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perspectives of clinicians who have provided post-abortion
emotional care and experienced abortion personally**

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Abigail Reider
Implications for Best Practices in
Post-Abortion Emotional Care:
Perspectives of Clinicians who have
Provided Post-Abortion Emotional
Care and Experienced Abortion
Personally

ABSTRACT

This study was undertaken to explore the factors that contribute to emotional distress post-abortion and interventions used to mitigate such distress. Qualitative interviews were conducted with 12 clinicians who had provided professional emotional care to women post-abortion and who had had one or more abortions themselves. Clinicians described their personal experiences with abortion and their process of healing from associated emotional distress, as well as the experiences of their patients and interventions that mitigated distress for their patients. Factors that protected against emotional distress post-abortion were explored, as were clinical practice issues that arose for participants in their professional roles.

The findings of this study determined numerous factors that can contribute to emotional distress, mostly in accordance with the literature. Clinicians recommended a range of interventions that varied based on the nature of women's emotional distress but always included aspects of nonjudgmental support. The findings of this study also suggest that it is important for clinicians working with patients post-abortion to conduct an assessment to determine the cause(s) of emotional distress and the individual needs of the patient in order to develop and apply the most appropriate and effective interventions. These findings may contribute to establishing best practices in helping women heal from emotional distress that can occur in conjunction with the abortion experience.

**IMPLICATIONS FOR BEST PRACTICES IN POST-ABORTION EMOTIONAL CARE:
PERSPECTIVES OF CLINICIANS WHO HAVE PROVIDED POST-ABORTION
EMOTIONAL CARE AND HAVE EXPERIENCED ABORTION PERSONALLY**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Abigail Reider

Smith College School for Social Work
Northampton, Massachusetts 01063

2014

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	3
III METHODOLOGY.....	16
IV FINDINGS.....	23
V DISCUSSION.....	67
REFERENCES.....	82
APPENDICES	
Appendix A Recruitment Email.....	86
Appendix B: Human Subjects Review Approval Form.....	87
Appendix C: Human Subjects Review Amendments Approval Form.....	88
Appendix D: Participant Consent Form.....	89
Appendix E: Transcriber Confidentiality Form.....	92
Appendix F: Interview Questions.....	93

CHAPTER I

Introduction

The purpose of this study was to explore post-abortion emotional distress and the interventions used to treat it. The central questions of this study focused on examining the factors that contribute to emotional distress post-abortion and then using that information to inform the exploration of post-abortion interventions.

Approximately one million abortions are performed every year in the United States, and approximately 30 percent of women will have an abortion by the time they are 45 (Guttmacher Institute, 2014). There is an ample body of literature that explores the emotional outcomes of abortion. Although studies have found that it is more common for women to feel positive emotions following an abortion, they also show that emotional distress occurs in some women as well (Adler, 1975; Adler, David, Major, Roth, Russo, & Wyatt, 1990; Adler, David, Major, Roth, Russo, & Wyatt, 1992; Major, Applebaum, Beckman, Dutton, Russo, & West, 2009). Little research has examined how to help women cope most effectively with emotional distress they may experience in conjunction with the abortion experience. Even if a minority of women experiences emotional distress post-abortion, it is still imperative to understand what abortion and mental health providers can do to support those women who do.

Toward that end, this study solicited the perspectives of 12 clinicians who had both provided professional emotional care to women post-abortion and who had had one or more abortions themselves. The study was a qualitative, flexible-methods research design with open-ended interview questions to gather narrative data from the clinicians. Clinicians were asked

both about their personal experiences with abortion and their process of healing from any associated emotional distress, as well as about their perceptions of their patients' emotional reactions to abortion and how they facilitated healing for those patients who experienced distress post-abortion. This study examined factors that increased emotional distress post-abortion, factors that protected women from experiencing emotional distress post-abortion, and interventions that helped women heal from emotional distress associated with their abortion experience(s). Clinical practice issues that arose for participants in their professional roles were also explored.

This study explored these aspects beginning with a comprehensive review of literature, followed by the narratives of 12 clinicians who intimately shared their perspectives and insight on how they and their patients experienced and coped with emotional distress post-abortion. The study sought to use this information to inform suggestions for future research and the establishment of best practices in post-abortion emotional care.

CHAPTER II

Literature Review

This literature review covers the current knowledge regarding the topics that were explored in this study. These topics include the nature of emotional distress post-abortion; contributing factors to post-abortion emotional distress, including abortion stigma; factors that may prevent post-abortion emotional distress; and interventions to combat emotional distress post-abortion. The review will inform this study and also point to gaps in the literature that highlight the need for further research, including this study's central research question to explore emotional distress associated with the abortion experience and the most effective post-abortion interventions to treat it.

Theoretical Framework

From a theoretical standpoint, the current study incorporated a few theories that related to different corresponding aspects of the content. Two articles reviewed used a *stress and coping* framework to conceptualize the abortion experience (Major et al., 1998). Within this framework, the abortion experience is seen as a potentially stressful life event that poses challenges to the individual to varying degrees, depending on individual circumstances, views, and coping styles (Adler et al., 1992). Although this framework does not account for possible differences between abortion and other stressful life events, no literature reviewed found that women must cope differently with abortion than they do with other stressful life events in order to heal from associated emotional distress (Lemkau, 1998).

In conducting a comprehensive literature review, Adler et al. (1992) noted that research on the impact of stressful life events indicates the importance of several variables that can affect the individual. Key variables that have been identified include social support, understanding of the cause of the event, ascribed meaning to the event, and coping strategies employed in dealing with the event (Adler et al., 1992). As discussed in the literature, all of these factors have been shown to play an important role in the emotional responses of women following abortion (Adler et al., 1992).

Through this lens, aspects of the abortion experience that contribute to emotional distress post-abortion include sociocultural factors and environmental context. The portion of this study regarding the environmental context that can contribute to emotional distress post-abortion was partially conceptualized within the framework of stigma theory and its application to abortion. Goffman (1963) conceptualized *stigma* as an attribution that discredits, taints, and discounts the individual. He theorized that even behaviors that are not visible can be stigmatized, in that stigma can create internalized shame and stigma in individuals regardless of whether others are aware of their behavior (Goffman, 1963). Although his work is eminent in the study of stigma, Goffman's theory was formulated in a time in which the social and political landscape differed significantly from today, and so it is important to conceptualize Goffman's theory in a more modern context.

Kumar, Hessini, and Mitchell (2009) followed by applying Goffman (1963) to a theory specifically pertaining to the stigmatization of modern abortion. They drew on Goffman (1963) to assert that *abortion stigma*, like all stigma, is socially constructed in various ways. Kumar et al. (2009) suggested that abortion stigma occurs because women who seek abortions challenge societal norms of womanhood. They theorized that the act of abortion challenges three

constructs of femininity that cause abortion to become stigmatized (Kumar et al., 2009). These three constructs are “female sexuality solely for procreation, the inevitability of motherhood, and instinctual nurturance of the vulnerable” (p. 628). While its root causes are complex, abortion stigma is at least partially propagated by systems of oppression, inflexible gender roles, and systematic attempts to control female sexuality (Kumar et al., 2009).

Despite its usefulness in theorizing abortion stigma so that it can be studied more effectively, the Kumar et al. (2009) study generalizes about views of womanhood across cultures. This limitation can be attributed to the lack of widespread data on abortion stigma. Kumar et al. (2009) acknowledged that the study of abortion stigma is a nascent and emerging field, and so the conceptualization of this theory does not include as much evidence from different communities and contexts as would be helpful. However, research on abortion stigma and its effects on patients is ongoing (Cockrill, Upadhyay, Turan, & Foster, 2013).

In another theoretical article, Upadhyay, Cockrill, and Freedman (2010) reviewed an extensive breadth of literature to determine best practices in emotional care for sensitive and stigmatized health issues, with the objective to apply these practices to future programs to improve emotional care of abortion patients. The authors found that a variety of patient-centered, evidence-based interventions used for other sensitive and stigmatized health issues could be applied to emotional care for abortion patients (Upadhyay et al., 2010). The types of interventions found to be most effective included self-assessments, peer counseling, encouraging active client participation, support groups, Internet-based support, and others (Upadhyay et al., 2010). While this study is useful in determining possible elements of post-abortion emotional care that might be helpful in mitigating psychological distress, the findings do not specify the differences between the types of sensitive and stigmatized health issues in relation to abortion;

therefore, assumptions were made without accounting for any unique aspects of the stigma associated with abortion or other health issues. However, as mentioned, through the stress and coping framework, it is not clear that emotional distress encountered in conjunction with the abortion experience differs from that encountered with other stigmatized issues (Lemkau, 1988). Further research should be conducted to determine if and what differences exist in the emotional distress that results from abortion stigma and stigma associated with other health issues and how any found differences might affect intervention effectiveness.

Empirical Literature

The existing empirical literature was reviewed to illuminate the current understanding of the nature of the emotional experience post-abortion, including factors that contribute to and help prevent post-abortion emotional distress. In addition, literature was reviewed that discussed interventions to mitigate emotional distress post-abortion. Gaps in the literature were also identified.

Nature of the emotional experience post-abortion. Much of the literature reviewed described key aspects of the abortion experience. Abortion was portrayed as a complex event in a woman's life that can elicit a range of emotions (Adler, 1975). In her qualitative study of 16 abortion patients at least 15 years after their abortion(s), Trybulski (2006) found that emotional reactions to abortion were not time-limited and occurred at various times post-abortion. Trybulski (2006) found that oftentimes thoughts and feelings about women's abortion(s) were triggered during subsequent reproductive events, by abortion in the news, and/or with friends' life events.

Studies explained the range of emotional experiences that women can have post-abortion, from experiencing positive feelings of relief and self-confidence for coping well with a stressful

life event, to various potential negative emotions described below (Major et al., 2009). These studies also cautioned against claims of the existence of Post-Abortion Syndrome, discussed by Rue and Speckhard (1992), that abortion directly causes symptoms similar to that of Posttraumatic Stress Disorder (Major et al., 2009). The most rigorous and substantiated reviews of studies on the abortion experience have criticized this syndrome as scientifically unjustified and instead determined that a majority of women experience positive emotions post-abortion, even if many women may have corresponding negative emotions (Adler, 1975; Adler et al., 1992; Dadlez & Andrews, 2010; Major et al., 2009). Research shows that many women do experience distressing emotions post-abortion, but that these emotions are most often consistent with experiencing a normal stressful life event, vary substantially based on individual circumstances, and/or occur with and possibly due to co-existing factors (such as mental health conditions or environmental context) that predispose women to emotional distress (Adler, 1975; Adler et al., 1992; Major et al., 2009).

Group statistical studies have also found that the rate of mental health issues among women who have had abortions is no larger than for women who have had unwanted pregnancies carried to term (Adler, 1975; Adler et al., 1990; Major et al., 2009; Upadhyay et al., 2010). However, two studies reviewed cautioned that this generalization does not account for the individual experiences of those women who do experience negative emotional outcomes as a result of issues related to their abortion(s), nor for whether or not they individually would have experienced negative emotional outcomes should they have carried an unwanted pregnancy to term (Major et al., 2009; Upadhyay et al., 2010). It is also important to consider that large quantitative studies could overgeneralize without accounting for very important outliers, and that samples may not be representative of all women who obtain abortions. In addition, even if a

majority of women experiences positive emotions post-abortion and may feel less distress than they felt pre-abortion, they may still experience co-existing emotional distress post-abortion. Some women may even experience clinically significant emotional distress post-abortion, although studies have found that clinically significant emotional distress post-abortion is highly correlated with pre-existing mental health conditions pre-abortion (Major et al., 2009). Still, as with other stressful life events that can trigger symptoms of pre-existing mental health conditions, this finding does not negate the need for interventions post-abortion to help women cope.

Studies reviewed determined various factors that contributed to emotional distress post-abortion. Upadhyay et al. (2010) theorized that several factors were associated with a reduced ability to cope after an abortion, and with corresponding feelings of guilt, anxiety, depression, and regret. These factors included but were not limited to low self-esteem, stigma, and low levels of social support (Upadhyay et al., 2010). Other studies confirmed this theory and found that factors that contributed to emotional distress post-abortion included conflict about the meaning of abortion and its relation to deeply held values or beliefs, perceived social stigma, low self-esteem, low self-efficacy, and lack of support (Adler, 1975; Adler et al., 1990; Cozzarelli, Sumer, & Major, 1998). Adler et al. (1975) found a sense of loss correlated with ambivalence about wanting the pregnancy and/or the decision to abort. Women at higher risk for emotional distress post-abortion also included those who were terminating pregnancies that were wanted and meaningful, who were more conflicted and less sure of their decision and coping abilities beforehand, who blamed themselves for the pregnancy, and who delayed abortion until the second trimester (Adler, 1975; Adler et al., 1990). Kimport, Foster, and Weitz (2011) found that two social aspects of the abortion experience affected women's emotional responses to abortion.

Namely, they found that women experienced more distress post-abortion if they felt the abortion was not primarily their decision or did not feel clear emotional support post-abortion (Kimport et al., 2011).

In addition, aspects of the experience at abortion clinics have been found to affect emotional outcomes for women (Cozzarelli, Major, Karrasch, & Fuegen, 2000; Kimport, Cockrill, & Weitz, 2012a). Interactions with antiabortion picketing at clinics on the day of the procedure were found to trigger negative emotional responses in women (Cozzarelli et al., 2000; Kimport et al., 2012a). Cozzarelli et al. (2000) found that antiabortion picketers particularly triggered emotional distress in women who already felt conflicted about having an abortion, and that this distress regarding picketers remained for these women post-abortion. Kimport et al. (2012a) found that, in addition to antiabortion protestors, security measures at clinics increased a sense of stigma for patients. Negative interactions with clinic staff, although less common than positive interactions on the whole, also caused negative emotional outcomes for women post-abortion (Kimport, et al., 2012a).

It is widely accepted that abortion stigma can have negative emotional consequences for women who undergo the procedure. Shellenberg et al. (2011) hypothesized that abortion stigma may affect a woman's emotional health and wellbeing. In her doctoral dissertation, Shellenberg (2010) found that abortion stigma created a negative feeling of self in abortion patients. It is important to note that Shellenberg (2011) found that stigma and social context, not the abortion itself, caused emotional distress. Kimport (2012) cautioned that the politicized debate over abortion regret has failed to provide space for complex feelings and, to the extent that it has contributed to social disapproval of abortion, has likely contributed to the emotional difficulties some women experience post-abortion.

Many of the studies cited found that abortion stigma affected women's willingness to disclose that they had had an abortion, which, in turn, built on the negative emotional effects experienced as a result of abortion stigma (Astbury-Ward, Parry, & Carnwell, 2012; Major & Gramzow, 1999; Shellenberg, 2010). The more women kept their abortion history a secret, the less social support they could obtain. Consequently, the very stigma that kept women from disclosing their abortion history also kept them from seeking or obtaining the necessary support to combat the internalized aspects of that stigma (Major & Gramzow, 1999). Kumar et al. (2009) warned that the adverse emotional effects of abortion stigma on the individual might be the most detrimental of all parts of abortion stigma.

The literature reviewed also indicated that the following factors correlated with higher levels of emotional wellbeing and lower levels of emotional distress post-abortion: emotional support for the abortion from a parent and/or partner, satisfaction with and lack of conflict around the decision to abort, higher levels of self-esteem and self-efficacy, and optimistic beliefs about being able to cope well post-abortion (Adler et al., 1990; Adler, et al., 1992; Cozzarelli, 1993; Cozzarelli et al., 1998; Major, Cozzarelli, Sciacchitano, Cooper, & Testa, 1990; Major et al., 1998).

