# *Abortion Clinics and Waiting Room Men: Sociological Insights*

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Sen. Hillary Rodman Clinton startled friends and foes alike when on Jan.24, 2005, at an event marking the 32nd anniversary of the High Court's ruling in Roe v. Wade, she urged opponents to find "common ground" to help prevent unwanted pregnancies and reduce abortions (a "sad, even tragic choice to many, many women"). (1) Ever since media attention to this possibility has been unusually high, though one revealing omission persists: While one would not know this from media and social science neglect, about 600,000 men (male partners in ill-timed and unwanted pregnancies) accompanied a client to her abortion appointment last year (about half of all abortion-seeking women generally have a man sitting by in the clinic or doctor's waiting room).

In this paper we will explain why the presence of the waiting room males offers a remarkable opportunity to make rapid gains - common ground gains - in reducing the frequency and toll of abortions. We will explore several intriguing sociological dimensions of the subject, and end by recommending policy changes we think worth support from both pro-Choice and even anti-Abortion activists.

**Background:**

In 1983-4, after an abortion experience of my own (A.S.) in the late 1970s, I led a self-financed research team in a large-scale effort to shed light on the experience of waiting-room men. A thousand mail surveys were secured from men in the waiting rooms of 30 cooperating clinics in 18 states. About 200 of the respondents were later interviewed, and I later was the principal author of the first - and still the only - academic book on the subject - Men and Abortion: Lessons, Losses, and Love (1984). (1)

Throughout 1999 and early 2000 I self-financed a small study to update my findings and see what difference, if any, 16 years had made. I was able to get completed surveys this time from 905 men in eleven clinics in eight states and Vancouver, BC. A separate survey I financed also in 1999 had several of my students volunteer to phone 127 clinics nationwide to ask what services, if any, were actually available - research that made plain a striking lack of male-aiding options - much as I had found 16 years earlier.

Most recently, much of the 1983-4 survey instrument (though not all of it) was completed in 2004 by 766 men in 12 clinics, allowing for a rare longitudinal study over a 20 year time period. This time very welcomed cooperation in doing computer and statistical work was made available by Ross Koppel, Adjunct Professor of Sociology and a faculty member at the Center for Clinical Epidemiology and Biostatistics School of Medicine, University of Pennsylvania, and also Jennifer Perkins, a student at Kenyon College. (2)

**Findings.**

1. **Continuity:** Much of value has been learned, although our data analysis is far from complete. For example, it would seem that the racial, religious, and marital makeup of the population of males who accompany women to abortion appointments has remained fairly stable over the last 20 years. In 1983-4, the percent of white males was 87%; in 2004, 76%: Black males, 10 and 14%; Hispanics, two and three percent. Similarly, Protestants were 45% in 1983, and now, 38%; Catholics, 33% and now 29%. Single males were 72% of all in '83, and 66% in '04; husbands, 18% and 16%.
2. **Aging:** One intriguing exception to continuity concerns age: In 1983 65% of the waiting room males were 25 years of age or younger (35% were 21 or younger), while in 2004 the percent dropped to 49% (only 25% were 21 or younger). Likewise, in 1983, the percent 36 years and older was only seven, while in 2004 it rose to 20%. Not surprisingly, therefore, the percent of males still in high school or college fell from 28% in 1983 to 14% in 2004. As for why the 2004 cohort is older we speculate it may reflect 1) a fall-off in teen pregnancies these past 10 years, 2) a gain in use by teenagers of contraceptives, 3) an increase in the substitution by young adults of oral sex for intercourse, and 4) the aging of Americans in general.
3. **Abortion Attitudes: Prior.** The better to make manageable the great amount of data produced by allowing our respondents many subjective choices, we combined several attitudinal measures into three broad and self-explanatory categories: "Ambivalents" (neutral), "Affirmers" (supporters), and "Antagonists" (detractors). As our three aggregations are subjective, they will always be open to disagreement, and we welcome your examination of the categories.

