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ABSTRACT

This mixed methods exploratory study piloted a non-validated online qualitative survey instrument to assess women's social and emotional experiences with abortion stigma from women recruited on college campuses in New England. Abortion stigma is defined as prejudices and discrimination directed at women who have abortions, and people and institutions that support women who have abortions. Thirty-nine women took an online survey instrument that asked respondents to: provide their reproductive health histories; report when they first learned of abortion; give information regarding their community's attitudes about abortion; state their feelings about abortion. Eight women, sampled from the qualitative survey pool, participated in a 30 to 45 minute in-depth telephone interview. Qualitative participants engaged in a dialogue about the survey, their experiences with abortion, and their community's attitudes about abortion. The researcher hypothesized that women who had one or more abortions would perceive and experience more abortion stigma, and all women, regardless of their reproductive health histories, would observe and have experiences with abortion stigma. The findings indicate that the first hypothesis was the reversed; women who had one or more abortions did not experience or perceive abortion stigma. Findings also suggest that there is a significant relationship between believing that abortion stigma affects women, and strongly identifying as a woman. Therefore, the second hypothesis was confirmed for the participants in this study. This finding has important implications for clinical social work practice, policy, and education, as social workers have an influential role in challenging stereotypes.

Keywords: *abortion stigma, abortion, New England, attitudes, stereotype, mixed methods*

WOMEN'S SOCIAL AND EMOTIONAL EXPERIENCES WITH ABORTION

Abortion is very connected to ideas of love and sex, and that changes for everyone too, so a baby can mean something completely different for one woman as it does for another. What society views as a woman's body, sex, and love can be completely different from an actual individual's views.

(Qualitative research study participant)

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2011 – 2012

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CHAPTER I

Introduction

In all countries around the world, women terminate pregnancies throughout all stages of their reproductive lives, regardless of whether or to what extent abortion is legal. In the United States, almost half of all pregnancies are unintended, and twenty-two percent of all pregnancies are terminated in abortion, excluding abortions due to pregnancy miscarriage. (Jones & Kooistra, 2011). It is critical that social workers deepen their understanding of the social and emotional experiences women face with abortion. One of the lesser-understood social and emotional experiences of abortion is abortion stigma. This paper will focus on abortion stigma pertaining to “elective,” “therapeutic,” or “induced” abortion, all terms used to describe termination of pregnancy for reasons other than miscarriage.

For the purposes of this research, abortion stigma is defined as the prejudices and discrimination directed at women who have abortions. Abortion stigma theorists have added that abortion stigma extends to people who support women who chose to terminate pregnancies because these supporters are also judged and discriminated against for being activist, abortion providers, academic researchers, and other clinical providers. Unlike other fields of stigma research, abortion stigma is a relatively “under-researched and under-theorized” field (Norris et al., 2011, p. S49). The purpose of this study is to expand the field of abortion stigma research by exploring whether women who have an abortion(s) internalize stigma significantly more than women who have not had an abortion. This research study explores whether all women,

regardless of their reproductive medical history, identify ways in which abortion stigma has impacted their lives. The researcher has studied the proposed question by asking women to describe their attitudes, observations and experiences with abortion.

Quinn and Chaudoir (2009) provide a conceptual framework for discussing stigmatized identities, particularly those that are invisible or concealable. Abortion is one of many concealable stigmatized identities. Other such identities that have been studied include being HIV positive or having AIDS, having mental illness, and having epilepsy. Quinn and Chaudoir state that living with stigma “encompasses issues of identity and self-definition” (p. 647). According to Major and O’Brien (2005), stigma affects someone with a stigmatized identity directly through discrimination, stereotypes and prejudicial attitudes. Stigma has an indirect, but active role in threatening personal and social identity (p. 393). Kumar et al. (2009) emphasize that abortion stigma is fostered by a culture of prejudice and discrimination in politics and law that reflect ideologies and norms regarding women, sexuality, and power. These belief systems are pervasive in many cultures.

Clinical social workers are familiar with Winnicott’s theory of the “good-enough mother.” Winnicott’s mother is one who is “emotionally available” to her child, and she is “free of narcissistic concerns” so that she may be comforting and supportive to her child (Winnicott 1965, as cited in Howard and Robert, 2002, p. 50-51). For some women, having and unintended and unwanted pregnancy, and considering to have, or having an abortion may threaten individual and group expectations of what it means to be a good enough mother.

“Stereotype threat” is a concept studied by many theorists. Claude M. Steele defines it as “a general threat not tied to the psychology of particular stigmatized groups. It affects the members of any group about whom there exists some generally known negative stereotype”

(Steele, 1997, p. 617). All women, regardless of whether they have had an abortion or have ever been pregnant, may experience stereotype threat with regard to unintended pregnancy and abortion.

Greene (2006) conducted in-depth interviews with young adult and adolescent mothers living in Edinburgh, Scotland to investigate expectations of “responsibility” regarding motherhood. Adding to Winnicott’s definition, Greene stated that good mothers are “self-sacrificing” (p. 31). The author states:

The stigma surrounding abortion made considering and choosing this option difficult even in situations where [women] felt certain that they were making, or had made, the right choice. Emerging from this discussion was an overwhelming belief that the decision to have an abortion was in some way ‘irresponsible,’ as opposed to the ‘responsible’ decision to see a pregnancy to term regardless of whether or not it was unplanned or unwanted. (p 36-37)

Major and O’Brien (2005) state, “Identity threat results when an individual appraises the demands imposed by a stigma-relevant stressor as potentially harmful to his or her social identity, and as exceeding his or her resources to cope with those demands” (p. 411). Women of reproductive age experience abortion stigma when beliefs associated abortion pose a threat to one’s identity or one’s self of self as member of a group of women who may consider abortion due to a fetal abnormality, pregnancy as a result of rape or incest, and/or unintended pregnancy. Irrespective of choice to or not to have an abortion, women may not be able to avoid the threat of abortion stigma in cultures, such as the United States where norms regarding abortion, motherhood, sexuality, sex, and politics about pregnancy are explicit.

In 2012, a presidential campaign year, there is an open dialogue about abortion. In addition to a dialogue about whether candidates support abortion rights, there is a debate about whether employers should be required to provide insurance coverage for abortion, who should fund abortion clinics, whether states should have more or less abortion providers, and what fetal gestational limits abortion providers should be permitted to perform the procedure in different states. Whether implicit or explicit, the choice made regarding these issues enter into belief systems, and they may contribute to abortion stigma.

Clinical social workers have an influential role in challenging stereotypes and supporting women who are facing decisions about pregnancy and abortion. Green (2006) calls for social workers to “call into question current political and social discourses, policies and services” and “encourage and work alongside pregnant teenagers and young mothers in challenging ideologies about the ‘good’ mother and the ‘bad mother’ in order to create a new vision about what it means to be a working-class and/or poor young mother” (p. 39-40). Understanding abortion stigma may give clinicians permission to include stigma reduction as part of social work practice in primary care, obstetrics, and gynecologic care settings.

Among the 1.2 million American women who had an abortion in 2008, the last year for which national data is available, no racial or ethnic group made up the majority of those obtaining abortions. Black women had the highest unintended pregnancy rate of any racial or ethnic group. Most women identified with a religious community, had one or more children, and were not married. Fifty-eight percent of women were in their 20s. More than half of women reported that they wanted to have “a child or another child” later in life (Jones, Finer, & Singh, 2010, p. 80). In 2008, about half of the women who had an abortion had incomes below the 100% of the Federal Poverty Level, and just over a quarter of women had incomes between 100

to 199% of the Federal Poverty Level (Guttmacher Institute, 2011). In 2008, then, most women who had an abortion were young, hoped to have another child later in life, and were socioeconomically disadvantaged.

In 2008, 19.6 women had abortions per every 1,000 women in the U.S., age 15 to 44. The abortion rate was slightly lower in Massachusetts in 2008: 18.3 abortions per 1,000 women of reproductive age (Jones, Finer, & Singh, 2010). This represents 2.1% of abortions in the United States. The incidence of abortion in Massachusetts is on par with the national average, making this research a relevant topic for the local population.

Thus, abortion is a common experience for a cross section of women in the United States and in Massachusetts. Despite abortion being a common experience, women who are young, women of color, women who are unmarried, or women who are poor have a greater chance to have an abortion. One stated reason for this trend is that women who have abortions report having difficulty using contraception consistently and are thus at higher risk for unintended pregnancy (Boonstra, Gold, Richards, & Finer, 2006).

It is important for social workers to be attuned to the disparities among women obtaining abortion services. The Preamble to the National Association of Social Workers Code of Ethics states, “The primary mission of the social work profession is to ...help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (p. 1). When clinical social workers develop relationships with women who may have had an abortion(s) in the past or may contemplate having an abortion in the future, social workers are working to meet the basic needs of women.

Social workers play a critical role in obstetrics and gynecology counseling and reproductive health advocacy. In a hospital or outpatient setting where abortions are provided,

clinical social workers typically serve as women's counselors in providing options counseling before women have made the decision about whether to terminate a pregnancy. For women who choose to have an abortion, clinical social workers often provide abortion counseling prior to the procedure (Ely, Dulmus & Akers, 2010, p. 103). The US Maternal Health Bureau has provided some social work master's programs with grants that focus on maternal and child health because it is a common field for social workers to enter. Nonetheless, the practice of social work has "historically emphasized children's health over maternal health" (Alzate, 2009, p. 111).

The proposed study is relevant to social work practice (both macro and micro), as well as social work education, because many women have abortions and are impacted by them. Because abortion stigma is a developing body of research, even if the data from the proposed study is not generalizable beyond the study population, the findings will contribute to a body of knowledge about abortion stigma in women's lives that could be incorporated into social work practice and training.

CHAPTER II

Literature Review

Provided that the field of abortion stigma research is newly developing, this review will examine empirical bodies of literature that explore women's reasons for abortion, abortion and mental health, and abortion restrictions in the United States. Theoretical review includes literature on stereotype threat, abortion stigma theory, disclosure theory, and theory regarding identity.

Public Discourse

Pregnancy, miscarriage, motherhood, abortion and adoption are neither neutral experiences nor neutral terms. Rather, each is dependent on an intersectional discourse that is full of political meaning. To make meaning, the discourse is reliant on cultural factors like age, race, religion, class, gender, sexuality, and even geographical location (Greene, 2006; Jones, Frohworth & Moore, 2008; Kumar, Hessini, & Mitchell, 2009; Norris et al., 2011; Stephens, Jordens, Kerridge, & Ankeny, 2010). Often, the abortion discourse in the United States collapses a very complex discourse to a polarized one: pro-life versus pro-choice. The dichotomy leaves little room for a nuanced discourse about abortion stigma. As women's rights to abortion have become increasingly restricted (Cockrill & Weitz, 2010), research about women's experiences with abortion has become a very important element of leveraging policy.

Unlike policy and law, women's experiences are nuanced. Yet, laws governing abortion affect women's attitudes and experiences, health care services, social movements, and social discrimination or stigma. Rohlinger (2006) explores abortion regulations through tactics employed by Planned Parenthood Federation of America [PPFA] and the National Right to Life Committee [NRLC]. In an empirical study analyzing two advocacy organizations that are

polarized on the abortion debate in the United States, Rohlinger investigated how media tactics are used amongst allies and opponents in social movements to inform policy. PPFA and NRLC used nearly identical media tactics throughout the period studied. Findings suggested that during “political opportunities,” which were defined as moments when the political climate favored either the pro-life movement or the pro-choice movement, respective organizations were silent in the media. Rohlinger (2006) argues this is because involvement in the media is costly, (both in monetary figures, and figures that are measured by the movement’s public reputation). Meanwhile, Rohlinger found PPFA and NRLC were respectively vocal in the media (by taking out ads, making public statements, leading campaigns) when their movement was threatened by a political leader opposing abortion or reinstating legislation that protects comprehensive reproductive rights (Rohlinger, 2006, p. 547, p. 555). Thus, because these respective movements are silent when the political climate favors either pro-life or pro-choice ideologies, and the social movements employ oppositional tactics when their position is threatened, abortion rhetoric is often charged with negative emotions. One might argue that these tactics work against a reduction in abortion stigma.

The pro-life and pro-choice abortion movements get a lot of media coverage during political elections, debating laws over abortion rights. Cockrill and Weitz (2010) completed a research study using empirical, qualitative methods to explore whether women who have just had an abortion have a perspective on policies that govern abortion. The study also explored whether or not women are informed about state and federal laws regarding abortion. Cockrill and Weitz (2010) conducted semi-structured interviews with 20 participants in two states, both of which have several laws that regulate abortion by prohibiting or limiting public funding, mandate waiting periods, require that women receive state-mandated information, or require adolescents

to obtain parental consent. Cockrill and Weitz (2010) found that women were confused by or did not know that there were laws governing abortion and had difficulty distinguishing state policy, federal policy, and individual clinic policy (p. 15). Women in the study, however, expressed knowledge of government opposition toward abortion providers and abortion services. Women also shared concern that allied with the antiabortion movement regarding women's decision-making process about having an abortion: wanting women to be thoughtful about their decision rather than be hasty or irresponsible (p. 18). Cockrill and Weitz point out that whether or not the women in the study valued views "claimed" by either side of the antiabortion debate, the main themes expressed were: empathy, safe and accessible health care, responsibility, privacy, and justice (p. 19). Because this study is qualitative and had only 20 participants from 3 clinics in 2 states, the findings are not generalizable. However, it is reliable because the researchers provide a lot of information for it to be potentially reproduced. The authors cannot, however, for reasons of confidentiality, disclose the states or clinics where the abortion patients were recruited.

The population Cockrill and Weitz studied raised the question of whether women are making the right choice when they choose to have an abortion, as the women in their study were concerned about the decision-making process. This is not a new question. Since *Roe v. Wade* in 1973, and arguably years beforehand, there has been a polarized political debate about abortion. One of many binaries is a hierarchy of 'better' and 'worse' abortions. This hierarchy is one way abortion stigma is manifested. Binary abortion rhetoric cites 'better' abortions, or termination of "wanted" pregnancies, such as abortion due to a fetal anomaly. 'Better' abortions are also ones that are completed to save the life of the mother, or, occasionally, abortions for young girls as a result of incest or rape. 'Worse' abortions are frequently cited as "repeat abortions," or discussed

in other ways that connote a sense of women's irresponsibility such as not using contraception (Norris et al., 2001, p. S50).

Contrary to this rhetoric are the reasons that women cite for having an abortion, all of which highlight thoughtfulness about the responsibility of parenting. Finer et al., (2005) report that 74% of women chose to have an abortion because they cannot care for a child while caring for other dependents, or it would interfere with work or education. Seventy-three percent of women report not being able to afford having a baby, and 48% cite relationship problems or not wanting to be a single mother (Finer et al., 2005, p. 110) as reasons for not having an abortion. One might argue that the above stated reasons demonstrate both thoughtfulness and responsible decision-making.

Abortion and Mental Health

None of the reasons cited by women for having abortions in Finer et al., (2005) mention mental health as a potential reason. There is debate about whether a causal relationship exists between abortion and mental illness. This debate in scientific research impacts the political debate, as well as women's perceptions of self and of other. Steinberg and Finer (2010) completed secondary quantitative analysis of data from the longitudinal National Comorbidity Study to evaluate the abortion-as-trauma framework to determine what correlates are linked between abortion and mental illness. The abortion-as-trauma framework views abortion as a trauma. It is noteworthy that abortion is discussed as comorbidity, a disorder in connection to mental illness. Steinberg and Finer (2010) found that if prior traumatic experience and prior mental illness were controlled [they were not previously], there was not a significant correlation between abortion and anxiety disorders (p. 72). As opposed to abortion-as-trauma, however, Steinberg & Finer found a link between prior experiences of trauma and prior mental illness

diagnoses with post-abortion symptoms of mental illness. The authors found that if women did not have a history of trauma or other mental illness, they were no more likely to experience episodes of mental illness after their abortion than the general population. These findings suggest that, opposed to previous research, abortion is not linked to post-abortion trauma.

Fergusson, Horwood, & Boden (2009) also examined the link between abortion and mental health by using secondary quantitative analysis of data from a longitudinal survey. They examined abortion and subsequent mental health from data in the Christchurch Health and Development Study in New Zealand. Fergusson, Horwood, & Boden (2009) stated that unadjusted numbers found greater significance between mental health problems and abortion-related distress (p. 424). These findings are congruent with Steinberg & Finer (2010). However, by contrast, this study examined the extent to which women became more resolved with their initial feelings of grief, guilt or loss over time. Fergusson, Horwood & Boden (2009) found that 85% of their sample reported at least one or more adverse reactions to abortion, and 85% felt their happiness, relief, and/or satisfaction offset those experiences and alleviated regret (p. 425). Similarly, in Major et al., (2000), a longitudinal study on emotional response to first-trimester abortion, the authors found that “most women” (69%) do not regret their abortion two years afterward. Of note, those who did report abortion regret tended to have a prior history of depression. Major et al., (2000) found higher incidences of regret than Fergusson et al., (2009). These studies are conducted in two distinct countries, and Major et al, (2000) recruited abortion patients from the United States, whereas both Fergusson et al., (2009) and Steinberg & Finer (2010) did secondary analysis of larger surveys, one from New Zealand, and the other from the United States. In sum, none of the studies found a causal relationship between abortion and mental illness.