Interventions to mitigate emotional distress post-abortion. It is crucial to understand the factors that contribute to emotional distress post-abortion in order to create successful interventions to alleviate them. I agree with many of the aforementioned researchers including Kumar et al. (2009), Major et al. (2009), and Shellenberg (2010) that future research should seek to expand upon the body of knowledge of factors, including abortion stigma, that contribute to emotional distress post-abortion. A portion of this study focused on seeking to understand how various factors contribute to individual patients' emotional distress post-abortion. The rest of the

study, however, sought to understand interventions used to mitigate post-abortion emotional distress, as recommended and described by the clinicians interviewed.

Multiple studies suggested that further empirical research would help to assess the effectiveness of initiatives to combat negative effects of stigma in abortion patients (Kumar et al., 2009; Major et al., 2009; Norris, Bessett, Steinberg, Kavanaugh, De Zordo, Becker, 2011). Understanding the effectiveness of elements of interventions would add to a growing body of knowledge about how to support abortion patients best and can serve as a basis for the design of future interventions (Ely, Dulmus, & Akers, 2010; Moore, Frohwirth, & Blades, 2011).

It is clear that abortion patients could benefit from counseling and emotional support services after they undergo the procedure. Kimport, Perruci, and Weitz (2012b) recognized the need for non-judgmental and apolitical emotional support for processing patients' feelings over time after their abortions. They found that talk-lines provided this type of crucial support, particularly since some women need support periodically and episodically at any time after an abortion (Kimport et al., 2012b). From their findings, Kimport et al. (2012b) called for integrating post-abortion emotional support more fully into the work of providers of emotional care of abortion patients. As mentioned, social support has been found to be one of the primary factors in decreasing internalized stigma and negative emotional effects experienced in conjunction with an abortion (Kumar et al., 2009).

It is possible to use the findings from previous research regarding pre-abortion emotional care to inform a study of post-abortion emotional care. For example, Moore et al. (2011) illuminated important themes for inquiry into women's experiences around post-abortion emotional care; the authors surveyed abortion patients to determine the type of counseling that they found helpful pre-abortion. Moore et al. (2011) found that the majority of women preferred

not to undergo mental health counseling since they feared providers would try to deter them from going through with the procedure; in effect, that providers might have shared the stigma against abortion. Both Moore et al. (2011) and Ely et al. (2010) found that pre-abortion options counseling did not ease emotional distress and could even be a source of potential emotional hardship if the woman had already made the decision to have an abortion.

These studies point to the notion that any counseling for abortion patients should focus on providing emotional support that considers the patient's individual needs at the moment and is determined on an individual basis, particularly because of the complex emotional nature of abortion that can present different issues for the patient depending on individual circumstances (Ely et al., 2010; Moore et al., 2011). Ely et al. (2010) and Moore et al. (2011) both recommended using an empowerment model that values the patient's beliefs and wishes and provides different levels and types of emotional support based on the specific needs of the patient (Ely et al., 2010; Moore et al., 2011). More research, however, is needed to determine the validity of these findings.

Very few studies have specifically evaluated the effectiveness of programs and interventions that seek to combat post-abortion emotional distress in women. Although there are numerous books that recommend certain interventions based on the author's individual experiences, I found only one study that tested and evaluated an intervention. Littman, Zarcadoolas, and Jacobs (2009) tested and evaluated an intervention designed to provide a supportive group environment to abortion patients. The program aimed to support women in their reproductive decisions, address stigma, and provide information to help women identify and avoid sources of abortion misinformation (Littman et al., 2009). The results were promising, as all of the 22 participants felt that they benefited from participating in the program and agreed that

similar programs should be offered to abortion patients (Littman et al., 2009). Support groups have been found to foster interpersonal connections and serve as an effective stigma management tool (Harris, Debbink, Martin, & Hassinger, 2011).

Main weaknesses of many qualitative studies are the scope and sample size. While Littman et al. (2009) provided important information to inform further research, conclusions about the generalizability of their intervention model cannot be determined. The sample was too small and homogeneous, and therefore the study cannot be used to conclude whether a similar intervention would work with another population in another community.

In their longitudinal study of 527 women who had first-trimester abortions, Major et al. (1998) demonstrated that positive reframing helps women successfully cope with abortion. They found that women who used positive reframing and acceptance to cope, and less avoidance and denial, experienced more positive emotions post-abortion (Major et al., 1998). Social support was also found to help improve emotional wellbeing, while coping with venting, denial, avoidance, or religious means were associated with poorer emotional adjustment post-abortion (Major et al., 1998). This research suggests that effective clinical interventions to mitigate post-abortion emotional distress could include helping women to reframe their experience in a positive way, to seek positive social support, and to avoid the aforementioned coping strategies associated with poorer adjustment post-abortion.

Many of the studies cited above discussed their shortcomings in terms of study design and the samples of the population used. One weakness of any study of patients encountering stigmatized events concerns the nature of stigma: those who are most affected by the stigma are likely to decline to participate in a study, as these patients would be reluctant to identify themselves to anyone, even to a researcher who would protect their identity. Adler et al.'s

(1990) analysis of various studies cautioned that women who are more likely to find the abortion experience stressful could be underrepresented in volunteer samples.

Additionally, as mentioned, much of the literature noted that abortion is a highly complex experience; co-existing factors affect an individual's response to abortion (Kumar et al., 2009; Upadhyay et al., 2010). Many of the studies included methodological weaknesses, did not account for researcher or participant biases, and were not comprehensive enough to account for the differences in emotional health outcomes and abortion stigma within different communities, as well as for the variation in interventions that might be most effective due to these differences.

Furthermore, the time at which participants were interviewed could have affected the outcomes of the studies, since most interviews were conducted with women shortly after they had an abortion. Only one study reviewed examined the long-term emotional impact experienced by women post-abortion (Trybulski, 2006). Therefore, most of the studies did not measure the level of emotional distress in the long-term or account for long-term effects of interventions.

As noted, in addition to the few studies mentioned that examined emotional care post-abortion, a fair number of articles and resources were found that suggested ways women can heal from emotional distress post-abortion. Although these suggestions are not evidence-based, they do present promising interventions based on observations of licensed clinicians who have counseled women post-abortion.

For example, Lemkau (1988) noted various psychotherapeutic strategies recommended in the literature that have been used to treat patients with emotional distress post-abortion. Lemkau (1988) suggested first conducting a comprehensive assessment to determine the reasons for emotional distress post-abortion, and then selecting appropriate clinical interventions that target

these specific issues, such as grief or ambivalence, that are most often not unique to the abortion experience. When appropriate, these therapeutic approaches could include grief work, including the possibility of a Gestalt grieving ritual; education approaches, including contraceptive information or normalizing the woman's experience; review of the decision-making process in order to facilitate integration; rituals of self-forgiveness in accordance with the woman's belief or value system; and/or offering empathetic support (Lemkau, 1988). It is important to note that Lemkau (1988) did not discuss the findings regarding the effectiveness of these proposed interventions in mitigating emotional distress post-abortion, nor did other resources found.

Although there has been an increase in the study of emotional responses to abortion and abortion stigma in the last ten years, and new methods for quantifying abortion stigma are being tested and refined, little research has used the existing data on the emotional aspects of the abortion experience to inform the study of post-abortion emotional care. There is a clear need for increased research on the programs that provide emotional care to woman post-abortion and other interventions that aim to treat emotional distress post-abortion. While numerous studies have informed best practices in pre-abortion options counseling, there is a dearth of research to inform best practices for emotional care post-abortion. Through the eyes of clinicians who had had one or more abortions themselves and had also treated patients post-abortion, this study explored post-abortion interventions aimed at reducing emotional distress in patients.

CHAPTER III

Methodology

There is an important need to understand more clearly the elements of programs and interventions that successfully reduce internalized stigma and other negative emotional consequences as a result of abortion, as well as those elements that are ineffective or even detrimental. There are currently no evidence-based best practices established for emotional care of patients post-abortion, though many agencies and organizations have designed their own interventions and resources for abortion patients based on their experiences in the field.

Therefore, the purpose of this study was to explore the nature of emotional distress associated with the abortion experience and the most effective post-abortion interventions to treat it. The central research questions were: 1) What factors contributed to emotional distress for participants and their patients post-abortion? 2) What factors helped prevent emotional distress for participants and their patients post-abortion? 3) What interventions did participants find to be most helpful in mitigating emotional distress post-abortion for themselves and their patients? 4) What clinical practice issues arose for participants in their professional work with patients post-abortion?

Through the eyes of clinicians who had also experienced abortion themselves, I sought to understand the elements of interventions that most helped women cope with emotional distress post-abortion. This study sought to accumulate as much pertinent information as possible to inform future design and implementation of interventions, as well as the design of future studies.

Research Design

Since there is so little literature on the topic of interventions to mitigate emotional distress post-abortion, it was most appropriate to use a qualitative, flexible methods research design, using open-ended questions to gather data through free-flowing narration. Anastas (1999) described how “in flexible methods research, unstructured data are used in order to capture the phenomena of interest in the words or actions of those who embody or live them and to capture them in context in terms that are as “experience-near” as possible” (p. 57).

Sample

Sample recruitment. This researcher used a purposive, snowball sampling technique to recruit participants. Via email, I contacted specific individuals whom I already knew fit the criteria, or who might be able to refer me to clinicians who fit the criteria (Appendix A). I also posted a request for participation to appropriate pages on Facebook. I asked colleagues and acquaintances to circulate my inquiry through their own channels to anyone they thought might fit the criteria or who might be a referral source. I contacted a number of organizations via phone and email to learn more about their emotional care resources provided to patients post-abortion and to establish contacts within the provider community. In these cases, once contact was established, I asked providers if they fit the criteria or could circulate my request for participants to anyone who did. I did not interview anyone whom I knew personally either socially or professionally.

Sample criteria. The inclusion criteria for participants were that they had personally undergone an abortion or multiple abortions and had provided professional counseling as part of their jobs to one or more patients who had undergone one or more abortions. Participants held at least one of the following credentials: MSW, MFT, Registered Nurse, Doctor of Psychology

(PsyD), PhD in Clinical Psychology, or certified abortion doula. The sample size was 12.

Participants were all of legal consenting age. I made every effort to recruit a diverse sample in regard to race, ethnicity, age, and varied professional work experiences with abortion patients.

It would have been impossible to determine fair and ethical results without interviewing people who had personally undergone an abortion. This specific provider population was chosen because they were assumed to be less vulnerable than the general population. They were also more likely to be motivated to participate due to implications for improved care. In addition, they could provide more informed insight into clinical interventions as well as into their own experiences.

Possible sample difficulties. It must be taken into account that providers' perceptions of successful interventions may not have actually reflected their patients' own experiences and might have more reflected their own experiences. Consequently, it was important to ask questions that sought to unearth specific evidence of the benefits of the interventions to their patients and to seek to understand any bias based on providers' personal histories. In addition, it was necessary to take into account the differences in knowledge of types of interventions between providers and the varied roles of providers in emotional care of abortion patients. This study included a nonprobability sample, as it would have been impossible to locate all women who had both experienced an abortion and provided emotional care to abortion patients.

Human Subject Review Provisions

This research project was reviewed by the Human Subjects Review Committee at Smith College. The methodology was approved. The official approval for the initial application can be found in Appendix B, and the official approval for amendments made to the original application can be found in Appendix C.

To ensure ethical treatment of the participants and the research data, I followed the following procedures: I explained to participants the purpose and design of the research project, and the nature, benefits, and risks of participation; I informed them that participation was voluntary and that all the information gathered would be held with strict measures of confidentiality in accordance with federal guidelines; and I informed them that they were free to withdraw at any time during the interview, or up to 72 hours after their first formal interview had been conducted, without penalty. Participants were notified that their information would be withdrawn from the study and immediately destroyed should they withdraw from the study within this timeframe. Participants were provided with the informed consent in advance of the official interview (Appendix D).

Participants were informed that there would be no financial compensation for their participation in the study. They were informed that although they may not directly benefit, aside from sharing their experience with a non-judgmental listener, their participation could help them evaluate their own provision of services to abortion patients. In addition, they were informed that their participation could help inform the development, implementation, provision, and general improvement of services provided to abortion patients in the future.

I recorded all interviews electronically via audiotape in a secure and private location owned by me, assuring that my conversations with participants were kept private to protect confidentiality. The interviews were audio-recorded with the consent of participants. I hired a professional transcriber to transcribe the audiotapes. This transcriber signed a confidentiality agreement as required by the Human Subjects Review Committee at Smith College (Appendix E).

Once responses were transcribed, all identifying information was stored in a separate,

secure location using a key to which only I had access. Until identifying information was removed, my research advisor did not have access to the transcripts. The transcriber and I were the only people who had access to any audiotapes, and the transcriber destroyed her copies of the recordings once she finished with the transcriptions. I have not included any information in this report that would make it possible to identify participants, nor will I include such information should I publish additional reports in the future.

All research materials, including recordings, transcriptions, analyses, and consent documents, have been stored in a secure location owned by this researcher and will be kept for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data has been password protected and will remain so during the storage period.

Data Collection

Initial contacts. Upon first contact with a potential participant, I assessed eligibility for the study by asking a series of short qualifying questions. If the woman did not qualify, I followed by asking for referrals to others who might qualify and be willing to participate. If the woman qualified, I followed by explaining the study, sending her the informed consent document, and asking if she had any questions she would like answered about her potential participation in the study. Each individual interviewed signed and returned the informed consent document before the start of any interview.

Interview scheduling. Each consenting participant was contacted via email to set up a formal one-hour interview. If possible, interviews were conducted in person. If not possible, interviews were conducted via video chat or over the phone.

Semi-structured interviews. Data collection was obtained through semi-structured interviews that lasted between 60 and 90 minutes, depending on the length of participants' responses. Participants were asked a total of eight open-ended questions (with some follow-up questions) pertaining to their clients' emotional experiences post-abortion as well as their own. The full list of questions can be found in Appendix F. Questions centered on the role in which participants counseled abortion patients, participants' observations of their clients' experiences as a result of the abortion experience, and participants' observations of the most effective and ineffective interventions in reducing emotional distress associated with the abortion experience. Participants were also asked about their personal experience with abortion and what they found to be most effective in helping mitigate any associated emotional distress. Finally, participants were asked to make informed recommendations about the type or services that should be available to patients post-abortion.

Demographic data. I collected two kinds of demographic data: personal and professional. Personal data on each participant included race, ethnicity, age, religion, state of residence, state(s) where and year(s) when their abortion(s) was or were obtained, state where they received any post-abortion emotional care services, and number of abortions undergone. Professional demographic data on each participant was collected, which included number of years working in the field counseling patients post-abortion, type of abortion counseling experience, type of relevant counseling training obtained, and number of patients counseled. This data was collected as part of the audio recorded semi-structured interview.

Data Analysis

For purposes of accuracy, interviews were transcribed completely and by a professional transcriber. These transcripts were reviewed multiple times to try to extract the correct meaning

of responses, and follow-up questions were asked during the interviews in order to clarify meaning. Memoing was used to highlight areas of potential significance in each interview. Patterns and themes from these memos were identified, sorted, and regrouped manually to provide the foundation for categories for the purpose of analysis. Similarities and differences in response between participants were noted, as were consistency and discrepancy within each individual participant's responses.

Summary

In summary, these methods of approaching the research data allowed me to confirm previous findings about the nature of post-abortion emotional distress and discover new insights into interventions that support women in coping post-abortion. The population sample of clinicians, who had both had abortions themselves and provided professional emotional care to patients post-abortion, also provided for findings regarding issues that arose within the clinical relationship when treating patients post-abortion.