We asked the men to recall as best as possible how they had felt about abortion before learning they were going to be involved in one. Our goal here was to explore the impact of an actual experience on male attitudes. We recognize the severe limitations of recall material of this sort, and are very leery of making too much of what we learned. Namely, abortion involvement does impact on male attitudes, though only slightly and in favor of what we call ambivalence, rather than in the direction of pro or anti-choice.

Possibly reflecting their older age profile, only 23% of our 766 waiting room males recalled being supportive of abortion (39% of all males in 2003 told the Gallup Poll abortion should be legal in all or most cases) (3) A much low percent (11%)

recalled having being "Antagonists" (58% of all men in 2003 thought it should be illegal in all or most cases). The majority remembered being neutral beforehand (66%), much as was true (in 2003) of 55% of the American public (the genders are alike in their attitudes here).

Discussions with several of the men over the past 20 years has us believe this is the sort of ambivalence that supports a woman's absolute right to decide to terminate her pregnancy, but also sides with Sen. Clinton is judging this a "sad, even tragic choice to many women." As well, the range of support varies greatly by reason for electing the option, with far less support offered when the reason is protecting one's career or schooling than when the reason is conception after rape or incest. Males are especially perplexed by the question of whether or not the law should require a wife to tell her husband of her intention to get an abortion, thereby allowing him time to explore the matter with her (56% of clinic males in 1983-4 and over 65% of the public support this right, though the Higher Courts do not). (4)

4. **Abortion Attitudes: Current.** Given this pre-abortion profile, we were very curious about the impact of finding oneself actually caught up in an abortion situation. As we had expected, there was attitudinal change, though not in the pro-choice direction we had expected. Instead, the men shifting slightly away from their "Affirmer" position (it fell from 23% to 19%) in favor of a bit more ambivalence (which went up from 66% to 74%). The percent of "Antagonists", in turn, fell from 11% to seven percent. Overall, the impact seems to have promoted ever greater protective ambivalence - a stressful mix of anxiety ("Will she be okay?"), puzzlement ("How did we ever get into this mess?", and resolve ("I never want to be here again, never!"). As for why such a grim mood developed, we found clues in the choice of key adjectives chosen to explain one's situation before and at the time.

Specifically, looking back at how one felt beforehand about abortion, at least one in five of the men emphasized four out of 14 attitude choices offered to them (they were free to tick off more than one): Supportive (40%), Neutral (39%), OK (36%), and Unsure (25%). At the time of the abortion at least one in five chose five out of 23 attitude choices: Supportive (51%), Nervous (36%), Guilty (24%), Relieved (21%), and Sad (21%).

What would seem pictured here is the shock of finding oneself unexpectedly in a no-nonsense "no second act" drama, whereby the well-being of a loved one (in most cases) is actually in jeopardy, and the well-being of a barely glimpsed stranger (the fetus) is being resolved emphatically - almost regardless of whatever feelings the male may have toward his putative offspring. The sense of powerless is great, and is aggravated by the remarkable loneliness of the men (59% have not discussed the abortion with anyone other than the clinic patient they accompanied). Little wonder that so many are nervous even as they especially

define themselves as supportive: Especially intriguing is the high percent who report feeling guilty and sad.

(A female graduate student in journalism who researched this subject wrote recently in Psychology Today - "Feelings of disassociation and guilt are typical for post abortive men. They are also commonly potent causes behind the impetus for males masking the personal effects of the abortion experience. Male partners, sitting in the clinic's waiting room, deny themselves permission to feel emotions they may experience ranging from loneliness to fear, helplessness and guilt ...The male partner may experience guilt on two levels. First, he perceives his experience as emotionally insignificant in comparison to the female's ordeal. Second, he feels responsible for having put his partner through such a physically and emotionally traumatic experience.") (5)

5. **Male Services.** Our attention as applied sociologists was quickly drawn to a finding first noted in 1983-4, namely, four out of five of the 1,000 males deemed the abortion experience one of the most difficult of their lives. And 93% said they would be more careful about risking pregnancy after this abortion. But, 25% were repeaters! And, in 2004, the figure was still a high 19%. Plainly, something was wrong as far too many waiting room males were taking a return seat.