Zolese and Blacker (1992) argue that termination of an unwanted pregnancy is, in and of itself, therapeutic. The authors identify risk factors that give women higher probability of having an adverse psychological reaction to an abortion, and they are, “Women with a past psychiatric history, younger women, those with poor social support, the multiparous, and those belonging to sociocultural groups antagonistic to abortion” (p. 742). Almost twenty years ago, Zolese and Blacker were calling for action. The authors were trying to provide clinicians with an affective assessment tool and intervention for women who present with biopsychosocial risk factors that may make them more at risk for an episode(s) of poor mental health following an abortion.

Studies on abortion and mental health, making an explicit or implicit connection to stigma have been conducted since the 1990s. The American Psychiatric Association has responded to these links between abortion and mental health in a publication titled, “Abortion and women's reproductive health care rights” stating that abortion “must be considered a mental health imperative with major social and mental health implications” (p. 726). The APA’s statement affirms their commitment to a woman’s right to choose to, or not to have an abortion, and the necessity for the medical and psychiatric communities to support women through their process.

Abortion Stigma

Abortion stigma is prevalent, and not all clinicians are attune to the risk factors. Kumar, Hessini, & Mitchell (2009) published a theoretical study on abortion stigma arguing that “the most destructive locus of abortion stigma” is within the individual; that the experience of shame and guilt, isolation, and negative health or non-health related consequences of the emotional and social experience of stigma is what makes abortion stigma devastating (p. 633). Referred to as a “compound stigma” – meaning that abortion stigma has other forms of discrimination and

injustice built into it including ageism, sexism, racism, classism – Kumar et al. (2009) call for more evidenced-based and women-centered knowledge about the impact of abortion stigma with comparative qualitative and quantitative research on its scope and manifestations (p. 634-635). The authors propose a research agenda that would also examine policy and law, stating that laws reflect ideologies and norms regarding women, sexuality, and power that are pervasive in many cultures and foster abortion stigma. For example, in some countries abortion is a crime, in other countries there are several restrictions on abortion, all of which act to marginalize women who seek out or obtain the procedure, even though the experience of unwanted pregnancy and pregnancy termination is common (p. 631-632).

Norris et al. (2011) expand on the work of Kumar et al. (2009) in an attempt to develop a stronger theoretical framework for understanding abortion stigma. Norris et al. (2011) see stigma enacted in several spheres, not just among women who have had an abortion, but also among persons that work in facilities that provide abortions, and among support networks of women who have had abortions (p. S49). Norris et al., (2011) call for more study in the field of abortion stigma research, and they specifically call attention to ways in which abortion stigma can be compared to other stigmas “such as cancer or homosexuality” (p. S52).

Stigma has been defined and measured, but to date, there is not a validated abortion stigma scale. Norris et al. (2011) state that researchers at the University of California at San Francisco’s Bixby Center for Global Reproductive Health, Advancing New Standards in Reproductive Health [ANSIRH] program are currently developing such a scale (p. S53). This is an area of need, because each type of stigma is unique, and a validated instrument to assess abortion stigma could be used in many different treatment modalities.

Until ANSIRH's abortion stigma scale and others like it are developed and evaluated, one can look at other stigma scales and indicators that have been validated. Such instruments exist for "chronic health conditions" (Van Brakel, 2006, p. 307) such as HIV and AIDS, epilepsy, leprosy, tuberculosis, and mental illness. For example, the AIDS Attitudes Scale (AAS) is one instrument that has been validated in the United States (Van Brakel, 2006), and cited in many studies as being able to validate health care provider's attitudes toward people with HIV/AIDS. It uses two different sub-scales: an avoidance scale and an empathy scale. Attitude is then calculated by measuring difference between the two scales (Froman 1992). It has since been adjusted to provide attitudes of the general public (Van Brakel, 2006, p. 320). The validity and standard of use of this instrument is useful for measuring stigmatizing others, and may be translated to other forms of disease.

The "Community Attitudes to Mental Illness" (CAMI) and the "Internalized Stigma of Mental Illness" scale (ISMI) are validated measures that are used in many contexts for measuring mental illness stigma, and cited frequently as being reliable tools (Van Brakel, 2006). The CAMI measures attitudes in the general population on authoritarianism, benevolence, social restrictiveness and community mental health ideology. The ISMI measures subjective experience of stigma, with subscales measuring alienation, stereotype endorsement, perceived discrimination, social withdrawal, and stigma resistance. Van Brakel came to the following conclusion after reviewing the literature and stigma scales:

The impact of stigma is remarkably similar in different countries and health conditions, despite enormous cultural diversity and differences in determinants. Stigma affects marriage, interpersonal relationships, mobility, employment, access to treatment and care, education, leisure activities and attendance at social and religious functions. This

similarity suggests that it may be possible to develop a set of “transcultural” generic instruments to assess the intensity of stigma and discrimination related to a particular condition in a given community. (p. 327)

Many interdisciplinary medical professionals have an impact on abortion care. One group that is not too dissimilar from clinical social work professionals in that they have many counseling responsibilities during patient interactions is obstetric and gynecologic nurses and midwives. Lipp (2010), using a grounded theory method, conducted qualitative interviews with nurses in Wales to study how their personal values, as well as expertise in abortion influence the way they view themselves as interacting with abortion patients. Lipp (2010) wanted to test the opinions of nurses, who (due to pending legislation) may have more rights to provide direct abortion care (perform first trimester abortions, prescribe “the abortion pill”), and therefore, interface with women having abortions more regularly. Themes that arose out of the study were that the nurses identified strengths in being “non-judgmental” such as being an attentive listener and being open-minded. Additionally, the nurses noted their biases or “judgments” which they attempted to conceal from patients by using maxims. A theme that evoked more judgment across the board [and is more stigmatized in the US as well] was patients that had “repeat abortions.” Lipp (2010) concluded that abortion stigma is implicit in participants’ [nurse’s] efforts to conceal their judgments, and Lipp (2010) suggests that to shift the paradigm to normalizing abortion within the healthcare system, nurses need more support and space to discuss their personal judgments, such as more supervision. While this study is not generalizable to the United States, and the nursing profession is different in training and in responsibility from the clinical social work profession, this study raises themes that are relevant to clinical social work practice: biases, use of language, use of professional support.

The Good Mother Stereotype

Many mental health professionals have defined expectations for the ‘good enough’ mother. Freud, Klein, and certainly Winnicott have developed a solid foundation of beliefs about maternal-child attachment, nurturing, and a therapeutic holding environment that can be very strengths-based (Applegate, 1996, p.82). These theories, though developed years ago, are applied in contemporary clinical social work practice today. Understandings of the mother-child relationship are useful when working with family systems, children, and adults alike. Yet, one could argue that the theoretical framework conforms to stereotypical expectations of women as caregivers. Having an abortion prevents one from mothering a child, and thus, abortion may not fit with the ‘good enough’ expectations for women to be nurturing. Others may argue that abortion is congruent with this framework, because women are considering the welfare of a potential child and their life as a mother. Many women want to be ‘good enough’ and that desire motivates them to have an abortion during periods when they do not feel it is a good time to have a child or another child.

Another form of women’s identity consciousness that there exist strong cultural expectations that women fit into mother roles is in literature. This identity dilemma is well articulated by women fiction writers. Chopin (1994) imagined a protagonist who does not want to be defined by her identity as mother:

I would give up the unessential; I would give my money, I would give my life for my children; but I wouldn’t give myself. I can’t make it clearer; it’s only something which I am beginning to comprehend, which is revealing itself to me. (p 46)

Being a woman and getting pregnant, and either having an abortion or being a mother is inextricably linked to sex. In the April 1950 edition of *Negro Digest*, Zora Neale Hurston

published an article titled *What white publishers won't print* and commented on racism and sexism in America, "it will remain impossible for the majority to conceive of a Negro experiencing a deep and abiding love and not just the passion of sex" (cited in Smith & Watson, 1992, p.43).

Contemporary research on the good mother stereotype among college age women suggests that college students believe that 'good mothers' stay home and care for their children, rather than return to school. Mottarella, Fritzsche, Whitten, & Bedsole (2008) state, "Gender-role theory asserts that society holds stereotyped expectations for the appropriate behaviors in which men and women should engage. Men are expected to adopt the role of breadwinner, and women the role of caretaker" (p. 223). Mottarella, Fritzsche, Whitten, and Bedsole surveyed 205 male and female students attending either a community college or 4 year university with a gender role scale instrument. The authors found that male students perceived mothers as less feminine than women who were not mothers, and all students viewed mothers who returned to school at six months after giving birth were viewed as "more cold-hearted than those who drop out" (p. 229-230). Again, this study demonstrates the ways in which expectations regarding women and their roles as mothers carry with them many pressures, stereotypes, and even judgment.

Summary

This literature review encompasses an overview of themes that relate to abortion stigma. Relevant bodies of literature include the public discourse on abortion, abortion and mental health, motherhood stereotypes and stereotype threat.

Social attitudes influence abortion politics in the United States and play a significant role in how the public discourse contributes to abortion stigma. The literature on abortion and mental health critiqued claims that internalized stigma causes poor health outcomes, including poor

mental health. Findings suggest that there is not a causal relationship between abortion and mental illness. Abortion, to many, is viewed as therapeutic. Women's experiences with and knowledge of abortion is linked to stereotypes about motherhood. Women's opinions about and/or personal identification with motherhood stereotypes may contribute to the level of perceived, internalized or projected abortion stigma they experience.

It would be helpful for future researchers to complete a more comprehensive review of each of these bodies of literature. There are many individual, cultural, and sociopolitical themes that contribute to perceived, anticipated, projected, and internalized abortion stigma. Further understanding of these themes may help clinical social workers that work in health care settings normalize abortion and reduce stigma. The current review informed the development of an exploratory mixed methods study to learn more about how women experience abortion stigma.

CHAPTER III

Methodology

This exploratory mixed methods study is designed to expand the field of abortion stigma research. For the purposes of this study, abortion stigma is defined as negative characteristic(s) attributed to women who chose to terminate a pregnancy. Abortion stigma is also defined as negative characteristic(s) attributed to people and places that support women who chose to terminate pregnancies. The study pilots an anonymous online survey instrument and confidential semi-structured in-depth telephone interview questions, with the aim of understanding whether women who have had an abortion internalize stigma significantly more than women who have not had an abortion. A secondary aim is to understand whether all women, regardless of their reproductive medical history, identify ways in which abortion stigma has impacted their lives. Further research may involve adapting this survey instrument or in-depth interview guide, and study protocol for more careful study of the research questions with a larger more diverse population.

The researcher asks the following questions using a quantitative online survey instrument with about forty ordinal questions, and data from qualitative semi-structured in-depth telephone interviews: 1) Who are the women who took the survey, and what impact do demographics have on data? 2) What are women's reproductive health histories, and how do those experiences affect opinions about abortion stigma? 3) When and in what context did women learn about abortion? 4) What are participant's community's attitudes about abortion? 5) What personal experience do women have with abortion? 6) In what ways does identity impact views on abortion? 7) What are women's attitudes about the possibility of having an abortion in the future?

The qualitative methods used in this study allowed respondents to articulate salient aspects of their experience in their own words during telephone interviews. Utilizing a mixed methods study protocol provides rich data to expand upon topics that the online quantitative instrument may have overlooked. These methods are particularly helpful in propagating new ideas in a pilot project Master's thesis exploratory study about abortion stigma, a newly developing field of empirical and theoretical research.

The quantitative survey instrument used in this research study was designed specifically for this social work Master's thesis; it is not validated and reliability tests were not completed prior to data collection. Before submitting an application to the Smith College School for Social Work Human Subjects Review Committee, the survey instrument was informally reviewed by external researchers who study in the field of reproductive health. These reviewers were: Celeste Royce, MD, Assistant Clerkship Director, Obstetrics and Gynecology Department at Beth Israel Deaconess Medical Center; Michele Hacker, Ph.D., Director of IRB Operations and an Epidemiologist in the Obstetrics and Gynecology Department at Beth Israel Deaconess Medical Center; Laura Dodge, MPH, doctoral student at Harvard School of Public Health and Clinical Research Assistant at Beth Israel Deaconess Medical Center; and Kate Cockrill, MPH, Research Analyst and Project Manager at Advancing New Standards in Reproductive Health [ANSIRH]. In addition, Timothy Creedon, a doctoral student at The Heller School for Social Policy and Management who has published peer-reviewed clinical research on mental illness reviewed the instrument and provided feedback regarding researcher bias. External review informed revisions in structure and content of the final version of the survey.

The instrument borrows about 10 questions from a semi-validated survey instrument developed by researchers at ANSIRH, which is a program of the Bixby Center for Global

Reproductive Health at the University of California, San Francisco. ANSIRH's survey instrument was used in a large study with over 550 participants to evaluate whether women who have had an abortion experience enacted, felt, perceived and/or anticipated stigma, and the first publications are expected soon. The Principal Investigator for the study states that, "understanding abortion stigma is an important aspect of understanding women's emotional experiences with abortion in the United States," and researchers at ANSIRH are developing an abortion stigma scale because a standard measure for understanding women's social and emotional experiences of abortion is not available at present (ANSIRH, 2011, p. 1). The Principal Investigator, Kate Cockrill, MPH was one of the informal external reviewers of this survey instrument. Please see Appendix L for a letter from Ms. Cockrill.

The purpose of this thesis is exploration. The researcher wished to "generate insights" about abortion stigma, as research in this area is "relatively new." The researcher aimed "to test the feasibility of undertaking" this research, and "develop the methods" to be used in a more controlled study (Rubin & Babbie, 2010, p. 41). This thesis sought to identify methodological weaknesses and areas for future research that will enhance understanding of abortion stigma.

Sample

In addition to agreeing to the terms of the informed consent form [see Appendix F], individuals must meet three eligibility criteria to participate in the research study: 1) be English-speaking 2) women 3) between the ages of 18 and 65. Nonprobability, convenience/availability and purposive sampling methods were used to recruit women to participate from three sites.

The researcher developed a convenient sampling frame using institutions in greater-metropolitan area of a large New England city. It is the community where the researcher resides. Subsequently, she investigated colleges and universities in the area that have more than 4000

students. The researcher also explored potential large clinic/hospital sites that perform abortion procedures on a weekly basis. Then, she contacted 10 colleges and universities, and three sites that provide abortions. During the thesis proposal and Human Subjects Review [HSR] application period, challenges in obtaining commitment letters from recruitment sites highlighted difficulties regarding the feasibility of this study design.

The aim was to recruit women from five colleges/universities and one clinic/hospital site. External Institutional Review Board approval was required for all but one university that responded to my outreach. Sampling frame reduction occurred due to time constraints, feasibility concerns, and the amount of external review required to approve the protocol. Women were recruited from three universities, rather than five, and the clinic/hospital site was removed from the sampling frame. Three predominantly white, private, liberal, metropolitan New England college campuses were identified as recruitment sites. Please see Appendix B detailing potential sites and the respective obstacles in sampling process.

The original purpose of having a nonrepresentative sample frame that included women from two different settings (either a college/university setting, or a doctor's office/hospital/clinic setting) was to obtain more demographic diversity, a range of reproductive health experiences, and to be able to contrast the findings from women who were sampled from either a college campus or clinic site. Demographic diversity and reproductive health experiences were limited by the removal of the abortion clinic/hospital recruitment site. Sampling became more homogenous, and study findings are limited due to the non-representative characteristics of the three recruitment sites. Please see the limitations section in Chapter Five for more detail.

Removing sites also reduced the probability that the researcher would reach her desired n (150 study subjects for the qualitative survey instrument). Therefore, the researcher considered

amending the protocol to include snowball-sampling methods using social media, and convenience and purposive sampling methods at another clinic site that offered the opportunity to recruit staff, rather than patients.

The researcher did not amend the protocol. If she sampled from her social network, the researcher could not guarantee that potential study subjects would be able to maintain their anonymity. Extended social network recruitment may have introduced too many biases.

After consultation with her thesis advisor, the researcher also decided not to sample from the clinic site with a population of staff members. The researcher, in collaboration with her thesis advisor came to this decision because it would be challenging to control for new variables a population of women who work as abortion providers (counselors, doctors, administrators, nurses, medical assistants) would introduce to the study. The survey instrument was not designed to assess experiences of abortion stigma among abortion providers. Recruitment at three relatively homogenous, liberal, private, metropolitan university sites in New England permitted the author to control for threats to internal validity in the sampling frame, even though it presented limitations for the generalizability of findings and contributed to methodological weaknesses.

Recruitment

For the first phase of the study, women were recruited to participate in the quantitative survey with flyers posted on three university campuses. Please see Appendix J for the flyer. It contained a brief description of the study, a URL for the survey [www.surveymonkey.com/s/WSE], and the researcher's contact information so potential participants had the option to call with questions. The researcher established a new Google

telephone number and Google email address for exclusive use during this study to protect her identity and maintain confidentiality.

Recruitment occurred in phases according to respective university Institutional Review Board approval. The online survey instrument was open for collecting data from the end of February 2012 to May 31, 2012. One campus had flyers on site from March through May 2012. The other two sites did not have flyers on campus until April 2012. The first participants responded to recruitment in early March, 2012. Please see Appendix A, C, D, and E for all IRB approvals. I posted flyers at all sites a second time in an attempt to recruit more participants. Unfortunately, response was low. It was particularly low at two of the three sites.