CHAPTER IV

Findings

This chapter contains the findings from interviews conducted with 12 female clinicians who had had at least one abortion themselves and provided professional emotional care post-abortion to one or more patients. The main goal of this study was to determine what has been and could be most helpful for women post-abortion in mitigating emotional distress associated with the experience of having an abortion. For the purpose of this study, the word *clinician* refers to the practitioners interviewed who held one of the following credentials: licensed psychologist (Ph.D. or Psy.D.), licensed social worker, licensed marriage and family therapist, registered nurse, or certified doula. In addition, the phrase *emotional distress* refers broadly to any emotional pain, suffering, sorrow, or anxiety related to the experiences associated with a person's abortion experience.

In order to understand what would mitigate emotional distress post-abortion, it was important to try to understand the nature of such distress, including factors that contributed to it and why certain women experienced more or less emotional distress post-abortion. Open-ended questions sought to elicit participants' views on the aforementioned topic as well as what they had found to be most successful in healing from emotional distress post-abortion both personally and professionally. Participants were asked about both their personal experiences with abortion as well as their work with patients and their understanding of their patients' experiences. The

final section of this chapter focuses on the services participants believe should be offered to patients post-abortion by facilities that provide abortions.

One main finding of this study was that all participants agreed that abortion can be a complex emotional experience, even when a woman believes she made the right decision for her at the time. To varying degrees, most participants (n=9) experienced some amount of emotional distress in conjunction with their abortion experience(s), and all 12 participants had worked with patients who had experienced emotional distress post-abortion. The most commonly cited factors contributing to emotional distress post-abortion included secrecy and silence, stigma, conflict with belief systems, lack of support, and feeling a lack of choice. All participants mentioned shame and guilt, as well as grief and loss, as significant and common feelings that can occur post-abortion.

The most common interventions that participants found to mitigate emotional distress associated with the abortion experience included individual counseling and connecting to other women who have experienced abortion, whether that be through a support group, talk line, informally, or in another way. Close, supportive relationships were also commonly cited as a source of support. Regardless of source, the most common characteristics of interventions recommended as most helpful to mitigate emotional distress post-abortion included creating a safe space free from judgment for patients to talk, process emotions, and feel supported. This finding is consistent with the literature on countering stigma and shame. All participants also believed that more emotional support services should be offered to patients by facilities that provide abortions. Services most often recommended included psychoeducation about the emotional component of abortion and referrals to counseling, support groups, and other resources for obtaining emotional support and connecting to others who have experienced abortion.

The data from the interviews is presented in the following sequence: demographic data, factors contributing to emotional distress post-abortion, factors that help prevent emotional distress post-abortion, and interventions to mitigate emotional distress post-abortion.

Demographic Data

This chapter is a presentation of the narrative responses from 12 female clinicians who had 1) had one or more abortions and 2) provided professional emotional care to at least one patient who had had one or more abortions. Of the 12 participants, six were licensed social workers (one of whom also had a Ph.D. in social work), two were licensed marriage and family therapists, one had her Ph.D. in clinical psychology, one had her Doctorate in Psychology (Psy.D.), one was a Registered Nurse, and one was certified as an abortion doula. Participants ranged in age from 31 to 67, with eight clinicians aged 59 to 67 and four clinicians aged 31 to 40. When asked about their race, ten participants identified themselves as Caucasian or White, and two participants identified themselves as Black or African-American. When asked about their religion, five participants identified as Catholic, four identified as Jewish, one identified as Protestant, one did not identify as any religion, and one declined to state. Of all the participants, only four reported that they practiced their religion currently. All participants were born in the United States and identified as American citizens.

The following section offers information pertaining to the participants' own abortions including quantity, date, age at the time, and location. Nine participants had one abortion to date, two participants had two abortions each, and one participant had three abortions. The participants' abortions took place from 1968 to 2013, including three women who had one abortion each before abortion was legalized by the 1973 U.S. Supreme Court ruling in *Roe v. Wade*. In addition, participants had five abortions from 1973-1978 post-*Roe v. Wade*, three

abortions from 1980 to 1983, three abortions from 1991-1997, one abortion in 2002, and one abortion in 2013. Participants were ages 16 to 40 when they had their abortions, with five abortions occurring between the ages of 16 and 20, ten abortions occurring between ages 21 to 30, and one occurring at age 40. Seven women had abortions in California, two had abortions in New York, one had an abortion in Illinois, one had an abortion in Michigan, and one had an abortion in Texas.

The following section provides information regarding the participants' location of practice and relevant professional experience. Ten of the clinicians currently reside in California, one is based in the Greater Washington D.C. Metropolitan Area, and one currently resides in the Greater New York City Metropolitan Area. These are the locations where the participants have provided professional emotional care to patients post-abortion as well. Eight participants provided said care within the context of a clinical private practice; these clinicians had over 180 years of experience in private practice total, ranging from seven to nearly 40 years each, but not necessarily working with patients post-abortion for the entirety of that time. Six participants provided emotional care to patients post-abortion within an agency setting not specifically oriented to abortion patients but rather to providing mental health services to various populations; these participants had between one and five years in these settings each. Two women provided emotional care to patients directly following their abortions within the medical facility in which these patients obtained their abortions; these women had over three years total working in these settings, where they work currently.

In addition, four participants had additional work experience in the field of abortion outside of providing emotional care for patients. Participant Four, a Registered Nurse, provided a range of care to over 500 patients over two years in that role at an abortion clinic. Participant

Five volunteered for three years in abortion clinics, working directly with patients, and has worked as an advocate in the field of reproductive health for over five years. Participant Seven interviewed over 40 women about their abortion experiences as part of a research project. In addition, two participants had experience providing emotional care to abortion providers.

Participants estimated that they had worked with between two and 500 patients post-abortion, with one participant not responding to this question. Four participants estimated that they had worked with between two and five patients post-abortion, four participants estimated that they had worked with between eight and 20 patients post-abortion, two participants estimated that they had worked with between 40 and 45 patients post-abortion, and one patient reported she had worked with approximately 500 patients post-abortion.

Factors Contributing to Emotional Distress Post-Abortion

In order to understand how to most effectively care for women experiencing emotional distress post-abortion, it is necessary to understand the nature of distress that can occur in conjunction with the abortion experience. Accordingly, participants were asked about factors that contributed to, as well as about the presentation of, emotional distress for themselves and their patients post-abortion.

Questions related to factors contributing to emotional distress post-abortion elicited a variety of responses. Although all participants acknowledged that unique circumstances exist for each person and that a multitude of factors can contribute to emotional distress, common themes emerged. The data are presented in a series of subsections: complex emotional nature of abortion, lack of choice and family or partner pressure, relationship stress post-abortion, shame and guilt, grief and loss, location, associated trauma, and presentation of distress.

Complex emotional nature of abortion. Participants often mentioned the complexity of the abortion experience and most reported that they believed it to be emotional by nature, even if they did not personally experience a significant amount of distress post-abortion. Participant

Three noted:

I don't know any woman who gets pregnant purposely so she can have an abortion... I do think every woman has some emotional response to it.

Participant Two discussed the complexity surrounding the decision to have an abortion and the resulting emotional distress that can result. She explained that, even when a woman makes the decision to have an abortion and feels that she made the right decision, she may still experience associated emotional distress:

A lot of times people assume that the only reason a person has an abortion is because they don't want the baby. And that's not necessarily always the case... Because it's not a situation where she doesn't want this baby, she just knows she won't be able to provide the best for the baby – maybe the best... that she feels the baby deserves. So you can't treat it like, "Oh it's no big deal this is what you wanted..." You have to take into account the emotional kind of ties that may be there, [including] the grief and loss that may be there...

Participant Four, who works at a clinic that provides abortions and estimates that she has worked directly with over 500 patients in some capacity over the past two years, reported that women have many different reasons for obtaining an abortion and respond emotionally for a large variety of reasons. She stated:

People come from so many different places... We get the people who have anomalies... then we have some people that are very confident in their decision and seem to be coping pretty well. And then you have those who are just beside themselves with loss and grief.

Lack of choice and family or partner pressure. When asked about factors contributing to emotional distress post-abortion, five clinicians mentioned that feeling a lack of choice in the decision to have an abortion or feeling pressured into choosing abortion significantly increased emotional distress for women post-abortion. Three of these participants expressed that they had

personally experienced significant emotional distress as a result of feeling that they were at least partly forced into having an abortion at the time by either parents or partners. Two of these three women stated they had regretted having an abortion afterward. The third woman, Participant Seven, did not struggle with regret about having the abortion but still suffered emotional distress as a result of not feeling like she had a choice at the time. All three of these women cried and expressed sadness when relaying their stories.

Regarding her experience, Participant Four, who was 16 at the time of her abortion, stated:

I was told by my parents who are religious that they would not support me financially, that I would need to move out and pretty much kind of be ostracized from the family if my choice was to have this child. So I felt forced into having an abortion, I thought, because my high school boyfriend's family [was] really poor... I come from an upper middle class family, and we wouldn't have been able to survive without their help... [It] felt like...I didn't have a choice... I really felt for the longest time I was forced into having an abortion and nobody at the abortion clinic asked me that. If they would've asked me that at the time, I would've said, "I'm being forced into this." I know it's a question they ask now, but it wasn't a question that was asked of me then.

Similarly, Participant Seven, who was 17 at the time of her abortion, reported experiencing distress because her aunt and mother had made the choice for her to have an abortion without consulting her. She recalled that her mother had noticed that she was experiencing what seemed to be morning sickness and sent her to the participant's aunt's house:

My aunt asked me that day to go home with her and I did. And we went to a clinic and I had a pregnancy test there... She called my parents and asked them what they wanted to do, and they said, "We don't know," and told her to deal with it. And so there was not really a conversation. My aunt was like, "Okay, I'll take care of it," and we went back the next day. But we didn't talk about what I wanted to do. We didn't talk about anything except for that this is what was gonna happen.

Participant Eight was 40 when she became pregnant with what would have been her second child, but her husband at the time was against her having another baby and threatened to leave her if she chose to go through with the pregnancy. She remembered:

He put it to me, “If you go ahead and have this baby, I might not stay.” Those were my choices, and I wanted to keep my family together... My husband and I had gone to talk to my therapist and I just couldn’t find my voice [to] say to him, “I don’t want this.” I didn’t want to be a single mom.

Relationship stress post-abortion. Following the issue of pressure and choice, many participants (n=8) reported that they had observed that relationship issues brought on by the abortion experience contributed to emotional distress post-abortion. Participant Three mentioned that it was especially difficult when partners were not in agreement about whether to abort or not and that she had witnessed consequent distress in many of her patients post-abortion. Participant Twelve echoed this sentiment in reference to one of her patients:

She did not want the child; he was very pro-life. So it was very painful for her. They’re still together, but it was definitely really hard for her... She probably struggled the most around the guilt [than my other patients] because of the partner being very pro-life, and he was not open to discussing it. There [was] really no outlet or support for her regards to him.

Although Participant Five reported that her husband had been extremely supportive, she also noted that relationship issues brought on by her abortion caused her emotional distress. The two issues she noted were that she felt more closed-off and self-conscious during sexual intercourse and that her husband had had a hard time accepting that she wanted to seek outside support to help heal from the abortion. She said, “I would say I was much more... open and free sexually [before the abortion] and now I can feel myself being more contained.” She also revealed, “It was hard for him to accept that I was reaching out to somebody [or] that I would need somebody else.”

Shame and guilt. All participants responded that they found shame and guilt to be common themes that arose for either themselves and/or their patients post-abortion for various reasons. Participants reported that factors that contributed to shame and guilt included feeling a sense that having an abortion was wrong as viewed by the greater society, their religion, their

community, their loved ones, and/or by themselves. As a result, participants also mentioned secrecy and silence as factors that contributed to shame and guilt. This section is divided into four subsections: internalized stigma as a result of religious or cultural norms; secrecy and silence; protestors and stigma in society; and feeling bad for feeling bad.

Internalized stigma as a result of religious or cultural norms. All 12 participants reported that conflict with religion or cultural norms had the potential to significantly increase emotional stress post-abortion. Participant Three discussed how belief systems could increase guilt and shame, regardless of whether that belief system was predicated on religion or not. She remembered patients who believed that they would be “punished” for choosing to have an abortion. Similarly, Participant One recalled a patient who was Catholic and had had a very hard time making the decision to have an abortion. She stated that the patient felt that her later struggle to become pregnant was a way that she was being punished for having an abortion:

I think it was more her conscience and her religion. It was here she decided to abort this fetus, and she had done something sinful. And she was being punished by not being able to conceive.

Five other participants reported that they personally experienced shame or guilt as a result of feeling that their religion, community, and/or family thought that abortion was morally wrong or an unacceptable choice. Participant Two and Seven commented that they did not feel like abortion was accepted by the African-American community and that this made it difficult for them (both who self-identified as African-American), as well as for their African-American patients, to feel okay about their decision to have an abortion or to feel comfortable talking about the experience. Participant Seven reported that she felt her family judged her for having an abortion and assumed they thought she was a bad person, as indicated by their silence on the issue.

Participant Eight spoke about how she felt ashamed within her Catholic community:

I grew up Catholic [with] that kind of attitude... our daughter was in Catholic school, and I would go to church on Sunday and I would feel like everybody in the church knew that I had an abortion... I was so ashamed.

Participants noted that they or their patients often felt shame and guilt as a result of internalized stigma or self-judgment for having had an abortion. Participant Three commented on how “deep” shame runs within the psyche and how hard it can be to counter. Many participants reported they or their patients felt like they were “bad,” “awful,” or “horrible” people for having an abortion.

Participant Four, who, as mentioned above, felt forced at the time by her parents into having an abortion, reported that she felt at the time like a “horrible person who killed her baby.” She stated:

It was heartbreaking because I didn't even want to be doing it... Even before I had my abortion, I always thought as a teenager... it was a choice that should be available, but it was a choice that wasn't for me... And then I did something against my own will, and I was really upset with myself for not sticking up for my beliefs [and] following through with it.

Participant Nine, who had three abortions, admitted that even though she comes from a liberal community and had no religious, cultural, or other belief system that condemned abortion, she grew to believe abortion was wrong. During the interview, she wavered many times, noting that she believes abortion should be legal and that she provides non-judgmental support to her patients who have had abortions, but also that she has grown over time to believe more and more that abortion is wrong. She noted her internal conflict with it and her feelings:

Over time, too, I also noticed that I got more and more thinking it was wrong. Even though politically I thought it was right; personally, as I got older, I found myself thinking it's really wrong. It's really bad. It is murder. I would find myself having thoughts, you know, these people that are bombing or talking trying to detour people at abortion clinics, you know, they have a point. But I secretly think that to myself. I'd never say that out loud 'cuz it's not politically correct... It was a way of getting out of a

major responsibility... I think it made me more spoiled in a sense. It was the easy way out of a mistake. And so maybe that's some of the guilt still talking. I don't know, you know? It's a complex thing.

Secrecy, silence, and stigma. As acknowledged in the literature, stigma and shame often bring compounding secrecy and silence. People feel resistant to discussing things they or others view as unacceptable or wrong and often fear others' judgment. In turn, this secrecy and silence propagates shame further by keeping people from being able to heal from their shame through the various interventions cited by participants and discussed later in this chapter. Participant Eleven explained how she has observed the process of secrecy, silence, and shame:

I think, you know, there's probably a lot of shame associated with not only getting pregnant and then unwanted pregnancy especially in this day and age where there's so many options to significantly reduce the possibility. But then to make a decision like that, there could be a lot of shame and shaming from people who will not believe they had made the right decision... So I think it tends to push a lot of women maybe even more to the underground to... as far as dealing with it, you know, just kind of stuffing those emotions and stuffing that process because they don't have a sense of where they can turn to really talk about it. And if somebody feels ashamed they tend to not talk to anyone.