It is possible that the absence of male services may be a major contributing factor, and we continue to research this possibility. Waiting room men are usually there of their own free accord, and have come along to provide support, commonly at the strong urging of their sex partner (only 13% of the males in 2004 identified themselves as platonic friends).

Once inside the clinic (having often had to pass through a gauntlet of vitriolic or prayerful anti-abortion protestors), males discover there is nothing for them save for nervous silent time-passing. Some 65% in 2004 (73% in 1999; 69% in 1983) would have liked to have accompanied their partner throughout the abortion - provided she first agreed. But only 23% of the clinics in 1999 made this possible, and there is no reason to believe the figure in 2004 was any higher. Similarly, some 87% in 2004 (92% of 1999; 91% in 1983) wanted to hold the hand of their partner in the Recovery Room, but only 24% of the clinics in 1999 allowed this.

(As for explaining our doubt about any improvements having occurred over time, we would note that while in 1983 some 68% of 30 cooperating clinics had a pamphlet rack and/or reading material specifically designed to help men answer their questions about abortion, the figure by 1999 had fallen to 22%).

Little wonder, accordingly, that a small, but significant percent of the males express an interest in discussing their situation with a professional during the hour and half wait. And they do so without any encouragement from the clinic. Some 25% in 2004 (55% in 1999; 74% in 1983) would have liked a private meeting with the

counselor and their partner before the procedure. But very few clinics (only 40% in 1999) offer this. Some 39% in 1999 vs. 62% in 1983 would have liked a private meeting with a clinic counselor during their wait. But only 40% of the clinics offer this service. Given the high percent who in 2004 say they feel guilty (24%), sad (21%), and afraid (18%), and the fact that 47% (in 1983-4) anticipate having disturbing thoughts after the experience, a case would seem strong for the provision of male counseling.

Many waiting room males want to know how to keep from repeating. Some 36% in 1999 vs. 56% in 1983 would have attended an educational group session focused on contraception (techniques, effectiveness, costs, etc.). But this is almost entirely unknown in actual clinic practice. Some 27% in 1999 vs. 51% in 1983 would have joined a small-group discussion made up of other waiting-room men and a clinic counselor. Again, an option conspicuous by its absence from the scene.

As neither of these services is so much as mentioned, better yet offered, there is good reason to expect actual enrollment would be larger in response to a sensitive promotion. Interestingly enough, 62% in 2004 (up from 50% in 1999) signaled their willingness to help pay for male service options. Some 51% in 1999 indicated that the couple's choice of a provider would have been influenced by the availability of male-aiding services.

6. **Clinic Response/Rebuttal.** As for why these services are not part of the scene, interviews with clinic directors and staffers suggest the following explanations: First, the client is the female, and not the couple: The male has no function other than a support role, and is not perceived as a legitimate claimant on attention. Second, clinic resources are hard-pressed to help females, and nothing remains to also help males. Third, male needs are specialized, and few, if any clinic staff (almost all of whom are female) have the appropriate skills. Fourth, male services would be costly, and there are no insurance policies for either gender to help meet the costs. Finally, males have not pressed the matter, and this would suggest nothing is amiss.

In response, one of us (A.S.), a longtime advocate of male services, argues that as a couple initiates a conception, we might be better advised to reinterpret the entire situation, and recognize that two people, rather than the female alone, warrant help. Second, clinic resources could be expanded if family planning philanthropies were approached for help in meeting the cost of male services. As well, males could be asked to help by paying on a sliding scale basis. Third, male counselors are probably available for employ, as they can be found everywhere else in the helping professions. Finally, the absence of male agitation for these services probably says more about their passivity when in officious health care settings (as in hospitals, etc.) than about the value-added nature of the missing services.

Reforms here are overdue ... and a very small cadre of clinic directors are already quietly and steadily urging their availability. (6) If we want couples to leave the clinic with the least possible harm done we cannot begin soon enough to help males come in from the cold.