Women in the second phase, or qualitative portion of the study were recruited from the participant pool that completed the online quantitative survey instrument. At the end of the questionnaire, participants will be asked if they would like to volunteer to participate in a telephone interview that will take approximately 30-45 minutes. Then, women had the option to click on a link that led them to a separate survey

[www.surveymonkey.com/s/Amazon_Volunteer]

Participants who chose to volunteer for the qualitative portion of the study had to click on a link that led them to a separate survey. Therefore their anonymity on the quantitative survey would not be compromised. Please see Appendix I for the quantitative survey, and Appendix K for the qualitative telephone message script. Sixteen participants clicked on the link and volunteered identifying information, indicating that they were interested in participating in additional research. The researcher contacted all of these volunteers. After outreach, eight participants volunteered, consented, and completed the in-depth interview.

Participation in the telephone interview involved providing demographic information and contributing to a conversation centered around the following three questions: (1) What was your experience taking the survey? (2) What are your views on abortion? (3) What are your community views on abortion? [See Appendix L for a copy of the interview guide, which details demographics collected and all potential follow-up questions.] Even though there was an interview guide, each interview was unique. The researcher used grounded theory techniques informed by prior research to develop the guide, and then followed patterns, themes and observations to have a more in-depth dialogue with participants. Rubin and Babie (2010) state: “Although researchers using this method might have some preconceived ideas of expectations based on existing theory and research, the analysis is not set up to confirm or disconfirm specific hypotheses” (p. 224).

If women agreed to participate in the telephone interview, the researcher made follow-up calls within 2 weeks from the date women volunteered. If participants did not answer when called, they received a voicemail message mentioning “a study they took.” The author provided the research subjects with the researcher’s Google telephone number for participants to call if interested. The researcher made one more attempt at outreach to assess interest in participation [see Appendix K for script]. If participants would prefer not to receive a voicemail message, they will be advised not to volunteer to participate in the telephone interview.

The purpose of the initial call was to discuss what participation in the in-depth telephone interviews involved in more detail. If one expressed interest after the call, I proceeded to mail them the informed consent form and scheduled a time for the interview (allowing time for participants to receive the forms, sign one copy and return it to me in a self-address sealed

envelope). Thus, interviews sometimes occurred weeks after study participants completed the quantitative survey.

At the beginning of the telephone interview, the researcher read a truncated version of the informed consent aloud. The researcher reminded participants that they had the right to withdraw at any time and provided Smith College School for Social Work Human Subject Review Committee's contact information. Subjects were assured that the researcher was interviewing them in a private space, and she made precautions ahead of time so that no one could overhear the interview. Participants were told that they may refuse to answer any question and were encouraged to ask for clarification when desired. Participants were not asked to provide an explanation as to why they refuse to offer a response to a question; the researcher would not make note the refusal and it would not be discussed as an outcome.

Then, the researcher asked study subjects if they had any questions about their rights as a research subject. The final question was whether participants agreed to be audio-recorded. If yes, the researcher announced that she was turning on the audio recording device, and proceeded with the interview questions.

Nature of participation

Individuals interested in participating in the study tear-off a tab of the flyer and type in the URL for the survey to make an informed decision about their participation. A more detailed description of the study, eligibility questions, and informed consent form are the first steps the potential research participant encounters on the survey website.

At a minimum, women are asked to participate in an anonymous quantitative survey that took approximately 20 minutes of their time. They had the option to enter personal identifying information in another survey instrument to volunteer to be entered into a drawing to receive a

gift certificate to Amazon.com. At a maximum, women participated in the quantitative survey, offered some identifying information (first name and telephone number), and participated in a qualitative in-depth interview that took an additional thirty to forty-five minutes of their time, totaling about 1.5 hours of commitment to the research study. All women who participated in the in-depth interviews received a \$5 gift card to Dunkin Donuts. Neither Amazon nor Dunkin Donuts are a sponsor of this incentive.

Ethics and Safeguards

The Smith College School for Social Work Human Subjects Review Committee, in addition to the Chairs of the two private metropolitan New England universities reviewed and approved the application(s) [See Appendix C, D, E.] One external university approved the research study after expedited review, and the other approved the study after full committee review. One site did not require review. All sites deemed that benefits of this study outweighed risks.

There were risks associated with participating in this study: participants risk having their confidentiality breached, and participants risked feeling some emotional discomfort disclosing their experiences and/or beliefs about a sensitive topic.

There were benefits to the study: participants may have felt satisfied or relieved by disclosing information; women may have felt like their participation in the research study is benefitting a larger body of knowledge. The findings from this study may contribute to a body of knowledge about the intersection of abortion stigma in women's lives that could be incorporated into social work practice and training, as well as add to the body of inquiry in the niche field of abortion stigma research.

A limitation of the study is women underreporting, or misreporting information. A woman would only disclose what she felt comfortable disclosing [unless she felt coerced]. To determine whether to report personal information, subjects weighed the potential benefits and losses of their disclosures. “If she has faith in the confidentiality assurances and the integrity of the interviewer and researchers, she may be inclined to report [her reproductive health history] accurately,” (Rasinski et al., 1999, p. 468). The researcher made every effort to protect subjects’ confidentiality.

With regard to emotional discomfort: it is unlikely that subjects felt distressed as a result of their participation in the study. However, due to the sensitive nature of the topic, some women may have experienced discomfort. Previous research that examined the psychological implications of stigma and abortion among women followed 2 years after their abortion procedure found that disclosure was benign or beneficial. Women who were not distressed about their abortion were comfortable or indifferent disclosing information about it. Women who were troubled about their abortion experienced decreases in distress after disclosing information about their experiences, (Major & Gramzow, 1999). It is likely that subjects experienced minimal risk by participating in the proposed study.

Steps were taken to ensure that participants had adequate time to consider their participation prior to formally providing consent. The researcher does not have control over how long participants spent reading the informed consent form on the online survey instrument. Prior to reading the informed consent page on the survey website, participants had to see the flyer, decided the study what of interest to them for xReason, and made the decision to go to the URL on the flyer to learn more. [Participants had a significantly longer time to think about their participation in the in-depth interview (IDI). Participants will be familiar with some of the IDI

study questions because they took the online survey; their consent was informed by that experience.]

The investigator was aware of having any undue influence over the population that may see the flyer, and deliberate measures were taken to reduce coercion. Flyers were posted on bulletin boards rather than handed to individuals. The researcher did not sample from her immediate or extended social network. By removing the clinic site where the researcher had her second year field placement, she removed a population from the study who she may have had contact with. No large incentives were utilized and incentives were not emphasized on the recruitment flyer.

Lastly, participants were recruited via non-probability sampling methods. Women who saw the flyer discerned whether a study about abortion is one that they were interested in. The researcher made a strong effort to be transparent about what participants should have expected when they participate. There is a large culture of women who take social and political action regarding their views on abortion. One of my outcome measures is study subjects' political affiliations and identities regarding "pro-choice" and "pro-life." Populations who share their views about a sensitive topic on a regular basis may be significantly less at risk of feeling discomfort talking about abortion because it is a topic they are interested in. My quantitative survey instrument was not able to determine whether a subject belongs to a sub-culture in which she takes political or social action regarding abortion, however, this topic may come up in the in-depth qualitative telephone interviews. Women who self-select to participate in a second portion of the study may be more interested in the topic than women who do not select to participate. Further study could explore these questions more rigorously.

Data Collection

All data collected through the quantitative survey instrument was accomplished with nominal and ordinal level of measurement questions. The researcher collected the following demographics: race, ethnicity, annual household income, relationship status, sexual identity, religion, political affiliation, education level, number of previous births, number of previous pregnancies, number of previous miscarriages, and number of previous abortions. Women were asked about their beliefs and values, their community's beliefs and values, and their experiences (personal or through a family member/friend/acquaintance) with abortion. Women were asked about when they first learned about abortion, and how abortion was framed in that context. Women were asked if they had a previous abortion(s), and if having an abortion became a part of their identity (and to what extent). Women were asked if they could imagine having an abortion in the future for (1) an unplanned pregnancy (2) fetal abnormality (3) rape or incest.

The qualitative in-depth interviews [IDIs] had a semi-structured interview guide that adapted questions from the quantitative survey to fit an open-ended discussion about women's social and emotional experiences with abortion [See Appendix L]. Women were encouraged to speak about the process of participating in the survey and identify any challenges, feelings, or questions that came up during participation. The interview was structured around three main questions: (1) What was your experience taking the survey (2) What are your views on abortion (3) What are your community's views on abortion. The researcher had many resources to offer participants if they desired, as well as rehearsed responses to questions women may ask about the survey/research, strong affect women may/may not have expressed. None of the participants indicated that they had interest in utilizing these resources.

The researcher worked to make her biases known to the extent that it was relevant to the research, and the researcher attempted to remain apolitical and neutral about opinions/attitudes/beliefs regarding abortion. Lastly, each participant was asked to provide the researcher with feedback on their overall experience of the research study when they completed the in-depth interview. The researcher asked participants whether they wished she were asked a question that she was not asked, and all participants were asked whether any of the questions were confusing. All participants were encouraged to contact the researcher after participation, until June, 2012 to provide additional feedback or to withdraw from the study.

Data Analysis

Quantitative data was recorded in Survey Monkey from March 2012 through June 2012. After data collection was complete, it was exported to Excel and imported to STATA. Unneeded variables were removed from the study: subject start date; end date; and two questions that zero or one subject responded to, “I understand why I am not eligible to participate in the study,” and “Please consider how having an abortion shaped your identity.” Seven subjects were dropped from analysis: three did not meet eligibility criteria because two identified as “male” gender and one identified as “other” gender; three other participants did not respond to the Informed Consent question and agree to participate; one participant completed the first four questions of the survey and then did not answer any of the other study questions. One participant completed about half of the survey questions, and her responses were included in the analysis.

The researcher re-labeled each question and re-coded most variables for analysis. [See codebook in Appendix I for detail.] The nominal demographic data was interpreted using descriptive univariate analysis. The ordinal data was interpreted using bivariate analysis to explore the relationships between variables. An abortion stigma composite measure was created

to test perceived abortion stigma. The researcher attempted to identify a numerical score of perceived abortion stigma for each participant with this composite measure. The four abortion stigma questions on page 10 of the survey plus the seventh question on page 11 of the survey were part of the composite. Each were coded one through five, five being equivalent to the most perceived stigma, and one being no perceived stigma. According to this model, if a participant had a score of 25, they would report the most perceived abortion stigma. The researcher developed another composite measure for perceived abortion stigma in community attitudes about abortion for the community questions on page 12 of the survey. There are seven questions regarding community beliefs about abortion. If a participant had a score of 35, they would perceive their community as having a lot of prejudice about abortion. [See Appendix I, Quantitative survey codebook for detail.]

Third, the researcher audio-recorded all but one in-depth interview in Garage Band, transcribed each verbatim in Microsoft Word, to include record of long pauses, and analyzed each using constant comparative methods. Themes emerged that were consistent between interviews and quantitative data analysis. First, qualitative data was analyzed quantitatively to describe the frequencies, similarities and differences among responses. Second, data was analyzed thematically with constant comparative methods (Rubin & Babie, 2010, p. 308) [See Appendix I for the qualitative in-depth interview codebook].

Methodological Weaknesses

This study design presents a few threats to internal validity. The primary threat in this study is selection bias. It is difficult to maximize the comparability of the dependent variable (women who have had an abortion), when only three study subjects identified themselves as

having one or more abortions. The survey instrument has a measurement bias, and the qualitative data is subject to the interpretation of the researcher.

Women who were more interested in committing their time to a research study are going to participate than women who have less time or do not wish to dedicate the time they have to participate in a study. Women who explicitly do not want to talk about abortion will not participate in a study that is advertised as being about the topic of abortion. The researcher does not know whether more women who “support” abortion are more likely to participate in the study, or whether the sampling frame is one that is more likely to be pro-choice. Further research could explore this question more in-depth. Methodological strengths include having a mixed methods study to be able to expand upon the quantitative findings with richer data.

CHAPTER IV

Findings

This exploratory mixed methods study investigated women's social and emotional experiences with abortion using an online quantitative survey instrument and in-depth telephone interviews. The study aimed to answer the question of whether women who have had one or more abortions experience abortion stigma significantly more than women who have not had an abortion. The study also aimed to explore whether all women, regardless of their reproductive health history, identify experiences of abortion stigma. For the purposes of this research study, abortion stigma was defined as prejudices and discrimination against women who have abortions, and people and places who support women who have abortions.

The quantitative survey instrument included about forty nominal and ordinal questions, divided into nine sections: (1) selection criteria (2) personal reproductive health history (3) abortion stigma (4) learning about abortion (5) perception of community attitudes about abortion (6) personal experience with abortion (7) identity (8) attitudes about abortion as potential experience for self / for others (9) demographics.

This chapter will provide the major findings of the quantitative study, beginning with the demographics, then descriptive analysis of ordinal data, followed by analysis of relationships between variables.

This chapter will also describe rich data from the in-depth interviews, and use quotations to illustrate themes from the quantitative survey instrument that were illuminated during the interviews. The qualitative data will provide survey instrument reliability insights by highlighting questions that confused or challenged subjects.

A total of 46 participants were reviewed for eligibility to take part in the quantitative survey instrument. 43 participants met eligibility criteria, and 39 participants completed the survey instrument. This small sample is a result of limitations in study design, timeframe, obstacles in institutional review, and potentially the research topic.

Out of the original 46 participants, data from the 39 study subjects who completed the survey were included in data analysis. Seven respondents were excluded because three did not meet eligibility criteria due to gender identification, three did not consent to participate, and one did not complete a majority of the survey. The participants in this study first responded to a flyer by going to www.surveymonkey.com/s/WSE to take the quantitative survey. Upon completion, if interested, subjects went https://www.surveymonkey.com/s/Amazon_Volunteer to enter their personal contact information if they were interested in participating in the qualitative portion of the study. 16 out of the 39 participants expressed interest in participating in additional research. Of those 16, 8 women responded to outreach, participated in the interview, and were included in data analysis.

Demographics

All participants were women. On average, participants in the study were young women affiliated with universities in Massachusetts. Most were white non-Hispanic highly educated women in their mid-20s who were of middle to upper-middle income. Many of the women who participated in this research study were non-religious and liberal. About half were in relationships and most were heterosexual.

Table 1a. illustrates age, race, education, and income demographics. The mean age of participants was 27, with a range from 18 to 62 years old. The age distribution was skewed with a steep negative slope due to outliers. Four middle-age study subjects (age 55, 56, 57, 62) offset

the data (standard deviation: 11.58). None of the women in the study identified as Hispanic, and 27 participants were white (71.05%). Of the 11 remaining participants in the study, three were African American, four were Asian, and four identified as “other” races.

All of the women in the study had some level of college education (76% were currently enrolled, and 24% were college graduates). Women were not asked to identify whether they were currently enrolled at the undergraduate or graduate level. About 40% of the participants made \$50,000 per year or less. Only three women made less than \$20,000 per year or less. A fifth of the participants did not know their annual household income.

Table 1a.

Demographic Characteristics of WSEEA Online Survey Participants*

Characteristics	Respondents (n = 39)**
Age	
Mean (SD)	27.23 (11.58)
Median (Range)	23 (44)
Race (non-Hispanic)—no. (%)	
White	27 (71.05)
Black	3 (7.89)
Asian	4 (10.53)
Other	4 (10.53)
Education Status—no. (%)	
Currently in college or graduate school	29 (23.68)
College graduate	9 (76.32)
Annual Household Income—no. (%)	
≤ \$10K/ year	3 (7.89)
≤ \$20K/ year	1 (2.63)
≤ \$50K/ year	12 (31.58)
≤ \$100K/ year	12 (31.58)
≥ \$100K/ year	2 (5.26)
“Don’t know”	8 (21.05)

*Women’s Social and Emotional Experiences with Abortion [WSEEA]

**Demographic information missing for one subject (2.6%)

Among the eight women who participated in the qualitative in-depth interviews [data excluded from Table 1a.], age was diverse and balanced: (18, 19, 23, 23, 32, 34, 55, 57). There was a similar race distribution among this group to that in the quantitative survey instrument. Five women (62.5%) identified as white; 2 women (25%) identified as Asian, and one participant identified as African American (12.5%). Women in the interview subset reported slightly higher incomes on average, relative to the larger survey population. While two women did not know their annual household income and one stated that her income was “very low,” five out of eight were in the middle to upper-middle income bracket (between \$50,000- \$100,000/year). One student in this group reported that she was dependent on her father’s annual household income and guessed that her parent made less than or equal to \$100,000.

Table 1b describes the relationship status, sexual identity, political affiliation, and religion demographic data for the quantitative survey participations. Women who participated in the qualitative interviews were not asked to report on relationship status, sexual identity, political affiliation, and religion. Often, these demographics were noted during discussion and they will be reported on later they illustrated a theme.