Participant Nine noted how secrecy and silence create a feeling of isolation that compounds the distress already being experienced. Participant Twelve agreed and described:

There was no social sanction for [abortion]. You know that women who were pregnant and had babies had baby showers. And women who had miscarriages had family and friends support the grief. But women who had an abortion were isolated. Because you shouldn't be telling anybody and no one wants to hear about it and no one knows what to say to you. And yet this huge thing is happening and has happened and you've made a really big decision.

Two participants who had obtained abortions illegally, before the 1973 US Supreme Court *Roe v. Wade* decision, talked about the increased distress that the secrecy around the procedure created for them. Participant Three mentioned that it did not fit her self-concept to sneak around and have to pay under the table. She also reported that she experienced the most

emotional distress from feeling like she could not tell her parents at the time. She noted that she believes it is highly “unfortunate that secrecy keeps women from really talking about it more.”

Participant Seven echoed this sentiment and also reported that she did not talk to anyone about her abortion, at age 17, until she was 30, and that she did not know during that period of time what to say or to whom to talk. She talked about her experience of keeping her abortion a secret:

I think that the part that was the most like traumatic was [the] silence thing... Like always feeling like I did something bad. Like always feeling like my family judged me for it and not knowing who knew or who didn't know. Like I knew who some of the people were who knew obviously. But just like feeling like, oh I think they know. And just feeling like my family judged me for it. That I was like a bad person, you know? And... by just never acknowledging it.

Protestors and pro-life activists. Four participants mentioned that encountering pro-life activists contributed to emotional distress for themselves or their patients. Participant Three mentioned that protestors outside of abortion clinics create an additional layer of “stress” for patients. Participant Four agreed with that sentiment and, regarding her own experience, recalled, “I had to walk past those pro-lifers with their signs, and it was awful.”

Participant Five remembered being in Washington, D.C. for a conference on something unassociated with abortion and feeling emotional distress as a result of seeing pro-life protestors:

There were these really, really, really young girls out with pro-life signs, very disturbing pro-life signs, and there was like a group of our cohort having a discussion, and I had to just get up and leave the area ‘cuz I just didn’t want to be around them... The feeling was discomfort and kind of subliminal, like... having somebody yelling hate crimes to you without yelling them at you but you’re still feeling the hate crime.

Feeling bad for feeling bad. In addition, a common theme that led to silence and consequent shame was when women thought, or believed others thought, that they should not have lingering emotional distress after having an abortion. Participants mentioned the notion that in some circles, abortion is not supposed to be “a big deal” and they should be okay with the

experience, particularly if they felt they made the right decision for themselves. In addition, two participants noted that they had heard the message in the pro-choice community that publicizing emotional distress associated with abortion gives credence to the political pro-life movement. Other women mentioned that being pro-choice made them feel like they were not allowed to be conflicted about their decision or have emotional ramifications. In addition, the majority of women reported having distressing emotions post-abortion even though they did not regret the decision to have an abortion. Participant Seven stated:

Giving women a message that you're not allowed to feel bad is bad. The message should be you're allowed to feel all the ways you feel about it and not just feel good. And that's what I realized made me feel so negative. The idea is that you should be fine. Be happy with the decision and you should be happy after the decision and go on with your life.

Similarly, Participant Nine noted that it irritates her when others talk about abortion as if it is easy:

People need to know that it's a big deal. It shouldn't be so breezy, easy peasy. Oh I'll just do that. I think there's a little bit with some people, not certainly other people, that are just distraught, distraught. But some people it's sort of, oh you know well they just do that and then you're fine. And I don't like that. But you can't have that experience and not feel all that happen to your body and not know it's a big deal.

Participant Five reported that she felt bad for experiencing emotional distress after her abortion. She said:

That actually did come up a little bit with my husband. I think he thought that because of the way I deal with most things in my life that sure it'd be hard for a little bit but then I'd get over it. That it wouldn't come up as much or that it wouldn't like trickle into other parts of our life. I think he had sort of hoped that it would happen and then be done... So in that way I felt a little bit of like I've had some tears around like I'm not strong enough... Like it's normal [and] a lot of people have had [an abortion], so like why am I having such a hard time still?

Loss and grief. In addition to shame and guilt, all 12 participants mentioned loss and/or grief as common feelings that either they and/or their patients experienced post-abortion.

Participants reported that factors that contributed to loss and/or grief included regretting having

an abortion, thinking of the fetus as a human life, thinking about what would have been had the pregnancy not been aborted, and experiencing fertility issues later on. Like with shame and guilt participants reported that women did not have to regret their decision to experience loss and grief. However, participants reported that feeling a sense of regret correlated very much with experiencing loss and grief. This section is divided into three subsections: regret, what if? and fertility issues later on.

Regret. Participants reported that wanting the baby at the time and/or regretting the decision to have an abortion seemed to have a significant negative emotional impact on themselves or their patients. Participant Four regretted her decision because she had wanted to be a mom and felt forced into it. She recalled becoming extremely depressed and suicidal as a result:

I was suicidal; I was so depressed. In my head, I had written notes to people, to family members. I imagined what my funeral would be like. I didn't have a plan as far as how I would do it.

Participant Eight remembered feeling a sense of deep loss for years after her abortion. She reported that she sold her car she had driven in to obtain the abortion and also avoided passing the location where it occurred because they both brought back feelings of loss. Initially, when she would pass the location, she said she would think to herself, "I left my baby there."

What if? Six participants mentioned that grief and loss can show up in the form of wondering about what would have been had they or their patients not gone through with their abortions. As consistent with prior literature, Participant Nine reported that some of her patients remember the anniversary of their abortion every year, what the child would look like, or what the child's age would be currently. She recalled that she had had those thoughts too, "but not in that type of obsessive way where it was still so present years later."

Despite not regretting her decision to have an abortion, Participant Three remembered feeling distress when thinking about what could have been had she decided not to terminate the pregnancy:

It opens up wounds when you do get pregnant then and you want a baby. You know you often think about the baby you decided not to have. I know when I see somebody... say they were born in 1968 or 1969, I often think, 'Wow, if I had had a child, they would be this person's age.'

Participant Twelve stated that she did not see how it was possible for women not to think about what could have been had the pregnancy not been terminated. She elaborated on the emotional struggle that this creates:

There's no way that you can't help but think 'what if?' And very, very conscious that this isn't just, you know, tissue that I'm getting rid of. And that's what makes me so upset about, you know, the protestors thinking there's no consciousness about what one does when they decide to have an abortion. You're giving up the potential of a life.

Fertility issues later on. Many patients reported that they or their patients experienced emotional distress as a result of having fertility issues later on that prevented them from being able to become a biological mother. They often described how the loss of the dream of becoming a biological mother led them to feel a sense of loss and grief associated with their abortion experience. For example, Participant One had a patient who was struggling with issues of infertility. She related:

[My patient] was extremely, extremely angry with herself and grief stricken. In the context of trying to get pregnant - that was all she could think about—that she'd given up this child.

Participant Two and Four both disclosed that they had struggled with fertility issues in the past few years and that this challenge brought up grief and loss associated with their abortion experiences. Participant Two expressed:

Obviously there's sometimes I wonder, 'If I had not given up a baby before, would I be a mother today?' One of the things in my life is I've always wanted to be a mother, and I

knew making that decision at that time could have affected me ever being a parent. And there's still sometimes in my life even now. I was 22 at the time, and now being 34 and wanting to be a mother and being in a position where I'm ready to be a mom and not being able to be a mother, there's just a whole lot of emotional stuff around that.

Participant Four had a similar experience:

So I think the kicker is for the last four years, I've been trying to get pregnant now that I'm married and have a career and a stable relationship. And I can't. So, lo and behold, that was my one chance, and I really, really always wanted to be a mom... And so now that I can't have kids, like, it kind of was all brought up for me again.

Furthermore, some participants described the fear of not being able to get pregnant later on that some women experience post-abortion. Participant Ten stated, "It could've been really bad if I had had these two abortions and then didn't get pregnant."

Location. Four participants talked about how the care or lack of emotional support at the facility where the abortion occurred could impact patients' feelings about their abortion afterward. Two participants used the word "assembly line" to describe the way it felt at the clinics they obtained their abortions. Participant Four remembered that there was no emotional support provided and that the location felt "emotionless" and "cold."

In accordance with the responses of other participants, Participant Seven described how important it is for women to have a good experience at the location where they obtain an abortion, and that a bad experience can lead to emotional distress. She stated:

The experience of the clinic... makes a huge difference... Certainly what people need and don't need is pretty clear but they don't always get that at a clinic... it's cattle-like. Some people are like, "I just felt like... they weren't being super supportive." ...A lot of times what really comes up [when women are talking about their abortion] is... not having a good feeling where they had their abortion. And that makes a huge difference in terms of... how you feel in general about your abortion.

Although Participant Five remembered that her doctor had been supportive, she also remembered having the option of whether to allow a male medical resident sit in on the procedure and feeling that this resident's demeanor made her feel uncomfortable. She recalled:

I remember that the resident felt uncomfortable to me. He was male, which I was really like excited there was a male abortion provider... I would've loved for him to have a little bit better bedside manner. He came in uncomfortable; he didn't look me in the eye. Like, there's some dignity there that he could've given me. And it wasn't a direct threat; it wasn't insulting [or] any of those things. It was he didn't feel comfortable in the room.

Participant Ten described how the contraceptive counseling provided in conjunction with her abortion felt shaming:

I wasn't trying to use this as a method [of contraception]. That's what they were saying, you know, "Are you trying to use this as a method of birth control?" And, no I wasn't... That was shaming. That was very shaming. Like you know, like, "Come on, woman ...how stupid are you?"

Participant Three had a similar experience, remembering that the nurse in the recovery room whispered to her, "Next time you'll use contraception."

Associated trauma. Five participants mentioned trauma associated with the abortion experience led to emotional distress post-abortion for themselves or their patients. Many women actually could not remember specifics about their abortions, though many attributed this lack of memory to the time that had passed since the abortion. However, Participant Two indicated she had a traumatic response to her abortion experience in the sense that she could not remember specifics. She stated:

I honestly have blocked out everything else around it... I have experienced a lot of trauma in my life... when I was younger and so... my way of dealing with that trauma has been to block it out... I think that I used that same kind of coping mechanism around this issue... It's sad. I can think back on it as a clinician, but I can't think back on it in the moment.

Participant Nine reported that she felt traumatized by being awake during the procedure and feeling the abortion occurring and then having to see what had been removed from her womb afterward:

The first time [I had an abortion], I saw it in this container... You feel it... your insides getting sucked out of you... That first time was the most traumatic... Yeah that's awful. Just that they had that there... They shouldn't have had that thing there for me to see... I

mean it's so hard to go through it. I could almost see why you'd want to be asleep, but then I don't think you'd really get what you're doing. Probably good you're awake. I was awake.

Participant Twelve reported she had flashbacks every time she heard her neighbor's coffee grinder, since it reminded her of the machine that was used to perform the abortion. She stated, "I never even listened to her coffee grinder until afterwards and then it was like every single morning until she moved; it was just horrendous."

Participant Three and Participant Six also mentioned that they had worked with patients who had become pregnant as a result of rape or sexual abuse, which, they stated, unsurprisingly significantly increased those patients' emotional distress following the abortion.

Presentation of distress. This section includes two subsections: other related feelings and non-linear healing process.

Other related feelings. Participants also mentioned other emotional states that are commonly associated with distress in conjunction with either feelings of shame, loss, and/or trauma. Four participants talked about detachment and repression post-abortion. Participant Nine, who had three abortions, described how she became increasingly numb to the experience each time she had an abortion. Participant Two reported that she could not remember most of the details or events surrounding her abortion and had compartmentalized the experience.

Participant Three recalled, "I just was cut off from my feelings."

In addition, five participants brought up anger as an emotion they felt toward others in their life regarding the roles they played in their abortion experience. Participant Three, for example, reported feeling a lot of anger toward her boyfriend who had gotten her pregnant, while Participant Four reported similar feelings toward her parents, who had insisted she abort her pregnancy.

Non-linear healing process. Many participants reported that the emotional healing process after having an abortion was not necessarily linear and that women could experience emotional distress at various times post-abortion. This finding is consistent with the literature on healing from both trauma and loss. Participant One affirmed other participants' comments and spoke at length about different issues that could bring up emotional distress associated with the abortion experience. She conceptualized the healing process as dynamic and something that often occurs at different associated developmental phases, such as during a later pregnancy, when having children later, when a woman's child is the age she was when she had an abortion, or when fertility issues arise. She added:

Making a decision isn't necessarily going to be the end of it. So...having the abortion or having the baby doesn't mean that you're at peace with... where you've gone with it or what decision you've made about it.

Participant Three noted how emotional distress associated with the abortion experience could be triggered unexpectedly:

I often warn people too it may come up again. You know someone may be talking about abortion— just the subject of abortion— and it will flood them or trigger them... There may be countless things that could trigger a feeling of just wanting to cringe or you know draw inward or run away.

Factors that Help Prevent Emotional Distress Post-Abortion

When asked about factors that contributed to preventing emotional distress post-abortion, participants mostly spoke of their own experiences. Clear themes emerged. The two most commonly cited factors that participants reported prevented emotional distress post-abortion were feeling supported by others and feeling a lack of conflict surrounding the decision to have an abortion. The data in this section are presented in the following sequence: supportive partner and/or other supports, lack of conflict surrounding decision, and relief of being able to conceive.

Supportive partner and/or other supports. As discussed earlier, participants routinely cited a lack of support as a factor that led to emotional distress post-abortion. Conversely, participants often cited supportive loved ones as protective factors in preventing emotional distress post-abortion. Four participants spoke about supportive partners, family members, and/or friends who supported them through the process.

Participant One remembered how helpful it was to have a partner who concurred with her decision, was supportive, and was not coercive in any way. She stated:

We were completely in agreement about doing this, and he was in the middle of graduate school, but he took the time off, and he came and he was with me... through the whole process... I think it would've been a very different path we would've taken if he had been pushing me to have the child and I didn't want it, or pushing me not to have the child and I did want it.

Similarly, Participant Five contrasted her experience with a supportive partner with that of a single friend. She recalled she and her husband called her abortion "our abortion," whereas her friend called it "my abortion" and felt a lack of support. She discussed that the support of her husband served to normalize the experience and make her feel less alone.

Lack of conflict surrounding decision. As discussed above, many participants reported that either regretting or feeling conflicted around the decision to have an abortion could significantly increase emotional distress post-abortion. In contrast, four participants discussed how a lack of conflict around their decision to have an abortion protected them from experiencing emotional distress post-abortion. Each of these participants reported that they did not believe personally that abortion was immoral or in conflict with their religion or belief system, nor did any of these participants experience pressure or judgment from loved ones. Both Participant One and Six stated they had "no doubt" in their minds about their decision. They

both felt certain they were not ready to be mothers, and they had the support of their partners. Participant One also mentioned, “It was never a child in my mind.”

Participant Three asserted that she did not feel “too badly” about her abortion because there was not a lot of shame or guilt in her family, it was early on in her pregnancy, and she had not planned to get married or have children at that stage in her life. She also recalled how she felt supported by her college roommate, who had also had an abortion.

Participant Five recalled that she, too, was not in a contemplative space around the decision to have an abortion and had made a “firm” decision with the support of her husband. She reported she felt comfortable with abortion from her work in the field and that it was extremely helpful to have her doctor’s support as well:

My doctor was absolutely remarkable... My husband’s older than me and he wants kids... I don’t know if I would’ve had the courage to bring [the possibility of abortion] up myself. She brought it up and... the ability to take that off of me was something I will never be able to thank her enough for. And she said, “You know you can have an abortion today and you can have a baby in a month, and I would still think it’s a good idea.” And that’s really empowering— to have a provider who’s that firm a believer in choice. So she created that space for us to even bring it up.