7. **Policy Reforms.** Were 600,000 men in 2005 to have the (now unavailable) service options waiting room men favor, we might soon have far fewer male repeaters. Many such men might leave an abortion clinic or medical office with a new understanding of family planning techniques, and with fresh resolve to help avoid any further resort to an abortion. Were even half of the 600,000 not to become repeaters, that would represent a sizeable reduction in the nation's 1,300,000 annual abortions.

This is achievable. Pamphlets have been written for free distribution (though unavailable in about 75% of the clinics). Many clinics could sponsor small-group discussions (complete with "show-and-tell" attention to the technologies of contraception) - an educational aid conspicuous by its absence. All of the clinics could add a VCR or DVD viewing machine to the waiting room and thereby put sound and pragmatic family planning material on view. All of the clinics could post large wall charts of family-planning ideas, and offer take-away wallet-size copies. All of the clinics could seek philanthropic grants to subsidize the costs of these new male-oriented services, and also charge the men a small token amount as a measure of their interest.

These measures might at first be voluntary, with their advocacy promoted by a new ad hoc Blue Ribbon Committee of activists from both side of the Abortion Divide, and leaders of the incipient Men's Movement. One national organization, perhaps a neutral party like the Population Council could get matters started. Later, laws might have to be considered.

Pro-Choice and anti-abortion activists could find common ground in advocacy here, much as was urged on Jan.24th by Sen. Hillary Rodman Clinton (Dem. NY). The gains could prove quite significant, as males with overdue craft in family planning could make far-reaching contributions to American life the rest of their entire life, gains that include and extend far beyond the abortion challenge.

**Matters for Further Research.**

Five questions especially warrant further research. To begin with, ours was a sample of convenience, with one especially empathetic clinic director drawing on her network of personal friends among directors to gain us entry to eleven other (diverse) clinics. (7) Accordingly, new research could help test the generalizability of these findings. As the demographics of our sample are very similar to those we secured from different clinic waiting rooms sampled in 1999-2000 and 1983-1984 we believe our data and findings defensible. Nevertheless, reaching out to gain surveys from far more than our small three

percent sample of the nation's 400-odd clinics is desirable. Better, of course, would be a representative random sample of all males involved with abortions.

Second, research should explore tinderbox female defensiveness where abortion decision-making is concerned. When I (AS) have been invited over the years to discuss men and abortion at gatherings either of clinic personnel or of feminists (the only groups that have asked me to speak about this; no men's group has thus far done so), the first response invariably has a woman rise to emotionally assert the right of a woman to decide Yes or NO, and thereby retain full control over her person. Men are represented as jealous of the woman's authority here, and as scheming in 101 ways to subvert it.

Slowly and with great care I try to separate my topic from this one, explaining in several ways that I have never meant to question the (Roe v. Wade) affirmation of a woman's sole authority in the matter. I struggle to direct attention back to the educational needs of men, and often wonder how successful I can be after the mood has been colored by a tirade against males intent on imposing their will on women. Further research into this fiery aspect of the War between the Sexes would seem well warranted.

Third, there is the question of how significant is the culture of an all-female setting in explaining the quiescent and passive way of waiting room males? If the percent of staffers who are female is not 100%, it is probably almost that, making this one of the very few settings males experience where their gender is utterly outnumbered and, placed from beginning to end in a subservient status. (8) Would males be more receptive to offers of contraception education if the offer came from a male staffer hired for that purpose? Only experimentation and related research can answer this important question.

Fourth, research is warranted into variables that do and do not matter. For example, we found religion did not explain differences in attitudes, while educational attainment did - the more schooling, the greater the likelihood of being an Affirmer. Similarly, more should be learned about major sub-types. For example, for unwed males this may be the first affirmation of their fecundity: Some may harbor a deep-reaching desire to know their offspring. Fathers of one or more children, in contrast, may be relieved not to have another mouth to feed. A very few (probably under five percent) may have cajoled their partner into having the abortion, while a few others (probably also under five percent) may be bitterly opposed. These divisions, and those by race (black males are vulnerable to claims about "race suicide"), or social class, merit new research on the multiple realties hidden behind the seeming sameness of a clinic waiting room crowd.