Table 1.b

Demographic Characteristics of WSEEA Online Survey Participants

Characteristics	Respondents (<i>n</i> = 39)*
Sexual Identity—no. (%)	
Heterosexual	30 (78.95)
Bisexual	5 (13.16)
Other	2 (5.26)
Lesbian	1 (2.63)
Relationship status—no. (%)	
Single	20 (52.63)
Partnered	11 (28.95)
Married	7 (18.42)
Politics—no. (%)	
Democrat	24 (63.16)
Independent	9 (23.68)
Republican	2 (5.26)
“I’m not political / I don’t know”	2 (5.26)
Other	1 (2.63)
Religion—no. (%)	
No religion	12 (36.36)
Jewish	8 (24.24)
Catholic	5 (15.15)
Christian (general)	2 (6.06)
Hindu	2 (6.06)
Muslim	1 (3.03)
Episcopal	1 (3.03)
Protestant	1 (3.03)
Presbyterian	1 (3.03)

*Demographic information missing for one subject (2.6%)

Just under half of the participants (47%) reported that they were currently married, partnered or married at the time of survey completion. Fifty-three percent of women reported that they were single. There was a significant difference in age by relationship status ($F(2, 35) = 4.36, P \leq 0.05$). On average, single women were 12.25 years younger than

married women ($P \leq 0.05$). Partnered women were 14.58 years younger than married women ($P \leq 0.05$).

The majority of study subjects labeled their sexual identity as heterosexual (78%). Five participants (13%) identified as bisexual, one identified as lesbian, and two identified as “other.”

Two thirds of survey respondents reported that they were Democrats (63.2%), a quarter of participants had an independent political affiliation, two participants identified as Republican, two participants reported that they were not political or did not have a political affiliation, and one participant identified with an “other” political party. Qualitative participants were not explicitly asked about their political affiliation; however, it often came up in discussion. When it did, most participants described themselves as “liberal” or “left-wing.”

Just over a third of women in the study report that they were not religious, a fifth report being Jewish, and 12.8% report being Catholic, and the remainder were affiliated with “other” religions [see the detail in Table 1b.]. If all Christian dominations are grouped, about 25% belong to a Christian faith. Of note, six participants (15.38%) skipped the question. There was a significant relationship between race and religion ($\chi^2(3) = 9.08, P \leq 0.05$). However, those who identified as “other” when asked about their race were the only group for which the difference was meaningful. More “others” than expected said they were not religious.

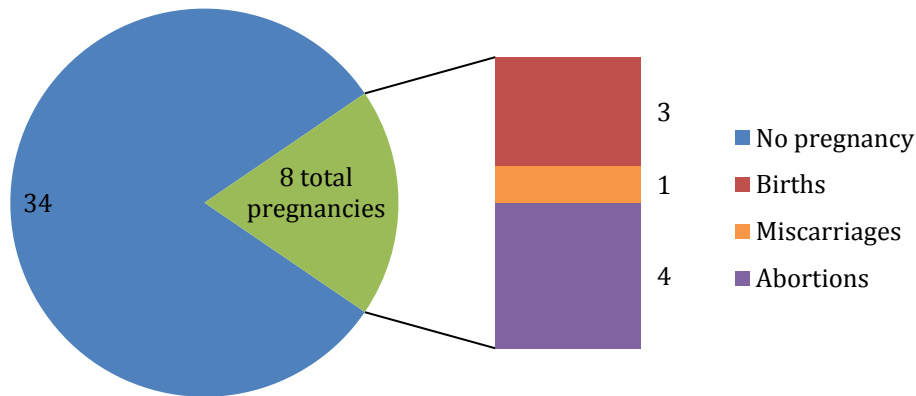
Reproductive Health History

The majority of women who participated in this study reported that they were never pregnant (87.18%). There was a significant relationship between age and pregnancy; the older a participant was, the more likely they were to have been pregnant ($F(3, 35) = 4.82, P \leq 0.01$). No women under age 29 had ever been pregnant. As can be seen in Figure 1, five women

reported eight total pregnancies. Three women were pregnant once, one woman was pregnant twice, and one woman was pregnant three times. Four of those pregnancies ended in abortion.

Figure 1:

Reproductive health history characteristics of WSEEA Online Survey Participants



$n = 39$

There was a significant relationship between subjects' race and whether subjects reported having an abortion. More Black women than expected reported having an abortion ($\chi^2(6) = 15.54, P \leq 0.05$). Of all three women who reported one or more abortions, none of the women were the same race.

Among the eight subjects who participated in the in-depth interviews, two reported having a previous abortion. Thus, two out of the three women in this research study who reported ever having a prior abortion participated in the qualitative in-depth interview. There is a significant relationship between having an abortion and participating in the in-depth interview where more people who had an abortion volunteered for and completed the interview than was expected ($\chi^2(1) = 4.25, P \leq 0.05$).

Both women who participated in the in-depth interview [IDI] and reported having an abortion commented on how they did not regret their decision. The researcher did not ask any of the qualitative research subjects whether they had an abortion. The survey data is anonymous, so the researcher cannot determine whether the third woman who reported having an abortion was among the eight subjects who volunteered to participate in the interview, and then did not respond to outreach. None of the in-depth interview participants reported giving birth or having a miscarriage; two participants reported having adopting a child.

For those who reported having an abortion, the researcher did not ask subjects to comment on their decision-making process. One participant stated, “It was not a particularly difficult decision, it was a tricky time in my life ...It was definitely the right thing to do, and I have never particularly regretted that decision that I made.”

Another women said,

I never actually felt regret. I was always very sure that I was making the right decision. The only thing that I will sometimes feel about it is, ‘oh, if I did not have an abortion, right now I would have a child that was like six months old’ or something of that sort.

Seventy-four percent of participants in the larger quantitative study identified as pro-choice. Twenty-one percent identified as “mixed or neither,” and two women identified as pro-life. All subjects had an opinion about abortion that could be encapsulated in one of those three categories. None of the participants stated “I don’t understand the question,” and 0% gave a “no opinion” response.

During the in-depth interviews, all women identified themselves on a spectrum of being “pro-choice.” A couple of women had “pro-life” views that have since changed. Qualitative participants mentioned the phrase “pro-choice” 22 times during interviews. “Pro-life” was

mentioned 20 times. The phrase “anti-abortion” came up four times, and “anti-choice” came up another three times.

One qualitative in-depth interview participant articulated frustration with binaries in labeling views about abortion “pro-choice” or “pro-life.” She states: “the discussion of abortion is sometimes oversimplified by saying you’re either pro-choice or pro-life: ...I think people either identify with one group, whether it’s pro-choice or pro-life, when actually the discussion has a lot more to offer than that.

Another interview participant commented on how her views on abortion have changed over time:

In the 1980s, ...there were a lot of things about me that were different from how I am now, and how I was before that. I thought it [a fetus], was more of a life at that point, I think. Then, I came out of that phase of my life. I think it’s like maturing. I started to see that there are nuances; it’s neither one way nor the other.

A participant commented on her expectations for participation in a survey about abortion during the in-depth interview:

I was surprised, I guess, by some of the questions. Not necessarily in a bad or good way, just challenged. ...I thought it was an interesting way to discuss abortion. When I found the [survey recruitment] flyer, I thought [the questions about abortion] would be more black and white. In that way it was very thorough because it challenged the audience, or participant in a way that wasn’t black and white.

Abortion Stigma

Most participants (87%) agreed or strongly agreed that there is an abortion stigma pertaining to women who have abortions, and nearly all women in the study (95%) disagreed or

strongly disagreed that women are not stigmatized, discriminated against, or judged for having an abortion. While slightly fewer, the many of subjects (77%) agreed or strongly agreed that abortion stigma affects people and places that support women who have abortions. The majority of participants disagreed or strongly disagreed (87%) that people and places that support women who have women are not stigmatized. While the relationship between these variables do not have statistical significance, it is interesting that more subjects perceived abortion stigma regarding women who have abortions and people and places that support women who have abortions when the question was phrased in the negative. [See Appendix I for quantitative survey instrument.]

In describing her responses to the quantitative survey about abortion stigma, one subject who participated in the IDI stated that she may have agreed with the definition of abortion stigma, however, she does not believe abortion stigma exists. She noticed a potential measurement bias:

I guess if you're asking if that's the way that I would define abortion stigma, then I would at least agree if not strongly agree with those sort of clinical definitions. I myself would never apply the stigma to somebody who has had an abortion. [...] I don't really feel that there's much of a stigma at all.

In this research study, there was a significant relationship between having an abortion and perceived abortion stigma. More women who had an abortion than expected said they “strongly disagreed” that abortion stigma is when people have prejudicial attitudes about women who have abortions ($\chi^2(6) = 19.25, P \leq 0.01$). More participants who had an abortion than expected “neither agreed nor disagreed” that women are not stigmatized, discriminated against, or judged for having an abortion ($\chi^2(6) = 20.07, P \leq 0.01$). The woman above who participated in the

IDI reported that she had an abortion, and she did not believe that stigma affects women who have had abortions. This finding is opposite of the researcher's hypothesis.

Two-thirds of women in this study felt they did not have to hide their feelings about abortion from people they are close to. 23% felt that they did have to withhold their beliefs from their close ones. The remainder ($n = 5$) neither agreed nor disagreed that they had to keep their feelings about abortion a secret.

By contrast, more than half of qualitative participants ($n = 5$) said that they rarely or never talk about abortion with people they are close to. Despite not having conversations, these IDI participants said they felt confident in assuming views of close ones based on knowledge of their politics.

When qualitative research subjects spoke of abortion stigma, participants mentioned stereotypes, experiences of friends, and personal experiences. Participants reflected on reasons for abortion stigma: it is not discussed frequently, it's concealable, and there are stereotypes about women who have abortions. Women who participated in the IDIs described abortion stigma in the following ways:

...there is a whole set of preconceived notions that people have about a women who would have an abortion. That's sort of what I would think of as stigma... 'oh, she's irresponsible.' Well, it can range all the way from 'she's irresponsible' to 'she's a murderer,' and there's a whole spectrum in between.

Another participant said:

Abortion stigma. ...I don't know. I think there are different stigmas. Even though it's been legal since 1973, and women have been having abortions since before that, I don't know how my family felt about it, and I don't know other people who had abortions, and

I know that [people who have abortions] are out there. So, that means to me that it's something that a lot of people don't talk about, and so therefore it's a stigma. ... People who have had abortions might be as likely to speak up and say that they've had one as they might be likely to say 'oh, I had depression,' or 'I have mental illness,' because it's a stigma like that.

One woman described experiences of internal and external abortion stigma. The interview participant shared stories about women she knows who have had abortions or who have considered abortion. She said:

I have one friend who had an abortion years ago who has had internal conflicts with it for over ten years now and can't even talk about it. I also have friends who had had multiple abortions and don't have any problems with it. It doesn't have so much to do with outer judgment because it is something you can conceal. So I think because an abortion is something you can conceal, you feel less direct judgment from other people, but more judgment and conflict within yourself, struggling with your identity as a whole and what it means to have an abortion. ... My friend who decided not to have an abortion was encouraged by pretty much everyone to have an abortion. She was much more judged for not having an abortion, ... that was just her community and that was just her group of friends and the demographics of the college kids she was living with. My parents, for example, would probably have judged her if she had an abortion.

Two of the other qualitative research subjects spoke about concealment, one from personal experience of having to conceal opinions about abortion, and the other participant commented on social norms that require people to conceal abortion and pregnancy during high school years.

My high school was definitely a place where abortion was ‘an option, but we prefer you didn’t use it. We’d also prefer you weren’t pregnant.’ It was like: ‘Know the risk, don’t be stupid.’ ...They wouldn’t outwardly approve. It would definitely be something you wouldn’t ever want to admit. It would be something that you wouldn’t ever speak of again. Whereas ... here, it’s much more, you know...open, and people are OK with talking about it.

One participant reported that she found relief in sharing her views on abortion with this researcher. Her views were interconnected with recently learning that her mother had an abortion after she was born. She stated, “Obviously my dad wasn’t supposed to tell me, so it’s kind of a secret so I haven’t been able to talk to any family about it. I guess I feel kind of relieved that I could talk about it.”

Learning about Abortion

Some women who participated in the survey could not remember when they first learned about abortion ($n = 7$). Among the women who could remember how old they were when they first learned about abortion, 38% were in latency, 26% were in adolescence, and 13% were under 10. Only two women reported learning about abortion between age 18 and 21. Of those who could remember how they learned about abortion ($n = 16$), 44% learned from the media (television, newspaper, magazine), 19% learned from their mother, 19% learned from a friend, and the remainder ($n = 3$) learned from a teacher or doctor.

One qualitative research subject reported that she learned of abortion in adolescence, but she learned of miscarriage much earlier. She said,

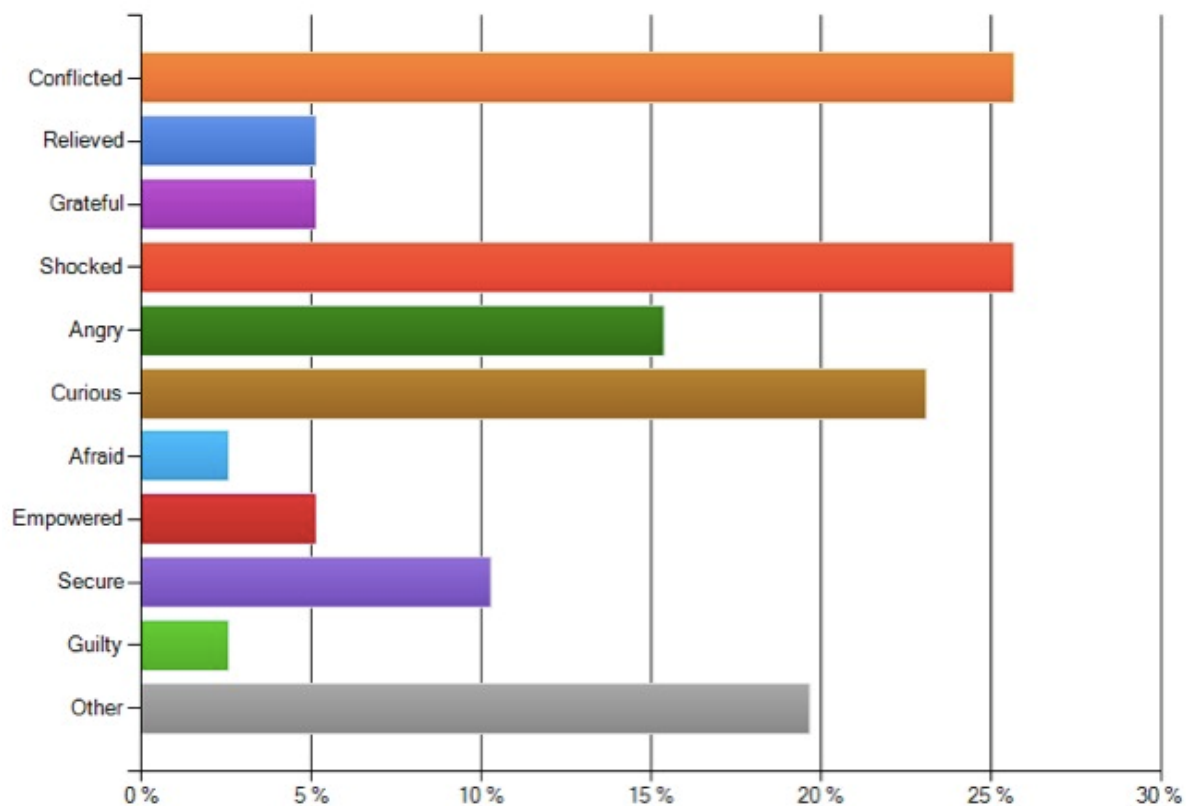
I heard of someone who had lost a baby or something like that. I mean, I probably didn’t know the term miscarriage, but I knew that something like that could happen. ... You

know, like my mother was telling my father about how she lost the baby and it was a serious conversation.

Figure 2

WSEEA Online Survey Participants' Emotional Reactions to First Learning of Abortion

*Emotions



*Not mutually exclusive categories.

As can be seen in Figure 2, the majority of women reacted to learning about abortion with conflicted, shocked, curious, or “other” feelings. Fifty-nine percent of subjects reported that their feelings have since changed, while 31% reported that their feelings about abortion stayed the same since their first reaction. Just over half (51%) of the participants reported that valuing women’s rights impacts their current views on abortion. Fifty-one percent of participants also

reported that abortion should be legal in “all cases,” and 36% of women reported that abortion should be legal in “most cases.” There is a significant relationship between the values that most impact women’s views on abortion, and subject’s views on the legal status for abortion.

Statistically, more women who valued religion or fetus’ rights than expected reported that abortion should be illegal in most or all cases ($\chi^2(28) = 83.69, P \leq 0.001$). More women than expected also identified as pro-life and reported valuing religion or fetus’ rights ($\chi^2(14) = 36.04, P \leq 0.001$).

Most participants who were interviewed during the qualitative portion of the study reported that their feelings about abortion may have started out as “vague” or “abstract” and then solidified later, in their 20s. One woman reported that her feelings changed slightly from her early 20s to her late 20s, “even five years before I [had an abortion], I was more of the opinion that ‘well maybe there might be circumstances when I would have it...it’s not an unthinkable option for me.’” Where before, this participant supported abortion rights, but could not imagine making the choice to terminate a pregnancy herself.

Perception of Community Attitudes about Abortion

The seven questions about women’s perception of their community’s attitudes about abortion contained three questions regarding generally unaccepting attitudes regarding abortion: (1) abortion is always wrong; (2) abortion is a sin; (3) abortion is the same as murder. The majority of participants (55%) thought that only “a few people” in their respective communities believed abortion is a sin, thought abortion is always wrong, or thought that abortion is the same as murder. None of respondents believed that most in their community believe abortion is the always wrong or the same as murder; one woman felt that most in her community view abortion

as a sin. About 30% thought “many” in their community viewed abortion as a sin. Twenty percent reported that “half” of their community believed abortion is the same as murder.