Relief of being able to conceive. Two participants mentioned they were relieved when they became pregnant because they had not believed that they had had the ability to conceive due to medical issues. Accordingly, they also did not feel as guilty as they might have felt about accidentally getting pregnant. Participant Ten conveyed that she did not experience emotional distress around her abortion for that reason:

I didn’t experience it as a loss. I kind of experienced it as a growing... The abortion and the pregnancy were kind of one. And the fact that I could get pregnant was fantastic to me because the way [my doctor] had made it sound was, “You aren’t gonna be able to have kids.” And that was what gnawed at me... I didn’t want a baby then, and so that I was really clear about. And my husband, both of us were. But I was very, very relieved that I could conceive.

Interventions to Mitigate Emotional Distress Post-Abortion

The most common characteristics of interventions recommended by participants as most helpful to mitigate emotional distress post-abortion included creating a safe space free from judgment for patients to talk, process emotions, and feel supported. This finding is consistent with the literature on countering stigma and shame. The most commonly cited sources of obtaining this support included individual counseling and connecting to other women who have experienced abortion, whether that be through a support group, talk line, informally, or in another way. Close, supportive relationships were also commonly cited as a source of support. All participants also believed that more emotional support services should be offered to patients by facilities that provide abortions. Services most often recommended included psychoeducation about the emotional component of abortion and referrals to counseling, support groups, and other resources for obtaining emotional support and connecting to others who have experienced abortion.

Sources of support. This section contains three subsections: ongoing counseling, twinship, and close relationships.

Ongoing counseling. Most participants (n=11) cited individual counseling as potentially beneficial in helping women heal from emotional distress associated with the abortion experience. Five participants, who felt lingering emotional repercussions from their abortion experiences, used therapy themselves for this purpose. Many participants described specific clinical interventions that will be described later in this chapter.

Participant Five cautioned that some women need professional support due to “serious trauma” that can occur around the abortion experience. While she did not obtain therapy for this reason, she reported that couples counseling has been helpful for her and her husband and that

she would like to attend therapy to deal with the impact that the abortion has had on their sex life. She stated:

Our sex life has been greatly impacted by it. I mean we talk about it. It's there. We've discussed it, but it doesn't mean that it's any easier... I'd love to like do some deep sex therapy work to like sort of get at that... and luckily I have a partner that I can even talk about it with.

Twinship. Seven participants talked about how helpful it was for them or their patients to connect with other women who have experienced abortion. They often stated that these connections helped them heal through feeling supported and that they were not alone.

Participant Two reported that she never went to therapy to discuss her abortion but instead reached out to other women who have had abortions. She stated, "I'm a very resourceful person, so if I feel like, 'Oh, I need to address this emotional wound in my life,' then I will figure out the best way to do that, and I feel like I've been able to do that through reaching out to other women who have had abortions." She elaborated on how connecting with other women after experiencing a miscarriage has helped her heal from her abortion:

[Speaking to other women makes me feel that] I'm not going through the emotion alone. It's huge seeing there are other women out there who feel that they made the right decision but still have these feelings around the decision that they made. I think that having people... kind of affirming the fact that I made the right decision for me at the time.

Participant Seven echoed this sentiment and spoke about her desire to hear about others' experiences:

I really just wanted to connect with other people who had the abortion experience and share and also listen. I really wanted to listen to other people. I really wanted to hear other people talk about their experience, and I didn't have any place for that.

Similarly, Participant Four advised how helpful it was to be able to talk about abortion with others who had experienced it:

I think what was truly important is to be able to talk about it and not have the stigma around abortion. To be able to talk to other women and know that they've been there before— that they had abortions as well— just knowing that you're not alone... And yeah it's really important to be able to share the experience and know that, okay I'm not the only one who's done this and I'm not the only one who feels lost. And I'm not the only one who felt regret.

Participant Five reported that she had phoned a talk-line that provides peer-to-peer counseling by women who have also had abortions. She stated she felt it was particularly helpful:

I loved the idea that there were people on the other end of the phone who had gone through it too... She told me what it felt like for her, and that's why I think peer-to-peer is so great, because I want to hear somebody else, and your friends aren't the same. I mean it's like why people go to therapy. It's neutral. It's like, "Yeah, you're totally right," or, "Am I gonna feel crazy about this?" or, "What if I want to shut down?" Or things I might not have said to my friends... Maybe even the fact it was over the phone I felt even more comfortable.

Participant Nine reflected that she thought a support group might have been helpful for her. She recalled the experience at the clinic and that she would have liked to connect with the other women. She said:

I was just reflecting earlier if having any kind of group support or people I didn't know would've been helpful. Because of all the people you see in the waiting room and that you see when you're in the back preparing and then the aftermath. They're all in there. And you're all kind of looking at each other but not really saying anything. It's kind of awkward. But you have so much you would say. But you don't want to intrude on anyone's privacy. It's such a private matter but it's sort of public and they're strangers. It's weird.

Another important topic brought up by one of the two African-American participants and the only self-identified lesbian participant concerned the importance of accessing support from other people like her who had had an abortion. She noted that it was important for both her patients and her to see people who looked like them racially and who identified with the same race, sexuality, or gender who had also gone through abortion. She relayed:

The other kind of thing for me being a black woman is that talking about abortion... is not something we usually do in the community of black women. And so having some type of support group in place so I could see women who look like me who are going through the kind of thing I'm going through would be huge. Another kind of aspect of that is I also identify as a lesbian. So in that kind of conversation when a lesbian woman has experienced a pregnancy loss there's so many other feelings and emotions that the world has about that and so having someone that looks like me in that sense as well to talk to would [have been] helpful.

The theme of accessing nonjudgmental support from others who have experienced abortion will be discussed further later in this chapter.

Close relationships. In addition to accessing support through therapy or other people who had had abortions, eight participants mentioned that they or their patients leaned on people they were close to for support during their healing process. Participant Two recalled:

I had really great significant others in my life who I have been able to open up to and talk to about it, and they have helped me. They have been my listening ear even though they didn't have the mental health, social work, or psychology [background] I had, they were still very helpful in me getting beyond kind of the regret and disappointment in all the feelings that I had. 'Cuz I was still carrying those even up until you know maybe a year or so ago.

Shame and guilt. In speaking about healing from shame and guilt in conjunction with the abortion experience, participants specified certain interventions and aspects of support that were most helpful to themselves and/or their patients. This section contains four subsections: elements of support; breaking the silence; reframing the experience, self-forgiveness, and self-compassion; and separation and individuation from family or belief system of origin.

Elements of support. As mentioned in participants' responses in the above section on Twinship, all 12 participants mentioned the importance of women having non-judgmental support in order to move past guilt and shame that can be associated with the abortion experience. Participants commonly identified that it was important for women to have a safe

space that allows patients to talk, process emotions, feel supported unconditionally, have their feelings accepted and validated as okay, and just have someone be there for them.

Participant Seven explained her philosophy when working with patients is to focus on making sure they feel supported without judgment because “after care is really about filling an emotional need.” In addition, she spoke at length about the importance of creating a space for women to “honor” their abortion experience so that they can talk openly about their story in whatever capacity they need.

As discussed previously, many participants cited the benefit of connecting to women who had also experienced abortion, whether through support groups, talk-lines, or other venues. Participant Ten mentioned that it could have been especially helpful for one of her patients, whom she described as “racked with guilt and shame,” to join a support group to connect to other women who had experienced abortion. Participant Seven connected the efficacy of twinship to a nonjudgmental and safe quality. When asked what she thought was most helpful for women post-abortion, she said:

Being able to connect with other people... who had a similar experience and who can listen and talk to you in a nonjudgmental way, and feeling very safe, also. Because you know that the people you're talking to or the person you're talking to won't judge you the way other people might.

Many participants (n=7) spoke about the importance of making sure patients know that it is okay for them to feel a range of emotions, regardless of whether they regret their decision.

Participant Twelve touched on the importance of validating patients mixed emotions and affirming that it is okay for them to “know it's the right thing to do but still feel terrible.”

Participant Four said that she believes women mostly need a nonjudgmental and supportive environment open to whatever the patient's experience may be, so that patients have the opportunity to process whatever emotions they feel, whether that be regret, sadness, anxiety, or

even relief. Participant Two reiterated this approach and described that she had found it effective to encourage her teenage patients to process all emotions in order to heal:

[I'll] just kind of reiterate and make sure that [my patients] have the full understanding about [their] feelings and that it's okay to feel guilt, and it's okay to feel remorse, and all of the feelings that you may feel, it's okay to feel. And so I think for those who were able to continue to open up and talk about it were in the place where they were able to heal more quickly, and, when I say healing, I don't mean that there's no thoughts or no pain around... what happened with them. But [they get to a] place where they're able to function again.

Participant Eleven referenced the importance of helping women “sort out” their emotions with respect to regret. She said:

You know there's always gonna be regret whether you regret your situation— or for some women, regret that they had the abortion— and so being able to sort through their kinds of emotions I think is really important.

Many participants (n=6) spoke about the importance of “just being there” for their patients to support them. Participants Seven and Ten both mentioned that “just listening” was most helpful in their professional experience. Patient Seven added that providing empathy through “understanding” and the sentiment consistent with, “I support you and I get it” are paramount and much more so than providing specific feedback. Participant Nine also noted the helpfulness of “just having somebody be there who's understanding” to ask the “right” questions and encourage patients not to be too hard on themselves. Participant Five remembered that she just wanted “to be held and heard” when speaking about her abortion.

Two participants who were raised Catholic mentioned that having a Christian or Catholic therapist accept them made it easier to heal from guilt and shame associated with their religion's disapproval of abortion. Participant Eight reported that she went to therapy for a long time and found it helpful, particularly that her therapist was also Catholic and “came from a place of

acceptance and understanding.” Participant Eleven explained how her therapist’s acceptance was powerful in her healing process:

There’s of course all of that in there— that even your therapist could judge you. Because it happened to be my therapist was Christian, not Catholic but Christian. So there was a concern on my part that my therapist may judge me. And so you know there was I think a part of me that still wanted to rationalize you know the situation I was in and... why I made the decision I did, even for my therapist... But, you know, I never had the thought that I was being judged... I felt just, you know, totally accepted... So that piece helped me then to be able to process it at a deeper level... and the strength of [her] kind of unconditional love. No matter what bad things I’ve done or bad decisions I’ve made... That in my therapist eyes, I was still lovable.

Breaking the silence. As discussed in the section on factors that contribute to emotional distress post-abortion, participants often reported that silence due to shame and stigma often contributed to emotional distress post-abortion. This section presents participant responses that describe how breaking the silence and talking can be healing.

Participant Twelve noted that she talks to patients about how discussing abortion can be seen as taboo in society and that it is important to know that it is okay to talk. Two participants mentioned that it was empowering to them to even say the word “abortion.” Participant Eleven reported that she educates patients about shame and the importance of talking in order to counter shame and heal:

I would normalize their fears and anxiety of what people might say or think. And help them get a sense of their own empowerment, that they get to choose who they talk to about it. And helping them to understand if there is a shame component that just fosters the secrecy or keeping it to yourself or not talking about it. And yet being able to talk about it sometimes can be an important piece in the healing process... So [it’s] just kind of educating clients about how shame works and what shame looks like and how to counter shame, so that they are able to not beat themselves up for what’s happened to them and the decision they’ve had to make. And to be able to fix the core, because if you can’t even talk about it, you’re not gonna fix the core.

Participant Three mentioned that speaking openly about her abortion helped her heal. She reported that she was able to do so more easily when she moved across the country and felt

more anonymous, in addition to feeling more confident at that point in her life, six years after her abortion.

Participant Four reiterated others' comments about providing a space for patients to express their emotions since some women have not told anyone that they are having an abortion.

Regarding the immediate aftercare provided at the clinic where she works, she said:

I mean, sometimes nobody else knows that they're there. And we're the only other people that they can talk about it with or even have an emotion in front of because not another soul knows they're doing this right now... It's totally free of judgment. It's their experience and it's their emotion.

Participant Seven, who did not talk about her abortion for 13 years after it happened, reported that she experienced a lot of healing in sharing her story and becoming open about her experience, which, in turn, resulted in healing through hearing more about other people's experiences and feeling less alone. She said, "You can think a lot of things in your head, but until you verbalize it, you can't really process the entire thing." She also detailed how she talked to both her mother and aunt about her experience in which they were both involved. She reported it was healing for her to have it out in the open, given misconceptions she had assumed about their judgment of her. After learning that both her mother and aunt thought about their role in her abortion on a regular basis, she said she felt relief and less alone. She reported it was important for her healing to hear their own struggles around the experience and that they did not judge her for it. Through these conversations, she also learned that her aunt had had an abortion. She stated:

[My aunt] said she thinks about it every time I have an accomplishment 'cuz it wouldn't have happened if I had not gone to college and graduate school and all the things I've done... But one of the things that happened in that sharing was she shared her own abortion experience with me... If she had not been so walled off about it or [had] shared her own experience, it might have made me feel less alone.

Reframing the experience, self-forgiveness, and self-compassion. Other aspects of recovering from shame and guilt that participants (n=9) discussed included the process of healing through self-compassion. By either reframing the experience to see it in a more positive light, letting go of some of the self-judgment, and/or engaging in self-forgiveness, participants noted that they and/or their patients were able to heal from shame and guilt.

Participant One, Eight, and Eleven spoke of helping Catholic patients forgive themselves.

Participant Eight recalled a particular case:

I asked her in session one day, “Well, do you think God has forgiven you?” And she said, “Yes.” I said, “Well, have you forgiven you?” And that really shifted her ‘cuz she could say no but understand that it was okay for her to forgive herself.

Many participants spoke about helping patients reframe their abortion experiences to recognize the positive aspects of the experience. Participant Two related that she tried to focus on a strengths-based perspective and how strong the patient had to be to make the decision to have an abortion. She talked about helping patients recognize that they made the best decision for themselves at the time without letting others’ judgments color that. If the patient regretted her decision, she would try to help her explore why she felt that way and consider alternative perspectives regarding the decision she made.

Participant Four, who stated she had been to workshops on abortion counseling and read a book on the topic, reported that she personally benefited from reframing her thoughts about her abortion experience to consider that she would not be able to be a successful nurse helping hundreds of women every year had she not had an abortion. She relayed that she learned some of this reframing technique from the aforementioned workshops and texts that encouraged counselors to ask open-ended questions to allow women to talk about whatever they feel

following an abortion. She noted she has learned the importance of helping patients understand their internal conflict and reframe around their guilt:

Is it a moral conflict rather than just conflict? Where is the conflict coming from? And then reframe it in a positive way. For example if they feel selfish... but yet their situation is they have four kids and they're on welfare and they just can't financially support another child. You know, it's like this is a loving decision that you've made for your other children and yourself. So, reframing it in a really positive light.

Participant Six described a breakthrough with a patient around reframing her narrative of her abortion experience:

I got her [when] I used the word 'survivor.' [She] survived this incredible experience. So it was kind of like doing trauma work where you have to redo it and redo it and retell it. And the narrative becomes a little bit different when she starts accepting this is the right thing for her to do.

Participant Eleven used the word "rationalize" to describe her process of reframing her experience:

When I was in therapy and talking about it, I had a way of rationalizing it that made it okay for me, not okay enough to talk to just anybody about it, but... I had to make it okay for myself... that I had gotten into this position first of all and secondly had to make the decision that I did. And so for me, rationalizing it I think really helped me... to be able to deal with the whole circumstances of it in many ways.