Finally, and as a variation on the puzzle above, which males would be more receptive to offers of contraception education if the offer were promoted, much as in the marketing of a new major on campus? What if wall posters featured endorsements from previous and varied takers of the clinic course? What if a VCR film available in the waiting room promoted the educational and counseling options much as do tasteful commercials on

Public Radio and Television? Would many more males sign up? Only experimentation and related research can answer this important question.

**Footnotes.**

1. 1) Shostak, Arthur; Gary McLouth; and Lynn Seng. Men and Abortion: Lessons, Losses, and Love. New York: Praeger, 1984. For a review, see Leo, John. --Sharing the Pain of Abortion: men Feel Isolated, Angry at Themselves and Their Partners.-- *Time*, September 26, 1983. p.78. See also Shostak, "I am NOT a Rock: Men and Abortion in America." *SWS Network News* (The Newsletter of Sociologists for Women in Society), December, 2003.
2. The data entry assistance of Lauren Hetland was indispensable, and we are very appreciative. Likewise, the data analysis of Jennifer Perkins, of Kenyon College, was quite valuable.
3. Saad, Lydia. "Poll Analysis: Roe v. Wade has Positive Public Image." Gallup Poll. January 20, 2003.
4. Shostak, et. al., Men and Abortion, op. cit., p. 316. Saad, ibid. The lower courts are increasingly given support to pre-notification laws where teenagers are concerned.
5. Kalish, Stacey (slk260@nyu.edu). "Men and Abortion: Ignoring the Other Half of the Abortion Experience." *Psychology Today*, March, 2004. pp.31-32. See also Nixon, J. Peter. --The Other half of the Abortion Story: Men and Abortion.-- U.S. Catholic, February, 2005, 70, 2. pp. 12-15.
6. Claire Keyes, the Director of a major Eastern Seaboard clinic, has been invaluable in 101 ways, and cannot be thanked enough: Many our interpretations have been revised and always improved after Claire critiqued the material. However, Claire cannot be held in any way responsible for this essay, which was done without her review. See Chen, Daryl. --Are You Ready to Really Understand Abortion? *Glamour*, September, 2003. pp. 264-7, 295-6, 299; Carpenter, Mackenzie. --Heart Full of Hurt: Abortion Clinic Messages Reflect New Counseling Philosophy.-- *Pittsburgh Post-Gazette*, January 6, 2004. pp. 12-13.
7. Ms. Keyes, for example, conducted a Poster Session promoting male services at the 2004 Annual Meeting of the National Council of Abortion Providers, and has since told me (A.S.) it was very well received.
8. There is a strong similarity here to the experience males have visiting their children's elementary school and finding the all-female world there an unexpected stressor.

Appendix: Questions, Scales in 2004

**Question 2: How did you feel about abortion before this pregnancy?**

| | | |
|---|---|---|
| Curious: | 87(n) | 11% |
| Frightened: | 108 | 14 |
| Grateful: | 58 | 8 |
| Neutral: | 300 | 39 |
| OK: | 273 | 36 |
| Opposed: | 76 | 10 |
| Relieved: | 62 | 8 |
| Repulsed: | 17 | 2 |
| Saddened: | 126 | 17 |
| Supportive: | 307 | 40 |
| Uninformed: | 78 | 10 |
| Uninterested: | 65 | 9 |

| | | |
|---|---|---|
| Unsure: | 194 | 25 |
| Other: | 48 | 6 |
| Total records: | 766(n) | |

**Antagonist Scale: (if he elected to check off the following terms with reference to his attitudes BEFORE the abortion to abortion) -**

| | | |
|---|---|---|
| Opposed: | 76(n) | 10% |
| Repulsed: | 17 | 2 |
| Saddened: | 126 | 17 |

**Affirmer (if he checked) -**

| | | |
|---|---|---|
| Grateful: | 58(n) | 8% |
| OK: | 273 | 36 |
| Relieved: | 62 | 8 |
| Supportive: | 307 | 40 |