The four generally accepting questions about women’s perceptions of their community views of abortion were: (1) abortion should be legal and available, (2) abortion is a woman’s right, (3) abortion is a good option for an unplanned pregnancy, and (4) abortion can be a good thing for some women. The most frequent response subjects gave to these set of four questions is that they thought “many people” in their respective communities believe that abortion is a woman’s right (37%) and community members think it should be legal and available (34%). Seventy-six percent of women (evenly divided) reported that either “a few people” or “half” of the people in their community believe that abortion is a good option for an unplanned pregnancy. Sixty-six percent of women (evenly divided) reported that their community members think abortion can be a good thing for some women.

Eighteen percent of women either “agree” or “strongly” agree that their views are the same at their community’s attitudes and beliefs. Twice as many participants reported that they think their views on abortion are different from their community’s views (43%). Several women (29%) could not determine whether their views were similar to their community’s attitudes and beliefs about abortion.

Many qualitative research subjects responded to questions about their community’s attitudes about abortion by contrasted different communities. Six out of eight interview subjects asked to clarify the meaning of community, and reported that they felt challenged by the community questions on the quantitative survey because they could not define their community. One subject stated:

It depends on what you mean by community. I have a community of friends were I go dancing and that's a community, or the school I'm at is a community, and it depends on where I am. If I'm in [state in New England] at school, versus at home in [state on the Mid-Atlantic coast]. Those are two different communities.

Two other participants expressed difficulty with the community questions this way:

I took community to be very literal. To be the town that I live in, and I think I did that because of the wording of the survey questions themselves. ...So this group of friends that I associate with. I think I would feel pretty confident judging what their opinions on abortion are, but not because we've particularly talked about that issue, but we do talk about other social and political issues, and I can infer from those that they probably have fairly similar opinions to the ones that I do.

The questions about community were difficult because I was thinking about whether it was about my little town that I live in or whether it was about the metropolitan area that is [large city in New England]. ...And I'm not from this area, and this is a very Catholic area. And the Catholic Church has their opinions on abortion. I'm not Catholic, but my husband is. I know that there is a huge part of the population here that is very anti-abortion. I live in a town that is a suburban town, kind of North-West of [city]. It's relatively affluent, well educated, a lot of high tech stuff. I don't think my community shares the same opinions about abortion that a lot of people in the [city] area might. So, I was trying to be accurate, but I wasn't sure what community I should be referring to.

One of the qualitative in-depth telephone interview subjects did not consent to be audio recorded. She reported that her current community is "very pro-choice" and stated that she has lived in that community for "over 10 years." This participant felt that people who hold pro-life

views in her community cannot or do not talk about them because the majority does not hold them.

Many subjects compared and contrasted the community they grew up in versus the community where they currently live. The following participants contrasted communities with different religious views:

I went to high school in a very Christian city, so it [abortion] was a topic that was often discussed in classes and there were trucks that would drive around that were pro-life and they tried to make a point against abortion. ...I only lived in the Christian community in high school. I actually grew up in Europe. It wasn't so much a topic in elementary in middle school. But yeah, the [New England university] community, being small, very richly diverse and young environment, as many college campuses and small liberal arts schools are, ... the pro-life sector... I think that's a little more disintegrated within the college environment.

I guess between India and here, I don't think the difference has anything to do with, you know, the traditional Indian system being more women friendly or anything. It's just that for religious reasons, it is not a topic of discussion. I guess there's no, you know the whole 'this is wrong because it says in this religious text' kind of discussion is just not there. At least for the majority of people in India.

I grew up in a very homogenous conservative community. All very religious, Christian. The majority of my community was very pro-life, anti-choice. In that point in high school I found myself very alone in my opinions about abortion. Now, it's – oh my god – it's a world apart. I go to [New England university]. The majority of students here are very

liberal and incredibly, ...how do I say this? Very liberal. Most people support a woman's right to choose.

The next participant compared community views on abortion between two separate educational environments she has identified with in the same city:

[New England university] may lean more toward being pro-choice in an ideological sense, like they believe in women's rights as an ideological issue, ...I mean, if students got pregnant they'd be in a situation where they would probably be able to support a child somehow. But I know that teaching at the high school [in the university's town], there were several of my students that had kids, and I know of one that had an abortion...so I feel like for them, they are also pro-choice, uh, in...it's more something they felt they had to do.

Personal Experience with Abortion

Though only three participants reported having one or more prior abortion, 60% of the women in this study reported that they knew someone who had an abortion. The Women's social and emotional experiences with abortion [WSEEA] survey asked respondents to list the women they knew who had an abortion by relation. Table 2 illustrates these findings. The majority of total women knew an acquaintance that had at least one prior abortion. Forty percent either did not know anyone who had an abortion, or were not sure whether anyone they knew had an abortion. Of the remaining subjects who knew someone, participants reported knowing that their mother, sister, and/or friend had at least one prior abortion. Not many women knew an aunt or mentor who had an abortion, and the survey did not ask women about their grandmothers or other relations.

All of the participants who reported having an abortion also knew a friend who had an abortion. Women who had one or more abortions reported that they told their current sex partner, friend(s), and/or therapist about the abortion.

Table 2

WSEEA Online Survey Participants Who Knew Women that Had Abortions

People who had abortions	Reported Hx of Abortion		No Reported Hx of Abortion	
	Total (*%)	(**no.)	(**no.)	(**no%)
Mother	13%	0	5	
Aunt	3%	0	1	
Sister	13%	1	4	
Friend	32%	3	9	
Acquaintance	34%	1	12	
Mentor	5%	0	2	
I don't know	24%	0	9	
No one I know	16%	0	6	

* The percent of respondents by category of women WSEEA survey subjects knew.

** Number of study subjects who reported they knew women who had an abortion by category.

Identity

As seen in Figure 3, the top five aspects of one's identity that participants cited were: 1) their values and moral standards, **87%**; 2) forming close relationships, **85%**; 3) future goals, **85%**; 4) being confident in self change, **79%**; and 5) being a woman **79%**.

Of the twenty-two options for identity traits, the least important aspects of identity to survey respondents were the following (starting with the least): 1) not having the ability to be a mother, **15%**; 2) not desiring motherhood, **23%**; 3) language, **39%**; 4) being a mother **39%**; and 5) others' opinions or judgments **39%**. Women were only asked if abortion influenced their identity if they had an abortion, and only one woman reported that abortion was one aspect of her identity for a period of time.

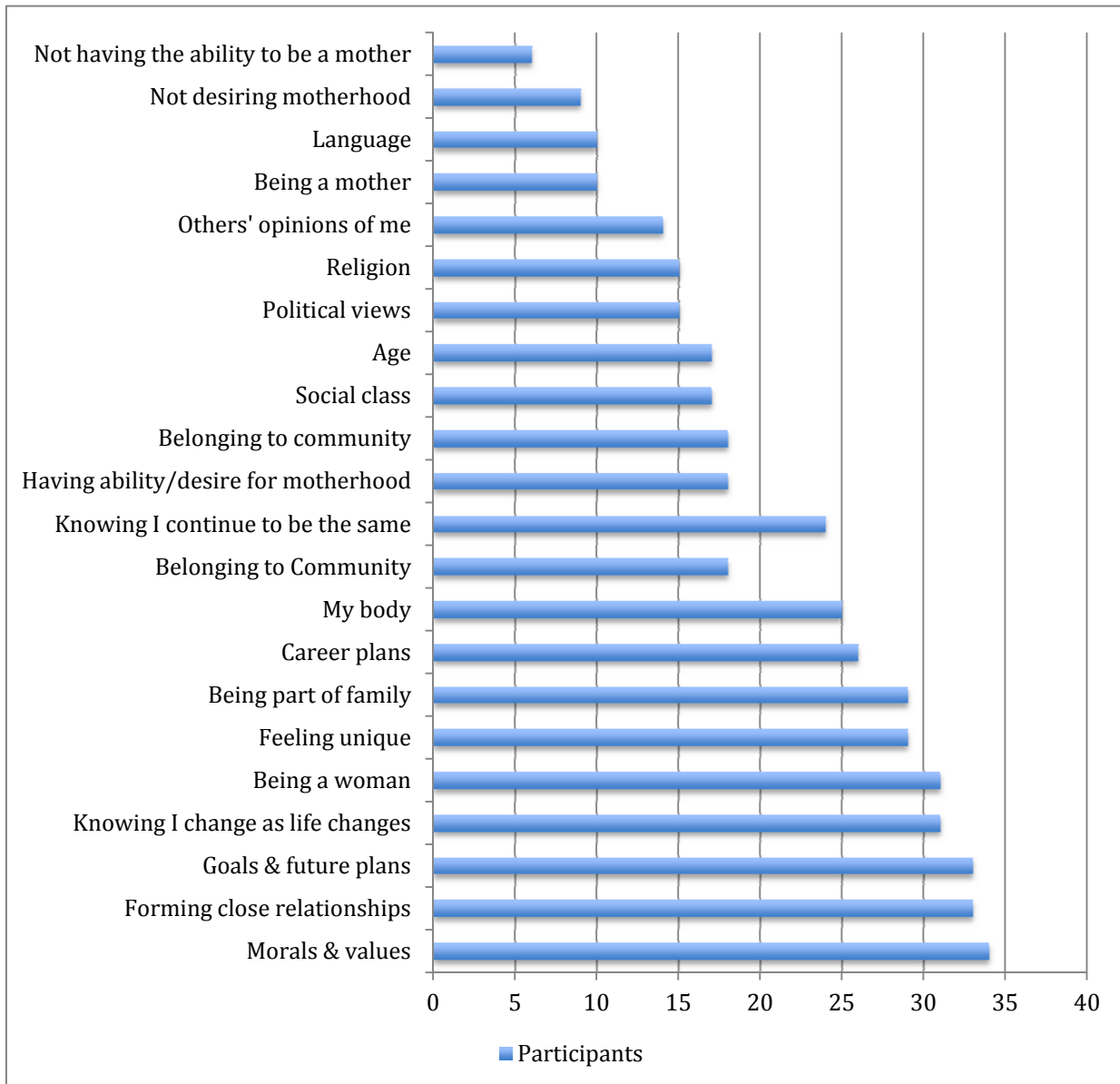
There was a significant relationship between abortion stigma and identifying as a woman ($\chi^2(12) = 22.92, P \leq 0.05$). More people than expected who “agreed” or “strongly agreed” that abortion stigma is associated with women who have abortions also reported that being a woman was an “important” or “extremely important” part of their identity.

There was a significant relationship between women who could imagine having an abortion in the future, and women who reported that their occupational choice and career plans were a significant part of their identity ($\chi^2(8) = 16.30, P \leq 0.05$). Sixty-seven percent of women reported that their career plans were an important aspect of their identity. More women who could imagine having an abortion for rape or incest than expected reported that their career was a part of their identity. There was also a significant relationship between whether women could imagine having an abortion for an unplanned pregnancy, fetal abnormalities, and rape or incest, and women's political identities. Thirty-eight percent of women reported that their political views were an important part of their identity. More women who reported that they could imagine having an abortion for an unplanned pregnancy reported that their political views were an important part of their identity ($\chi^2(8) = 17.31, P \leq 0.05$). More women who reported that they could imagine having an abortion for a fetal abnormality than expected

reported that their political views were “somewhat important,” “important,” or “extremely important” ($\chi^2(8) = 20.97, P \leq 0.01$).

Figure 3

Important Aspects of WSEEA Study Participants' Identity



Identity values are not mutually exclusive.

In-depth interview participants reacted to the question of whether abortion is part of their identity in different ways. The following comments offer an example of women with differing views. One woman associated abortion with her identity, and another women did not.

I think that abortion is something that influences my identity more than I realize because it is something that I haven't had to confront directly myself. ...I think that if I did it would create much more of an identity crisis for me because, 'in what situations would I have an abortion or would I not?' Because I support pro-choice and giving women the right doesn't mean I necessarily would easily have an abortion.

Another participant who had an abortion in the past disagreed. She did not think that abortion is now, or has ever been a part of her identity:

I've never actually thought about [whether abortion is part of my identity], but I – I don't think I ever felt that way. I don't think that [my abortion] began to identify me. ...My political views...in general? ...Generally, my political views do enter into the way I am.

A third of IDI research subjects spoke about motherhood and identity. Each participant had a different perspective.

I had some problems with questions about motherhood and being a mother [on the quantitative survey instrument] because I have an adopted child and I am a mother, but I also haven't given birth to a child. So, I was thinking about how to describe...and essentially because you're talking about abortion, ...I think if I were to answer this survey now [my responses] may be different than at a different point in my life. ...My identity now is probably different than identity back when I was trying to get pregnant, you know. Because it was a much bigger...I think wanting to be [a mother] was a much bigger part of my identity then, whereas now, it's not. But being [a mother] is.

A second participant spoke of her desire for parenthood in the future, and the conditions for motherhood that she imagines may play a role in her decision-making process.

I think I do [want to be a mother] ...my hesitancy would be not having enough money to do what I want to. ...My boyfriend is a musician and he wants to film score, and he already said that he wants to be a stay-at-home dad. That's good because I don't want to be a stay-at-home mom, but I want someone to stay at home with the kids.

A third participant expressed desire for motherhood and wondered how much that identity would define her. "I definitely think that being a woman is part of my identity. ...And I would like to be a mother. Since I don't have children, I don't know how much being a mother would change me or define me."

Two women reported that their religious identity was part of their family culture, and it played a role in their views about abortion. One woman reported that she first learned of abortion from the Catholic Church, and her views on abortion were informed by her religion. This participant reported that she believed "life began at conception" until during graduate school. She stated that the biggest contributing factor in changing her views to being pro-choice where her liberal politics and her liberal friends who questioned how she could have "these political views" and be pro-life. She reported that she is still "culturally Catholic," and after identifying as a lesbian, her religious identity is the most significant to her, followed by African-American race, being a woman, then being a Democrat. This participant also reported that she is a mother; she did not mention motherhood as an important aspect of her identity.

The other participant who mentioned religion as a contributing factor to her identity and views on abortion stated:

Jewish, all of them. ...Jewish views on abortion vary depending on what Jewish community you look at. Orthodox Jews are very much against it. Reformed Jews are

generally very much for it, and um, conservative is kind of split. And I and my family kind of bounce between reformed and conservative.

Attitudes about the Possibility of Having an Abortion

The majority of study participants could imagine having an abortion in the future. Seventy-six percent of women said they could imagine having an abortion for a pregnancy that resulted from rape or incest; 66% reported that they could imagine having an abortion due to fetal abnormalities; and 53% of women said that they could imagine having an abortion for an unintended pregnancy. Ninety-five percent of participants thought abortion should be legal for cases of rape or incest. Two participants thought abortion should not be legal in these cases. Eighty-two percent of women thought abortion should be legal for unplanned pregnancy, four participants were not sure, and three participants did not think abortion should be legal in this case. Seventy-six percent of women thought abortion should be legal for fetal abnormalities, four did not think abortion should be legal in this case, and five women “did not know” what their views were.

All of the qualitative interview participants reported that they were pro-choice, and all supported abortion being legal for unintended pregnancy, rape, and fetal abnormalities. Most articulated nuance in their views on abortion, which were different from their stance on laws regarding abortion. Some women explained how abortion is complicated by certain conditions for motherhood. One IDI participant exemplified her views on abortion in the following statement:

I once knew a woman, a young woman who had a child, and she said that she wanted to get pregnant again, and then she changed her mind and decided that she wanted to get an abortion. And so, in situations like that I just feel like it's wrong. I think she made a

conscious decision to become pregnant. And then she made a conscious decision to have an abortion. ...I think that dancing around when life begins, that was a potential life. But, I think that in situations where a person becomes pregnant and doesn't want to give birth to the child or can't birth a child, and feels that abortion is right for them, then I think it should be legal and available. ...I think that there are these shades of grey in between, so abortion right or abortion wrong, I think it's hard to say one way or the other. I think there are different answers to the question.

Another participant reflected on her views about abortion by stating, "I'm generally in favor of abortion except for very late term abortions...with the caveat that if the mother's life is in danger, that comes before anything." The study subject continued later, "If the mother's life isn't in danger and she just wants an abortion – if a fetus is a baby and can be viable on it's own – then I'm not okay with it."

Some women differentiated between their beliefs about abortion pertaining to others, and their beliefs pertaining to self. A participant said, "my views are very strong. I believe the life of the mother supersedes the life of the fetus. I think that can be applied to every abortion situation." Later in the interview, she elaborated:

In terms of fetal abnormalities, while I do believe that the choice should ultimately be left up to the mother in all circumstances, I also encourage females to...you know, respect. How should I phrase this? This is a really difficult question. They definitely have the choice to [have an abortion]. The choice should be legal, it should be allowed. ...My personal choice would be to keep that child.

There was a significant relationship between whether participants could imagine having an abortion for a fetal abnormality, and whether participants thought abortion should be legal for

fetal abnormalities ($\chi^2(4) = 37.93, P \leq 0.000$). More women who would not have an abortion for a fetal abnormality than expected did not think abortion should be legal in this case. More women than expected who did not know whether or not they would have an abortion for a fetal abnormality also did not know whether they thought abortion should be legal in cases when there exists a fetal anomaly. Similarly, there was a significant relationship between whether participants could imagine having an abortion for rape or incest, and whether participants thought abortion should be legal in cases of rape or incest ($\chi^2(2) = 13.93, P \leq 0.001$). More women who could not imagine having an abortion if they were raped than expected did not think abortion should be legal for rape or incest.