Participant Twelve also described how she reframed her experience to view her second abortion as a wake-up call. She reported she was at the time engaging in promiscuous sexual behavior that she recognized as self-destructive in hindsight, and her abortion showed her the consequences of her actions and helped her adopt a healthier lifestyle. She said that she looked at her abortion as a sacred event, and referenced this perspective in the book *The Sacrament of Abortion* by Ginette Paris. She called the book "terrific" and stated that she came to view her abortion experience, although very "painful," as a "sacrifice of that kid to preserve me."

Separation and individuation from family or belief system of origin. Five participants talked about how separating from the belief system they or their patients were raised in helped

them or their patients let go of some of their guilt or shame. Participant Six spoke of helping teenage patients see that their belief system might not allow room for their abortion experience.

She said:

I talked about it like... they were becoming young adults and they could live their own lives for themselves. So to speak to [Eric] Erikson's *individualization and separation*... [I would say,] "As an adult, you make your own adult decisions. And I understand how hard that could be given the fact that you've lived 18 years or 19 years under your parent's guidance and values and ethics." So we talked about that, too.

Participant Eleven recalled her own experience separating from the religion of her family of origin:

That was the point in time in my life I think that I rejected... my religious upbringing. It was just not in line with who I was and who I wanted to be. And I just knew that for my own mental well-being— spiritual well-being— that I should reject that.

Loss and grief. In speaking about healing from grief and loss, participants mentioned accessing support through individual counseling and twinship as discussed previously.

Participants also reported specific interventions that they administered with patients. One participant also spoke of her own experience utilizing a website called *What to Expect* to access support from other women who had experienced pregnancy loss. This section contains three subsections: grieving ritual, stages of grief, and what if?

Grieving ritual. Three participants described grieving rituals that they would do with patients to help them move on from their grief. Participant Three described:

I try to use visualization in terms of letting go... so usually visualization and a sense of letting go and after they've had the abortion usually I do a whole visualization regarding kind of cleaning out the womb. Being able to make a place, a nice healthy place [so] when you do want to have a child, you know it's real cushiony and you'll clean it out and everything will be fine. So I do visualization afterwards.

Participant Nine referenced an intervention she would perform with patients experiencing loss to help them say goodbye to the lost baby. This involved a Gestalt technique of having them

pretend to have the unborn child in a chair and role-play the process of saying goodbye.

Participant Twelve described a similar objective through the type of rituals in which patients engaged:

I don't know exactly what [one patient] did other than do some writing. But [for another patient], we talked about a specific day that she would dedicate some hours to, that she would maybe have some possessions or things that she would use symbolically... and talk about saying goodbye. I don't know if she buried something or not. She might have. But to make it more tangible to say goodbye.

Stages of grief. Two participants specifically described elements of Elizabeth Kübler-Ross's *Five Stages of Grief* to help patients heal from grief and loss post-abortion. Other participants referenced parts of these stages, like bargaining, anger, or denial, but did not mention Kübler-Ross specifically. Participants Two and Six both provided psychoeducation to their patients around stages of grief so that they could understand the process. Participant Two stated:

[We talked about] understanding the stages of the grief and loss process. And that it's not linear; it's something that's gonna happen that can happen cyclically. And it's okay to have all of those feelings. And so really helping her to understand, trying to help her understand some of the basic emotions she may go through even though, you know, we can't always say, you're gonna feel this way about whatever just happened to you. But studies have shown that most people go through these stages. And so these are what the stages are so these are the things that you can look for so that you're not freaking out about what's going on... Because this is something I thought I wanted to have but now I'm feeling guilt around it or I'm feeling like I need to bargain with someone to bring back my child.

Participant Six recalled using Kübler-Ross with a specific patient:

This was a loss for her because even though she was 17 years old, she always wanted a baby, so I talked to her about what are the loss issues involved and what are the feelings that go around this. So I took a little bit of psych education about depression and anger... the bargaining [and] acceptance. Acceptance that she made a good decision for herself and also that you're only 17. You have many years ahead of you of child bearing years. She was still getting her periods regularly. I mean she started to get about three or four after her abortion. And she felt good about that and we talked about who is the kind of husband you would like to have a child with? Would kind of look forward to the future with her. And that really helped her with the acceptance part.

What if? Participant Five reported that it was helpful for her to know behavioral techniques “to push out the negative thoughts of the ‘what if’s?’” as part of her education, which allowed her to refrain from this line of questioning. She reported, “I don’t let myself go there... I’m not stuffing it, but I’m not exploring it.”

Two participants also discussed using reframing as mentioned in the *Shame and Guilt* section above, including helping patients normalize the abortion experience and coming to understand that, in giving up the baby, they were also gaining something in some way.

Other clinical interventions. This section includes two subsections: healing trauma and working with adolescents.

Healing trauma. Two participants talked about specifically working with their patients to heal from trauma experienced in conjunction with the abortion experience. Participant Six talked about using Judith Herman’s *Trauma and Recovery* theory to help women heal from trauma associated with the abortion experience.

Working with adolescents. Participants Two and Six both spoke at length about working with adolescents who had experienced abortion. They both reported using psychoeducation to help them understand the development of their ego strengths and how to utilize certain ego functions to both perceive the situation and cope successfully. Participant Six mentioned also teaching adolescent patients about *Roe v. Wade* to help them feel supported by the fact that society chose to support abortion.

Healing through other life experiences. This section includes two subsections: having children and becoming a parent, and passage of time.

Having children and becoming a parent. Three participants mentioned that it was healing for them to have healthy children after their abortion(s). Participant Three had her first child nine years after her abortion and recalled that it helped her heal. She stated:

That's a joyous occasion. That's something you purposely choose to have... It's a pregnancy you decide to keep and so that really helps heal.

Participant Eleven went into more detail about how giving her children support that she did not have growing up provided a reparative experience. This experience, she reported, helped her heal from her abusive childhood and the emotional distress associated with her abortion:

I haven't talked to my children about [my abortion]. And never really felt that I needed to necessarily, although I always [used] a very non-judgmental... stance... [I told them], "I always hope, no matter what it is, that you will know that you can come and talk to me about it, and I will love you unconditionally. I will support you in whatever kind of decisions need to be made..." It was a difficult situation for me back in the day. I felt like I learned so much about how to be... a loving supportive mother for my own children... It created a corrective experience for me because I was able to give to my children what I really needed... For me to be able to give my children that peace that I didn't get... it's kind of like the re-parenting theory... how to take care of the child in yourself.

Passage of time. Five participants mentioned that the passing of time was healing for them in overcoming distress post-abortion. Participant Three stated:

It's been so many years. I think I really made peace with the fact that I made that decision, and, you know, I think maybe it might have been more hurtful for the first six or seven years, and then it began to fall in the background.

Participant Nine echoed this sentiment, "The farther you get from the experience, the more we sort of come to accept it and it's in the past."

Opinions on services that would help patients further. This section details participants' responses regarding emotional support services that they believe should be offered at locations that provide abortions. This section is divided into two subsections: offerings that were helpful and what should be offered.

Offerings that were helpful. Only two participants recalled that they accessed emotional support services that were either provided by the facility where they obtained an abortion or referred to by the facility. However, multiple participants also stated that they did not remember if services had been offered due to the overwhelming nature of the procedure or because so much time had passed. Participant Five reported that she knew to ask for referrals given her history of working in the field, but that she also believed referral information was provided in a packet that she received after her abortion. She was referred to Exhale, a talk-line that provides peer-to-peer counseling by women who have had abortions themselves. As reported above, she found her one phone call to be helpful in healing from emotional distress associated with her abortion.

Participant Twelve reported that she obtained support counseling through the clinic where she had her second abortion. She remembered that she felt better after the session, but also recalled that she had wished the session had taken place elsewhere, as it was triggering for her to return to the clinic.

Participant Seven did not utilize counseling herself at the time of her procedure, but reported that she knows that the talk-line, Backline, comes highly recommended by professionals in the field of abortion work. She stated she believes that their counselors are taught to let people lead the conversation.

Participant Four described that the clinic she works at provides counselors who refer patients elsewhere post-abortion if they are having a lot of struggle with their decision. She also mentioned the Backline hotline as a common referral and noted that counselors also make referrals to outpatient mental health clinicians, because her facility does not have the resources to continue to provide support longer-term. She stated, however, that the clinic definitely tries to provide resources and referrals for patients.

What should be offered. All 12 participants responded that they believed that emotional support services should be offered post-abortion by facilities that provide abortions. Participants suggested various ideas about the type of support that should be provided. Ideas included psychoeducation about the nature of post-abortion distress and what to expect; referrals to counseling services, talk-lines, support groups, or other emotional support services; and counseling and groups provided directly by the facility.

Many participants reported that they believed facilities should educate patients on the possibility of feeling emotional distress post-abortion and referrals for services that might help alleviate that relief. Participant One reported that she thought it would be helpful for facilities “to make women aware that they could have some reactions,” that “counseling would be available and advisable for them,” and that they could return to the facility to obtain counseling or referrals at any point post-abortion. Participant Eleven stated:

I would say yes if the facility that provides abortions could give referrals, wow that would be awesome. At least you know the words of you know saying it might be really helpful if you can find someone to talk to whether it's a therapist or a loved one, somebody that feels safe for you to be able to just kind of sort through anything that comes up after this. It'd be you know in your best interest... And even just ask, “Can I help you with you know some referrals? Or is that something you'd like to do on your own?” It's so, so important for women to know that they have choices. So even just offering a quick list of help— it should just be very open-ended and let them know that they can make that choice themselves.

Participant Two spoke to how helpful it could have been for her to have some psychoeducation around what she might have gone through emotionally post-abortion. She reported:

I was young and I was in college and I wasn't telling anyone about [my abortion]. And so the situation for me was, if I had had that even at the clinic, if someone would have given me a packet of information like the doctors do for everything else we have surgery for, right? Just to say at least you know these are some of the feelings you may have and these are some of the places you can look for information. I think that would have helped me by leaps and bounds. 'Cuz it wasn't a conversation to have with my mother who I was

living with at the time. It wasn't a conversation to have with the person I was in a relationship with. So it was it was just so much. It would've been helpful to have that extra kind of piece there... I just recently had my wisdom teeth taken out. And so after that they told me what I should expect, when to take my pain medicine, what kind of feelings I may be having like the actual physical feelings. How the medication might make me feel. All of that information was given to me the day of my surgery, right? And so my thought process is... [post-abortion], some information should be provided around grief and loss and these are some of the feelings you may feel and these are some of the places you can go if you want to remain anonymous or if you want to have additional support... I think that would be very helpful.

Many participants (n=8) referenced that facilities should provide follow-up counseling to patients post-abortion or at least referrals for counseling. Participant Six mentioned that clinics should call patients afterward to follow-up and ask how they are doing and if they can refer them on for more services. Participant Twelve specified that she believed clinics should provide support post-abortion but that those services should be provided elsewhere so that patients do not have to encounter protestors each time they return to the clinic. Participant Five responded, "Whether it's a peer or a clinician, could you imagine if we all knew that Planned Parenthood also had this ongoing counseling service that, even 20 years out, you could call and go in and meet with somebody?"

Participant Five and four other participants suggested that clinics should offer peer-to-peer counseling and/or support groups or referrals for such services post-abortion. Participant Five noted that in addition to feeling supported from people who truly understand, a peer-to-peer network could serve to break down stigma on a broader level. She stated:

Imagine if the network was spreading the knowledge and the awareness through us: the people who've taken advantage of the service of the resource. And [abortion] doesn't have a face; I think people think abortion is the rape victim [or] the 14-year-old or it's a conscious choice after your third child or before your first... But, I mean, peer-to-peer support—we know that works for alcoholics anonymous and other things. I would've loved to have been able to reach out to a person that I don't know to be able to provide some additional and ongoing support. And to know that seven steps back somebody could still call me and say, "Hey, there's somebody here who really needs access to more services. How do we help them get that?" So that we become basically a unit of women

to break down the stigma and to say, “I trained so-and-so who trained so-and-so who trained so-and-so, and we’re all here to support each other.”

However, Participant Eight, who reported that she feared judgment post-abortion by members of her community, countered that she thought groups could be problematic for patients because they might allow the opportunity for further judgment. She feared that group members might shame each other based on their disparate perspectives and circumstances.

Finally, some participants also mentioned specific talk-lines, organizations, or other resources that clinics could refer patients to in order to access support from either peers or counselors. One participant each mentioned Exhale and the Postpartum Alliance, and two participants mentioned Backline. One participant referenced an online community called What to Expect that provides a message board for people seeking support after experiencing pregnancy loss. Another participant cited an online podcast called The Abortion Diary Podcast where women can listen to others recount their stories of abortion, as well as access resources.

Clinical Issues for the Practitioner

The following section pertains to clinical issues experienced by participants in their professional role that affected their care of patients. This section is divided into four subsections: countertransference, increased efficacy due to personal experience, self-disclosure, and clinical and advocacy work as reparative experiences.

Countertransference. Four participants cited countertransference as a pertinent clinical issue and that maintaining as much objectivity as possible was crucial to supporting patients effectively and even ethically. Participant One described the importance of withholding personal judgment and keeping countertransference in check. She stated:

People need to... process [their experience] in their own unique, idiosyncratic way. So I think the most helpful part is knowing yourself as a clinician and being able to withhold

your own judgment and thoughts about it and allow a person's own feelings about it to unfold.

Participant Two described the difficulty she currently experiences when working with adolescents going through abortion because she had an abortion and is currently struggling to get pregnant. She declared the importance of removing herself from the situation emotionally and processing her personal feelings with her "lifeline" so that they do not get in the way of her patients' treatment.

Participant Four said that her most important lesson in helping others came from realizing that not everyone reacts to their abortion experience as she did. She noted the importance for the practitioner to understand the array of emotions that can occur other than the sadness and regret that she experienced. She commented:

My most helpful lesson in helping others [was] not having that assumption that they're sad I think. Like, I was sad after my abortion—horribly, horribly depressed and sad. And so I had that assumption that everyone was gonna be sad and that's what those tears were. And, so to learn and understand the array of emotions that can happen afterwards and especially the relief, and understanding that relief. It doesn't mean, you know, they aren't still grieving and having loss and sad about it. But understanding that that's also another real emotion that you can have.

Increased efficacy due to personal experience. All 12 participants responded that they believed their own experience with abortion helped them be more effective in treating patients experiencing emotional distress post-abortion. Many participants stated that they had insight into the experience that others might not have and/or that they could truly empathize with patients because they had experienced similar emotions or occurrences around their own abortion. Participant Three spoke of really understanding the shame and secrecy around the abortion experience on a personal level and how that helped her understand her patients. Participant Two described how thinking about the emotional support she had needed and not received around her own experience has informed her philosophy in helping her patients.

Participant Six, who reported having had an abortion under the best of experiences, stated she believed she was more understanding of her patients because she understood what the procedure felt like. Participant Eight elaborated on this theme:

I just felt like I could hold [my patient's] feelings in a very sensitive and kind way... I think just being able to come from a place of understanding because I've had the experience. Because it's one thing to have empathy for somebody [when] you haven't had the experience. It's an entirely another thing to just know.

Participant Four remarked that she had received a lot of positive feedback from patients who felt particularly supported by her, and she credited this in part to having had an abortion herself:

It's interesting. So many of [my patients] will thank me [and tell me I was] meant to do this work. Yeah, they just feel something... I don't think I would be as good at it if I hadn't had my own experience... I'm grateful to be able to understand it on a level that nobody can unless they've been through it.

Self-disclosure. As discussed, many participants stated they thought having experienced abortion made them more effective in treating patients' emotional distress post-abortion.