**Ambivalent (neither ANTI- nor PRO):**

| | | |
|---|---|---|
| Curious: | 87(n) | 11% |
| Frightened: | 108 | 4 |
| Neutral: | 300 | 39 |
| Uninformed: | 78 | 10 |
| Uninterested: | 65 | 3 |

**Question 3: How do you feel about this abortion?**

| | | |
|---|---|---|
| Afraid: | 138(n) | 18% |
| Angry: | 45 | 6 |
| Anxious: | 101 | 13 |
| Confident: | 94 | 12 |
| Curious: | 36 | 5 |
| Frightened: | 90 | 12 |
| Guilty: | 183 | 24 |
| Happy: | 38 | 5 |
| Helpful: | 89 | 12 |
| Helpless: | 82 | 11 |
| Mean: | 11 | 1 |
| Nervous: | 277 | 36 |
| Neutral: | 131 | 17 |
| Numb: | 58 | 8 |
| Opposed: | 15 | 2 |
| Relaxed: | 62 | 8 |

| | | |
|---|---|---|
| Relieved: | 164 | 21 |
| Resolved: | 80 | 10 |
| Sad: | 162 | 21 |
| Silenced: | 52 | 7 |
| Supportive: | 389 | 51 |
| Trapped: | 28 | 4 |
| Other: | 20 | 3 |
| Total records: | 766 | |
| **Antagonist Scale: (if he checked)-** | | |
| Angry: | 45(n) | 6% |
| Guilty: | 183 | 24 |
| Mean: | 11 | 1 |
| Opposed: | 15 | 2 |
| Sad: | 162 | 13 |
| Silenced: | 52 | 7 |
| Trapped: | 28 | 4 |
| **Affirmer (if he checked) -** | | |
| Confident: | 94(n) | 12% |
| Happy: | 38 | 5 |
| Helpful: | 89 | 12 |
| Relaxed: | 62 | 8 |
| Relieved: | 164 | 21 |
| Resolved: | 80 | 10 |
| Supportive: | 389 | 51 |
| **Ambivalent (if he checked) -** | | |
| Afraid: | 138(n) | 18% |
| Anxious: | 101 | 13 |
| Curious: | 36 | 5 |
| Nervous: | 277 | 36 |
| Neutral: | 131 | 17 |
| Numb: | 58 | 8 |

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# *Men Have Needs Too*

**Many Men Are Involved in Unplanned Pregnancies and Are at Risk of STDs, yet Lack Access to Services**

Half of American men do not receive sexual and reproductive health care, and many of those who do receive only limited services, according to "Patterns of Men's Use of Sexual and Reproductive Health Services," by Debra Kalmuss and Carrie Tatum, published in the June 2007 issue of Perspectives on Sexual and Reproductive Health.

Kalmuss and Tatum's study, based on data from the National Survey of Family Growth, finds that only 48% of men received any sexual or reproductive health services in the past year, most commonly a testicular exam (35%) or services for HIV (21%) or other STDs (19%). Further, 70% of men did not receive any of the most common nontesticular services—STD services, HIV care and birth control services—at all in the past year. These findings are particularly alarming given existing research suggesting high levels of unprotected sex and other risk behaviors among men.

The authors suggest a need for more accessible sexual health services for men, and note that several factors make it difficult to achieve that goal. There is currently a lack of formal screening or service guidelines for males, and a shortage of comprehensive or integrated services for men's health care. Add to that the economic barrier—22% of men aged 20–44 lack health insurance—and the finding that men are not accessing the services they need is not surprising.

Men's Health Week, June 11–18, is a good time to raise awareness of the current gaps in men's access to sexual and reproductive health care, and to think about how to improve the situation. Recommendations from the study's authors include finding consensus among health care providers on the standards of care for clinical practice by identifying which services men need and at what age and how often they need them; performing outreach to assure men that sexual and reproductive health care is both necessary and appropriate; and increasing public funding for men's sexual and reproductive health care so that men's services do not have to compete with women's services for already limited resources.