Many qualitative research participants mentioned confident feelings about how abortion will exist in practice, despite legality, and prefaced their views as such. One subject stated,

Women, if they really want an abortion, they will try and get one, so it's better to have it regulated by the same practices done by an actual doctor. ...I feel like it should be legal, and I feel like it should be an option for any woman for whatever reason, but, I feel like it's something I just wouldn't be able to go through, on a personal level ...my emotional reaction is that I could never do that [have an abortion].

As mentioned above, among the larger quantitative study population, there was a marginal difference between women who could imagine having an abortion for unplanned pregnancy, fetal abnormalities, and rape or incest, and the percentage of women who believed abortion should be legal in those scenarios. Slightly more women supported legality than could imagine having an abortion themselves; the percent change was not significant.

Many women mentioned how abortion is political. Some brought up the current presidential election campaign. The following women articulated political dispute over abortion.

I mean with the election, what really terrifies me is the thought that abortion may not be available. It really freaks me out because I know my boyfriend and I have sex. Luckily we have never been in that position, but if I were to become pregnant with a fetus that I don't want slash can't even afford, I feel really strongly that women should have the right to choose.

Thankfully I haven't encountered anybody with those views [prejudicial views toward abortion] personally, but definitely in the media, especially with the election campaign season.

She's totally accepted and everything, she's great. It [abortion] is always kind of, it's one of those things that we now don't want to talk, we actively try not to talk about because we don't feel like having an argument. ...It wasn't something that was talked about before, but we don't want to bring it up anymore. We know she's conservative so we try very hard to not bring up any politics at all and we try to avoid ...a lot of people in that community are very opinionated and it's much better for the community as a whole to say 'ok, what we do here is we dance and we don't talk about politics.'

I think that it [abortion] would a part of the ...it would be a factor in the decisions I make on candidates.

CHAPTER V

Discussion

Introduction

This mixed methods study explored whether and how abortion stigma impacted women who participated in this research study. At present, the United States is in an election year, and abortion politics are part of the campaign discourse. Health care reform acts are in legislation, and abortion proponents and opponents want to influence the reforms at the state and federal level. Every day, women have abortions. Every day, women live in a culture that sets norms regarding motherhood, to include pregnancy and abortion. The personal and political are entwined with abortion. Cannold (1998) stated:

The abortion issue is not separate from the complex web of women's experiences, understandings, and feelings about mothering children, but part of it. Women's decisions about abortion are the same sorts of decisions they make about mothering, only with different outcomes. (xxii)

Throughout the course of exploring this research topic, an untested, non-validated quantitative survey instrument was piloted during survey implementation with 46 respondents, 39 of which were included in analysis. The survey questions were enriched with eight in-depth telephone interviews. The researcher's hypothesis was that women who have had one or more prior abortions would have experienced or perceived more abortion stigma than women who have not had an abortion. Furthermore, the researcher hypothesized that all women, regardless of reproductive health history, have experienced and perceived abortion stigma.

Abortion stigma was defined as discrimination and prejudice directed at women who have abortions and people and institutions that support women who have abortions; it is a

definition used by other abortion stigma researchers and theorists (Kumar et al., 2010; Major & O'Brien, 2005; Norris et al., 2011; Quinn & Chaudoir, 2009). This field is newly developing (Norris et al., 2011). While not generalizable, this study contributes to an understanding of how abortion stigma affects women, providing additional perspectives from women for clinical providers, academic researchers, and policy makers to consider in future anti-stigma work.

The research is interpreted in this chapter to the extent allowable given study limitations. First, the quantitative data are explored. Next, the themes in the qualitative data are considered. Finally, the implications of this research on clinical practice, the limitations of this study, and directions for future research are discussed.

Interpretation of Results

The researcher hypothesized that all women who participated in the research study, regardless of reproductive health history, would experience and perceive abortion stigma. The first aim of the study was to differentiate between women who have had one or more abortions. The researcher hypothesized that women who have experienced abortion would also experience more abortion stigma than women who have not had an abortion. This hypothesis proved to be the opposite. The women who reported having one or more abortions reported less abortion stigma than women who have never had an abortion. While these results have to be interpreted through the understanding that only three out of 39 participants who participated in this study reported having one or more abortions, data analysis showed that all women experienced and perceived abortion stigma, regardless of the reproductive health histories they reported. Therefore, one of the two hypotheses proved to be congruent with data results.

Demographics and Reproductive Health History

The women in this study are not representative of the general population. They have more education, and they reported higher incomes, in general, than most women in the United States.

The population studied is different from the population of women who had the most abortions in the United States in 2008 (Jones, Finer, & Singh, 2010, p. 80). Over 30% of the women in this study were not very religious; very few women had children; only three women reported incomes below 200% of the Federal Poverty Level. No women under age 29 in this study reported ever being pregnant. While no racial or ethnic group made up the majority of women who have abortions in the United States, more Black women than expected reported having an abortion in this study. This result has as to be considered with a lot of caution due to an extremely low number of total abortions reported ($n = 4$), and report is not intended to reinforce stereotypes.

This researcher does not have data on whether more “liberal” woman report having had an abortion in the past, and/or whether more “liberal” women express interest in abortion research. The majority of participants in this study reported that they were liberal, and participants in the qualitative study frequently linked politics and abortion.

The researcher does know that underreporting of abortions is a common occurrence. Rasinski, Willis, Baldwin, Yeh, and Lee (1999) state, “Survey respondents often give inaccurate responses to questions about sensitive topics. For topics such as substance abuse, abortion reporting and sexual behaviour, underreporting is a typical problem,” (p. 465). Peytcheva, and Groves (2010) state:

For underreporting of abortions, at least to some degree, we interpret these results by judging that the social stigma was a common cause. ... Incentives may help respondents

to overcome this stigma in order to participate and report abortions, but future research is needed to explore other possible protocol changes that can reduce the link between these error sources. (p. 326)

Minor incentives were used in this study, and women could choose the environment where they participated and were asked to report on their reproductive health histories. Subjects were informed that the survey was anonymous. Yet, women who participated in the quantitative survey were not asked about their experience. Only women who volunteered to participate in the in-depth interview were asked about their experience. The subset that were interviewed is biased because they were interested in participating in additional research. Those that may have had a negative or neutral experience, were not likely to volunteer for the qualitative phase.

It is difficult to determine whether there was underreporting of abortion in this study. The demographics of this study population does not match the national demographics of women who had abortions in 2008, and there was a significant relationship between having an abortion and participating in the in-depth interview. More women who reported having an abortion volunteered for and participated in the interview. Future research could examine whether this is a pattern among a larger, more representative population. Rasinski, Willis, Baldwin, Yeh, and Lee (1999) add, “When the respondent agrees to an interview, rather than accepting an obligation to tell the truth on all questions, he or she may interpret the obligation as that of reporting truthfully to questions that pose no threat,” (p. 482).

Interestingly, more pregnancies reported in this study ended in abortion than the national average. In the United States, almost half of all pregnancies are unintended, and 22% of all pregnancies are terminated in abortion, excluding abortions due to pregnancy miscarriage. (Jones & Kooistra, 2011). In this study, half of all pregnancies reported ($n = 8$) ended in abortion

($n = 4$). This result has to be interpreted with caution due to the low n . Future research could examine whether this is a pattern among a population of highly educated, homogenous, majority white, young women who live in a liberal state in New England.

Abortion Stigma

As noted above, women who reported one or more abortions were less likely to perceive or experience abortion stigma than women who did not report having an abortion. Meanwhile, almost 90% of women who participated in the study agreed or strongly agreed that abortion stigma affects women, and 95% believed that women who have abortions are stigmatized, discriminated against, or judged for having an abortion. Therefore, the majority of women perceived abortion stigma, but women who reported having an abortion did not believe that abortion is stigmatized. It would be interesting to see whether this result could be repeated in a larger study of the same population, and whether it could be repeated in a larger, more socioeconomically, educationally, and geographically diverse population.

One participant who had an abortion noted that she was grateful that she lives in an area that is very “accepting” of abortion. She said she knows that there are women who have abortions that have had a very different experience than she did. She noted that there were not any abortion protesters outside of the clinic where she had her abortion. Therefore, perhaps the women who had abortions responded to this question based on their own experience, rather than their perceptions of abortion in general. Further research could make these questions more explicit to differentiate between abortion stigma experienced by the individual who is participating in the survey, versus abortion stigma experienced by women who have abortions in general.

Women who participated in the qualitative study believed that there is abortion stigma. Participants reported that stigma was evident because there are stereotypes about abortion, abortion is concealable, and abortion is not discussed frequently. This definition is consistent with the definition that abortion stigma theorists have used (Kumar et al., 2009, Norris et al., 2011). Most participants reported that they felt they did not have to hide their feelings about abortion, yet they said they did not talk about abortion with those whom they are close to. It would be interesting to explore the meaning between these two findings. It would also be interesting to explore the connection between political views and abortion. A few qualitative participants used “political views” or “liberal” or “progressive” language interchangeably with “abortion” or “pro-choice.”

Perception of Community Attitudes about Abortion

The community questions have to be interpreted with caution, because a major finding of the qualitative in-depth interviews was that six out of eight participants reported that they were challenged by these questions. All six participants said they did not know what the researcher meant by “community” and therefore were not sure how to respond to questions about their community’s attitudes about abortion. The researcher believes that this information is valuable for future researchers, as defining variables makes measurement more precise.

Still, it is interesting to consider how respondents answered these questions, despite feeling challenged. Many participants believed that their community members felt that abortion is a “woman’s right.” Many participants also believed that their community members think that abortion should be “legal and available.” None of the respondents believed that most of their community members believed abortion is “always wrong” or that abortion is the “same as murder.”

What is most curious to the researcher about these community attitude responses is that twice as many participants believed that their views on abortion are different than their community's attitudes. Only 18% of women felt that their views about abortion were very similar to their community's views. So, even though the majority (74%) of women described their views as "pro-choice," and the majority of women thought that their community felt that abortion should be legal, available, and a woman's right, most did not perceive their views to fit with the opinions of the community.

Personal Experience with Abortion

Most of the women in this study have the ability to be mothers, and have the desire to be mothers. The majority of women in this study identify strongly as a woman, value their close relationships, believe their future goals are important, and feel confident and believe in their ability to change. Even though the majority of women in this study had never had an abortion, most could imagine having an abortion in the future.

Interestingly, women could imagine having an abortion in the following order: 1) if they were raped, 2) if they had a fetal abnormality, and 3) if they had an unintended pregnancy. The most women thought abortion should be legal in cases of rape or incest. However, more women thought abortion should be legal for unplanned pregnancies than for fetal abnormalities (6% difference). Therefore, more women ranked having an abortion for a fetal abnormality higher than fetal anomaly legal status.

This finding may be explained, in part, by the 'good mother' stereotype. Further research would have to explore these findings more in-depth with a larger, more diverse population to see whether they were replicable. However, for this group of women, a theme emerged regarding being responsible and being a good mother. Most women in the qualitative interviews contrasted

women who did not have financial means to care for a child with women who did. In making this comparison, women either explicitly or implicitly stated that it was more acceptable for women with less financial means to have an abortion. Some subjects stated that women with financial security would be able to care for a child, and therefore, abortion may make “ideological” sense, but it would not make “practical” sense.

Is the ‘good enough’ mother one who takes a pregnancy to term if they know there is a fetal abnormality, or one who has an abortion if they have this information? Further research may be able to explore this question more accurately with case vignettes. Jones, Frohwirth, and Moore (2007) acknowledge the social stigma associated with abortion and the authors speculate that some women who have abortions may “overemphasize reasons or circumstances that they believed were more socially acceptable” (p. 96). For the 39 women in this study, it is possible that they may have not been able to imagine being “irresponsible” in the future. Irresponsibility has been associated with unintended pregnancies. Whereas fetal abnormalities are entirely uncontrollable and not related to “responsibility.” However, in considering legality, perhaps women felt it was more benevolent or socially acceptable to say that abortion should be legal in cases when there is an unintended pregnancy than in cases of a fetal anomaly. Unintended pregnancies are more common and less associated with “potential life.”

Questions, Implications and Areas for Future Research

Women terminate pregnancies for all assorted reasons, at all stages of their reproductive lives, whether they are partnered or single, whether they have children or not, and whether they have community support regarding their decision (Finer et al., 2005). Among the 39 respondents whose ideas were represented in this research, concerns about future children and finances, good

enough mothering, current relationships, and career goals were mentioned in relation to ideas about abortion.

King and Botsford (2009) studied pregnancy stigma, pertaining to factors and outcomes of pregnancy disclosure in the workplace. They found that many women who are pregnant are hesitant to disclose their pregnancy to their supervisor, and many employees view pregnant women as unproductive (p. 314). Unlike abortion, pregnancy is not concealable because women start to “show” at later gestational ages. Therefore, stigma related to pregnancy disclosures and abortion stigmas are not analogous. Yet, both stigmas relate to identifying as a woman, and identifying as a mother. Unlike pregnancy stigma, abortion stigma does not require a disclosure. All women who reported that they had one or more abortions reported that they told their current sexual partner, their friend and/or their therapist about their abortion. It would be interesting to use case vignettes to compare pregnancy stigma with abortion stigma to identify similarities and differences. When are women seen as good, and when are women seen as bad?

It would be valuable to use case vignettes in future research, and model the research protocols after stereotype threat research (Steele, 1997). Vignettes could include three women who had an unintended pregnancy who had parallel demographics. One case vignette would be a woman who has an abortion, another woman would take the pregnancy to term and keep the child, and another woman would choose adoption. In each of three cases, participants [women 18-65 years of age] would be asked questions regarding stereotypes. Similarly, future research could use case vignettes to explore the ‘good enough woman’ stereotypes.

This researcher would like to modify the existing quantitative survey instrument to include case vignettes and administer it to a larger more representative (socioeconomically, educationally, geographically, and politically) population. It would be valuable to have at least

three times the number of participants, and it would enhance research analysis to interview a quarter of those who participate in the survey so that themes and patterns in the qualitative data can be more generalizable to the survey population.

Recently, Corrigan and Ben-Zeev, (2012) asked, “Is stigma a stigmatizing word?” in the journal *Stigma Research and Action*. The authors discussed stigma pertaining to mental illness, and they did not come to any conclusions. However, the recommended community based participatory research (p. 64) to make progress in anti-stigma work, and also tackle some of these difficult questions. During the process of completing this thesis project, the researcher conducted a meta process examination of abortion stigma. When describing her thesis, the researcher rarely told close ones or acquaintances that she was studying abortion stigma. Rather, she often said that her thesis was about “stigma.” If asked to elaborate, only then would the researcher disclose that the thesis was about abortion stigma, and provide more detail. Close ones and acquaintances often responded by stating that the topic is “heavy” or “intense” when they learned that it was about abortion stigma, but not until the mention of abortion.

However, this thesis project rarely to never felt like an emotionally “intense” topic. The only time the researcher encountered very strong emotional affect was when one of the qualitative interview participants disclosed that she had attempted suicide two years before the interview took place. Therefore, this intensity did not even occur when a participant was speaking directly about abortion. This felt challenging at the time because researcher was faced with the task of balancing clinical social work skills (do I do a suicide assessment now?), and a desire to maintain the integrity of the research protocol. In this particular example, the participant was well supported with friends and a therapist, so the researcher diverged from the in-depth interview guide for a brief period during the 45-minute interview.

This research study cannot address the question of whether stigma is a stigmatizing word. Future research on the topic may benefit multiple stigmas that people face, as language influences attitudes and beliefs.

Limitations of Study

Methodological weaknesses pertain to the non-probability sampling techniques used for both the quantitative study frame. The qualitative portion of the study also utilized non-probability sampling methods. A subset of participants who completed the quantitative survey instrument volunteered for portions of the IDI. The purposive sampling had a strong bias: all recruitment sites were private liberal arts universities in a metropolitan area of New England. Many participants mentioned being “liberal” and recruitment occurred in a state that has a majority of liberal or progressive individuals.

The population studied was highly educated, and all participants needed to have access to the Internet in order to participate. Wei and Hindman (2011) studied the “digital divide” and found that, “education, a surrogate of socioeconomic status ... is the only demographic factor that makes a difference in predicting Internet access and information use (p. 228).

The survey instrument may have had a measurement bias. Some of the response options were imprecise, thus providing respondents with choices that were not clearly defined. As discussed in the findings, six out of eight women who participated in the interview stated that they were confused by what the researcher meant by “community,” and thus felt challenged by the questions where they were asked to assess their community’s attitudes about abortion. It was valuable to have women who participated in the IDI report this finding because now the researcher knows that the community findings may be invalid. The researcher borrowed the community questions from ANSIRH’s survey instrument. It would be interesting to know if

ANSIRH had a similar finding. The researcher recommends that future investigators define response options and what the researcher means by “community” with more precision, even if future researchers which participants to define it.

Another example of measurement imprecision is data regarding annual household income. The researcher did not collect information about whether participants had independent or dependent status. Provided that participants were recruited from university sites, it is likely that many college students who participated were still dependent on their parents’ annual household income. For those who are independent, the question did not provide room for respondents to define whether they have dependents and/or whether participants pool income with others in their household.