However, most participants (n=11) said that they did not disclose to their patients that they had had an abortion. Only Participant Two reported that she would use self-disclosure around her own abortion experience to help her patients feel less alone or judged, particularly with those patients who shared her African-American or lesbian identities. She explained:

They're gonna have their own kind of beliefs based on the adults in their life, based on what they see in the media. So if I'm able to open up to you by saying, "I'm not gonna judge you either way." I think helps to immediately build that rapport that's needed to engage in a meaningful conversation to get [them] to a place of healing more quickly... So for my masculine-identified lesbian clients... I will share with them that I at one point in my life also had an abortion. And I also identify as lesbian. So we're able to connect on that level so that they don't feel as alone. So I think having that conversation with them really opens them up to being able to really talk.

Two participants stated that they believed their patients might be able to tell that they had experienced abortion and found that helpful, even though they did not formally self-disclose.

Participant Twelve said, “I suspect that they think I have, just because of how I talk to them and respond to them, answer questions, and you know talk about the ritual to say goodbye; I just know way too much.”

Other participants reported they would disclose they shared a religion with patients and then showed acceptance to help patients struggling with stigma associated with religion. As reported, two participants stated that acceptance from a therapist who shared their religion helped them let go of some of their own shame or guilt post-abortion.

Clinical and advocacy work as reparative experiences. Six participants mentioned that working in the field of abortion either as a clinician or advocate has been healing to them on a personal level. Participant Four reported that her work as a nurse in an abortion clinic has been the “biggest healing space” in her life and what she has felt to be most effective in healing from emotional distress associated with her abortion experience. She said it has provided her with the knowledge that she is not alone in her experience. Participant Two explained:

One of my biggest things about social work and just the work that I do is the belief that we are in social work because of something that happened in our lives. So we’re trying to help heal whatever that was. But also one of my favorite quotes is, *“In trying to heal another’s wounds, my own have passed away.”* [In] really helping these girls... get through whatever it is happened for them, it really helps me to kind of heal. In another way too, because in providing the support, my eyes are opened when I’m doing research about how I can help her get through this... I see it for myself, and I’m able to kind of implement those things in my own life as well.

Participant Eleven expanded on this theme:

I think that anytime we’ve been through difficult, challenging, or traumatic experiences... when we reach out to others who are going through similar experiences, we can offer them love and non-judgmental support that is always... [on] the whole societal level, it’s beyond reparative [and] definitely individually, too.

Summary

This chapter presented and summarized the findings from interviews with 12 women who had both had at least one abortion and provided professional emotional care post-abortion to one or more patients. Questions sought to elicit participants' perspectives on the most effective means of treating emotional distress post-abortion. In order to convey the appropriateness, importance, or relevance of certain interventions, participants were also asked about the causes and nature of emotional distress post-abortion. In providing their responses, participants reflected both on their own experiences with abortion and those of their patients, as well as on their professional experiences working with patients post-abortion.

In their interviews, clinicians detailed the multifaceted factors that they found to contribute to emotional distress post-abortion, as well as protective factors that they found to prevent said distress. Participants also offered their views about the most effective interventions to mitigate post-abortion distress and included suggestions for emotional support services that facilities should provide post-abortion. Common themes discussed in the interviews included the post-abortion presence and treatment of shame and guilt, as well as of grief and loss. To facilitate healing, participants spoke to the importance of psychoeducation about the nature of emotional distress post-abortion, talking about and processing emotions regarding the experience, and receiving nonjudgmental support. Participants also all reported that it had been therapeutic for them and/or their patients to hear from other women about their abortions and/or share their own abortion stories with others. In most areas, participants provided a variety of responses that predominantly supported each other.

The following chapter will discuss these findings and the relevance to the previously reviewed literature. It will also consider the implications of the data and the relationship to social work practice.

CHAPTER V

Discussion

The objective of this qualitative study was to explore post-abortion emotional distress and the interventions used to treat it. Participants' descriptions of the post-abortion emotional experience supported the literature in many respects, as did many recommendations regarding interventions used to treat emotional distress post-abortion. However, participants also described new and compelling insights into factors that caused distress post-abortion and interventions that could combat distress.

Due to the abortion's complex nature, which was confirmed by participants' narratives, a range of factors can contribute to emotional distress post-abortion, and, therefore, a range of corresponding interventions may be appropriate depending on individual circumstances. Participants were either unanimous or almost unanimous in their responses about certain key factors that contribute to emotional distress post-abortion, as well as when describing key elements of interventions. This chapter discusses the findings in the following order: 1) key findings, describing the relationship between the study results and previous literature; 2) implications for social work practice, discussing how social workers can incorporate the findings from this study and why this is important to the field of social work; 3) strengths and limitations of the study; and 4) recommendations for future research in the area of post-abortion emotional care.

Key Findings: Comparisons with the Previous Literature

Post-abortion emotional distress and interventions used to combat it were explored through the narratives of clinicians who had both had one or more abortions and who had worked with patients who had had one or more abortions. This section presents the key findings from the study in relation to previous literature. These findings will be presented in the following order: contributing factors to emotional distress post-abortion; factors that help prevent emotional distress post-abortion; interventions to mitigate emotional distress post-abortion; clinical issues for the practitioner; and summary.

Contributing factors to emotional distress post-abortion. The findings of this study point to the importance of understanding emotional distress associated with the abortion experience in order to determine the most appropriate and effective interventions to combat such distress. Due to the complex nature of abortion and the factors that can lead to emotional distress post-abortion, this study found that certain interventions are only applicable if the patient is experiencing a certain type of distress. Participants confirmed literature that addressed the complexity of abortion and emotional distress post-abortion. This finding reflects the assertions of Kumar et al. (2009) and Upadhyay et al. (2010) that abortion is a highly complex experience, that co-existing factors affect an individual's response to abortion, and that the sociocultural environment highly impacts norms within a community that affect abortion stigma.

One finding of this study showed that the emotional healing process after having an abortion was not necessarily linear and that women could experience emotional distress at various times post-abortion. This finding aligns with Kimport et al. (2012b) and Trybulski's (2006) finding that emotional reactions to abortion occur at various times post-abortion and can be triggered by a range of subsequent events. Trybulski (2006) wrote that women experienced

thoughts and feelings about their abortion(s) during subsequent reproductive events, by abortion in the news, and/or with friend's life events. One participant echoed Trybulski (2006) and other participants when conceptualizing the healing process as dynamic and something that can be triggered by associated developmental phases, such as during a later pregnancy, when fertility issues arise, or at other times.

All participants acknowledged that circumstances can vary significantly for each abortion patient, and that a multitude of factors can contribute to emotional distress post-abortion. This finding is in accordance with the literature reviewed, including but not limited to Adler (1975), Adler et al. (1992), and Major et al. (2009). Despite Adler's (1975) finding that the majority of women experience positive emotions post-abortion, most participants (n=9) reported that they experienced some amount of emotional distress in conjunction with their abortion experience(s). All 12 participants had worked with patients who had experienced emotional distress post-abortion. Of course, people seeking emotional support from clinicians would be in need of emotional support, so, in addition to the small sample size, it is impossible to deduce from these findings that a higher percentage of women than in Adler's (1975) study experiences emotional distress post-abortion, or to what degree.

In this study, participants most commonly cited the following factors as contributing to emotional distress post-abortion: secrecy and silence, stigma, conflict with belief systems, lack of support, and feeling a lack of choice. These findings are consistent with much of the literature reviewed, including Adler et al. (1992), Kimport (2012), Kimport et al. (2011), Kimport et al. (2012b), Major et al. (1990), Major et al. (1998), Major & Gramzow (1999), and Major et al. (2009). Similarly, Upadhyay et al. (2010) theorized that low self-esteem, stigma, and a lack of social support could contribute to a reduced ability to cope post-abortion, and with corresponding

feelings of guilt, anxiety, depression, and regret. All participants mentioned shame and guilt, as well as grief and loss, as significant and common feelings that can occur post-abortion. This finding is consistent with Adler's (1975) study that found that shame and guilt can occur post-abortion, but inconsistent with how often these feelings occur. Again, the small sample size for the current study makes it impossible to generalize to other research. This limitation will be discussed further in the *Strengths and Limitations* section.

For those women who did experience loss post-abortion, Adler (1975) found that a sense of loss correlated with ambivalence about wanting the pregnancy and/or the decision to abort. Adler's (1975) finding was confirmed in this study, as participants reported that wanting the baby at the time and/or regretting the decision to have an abortion caused significant emotional distress post-abortion. Kimport et al. (2012b) and Major et al. (1998) also found that a difficult decision-making process and/or a lack of support could lead to emotional distress post-abortion. These findings are also consistent with this study's finding that feeling a lack of choice in the decision to have an abortion or feeling pressured into choosing abortion (and hence a lack of support) increases emotional distress for women post-abortion, which was substantiated by Major & Gramzow (1999). In this study, lack of agreement between partners about what to do about the abortion was also cited as contributing to emotional distress for women post-abortion, as found by Kimport (2012).

All participants responded that they found shame and guilt to be common themes that arose for either themselves and/or their patients post-abortion for various reasons. Participants reported that factors which contributed to shame and guilt included feeling that having an abortion was wrong as viewed by the greater society, their religion, their community, their loved ones, and/or by themselves. These findings replicate studies conducted by Adler (1975) and

Adler et al. (1992), who found that conflict about the meaning of abortion and its relation to deeply held values or beliefs, perceived social stigma, or lack of support could contribute to emotional distress post-abortion.

Findings from this study also support numerous studies' findings that abortion stigma can contribute to emotional distress (Cockrill, et al., 2013; Cozzarelli et al., 2013; Kimport et al., 2011; Kumar et al., 2009; Littman et al., 2009; Major & Gramzow, 1999; Shellenberg, 2010). Participants noted that feeling internalized stigma or self-judgment for having had an abortion caused emotional distress, which coincides with Shellenberg (2010), who found that abortion stigma created a negative feeling of self in abortion patients. Participants in this study reported that stigma affected women's willingness to disclose that they had had an abortion, which, in turn, built on the negative emotional effects experienced as a result of abortion stigma, as found by Astbury-Ward et al. (2012), Kimport et al. (2012b), Major & Gramzow (1999), and Shellenberg (2010). In the literature and in this study, the stigma that kept women from disclosing their abortion history also kept them from seeking or obtaining the necessary support to combat the internalized aspects of that stigma.

This study also found that aspects of the experience at the clinic on the day of the procedure could cause lingering emotional distress. These aspects included antiabortion protestors, unsupportive clinic staff, and/or aspects of the procedure itself. Negative reactions to protestors and unsupportive clinic staff were consistent with findings from Cozzarelli et al. (2000) and Kimport et al. (2012a). The abortion experience itself was only described as a cause of emotional distress when patients remembered certain events that could have been prevented that fit into the three categories of emotional distress post-abortion found by Kimport (2012). For example, seeing the fetus afterward caused emotional distress for one participant, which was

similar to Kimport's (2012) notation about emotional attachment to the pregnancy. For two other participants, a nurse conveying shaming remarks caused emotional distress, which fit into Kimport's (2012) category of social disapproval.

An aspect of the abortion experience not discussed in the literature was the common theme cited by participants that women experienced emotional distress post-abortion if they thought, or believed others thought, that they should not have lingering emotional distress after having an abortion. This finding aligns with Kimport (2012), who noted that social disapproval can lead to emotional distress post-abortion, but not only in the way that Kimport discussed, namely that social disapproval for the abortion itself could make women feel distressed. Although Kimport's (2012) finding was confirmed in this study, participants also noted that in some circles, the message is conveyed that abortion is not supposed to be a big deal and that women should be okay with the experience, particularly if they felt they made the right decision for themselves. In alignment with Kimport (2012), participants routinely cited that, although regret about the abortion coincided with emotional distress post-abortion, regret was not a necessary factor in experiencing emotional distress.

Factors that help prevent emotional distress post-abortion. The two most commonly cited factors that participants reported as preventing emotional distress post-abortion were feeling supported by others and feeling a lack of conflict surrounding the decision to have an abortion. The three participants who did not experience emotional distress post-abortion had a lack of conflict regarding the decision to abort, did not find abortion to be immoral or in conflict with their religion or belief system, and did not experience pressure or judgment from loved ones. The literature reviewed supported these findings (Adler, 1975; Adler et al. 1990; Adler et al., 1992; Cozzarelli, 1993; Kimport, 2012; Kimport et al., 2012b). Counselors may wish to take

these findings into consideration when assessing for emotional distress post-abortion and determining whether patients might benefit from additional emotional care and support.

Interventions to mitigate emotional distress post-abortion. Participants' narratives provided rich content around the elements of interventions that they found to be most helpful for themselves and/or their patients to heal from post-abortion emotional distress. A range of interventions were suggested, which can be understood due to the complex and varied nature of abortion and factors that contribute to emotional distress. For example, a woman who suffers emotional distress due to a conflict with her partner over her decision to abort will likely benefit more from a different intervention than a woman who suffers emotional distress post-abortion due to fertility issues years later. However, similarities in the majority of participants' responses about the nature of support post-abortion speak to the possibility that some types of support and care may help most women who experience emotional distress post-abortion.

The most common interventions that participants cited included individual counseling and connecting to other women who have experienced abortion, whether that be through a support group, talk-line, informally, or in another way. Kimport et al. (2012b) recognized this need for non-judgmental and apolitical emotional support for processing patients' feelings over time after their abortions. They found that talk-lines provided this type of crucial support, particularly since some women need support periodically and episodically at any time after an abortion (Kimport et al., 2012b; Trybulski, 2006). Close, supportive relationships were also commonly cited as a source of support, in conjunction with Adler et al. (1992) and Kimport (2012).

Regardless of source, the most common characteristics of interventions recommended as most helpful to mitigate emotional distress post-abortion included creating a safe space free from

judgment for patients to talk, process emotions, and feel supported. Participants often stated that social connections helped them heal through breaking the silence and stigma surrounding abortion, feeling supported, and feeling that they were not alone. Participants described the healing that can occur from talking about abortion, and some pointed to the importance of providing a space for patients to express their emotions since it might be the first time women have disclosed their abortion to anyone besides medical staff. These findings are consistent with the reviewed literature on countering stigma and shame and the utility of disclosing and discussing the abortion experience (Harris et al., 2011, Kimport et al., 2012b, Kumar et al., 2009; Littman et al. (2009); Major & Gramzow, 1999; Upadhyay et al., 2010).

When speaking about healing from emotional distress post-abortion, participants specified certain interventions and aspects of support that were most helpful to them and/or their patients. Many participants (n=7) spoke about the importance of encouraging patients to talk about whatever comes up for them and making sure patients know that it is okay for them to feel any emotion that arises. This finding supports using an empowerment and person-centered approach and points to the notion that any counseling for abortion patients should focus on providing nonjudgmental emotional support that is determined on an individual basis and recognizes the emotional needs of each patient (Ely, 2007; Ely et al., 2010; Moore et al., 2011). Ely (2007), Ely et al. (2010), and Moore et al. (2011) all recommended using an empowerment model consistent with feminist counseling models that values the patient's beliefs and wishes and provides different levels and types of emotional support based on the specific needs of the patient.

Other aspects of recovering from shame and guilt that participants (n=9) discussed included the process of healing through self-compassion. By either reframing the experience to

see it in a more positive light, letting go of some of the self-judgment, and/or engaging in self-forgiveness, participants noted that they and/or their patients were able to heal from emotional distress post-abortion. This finding confirms Lemkau's (1988) recommendation and Major et al.'s (1998) finding that using reframing can improve emotional outcomes for patients post-abortion.

