status			
Married	Reference		
Not married, cohabitating	1.12	.793	0.48–2.59
Never married, not cohabitating	1.05	.892	0.49–2.24
Previously married, not cohabitating	1.37	.518	0.53–3.54
Nulliparous	1.57	.100	0.92–2.67
Depression/anxiety	0.72	.176	0.44–1.16
Social support			
Told no one	Reference		
Negative support	2.63	.081	0.89–7.78
All support	0.99	.964	0.62–1.57
No pregnancy test counseling	0.79	.338	0.48–1.28
Difficulty deciding			
Very easy	Reference		
Somewhat easy	0.88	.736	0.41–1.86
Neither easy nor difficult	0.52	.105	0.24–1.14
Somewhat difficult	0.79	.510	0.39–1.60
Very difficult	0.96	.913	0.47–1.98

Abbreviation: FPL, federal poverty level.

and mandate the provision of state-approved materials to women seeking abortion care. We do not know whether women in states that regulated aspects of counseling who perceived counseling as less helpful were aware that the information or materials they received were mandated by the state and, if they were aware, whether they considered the information less credible as a result. It is also possible that providers may have influenced participants' opinions of the laws, if they made negative comments about them during their interactions with the women.

We had intended to examine whether receipt of counseling or counseling helpfulness were associated with women's feelings that the abortion was the right decision for them. However, because 95% of women reported that the abortion was the right decision for them, we were unable to conduct this analysis. It is worth pointing out, however, that the fact that nearly all of the women reported feeling that the abortion was the right decision for them suggests that facility decision-making counseling procedures were not interfering with women's confidence in their decision.

There is an interesting discrepancy between women's reports of having received counseling and facilities' reports of providing it. As described previously, facilities reported that they always provide information about the procedure (96%), assess the certainty of patients' decisions (92%), and assess patients' feelings/provide emotional support (74%; Gould et al., 2012). Yet, one third of the women reported not receiving counseling about whether to have the abortion. Receiving abortion care at facilities that perceived their role as including providing emotional support, as well as receiving care at facilities reporting that they always assess patients' feelings, were both associated with higher odds of women reporting having received counseling. It is possible that, despite providers' policies, some women actually did not receive counseling. If this were the case, future research would be warranted to assess whether any of these women wanted to receive counseling or would have benefitted from it. However, it is also possible that, despite our efforts to focus the questions we asked women on counseling about decision-making counseling, women still interpreted the term counseling as including emotional content. Because there is no clear consensus among providers on a definition of abortion counseling, and there are limited data on what women think abortion counseling is or should be (Ely, 2007; Gould et al., 2012; Moore et al., 2011; Perrucci, 2012; Picker Institute, 1999; Upadhyay et al., 2010; Zapka et al., 2001), the discrepancy we observed may reflect differing interpretations of the term "counseling" between providers and women. From a provider perspective, a counseling interaction nearly always involves informed consent and assessment of the quality of a woman's abortion decision, but may or may not involve in-depth discussions about emotions. In addition, whether counseling includes discussions about emotions may depend on the provider's perception of the individual patient's needs and desires and the provider's perception of his/her role. From a patient perspective, the term "counseling" may only refer to in-depth conversations with providers about feelings regarding the abortion that resemble a therapeutic session with a mental health professional. Examining how women perceive different aspects of abortion counseling and how individual providers set counseling policies are important areas for future research.

This study has some limitations. First, the sample of facilities, although diverse, overrepresents second trimester facilities. Second, the wording of the counseling-related questions in the Turnaway Study interview focused on decision making and did not ask explicitly about emotional aspects of counseling. More research is needed to develop valid and reliable measures of counseling provision and receipt. Third, these data are based on women's self-reports of their experiences based on two quantitative questions, and the reports from one key informant from each facility. Finally, facilities may have some latitude in how they interpret and implement state laws or communicate about these requirements to their patients. We do not know which aspects of the mandated counseling women did not find helpful. However, the fact that the women receiving care at the facilities required to implement the laws were significantly less likely to report finding counseling helpful suggests that these laws may reduce the quality of care or, at the very least, may be having a negative effect on some women's counseling experiences.

In the United States, Britain, and several other European countries, there is an active debate about whether abortion counseling should be mandated, as well as what information should be imparted to women and by whom (Lee, 2011; Pinter et al., 2005; Rowlands, 2008). This study suggests that more work is needed to understand how women define counseling, their expectations and desires regarding the provision of it, and how to measure it, before we will be able to fully understand their experiences and preferences. More research is needed to investigate whether counseling (i.e., informed consent, patient education, and emotional support practices) can improve post-abortion outcomes, such as mental health, emotions, coping, and stigma. A more thorough understanding of facility practices would enable development of effective practice standards for abortion counseling. Laws requiring the provision of state-mandated, abortion-specific information beyond what is included under existing informed consent laws do not seem to be helpful to women presenting for abortion care. More research is needed to assess women's knowledge about whether the counseling they receive is required by the state and to understand whether these laws have any deleterious effects on women, such as interfering in the development of trust between women and their healthcare providers or contributing to less effective coping after an abortion.

Implications for Practice and/or Policy

Although the findings from this study do not reveal any specific recommendations that providers can use to counsel patients, they do suggest that the counseling U.S. facilities are currently providing is generally considered helpful by most women who receive it. Legal mandates that regulate aspects of abortion counseling do not seem to be helpful to women.

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