Another important measurement bias to consider is that the qualitative interview process permits the researcher to cater questions to each individual participant. Therefore, each subject had a different interview experience based on the questions asked and the interaction between researcher and subject. In addition, some subjects were not interviewed until weeks following their participation in the quantitative survey, whereas others participated within days. It is difficult to calculate this margin of error if participants have different recall. Furthermore, the qualitative data is subject to the interpretation of the researcher.

Unfortunately little direct information was gathered about what motivated participants to participate in the survey, and what their experience was taking the survey. The researcher does not know whether any snowball sampling occurred. While the IDIs provided rich data to broaden quantitative subjects’ perspectives, very few participants completed the qualitative portion of the study (**21%**). The entire study has a small n ; therefore, results must be interpreted with that in mind.

There is a heteronormative bias to this study. Only people who identified as “women” could participate; people who identified as transgender, men, and other were excluded during selection criteria. Two “men” and one “other” responded to the survey and were routed to the disqualification page, thus not permitted to participate beyond the gender criteria question. All flyers stated that this research study is a study for women [see Appendix J]. Yet, this limits data, as individuals who identify as different genders may have had an abortion in the past, and certainly have important information to contribute to abortion stigma research.

There is a social desirability bias. For example, underreporting of abortion has been researched (Peytchev, Peytcheva, & Groves, 2010; Rasinski, Willis, Baldwin, Yeh, & Lee, 1999), and it may have occurred in this study. Subjects may have inflated or deflated their salaries due to how the question was asked ($\leq \$10K$, $\leq \$20K$, $\leq \$50K$, $\leq 100K$, $> \$100K$). During the IDIs, subjects may have responded to the researcher’s biases (the researcher is pro-choice, and while this was not made explicit, it is likely that implicit messages came through during the interview). Participants may have reported more “pro-choice” views in order to be viewed as benevolent by the researcher.

The researcher was cognizant of the conflict between clinical social work skills and qualitative in-depth research interviewing skills. At times, the researcher was curious about subjects’ lives and asked a question that was not pertinent to the research question. On one occasion, the researcher felt concerned for the safety of a research subject who revealed that she had attempted suicide. There existed tension between a desire to do a suicide assessment, and a desire to maintain the integrity of the research by not diverging from the interview guide by a significant degree.

Finally, there exists a selection bias due to sampling bias and time interval of recruitment. The sample was not random and recruitment occurred for a different length of time at different sites. Recruitment terminated prior to desired n due to predetermined thesis timeline and following recruitment of two of three women who reported having at least one abortion. Though this was not planned, it was desirable to increase by three percent, because the researcher was hoping to have an even larger percentage of women (**20%**) who had an abortion in the past.

Summary

This study examined whether women who have had one or more abortions experience abortion stigma more than women who have not had an abortion. The study also examined whether all women, regardless of whether or not they have had an abortion in the past, experience or perceive abortion stigma. While these findings are not generalizable beyond the study population of 39 women age 18 to 65 who were recruited from private, liberal arts college campuses in New England near a large metropolitan city, the findings contribute to the newly developing field of abortion stigma research. The researcher found that women who had one or more abortions did not experience or perceive abortion stigma. Therefore, the first hypothesis was opposite of that the researcher expected. The second hypothesis was confirmed. Nearly 90% of this study population experienced or perceived abortion stigma. This study contributes to a body of knowledge that may help clinicians, policy-makers, and academics understand women's social and emotional experiences with abortion. Clinical social workers can use this information in social work practice and training to further reduce stereotypes and actively work to reduce abortion stigma.

REFERENCES

- Abortion and women's reproductive health care rights. (2010). *The American Journal of Psychiatry*, 167(6), Retrieved from EBSCOhost.
- Alzate, M. M. (2009). The role of sexual and reproductive rights in social work practice. *Journal of Women & Social Work*, 24(2), 108-119. doi:10.1177/0886109909331695
- ANSIRH. (2011). Social and emotional aspects of abortion. Retrieved from <http://www.ansirh.org/research/aspects.php>
- Applegate, J. S. (1996). The good-enough social workers: Winnicott applied. In J. Edward, J. B. Sanville (Eds.), *Fostering healing and growth: A psychoanalytic social work approach* (pp. 77-96). Lanham, MD US: Jason Aronson.
- Boonstra H. D. Gold, R. B., Richards, C. L., Finer, L. B. (2006) Abortion in women's lives. New York: *Guttmacher Institute*.
- Cannold, L. (1998) *The abortion myth: Feminism, morality, and the hard choice women make*. St. Leonards, New South Wales, Australia: Allen & Unwin.
- Cockrill, K., & Weitz, T. A. (2010). Abortion patients' perceptions of abortion regulation. *Women's Health Issues*, 20(1), 12-19. doi:10.1016/j.whi.2009.08.005
- Corrigan, P., & Ben-Zeev, D. (2011). Is stigma a stigmatizing word? A political question for science. *Stigma Research And Action*, 2(2). doi:10.5463/sra.v1i3.28
- Ely, G. E., Dulmus, C. N., & Akers, L. (2010). An examination of levels of patient satisfaction with their abortion counseling experience: A social work practice evaluation. *Best Practices in Mental Health: An International Journal*, 6(2), 103-114. Retrieved from EBSCOhost.

- Fergusson, D. M., Horwood, L., & Boden, J. M. (2009). Reactions to abortion and subsequent mental health. *British Journal of Psychiatry, 195*(5), 420-426.
doi:10.1192/bjp.bp.109.066068
- Finer, L. B., Frohwirth, L. F., Dauphinee, L. A., Singh, S., & Moore, A. M. (2005). Reasons U.S. women have abortions: Quantitative and qualitative perspectives. *Perspectives on Sexual & Reproductive Health, 37*(3), 110-118. Retrieved from EBSCOhost.
- Finer, L. B., & Kost, K. (2011). Unintended pregnancy rates at the state level. *Perspectives on Sexual & Reproductive Health, 43*(2), 78-87. doi:10.1363/4307811
- Greene, S. (2006). Becoming responsible: Young mothers' decision making regarding motherhood and abortion. *Journal of Progressive Human Services, 17*(1), 25-43.
doi:10.1300/J059v17n01□03
- Guttmacher Institute In Brief. (2011). The facts on induced abortion in the United States. New York, NY: *Guttmacher Institute*.
- Johnson, B. (1985). Thresholds of difference: structures of address in Zora Neale Hurston. *Critical Inquiry, 12* 278-289.
- Jones, R.K., Finer, L. B. & Singh, S. (2010) Characteristics of U.S. abortion patients, 2008. New York, NY: *Guttmacher Institute*.
- Jones, R. K., Frohwirth, L. F., & Moore, A. M. (2008). I would want to give my child, like, everything in the world. *Journal Of Family Issues, 29*(1), 79-99.
- Jones, R. K., & Kooistra, K. (2011). Abortion incidence and access to services in the United States, 2008. *Perspectives on Sexual and Reproductive Health, 43*(1), 41-50.

- King, E. B., & Botsford, W. E. (2009). Managing pregnancy disclosures: Understanding and overcoming the challenges of expectant motherhood at work. *Human Resource Management Review, 19*(4), 314-323. doi:10.1016/j.hrmr.2009.03.003
- Kumar, A., Hessini, L., & Mitchell, E. H. (2009). Conceptualizing abortion stigma. *Culture, Health & Sexuality, 11*(6), 625-639. doi:10.1080/13691050902842741
- Lipp, A. (2010) Conceding and concealing judgment in termination of pregnancy; A grounded theory study. *Journal of Research in Nursing, 15*(4) 365–378.
doi:10.1177/1744987109347031
- Major, B., Cozzarelli, C., Cooper, M., Zubek, J., Richards, C., Wilhite, M., & Gramzow, R. H. (2000). Psychological responses of women after first-trimester abortion. *Archives of General Psychiatry, 57*(8), 777-784. doi:10.1001/archpsyc.57.8.777
- Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology, 56*(1), 393-421. doi:10.1146/annurev.psych.56.091103.070137
- Major, B., & Gramzow, R. H. (1999). Abortion as stigma: Cognitive and emotional implications of concealment. *Journal of Personality and Social Psychology, 77*(4), 735-745.
doi:10.1037/0022-3514.77.4.735
- Mottarella, K., Fritzsche, B., Whitten, S., & Bedsole, D. (2009). Exploration of “good mother” stereotypes in the college environment. *Sex Roles, 60*(3/4), 223-231. doi:10.1007/s11199-008-9519-y
- National Association of Social Workers (2008). NASW Code of Ethics. Washington, DC: NASW.

- Norris, A., Bessett, D., Steinberg, J. R., Kavanaugh, M. L., De Zordo, S., & Becker, D. (2011). Abortion stigma: A reconceptualization of constituents, causes, and consequences. *Women's Health Issues, 21*(3), S49-S54. doi:10.1016/j.whi.2011.02.010
- Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology, 97*(4), 634-651. doi:10.1037/a0015815
- Rubin, A. & Babbie, E. (2010). *Essential research methods for social work* (2nd ed.). Belmont, CA: Brooks/Cole.
- Smith, S., & Watson, J. (1992). *De/Colonizing the subject: The politics of gender in women's autobiography*.
- Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist, 52*(6), 613-629. doi:10.1037/0003-066X.52.6.613
- Steinberg, J. R., & Finer, L. B. (2011). Examining the association of abortion history and current mental health: A reanalysis of the National Comorbidity Survey using a common-risk-factors model. *Social Science & Medicine, 72*(1), 72-82. doi:10.1016/j.socscimed.2010.10.006
- Van Brakel, W. H. (2006). Measuring health-related stigma--A literature review. *Psychology, Health & Medicine, 11*(3), 307-334. doi:10.1080/13548500600595160
- Wei, L., & Hindman, D. (2011). Does the Digital Divide Matter More? Comparing the Effects of New Media and Old Media Use on the Education-Based Knowledge Gap. *Mass Communication & Society, 14*(2), 216-235. doi:10.1080/15205431003642707

Whelan, P. (2010, April). Abortion rates and universal health care. *New England Journal of Medicine*. p. e45. doi:10.1056/NEJMp1002985.

Zolese, G., & Blacker, C. (1992). The psychological complications of therapeutic abortion. *The British Journal Of Psychiatry: The Journal Of Mental Science*, 160, 742-749. Retrieved from EBSCOhost.

APPENDIX A



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February 13, 2012

Alicia Flanagan

Dear Alicia,

You did a very nice job on the revisions and letters. You are approved and ready to go. Thank you very much.

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.

Good luck with your research.

Sincerely,

A handwritten signature in black ink that reads 'David L. Burton'.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Joan Lesser, Research Advisor

APPENDIX B

1. Bentley University[∅]
2. Berklee College of Music^Ω
3. Boston College^{∅*}
4. Boston University[∅]
5. Brandeis University[∅]
6. Bunker Hill Community College^Ω
7. Cambridge College[∅]
8. Emerson College[∅]
9. Harvard University^Ω
10. Lesley University^{•∞}
11. Massachusetts Institute of Technology[∅]
12. Northeastern University[∅]
13. Roxbury Community College[†]
14. Simmons College[‡]
15. Smith College[§]
16. Suffolk University[‡]
17. Tufts University^{•§}
18. University of Massachusetts Boston

Beth Israel Deaconess Medical Center^{§†¶}

Women's Health Services[‡]

Planned Parenthood League of Massachusetts[§]

[∅] Did not contact

* College is a private Roman Catholic Jesuit school with policies regarding reproductive health that are prohibitive to posting flyers on campus regarding a study about abortion.

^Ω Did not respond to outreach

[‡] Researcher determined she had too many personal contacts at the college/university to pursue it as a recruitment site / or population incongruous with study protocol (Women's Health Services)

† Institution informed researcher that she must be affiliated with the institution to conduct research

‡ Institution informed researcher that she may have co-investigator

∞ Required expedited IRB review in addition to SSW HSR review

§ Required full committee IRB review in addition to SSW HSR review

◇ Institution used SSW HSR approval and did not require additional review

APPENDIX C



OFFICE OF THE VICE PROVOST

Social, Behavioral, and Educational Research
Institutional Review Board
FWA00002063

April 17, 2012 | Notice of Action

IRB Study # 1203008 | Status: ACTIVE

ATTENTION: BEFORE CONDUCTING ANY RESEARCH, PLEASE READ THE ENTIRETY OF THIS NOTICE AS IT CONTAINS IMPORTANT INFORMATION ABOUT PROPER STUDY PROCEDURES.

Title: Women's Social and Emotional Experiences with Abortion (Previously Approved by Smith College IRB on 2/13/2012)

PI: Alicia Flanagan
Co-Investigator(s): Celeste Royce

The PI is responsible for all information contained in both this notice of action and on the following **Investigator Responsibilities Sheet**.

Only copies of approved stamped consent forms and other study materials may be utilized when conducting your study.

This research protocol now meets the requirements set forth by the Office for Human Research Protections in 45 CFR 46 under Expedited .

Reviewed 4/4/2012 – Expires 4/3/2013

- Approved for 150 participants for the duration of the study.

Protocol Management:

- For all changes to the protocol, submit: *Request for Protocol Modification* form
- All Adverse Events and Unanticipated Problems must be reported to the Office of the IRB promptly (no later than 7 calendar days after first awareness of the problem) using the appropriate forms.
- Six weeks prior to the expiration of the protocol on 4/3/2013, investigators must submit either a *Request for Continuing Review* or a *Request for Study Closure*
- All forms can be found at: <http://www.tufts.edu/central/research/IRB/Forms.htm>

IRB Administrative Representative Initials: 

APPENDIX D

Brandeis University IRB Approval
[Deliberately excluded to protect confidentiality]

APPENDIX E

Dear Alicia,

Terry Keeney and I, as Co-Chairs of the Lesley University Human Subjects Committee, have informally reviewed your research documents as approved by the Smith College School for Social Work's Human Subjects Review Committee. All looks to be in order and we feel that this project, while sensitive, sufficiently ensures the safety of participants and does not pose undue risk to Lesley students who may be recruited to participate.

Kind regards, Robyn Cruz

Robyn Flaum Cruz, Ph.D., BC-DMT

Associate Professor, Expressive Therapies Ph.D. Program

Co-Chair, Lesley University Institutional Review Board

Lesley University, Cambridge, MA

APPENDIX F

INFORMED CONSENT FORM

INTRODUCTION

You are invited to participate in a research study on women's social and emotional experiences with abortion. Social and emotional experiences with abortion include your attitudes and beliefs about abortion, any experiences you have had with abortion, and the opinions you encounter in your community about abortion. A master's student from Smith College School for Social Work whose name is Alicia Flanagan is conducting this study. She will be using data from this research study for a master's thesis, publications and presentations.

In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This process is known as "informed consent."

This consent form provides detailed information about the research study. A study researcher is available by telephone to discuss the study with you at **(personal information deleted by Laura H. Wyman, 11/30/12)**. Before you sign this consent form, there are several general principles that apply to participation in any research study:

1. Your participation is voluntary.
2. You may or may not benefit from participating in the study, but your participation may contribute to knowledge that will benefit others.
3. You may withdraw from the study at any time.

Once you understand the study, you will be asked to agree with the terms in this informed consent if you wish to participate.

NATURE OF PARTICIPATION

You are invited to participate in this study because you meet the inclusion criteria (you are a woman who reads and writes English and is between the ages of 18 and 65). You are being selected from one of three sites participating in the study.

Participation in the research study involves taking a survey that has a set of 34 questions about your social and emotional experiences with abortion, and 8 questions about your demographics. It takes about 20 minutes to complete. Some of the questions are:

- (1) What are your feelings about abortion?
- (2) Have your feelings changed or stayed the same since your first learned about abortion?
- (3) What are your community's attitudes and beliefs about abortion?

The researcher, Alicia Flanagan, will analyze survey data.

You do not have to answer any questions you do not want to and you may stop the survey at any time. There are no right or wrong answers to any of the questions.

After you complete the survey, you will be asked if you would like to participate in a phone interview that will take 30-45 minutes to complete. During the interview, Alicia Flanagan will ask you some more questions related to the questions on the survey: **(personal information deleted by Laura H. Wyman, 11/30/12)**

- (1) What was your experience taking the survey?
- (2) What are your views on abortion?
- (3) What are your community views on abortion?

Telephone interviews will be audio recorded, transcribed, and analyzed by the researcher.

There will be a separate informed consent process for the telephone interview portion of the research study. If you sign this informed consent, you are not consenting to participate in the telephone interview. If you volunteer for the telephone interview, Alicia Flanagan will contact you at a later date to discuss that part of the research in more detail.

RISKS AND BENEFITS:

There are risks and benefits to participating in the research study. This study is about the sensitive topic of abortion. You may risk feeling some emotional discomfort sharing your opinions and/or experiences with abortion. This may feel risky because you may be concerned that your confidentiality will be breached. The research survey is anonymous, and assurances are put in place so that data cannot be traced to you. The telephone interview is confidential, but it is not anonymous. You may choose to use a fake name, however, in order to participate you must provide your telephone number and some other contact information so you may give truly informed consent if you wish to participate. Therefore, you may experience some discomfort disclosing identifying information and sharing opinions about abortion.