Three participants described grieving rituals similar to those suggested by Lemkau (1988) that they performed with patients to help them move on from grief associated with their abortion(s). These and other participants' responses supported Lemkau's (1988) suggestions that clinical interventions to help women cope with emotional distress post-abortion could include grief work, including the possibility of a Gestalt grieving ritual; education approaches, including contraceptive information or normalizing the woman's experience, as noted also by Ely (2007) to be an effective technique in pre-abortion counseling; review of the decision-making process in order to facilitate integration; rituals of self-forgiveness in accordance with the woman's belief or value system; and/or offering empathetic support. Again, both this study and Lemkau (1988) call for a range of clinical interventions based on the specific type(s) and cause(s) of the experienced distress. Lemkau (1988) recommended that therapists administer a comprehensive assessment with patients to determine co-existing sources of emotional distress and deliver corresponding interventions accordingly. Given the complexity of abortion and emotional reactions found in this study and confirmed by the literature, Lemkau's (1988) advice to therapists seems appropriate.

Some participants referenced interventions not specified in the literature to help cope with emotional distress post-abortion. As interventions specifically designed to mitigate emotional distress post-abortion have not been developed or studied widely, it makes sense that

participants would apply interventions used to reduce certain types of emotional distress to the abortion experience. For example, responses from participants in this study suggest that grief due to loss experienced as a result of an abortion may be dealt with effectively in the same way as grief from the death of a loved one. Two participants specifically described elements of Elizabeth Kübler-Ross's *Five Stages of Grief* to help patients heal from grief and loss post-abortion. Other participants referenced parts of these stages, such as bargaining, anger, or denial, but did not mention Kübler-Ross specifically. Two participants said they provided psychoeducation to their patients around grief so that they could understand the emotions they might encounter.

All 12 participants responded that they believed that emotional support services should be offered post-abortion by facilities that provide abortions, which is consistent with recommendations from Kimport et al. (2012b). Participants suggested various ideas about the type of support that should be provided. Ideas included psychoeducation about the nature of post-abortion distress and what to expect; referrals to counseling services, talk-lines, support groups, or other emotional support services; and counseling and groups provided directly by the facility. Many participants reported that they believed facilities should educate patients on the possibility of feeling emotional distress post-abortion and referrals for services that might help alleviate that relief.

Many participants referenced that facilities should provide follow-up counseling to patients post-abortion or at least referrals for counseling. Five participants suggested that clinics should offer peer-to-peer counseling and/or support groups or referrals for such services post-abortion, which is consistent with Upadhyay et al. (2010). Finally, some participants also mentioned specific talk-lines, organizations, or other resources that clinics could refer patients to

in order to access support from either peers or counselors. Kimport et al. (2012b) found that these talk-lines and organizations can be helpful for women needing support post-abortion, but that additional services, such as mental health counseling delivered by professional clinicians, should also be available to women, especially those suffering from clinically significant levels of emotional distress post-abortion.

Clinical issues for the practitioner. As no literature was found that studied clinicians working with patients post-abortion, and therefore none were found that studied the further subsection of clinicians interviewed in the study, this study's findings regarding important clinical issues for clinicians working with patients post-abortion cannot be substantiated. However, these findings can form the basis for future lines of inquiry, as discussed later in this chapter.

It is important to identify and examine any issues that may arise for clinicians who care for patients post-abortion, so that clinicians can be well prepared to encounter these issues in a way that is conducive to and does not interfere with treatment. Participants in this study identified four issues that affected clinicians' counseling of patients' post-abortion. These issues included countertransference, empathy, self-disclosure, and personal healing. Only one issue, countertransference, pertains to clinicians who have not had abortions themselves. Four participants emphasized that maintaining as much objectivity as possible was crucial to supporting patients effectively and ethically. As with counseling patients with any potentially triggering issue, withholding personal judgment and processing potential countertransference with colleagues was found to be of importance. This finding is not unique to countertransference within the therapeutic relationship with patients who have experienced abortion but is still important for clinicians working with abortion patients to prepare for, given abortion is a

politicized issue that brings up strong ethical and moral views in many people, including clinicians.

All 12 participants responded that they believed their own experience with abortion helped them be more effective in treating patients experiencing emotional distress post-abortion. Many participants stated that they had insight into the experience that others might not have and/or that they could truly empathize with patients because they had experienced similar emotions or occurrences around their own abortion.

Only one participant reported that she had used self-disclosure around her own abortion experience to help her patients feel less alone or judged, particularly with those patients who shared her African-American or lesbian identities. Most participants reported they would not self-disclose, as they did not find it to be helpful or appropriate in the clinical setting for patients.

Six participants responded that working in the field of abortion either as a clinician or advocate has been healing to them on a personal level. This finding provides evidence that a possible intervention to mitigate emotional distress post-abortion would be for women to become involved in the field of abortion through supporting patients or advocacy work.

Summary. As confirmed by the literature and found in this study, the abortion experience is highly complex. A range of factors can contribute to emotional distress post-abortion, and so only a range of interventions would be appropriate to help women cope post-abortion. Interventions participants recommended that had helped them and/or their patients cope with emotional distress post-abortion included but were not limited to nonjudgmental support; breaking the silence to speak about the experience; connecting with other women who had undergone abortion(s); accessing social support from loved ones; normalizing women's experiences and/or the occurrence of abortion; reframing the experience; self-forgiveness and

self-compassion; grief work; separation and individuation from a family or belief system of origin; working with abortion patients or advocating on their behalf; and psychoeducation about a range of related issues, from possible emotional reactions to the complexity of abortion to stages of grief. However, certain elements of interventions, like social support and nonjudgmental listening, were found to be helpful for most patients post-abortion. The findings of this study suggest that it is important for clinicians working with patients post-abortion to conduct an assessment to determine the cause(s) of emotional distress in order to develop and apply the most appropriate and effective interventions, as consistent with Lemkau (1988). The findings also point to the importance of using an empowerment counseling model that validates and normalizes the patient's experience, provides nonjudgmental support, and values the patient's individual needs and wishes, as consistent with Ely (2007), Ely et al. (2010), and Moore et al. (2011).

Implications for Social Work Practice

The findings from this study have important implications for clinical social work practice. First, many social workers will come into contact with women who have experienced or will experience abortion(s), so these clinicians must be equipped appropriately with an understanding of how best to counsel and advise patients in order to help patients cope effectively. In addition, it is crucial for the academic social work community to be on the forefront of combating abortion stigma, which oppresses and marginalizes women who undergo abortion. This research could also be used to inform policies and programs aimed at reducing abortion stigma or emotional distress in patients post-abortion.

Strengths and Limitations

The strengths of this study lie in the implications for social work practice discussed above as well as in the nature of the study itself. As no previous literature was found that studied clinicians who have worked with patients post-abortion nor the population of clinicians who have worked with such patients and who have experienced abortion(s) themselves, this study provided new insights into an important area of research. Furthermore, the qualitative nature of the study allowed participants to convey rich and meaningful content that presented themes not originally anticipated. This content can serve as the basis to formulate future research studies. In addition, by confirming and adding to the existing literature regarding the nature of emotional distress post-abortion and interventions used to mitigate it, this study builds on the knowledge base in this area of study.

There are a few key limitations inherent in this study's design and methodology. First, the sample was relatively small and did not demographically represent the range of women who undergo abortion. Only two women of color were interviewed, a majority of participants had their abortion(s) and worked in California, and the time of and time since participants' abortion(s) varied significantly. With a study of this limited sample, the inevitable omission of huge numbers of clinicians and abortion patients make it hard to generalize about the research findings. The findings cannot be assumed to be true across populations and locations, including anywhere outside of the United States.

In addition, participants' discussion of their patients' experiences were inherently biased. Participants had no way of measuring the success of the interventions they used with their patients, likely had an emotional investment in believing that their interventions were successful,

and their personal experiences with abortion may have colored their views of their patients' experiences.

Recommendations for Future Research

There is a clear need for increased research on the efficacy of interventions and programs that seek to mitigate emotional distress post-abortion in order to inform the establishment of best practices for post-abortion emotional care. There has been an increase in the study of abortion stigma in the last ten years, including the development of a scale to measure abortion stigma (Cockrill et al., 2013), and a fair amount of research has been conducted on contributing factors to emotional distress post-abortion; however, little research has used existing knowledge of these areas to study post-abortion emotional care. Many articles and books call for certain interventions to be used in post-abortion counseling but do not provide scientific data to support their recommendations.

Although perhaps impossible due to the highly politicized nature of abortion, studies should be conducted by unbiased researchers who are not funded by political interests of any kind. To avoid the limitations of this study, future studies should have much larger and diverse samples and scientifically measure women's emotional distress before and after interventions while accounting for important variables. In the interest of millions of women who undergo one of the most common surgical procedures currently available, more substantive research must be undertaken to support women's emotional health post-abortion.

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Appendix A

Sample Recruitment Email

Dear (NAME),

I am conducting research for my thesis as part of my master's degree program at Smith College School for Social Work. I am writing to invite you to participate in this study and/or circulate this message to any contacts who might be willing to participate.

I am hoping to interview women who have both provided professional emotional care to one or more abortion patients and who have also had an abortion (or multiple abortions) themselves. My research will seek to explore patients' experiences of abortion and the most effective interventions to improve emotional well-being post-abortion. Very little has been written about how to care effectively and compassionately for women post-abortion, despite that over a third of women undergo abortion by the age of 45. There is still a lot of stigma around the issue, and the abortion experience can be emotional for a variety of reasons. My hope is that this project will contribute to establishing best practices in providing emotional care for women post-abortion.

If you might be willing to participate in a 60- to 90-minute interview in-person in the San Francisco Bay Area, or remotely via phone, Skype, or Google Video Chat, please contact me at xxx-xxx-xxxx or email xxxx@smith.edu to learn more.

Please feel free to share this information with anyone who you think might be interested. I am also interested in hearing from people who have expertise in this topic, but who may not qualify for participation in the study.

Thank you so much in advance!

Sincerely,

Abigail Reider
Smith College School for Social Work
MSW Candidate, August 2014

Appendix B

Human Subjects Review Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 24, 2014

Abigail Reider

Dear Abby,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Elizabeth Johnston, Research Advisor

Appendix C

Human Subjects Review Amendments Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-
7994

March 8, 2014

Abigail Reider

Dear Abby,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Liz Johnston, Research Advisor

Appendix D

Participant Consent Form

**Consent to Participate in a Research Study
Smith College School for Social Work - Northampton, MA**

.....

Title of Study: Exploring Emotional Care of Abortion Patients in order to Inform Best Practices: Perspectives of Providers Who Have Also Experienced Abortion

Investigator:

Abigail Reider

Master in Social Work Candidate, Smith College School for Social Work

Phone: 203-645-6062

.....

Introduction

You are being asked to participate in a research study about the emotional care provided in conjunction with a medical abortion procedure. You were selected as a possible participant because you have provided professional emotional care to (an) abortion patient(s). It is also a requirement for participation that you have had an abortion yourself. Participants must have one or more of the following professional qualifications: Master’s degree in Social Work, psychology, counseling, or Marriage and Family Therapy; Ph.D. in psychology; Doctor of Psychology (PsyD); professionally certified as a doula post-bachelor’s degree; Registered Nurse or Nurse Practitioner specializing in psychiatry; MD specializing in psychiatry. If it is impossible to arrange an in-person interview, participants must also either have access to a computer with Skype or Google Video Chat, or to a telephone, and be able to mail me a hard copy, signed in ink, of this Informed Consent form before the start of the interview, in accordance with federal regulations. Please read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

The purpose of the study is to explore the emotional needs and care of abortion patients in order to inform best practices in treatment. Successful treatment will be defined as that which helps reduce internalized stigma and emotional distress around the abortion experience. This study is being conducted as a thesis requirement for my Master’s in Social Work degree. Ultimately, this research may be published or presented at professional conferences, but names or any identifying information will be kept absolutely confidential and will not be shared with anyone.

Description of the Study Procedures

If you agree to be in this study, you will be asked to do the following things:

- 1) Turn in this informed consent form, signed.

- 2) Communicate with me via email or phone to answer brief qualifying questions and to schedule an interview. Most likely, you have already completed this part of the process.
- 3) Participate in a 1-hour interview, either in-person in a confidential, private, and comfortable location; over video chat; or via phone. If impossible in person, I will be in a private and confidential location during the video or phone interview.

Risks/Discomforts of Being in this Study

The study has the risk to bring up emotional distress associated with this sensitive subject. There are no other foreseeable risks of your participation.

Benefits of Being in the Study

This study is being undertaken to improve emotional care for abortion patients. Thus, your participation may help improve care for future patients. It may also be helpful for you to share your personal story with a non-judgmental listener. Since you are a provider of services, this interview may also help you evaluate your provision of services.

Confidentiality

Your participation in this study will be kept strictly confidential. Interviews will be conducted privately, and nobody will be informed of your name or identity besides me. Research records will be kept in a locked file, and all electronic information will be coded and secured using a password-protected file. All research materials including recordings, transcriptions, analyses, and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password-protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

I will make use of a professional transcriber to transcribe the interview, but that person will be required to follow the above protocol, keeping any records in a password-protected file. They will delete all audio files and electronic records of transcriptions once they have sent me the completed transcriptions. This person will not have access to your name, and they will be required to sign a confidentiality agreement that states they will comply with the above and will keep strictly confidential any information that may make it possible to identify you.

Payments

I am unfortunately not able to offer any financial payment for your participation.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time*, and can decide to withdraw up to 72 hours after your interview without affecting your relationship with me or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You also have the right not to answer any question during the interview. If you choose to withdraw from participation, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by 72 hours after your interview. After that time, your information will be part of the thesis.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study at any time, feel free to contact me, Abigail Reider, at xxxx@smith.edu or by telephone at XXX-XXX-XXXX. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

Your signature below indicates that you have decided to volunteer as a research participant for this study and have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

1. I agree to be audiotaped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix E

Transcriber Confidentiality Form

Professional Transcriber's Assurance of Research Confidentiality

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.
- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, Abigail Reider, shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, - *insert name of researcher* - for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

Christy Sanders

Signature

3-7-14

Date

Abigail Reider

Insert name of researcher

3-7-14

Date

Appendix F

Interview Questions

- 1) In what role have you provided professional emotional support to abortion patients?
Please describe the nature of this support and any training you underwent to provide it. This could include training in applicable therapeutic theories or interventions, graduate training, training within a professional setting, or other training.
- 2) a) How were patients referred to you?
b) If you were not a direct referral from the location in which your patients received an abortion, do you know if that location provided any emotional care services or referrals to its patients?
- 3) What contributed to your decision to provide emotional support to abortion patients in a professional setting?
- 4) If you are willing and feel comfortable, please tell me about your own experience with abortion. You can choose to include whatever details feel relevant to you. Some ideas include how old you were, any surrounding events you feel comfortable disclosing, the support or lack of support you experienced, your decision to disclose your choice to have an abortion, and/or anything else that feels relevant to your emotional well being surrounding the abortion experience.
- 5) What did you feel was most helpful in mitigating emotional distress in conjunction with your abortion experience?
- 6) Did you receive any referrals or emotional care at the location where you received the abortion? Please tell me about the process and any services you were offered and/or provided.
- 7) Did you or any of your patients experience emotional distress associated with the way care was provided at the location providing the abortion? This could include any kind of care, from consultation and admission through the end of the procedure and follow-up.
- 8) Thinking about your own experience and that of your patients:
 - a) What are the key issues and factors that contribute to emotional distress after abortion?
 - b) What factors are most important to prevent potential distress?
 - c) If distress occurs, what are the most effective interventions for treatment?
 - d) What services should be developed to treat patients who are emotionally distressed?
 - e) How should these services be offered and provided?
 - f) Did you find that any interventions that you provided or received, or that were previously provided to your patients, were ineffective or detrimental in any way? If so, please describe.
 - g) Do you believe access to services to be an issue? If so, how would you recommend improving access?