Any identifying information you provide will be kept in a locked filing cabinet, and it will be separated from study data. If you consent to participate in the telephone interview, Alicia Flanagan will conduct them in a private space and she will make assurances so that no one else can overhear the conversation. If you have questions about your privacy, or if you would like clarification about the difference between anonymity and confidentiality, please contact Alicia Flanagan at **(personal information deleted by Laura H. Wyman, 11/30/12)**.

There are benefits to participating in the research study. You may feel satisfied or relieved by disclosing information about your beliefs and/or experiences with abortion. You may feel pleased that you are contributing to a research study, the findings of which will contribute to a body of knowledge about abortion stigma in women's lives that could be incorporated into social work

practice and training, as well as add to the body abortion stigma research. There will be a diverse list of resources provided.

If you consent to participate in the survey, you may choose to enter a drawing to win a \$100 gift card to Amazon.com. One participant from the study will be chosen at random to receive the gift certificate.

If you consent to participate in the telephone interview, you will be given a \$5 gift certificate to Dunkin Donuts. Not all of the volunteers for the phone interview will be given the gift certificate, just those that participate, as the researcher is conducting a limited number of interviews. If you participate in a portion or the entire interview and then decide to withdraw from the study, you are still entitled to receive the gift certificate.

PROTECTION OF CONFIDENTIALITY:

Information derived from this research study will be reviewed, recorded (in some cases, audio recorded), transcribed, and analyzed by the researcher, Alicia Flanagan with protection of confidentiality so far as permitted by applicable law. Though you may volunteer your telephone number, which is identifying information, all identifying information will be kept separate from the information that you provide. The researcher will store all of the data collected from you separately from any identifying information in a locked file cabinet.

The data collected from this study will eventually be used for a master's thesis, public presentations, and publications. All data will be presented as a whole; quotes that are helpful in illustrating a topic will be disguised. All notes, tapes, transcriptions, and files will be kept for 3 years in accordance with Federal regulations. If data is kept longer than 3 years for the purposes of publication or additional research, the data will continue to be protected and secure in a locked environment. Data will be destroyed and permanently erased when it is no longer necessary for use.

STUDY PARTICIPATION AND WITHDRAWAL:

Participation in this study is voluntary. You have the right to refuse to take part in this research study. If you consent to participate, your survey data will be anonymous. If you enter responses to the survey and would like to withdraw, the researcher will not be able to isolate your survey data from other participants' data. You may refuse to answer any question, and you may stop at any time, but you may not remove any responses you submit from the research study.

If you consent to participate in the telephone interview, you have to right to withdraw your participation from the study. If you choose to withdraw from the telephone interview, the researcher will destroy all study materials related to your telephone interview and it will not be used in data analysis. The last date for withdrawal is May 1, 2012.

To withdraw, please send an e-mail or call the Principal Investigator, Alicia Flanagan:
(personal information deleted by Laura H. Wyman, 11/30/12)

[State in your message that you participated in a research study on women’s social and emotional experiences with abortion, and you would like to withdraw from the study.](#) Please be aware that the researcher cannot, and is not required to destroy or retrieve any of your data that has already been used for the purpose of this research. All survey data will already be in use from the time it is entered, and all telephone interview data will already be in use by May, 2012.

If you have questions about your rights as a research subject, or if you have questions about any aspect of this study, please feel free to contact the researcher, Alicia Flanagan, BA, MSW Intern at **(personal information deleted by Laura H. Wyman, 11/30/12)**. You may use a fake name. Any contact information you use will not be saved when you call or email. You may also call the Chair of Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY CHECKING THE BOX BELOW THAT STATES “I AGREE,” YOU ARE INDICATING THAT YOU:

- **ALL OF YOUR QUESTIONS ARE ANSWERED AND YOU HAVE NO FURTHER QUESTIONS AT THIS TIME;**
- **YOU UNDERSTAND WHAT YOUR PARTICIPATION INVOLVES;**
- **YOU UNDERSTAND YOUR RIGHTS;**
- **AND YOU AGREE TO PARTICIPATE IN THE STUDY.**

I AGREE

I DO NOT AGREE TO PARTICIPATE IN THE STUDY

APPENDIX G

INFORMED CONSENT FORM Telephone Interviews

INTRODUCTION

You are invited to participate in the second phase of the research study on women's social and emotional experiences with abortion. Social and emotional experiences with abortion include your attitudes and beliefs about abortion, any experiences you have had with abortion, and the opinions you encounter in your community about abortion. A master's student from Smith College School for Social Work whose name is Alicia Flanagan is conducting this study. She will be using data from this research study for a master's thesis, publications and presentations.

You already completed the survey. In order to decide whether you wish to participate in this portion of the research study, the telephone interview, you should understand enough about its risks and benefits to be able to make an informed decision. This process is known as "informed consent."

This consent form provides detailed information about the research study. A study researcher is available by telephone to discuss the study with you at **(personal information deleted by Laura H. Wyman, 11/30/12)**. Before you sign this consent form, there are several general principles that apply to participation in any research study:

1. Your participation is voluntary.
2. You may or may not benefit from participating in the study, but your participation may contribute to knowledge that will benefit others.
3. You may withdraw from the study at any time.

Once you understand the study, you will be asked to agree with the terms in this informed consent if you wish to participate.

NATURE OF PARTICIPATION

You are invited to participate in this study because you meet the inclusion criteria (you are a woman who reads and writes English and is between the ages of 18 and 65). You are being selected from a group of survey respondents who volunteered to participate in the second phase of this research study.

Participation in the research study involves taking having a telephone conversation with the researcher, Alicia Flanagan that is audio recorded. It may take about 30-45 minutes. You will be asked a few questions about your demographics, and the remainder of the conversation will be an open discussion about the topics raised in the survey you took. Some of the questions are:

- (1) What was your experience taking the survey?
- (2) What are your views on abortion?

(3) What are your community views on abortion?

Telephone interviews will be audio recorded, transcribed, and analyzed by the researcher.

RISKS AND BENEFITS:

There are risks and benefits to participating in the research study. This study is about the sensitive topic of abortion. You may risk feeling some emotional discomfort sharing your opinions and/or experiences with abortion. This may feel risky because you may be concerned that your confidentiality will be breached. The research survey was anonymous, and the telephone interview is confidential. The difference is that I, Alicia Flanagan cannot identify the individuals who participated in the survey. Your survey data is anonymous, so I do not know what your responses were. This interview is highly confidential, but not anonymous because in order to participate, you must provide some identifying information: your telephone number, your mailing address, and your first name (or a fake first time).

Any identifying information you provide will be kept in a locked filing cabinet, and it will be separated from study data. If you consent to participate in the telephone interview, Alicia Flanagan will conduct them in a private space and she will make assurances so that no one else can overhear the conversation. If you have questions about your privacy, or if you would like clarification about the difference between anonymity and confidentiality, please contact Alicia Flanagan at **(personal information deleted by Laura H. Wyman, 11/30/12)**

There are benefits to participating in the research study. You may feel satisfied or relieved by disclosing information about your beliefs and/or experiences with abortion. It may be helpful to talk about these topics more in-depth with the researcher to feel more personally connected to your research study participation. You may feel pleased that you are contributing to a research study, the findings of which will contribute to a body of knowledge about abortion stigma in women's lives that could be incorporated into social work practice and training, as well as add to the body abortion stigma research. There will be a diverse list of resources provided.

If you consent to participate in the telephone interview, you will be given a \$5 gift certificate to Dunkin Donuts. Not all of the volunteers for the phone interview will be given the gift certificate, just those that participate, as the researcher is conducting a limited number of interviews. Whether you participate in a portion or the entire interview and then decide to withdraw from the study, you are still entitled to receive the gift certificate.

PROTECTION OF CONFIDENTIALITY:

Information derived from this research study will be audio recorded, transcribed, reviewed, and analyzed by the researcher, Alicia Flanagan with protection of confidentiality so far as permitted by applicable law. Though you may volunteer your telephone number, which is identifying information, all identifying information will be kept separate from the information that you provide in your responses to questions in the interview. The researcher will store all of the data collected from you separately from any identifying information in a locked file cabinet.

The data collected from this study will eventually be used for a master's thesis, public presentations, and publications. All data will be presented as a whole; quotes that are helpful in illustrating a topic will be disguised. All notes, tapes, transcriptions, and files will be kept for 3 years in accordance with Federal regulations. If data is kept longer than 3 years for the purposes of publication or additional research, the data will continue to be protected and secure in a locked environment. Data will be destroyed and permanently erased when it is no longer necessary for use.

STUDY PARTICIPATION AND WITHDRAWAL:

Participation in this study is voluntary. You have the right to refuse to take part in this research study. If you consent to participate, your data will be confidential. You may refuse to answer any question, and you may stop at any time. You have the right to withdraw your participation from the study. If you choose to withdraw from the telephone interview, the researcher will destroy all study materials related to your telephone interview and it will not be used in data analysis. The last date for withdrawal is May 31, 2012.

To withdraw, please send an e-mail or call the Principal Investigator, Alicia Flanagan:
(personal information deleted by Laura H. Wyman, 11/30/12)

[State in your message that you participated in a research study on women's social and emotional experiences with abortion, and you would like to withdraw from the study.](#) Please be aware that the researcher cannot, and is not required to destroy or retrieve any of your data that has already been used for the purpose of this research. All survey data will already be in use from the time it is entered, and all telephone interview data will already be in use by June, 2012.

If you have questions about your rights as a research subject, or if you have questions about any aspect of this study, please feel free to contact the researcher, Alicia Flanagan, BA, MSW Intern at **(personal information deleted by Laura H. Wyman, 11/30/12)**. You may use a fake name. Any contact information you use will not be saved when you call or email. You may also call the Chair of Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

**YOUR SIGNATURE INDICATES:
THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION,
THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE
STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS,
AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Signature: _____

Date: ____ / ____ / ____

I AGREE TO BE AUDIO RECORDED DURING THE TELEPHONE INTERVIEW

I DO NOT AGREE TO BE AUDIO RECORDED

APPENDIX H
RESOURCES

·Find a counselor:

<http://www.helpstartshere.org/find-a-social-worker>

·Massachusetts Commission on the Status of Women; MA Women's Information Network:

www.mcswnetwork.com

·The National Women's Health Information Center:

<http://www.womenshealth.gov/>

·Birth control options:

<http://www.plannedparenthood.org/health-topics/birth-control-4211.htm>

·Call an after-abortion counseling talk line:

1-866-4 EXHALE [1-866-439-4253]
<http://www.4exhale.org/>

·Call a suicide prevention and grief support hotline:

1-877-870-4673, <http://samaritanshope.org/>

·NAF *are you pregnant?* Resources for abortion, adoption and parenthood:

<http://www.prochoice.org/Pregnant/index.html>

·Get help funding an abortion:

<http://www.fundabortionnow.org/get-help>

·Project Voice: is a oral history project documenting abortion stories. Read stories or share your own.

<HTTP://www.theabortionproject.org/>

APPENDIX I
Quantitative Survey and Codebook

SELECTION CRITERIA 1

[Mandatory Question]

What is your gender?

Coded as constant variable: "woman"

[drop-down menu]

- Woman
- Man
- Transgender
- Other

Skip to Page 3

Skip to Page 5

Skip to Page 5

Skip to Page 5

NEXT

Page Break

Page 3

SELECTION CRITERIA 2

[Mandatory Question]

How old are you?

Coded as continuous variable.

[drop-down menu]

Numbers 01-100 available as an option

If age < 18 or > 65

Skip to Page 5

If $18 \leq \text{age} \leq 65$

Skip to Page 4

NEXT

Page Break

Page 4

C SELECTION CRITERIA 3

[Mandatory Question]

Do you read and write English?

Removed from analysis

[Fill-in boxes]

Yes
No

Skip to page 6
Skip to page 5

NEXT

Page Break

Page 5

Thank you for expressing interest in this study on abortion stigma.

Unfortunately you do not meet the selection criteria. To be eligible to participate in the study, you must be a woman between the ages of 18 and 65 who writes & reads English.

Please feel free to share this link with anyone you think may be eligible.

Page Break

Page 6

D: INFORMED CONSENT

...[Consent will be filled in here]...

BY CLICKING THE BOX BELOW THAT STATES "I AGREE," YOU ARE INDICATING THAT YOU HAVE NO QUESTIONS AT THIS TIME, YOU UNDERSTAND WHAT YOUR PARTICIPATION INVOLVES, YOU UNDERSTAND YOUR RIGHTS, AND YOU AGREE TO PARTICIPATE IN THE STUDY.

I AGREE

Skip to Page 8

I DO NOT AGREE TO

Skip to Page 7

PARTICIPATE IN THE STUDY

NEXT

Page 7

Thank you for expressing interest in this study on abortion stigma.
The researcher appreciates the time you spent reading the informed consent.

**This question was dropped from analysis because no study subjects responded to it.*

Unfortunately, you do not meet selection criteria because you did not agree to participate in the study.

Thank you again.

- I understand why I am not eligible to participate
- I do not understand

Page 8

RESOURCES

**See other research documents for this information*

NEXT

PAGE 9

1. *How many times have you been pregnant?* *Coded as continuous variables*

[drop-down menu]

Numerical list 0-30

2. *How many times have you given birth?*

[drop-down menu]

Numerical list 0-30

3. *How many miscarriages have you had?*

[drop-down menu]

Numerical list 0-30

4. *How many abortions have you had?*

[drop-down menu]
Numerical list 0-30

NEXT

Page Break

Page 10

1. Abortion stigma is when:

people assume bad things about women who decide to have an abortion.

- Strongly Disagree 1
- Disagree 2
- Neither Agree nor Disagree 3
- Agree 4
- Strongly Agree 5

2. Abortion stigma is when:

people assume bad things about other people & places that support women who have abortions.

- Strongly Disagree 1
- Disagree 2
- Neither Agree nor Disagree 3
- Agree 4
- Strongly Agree 5

3. People and places that support women who have abortions are not stigmatized, discriminated against, or judged for showing support to women who have abortions.

- Strongly Disagree 5
- Disagree 4
- Neither Agree nor Disagree 3
- Agree 2
- Strongly Agree 1

4. Women are not stigmatized, discriminated against, or judged for having an abortion.

- Strongly Disagree 5
- Disagree 4
- Neither Agree nor Disagree 3
- Agree 2
- Strongly Agree 1

Page 11

LEARNING ABOUT ABORTION

1. *How old were you when you first heard about abortion?*

[drop-down menu]

- | | |
|--|----|
| <input type="checkbox"/> Younger than 10 | 1 |
| <input type="checkbox"/> Between 10 and 13 | 2 |
| <input type="checkbox"/> Between 14 and 17 | 3 |
| <input type="checkbox"/> Between 18 and 21 | 4 |
| <input type="checkbox"/> In my 20s | 5 |
| <input type="checkbox"/> In my 30s | 6 |
| <input type="checkbox"/> In my 40s | 7 |
| <input type="checkbox"/> In my 50s | 8 |
| <input type="checkbox"/> In my 60s | 9 |
| <input type="checkbox"/> I don't know | 88 |

2. *Who was the first person to tell you about abortion? /*

Where did you first learn about abortion? *Check ONE box.*

- | | |
|---|----|
| <input type="checkbox"/> mother | 1 |
| <input type="checkbox"/> father | 2 |
| <input type="checkbox"/> sibling | 3 |
| <input type="checkbox"/> friend | 4 |
| <input type="checkbox"/> other family member | 5 |
| <input type="checkbox"/> doctor/nurse | 6 |
| <input type="checkbox"/> counselor | 7 |
| <input type="checkbox"/> teacher | 8 |
| <input type="checkbox"/> TV show | 9 |
| <input type="checkbox"/> internet | 10 |
| <input type="checkbox"/> other media (news, magazine) | 11 |
| <input type="checkbox"/> I don't remember | 12 |

3. What BEST describes your reaction when you FIRST learned about abortion?

Please check ALL boxes that apply.

- | | |
|---|----|
| <input type="checkbox"/> Conflicted | 1 |
| <input type="checkbox"/> Relieved | 2 |
| <input type="checkbox"/> Grateful | 3 |
| <input type="checkbox"/> Shocked | 4 |
| <input type="checkbox"/> Angry | 5 |
| <input type="checkbox"/> Curious | 6 |
| <input type="checkbox"/> Afraid | 7 |
| <input type="checkbox"/> Empowered | 8 |
| <input type="checkbox"/> Secure | 9 |
| <input type="checkbox"/> Guilty | 10 |
| <input type="checkbox"/> Selfish | 11 |
| <input type="checkbox"/> Sad | 12 |
| <input type="checkbox"/> I can't remember | 13 |

4. Have your feelings about abortion changed or stayed the same?

- | | |
|--|----|
| <input type="checkbox"/> Changed | 1 |
| <input type="checkbox"/> Stayed the same | 0 |
| <input type="checkbox"/> I don't know | 88 |

5. What is the ONE value that has the most impact on your thoughts and feelings about abortion? *Please check ONE box.*

- | | |
|--|----|
| <input type="checkbox"/> I am financially responsible | 1 |
| <input type="checkbox"/> I value being in a relationship | 2 |
| <input type="checkbox"/> I am a feminist | 3 |
| <input type="checkbox"/> I am concerned about the law | 4 |
| <input type="checkbox"/> I am religious | 5 |
| <input type="checkbox"/> I am spiritual | 6 |
| <input type="checkbox"/> I believe a fetus has rights | 7 |
| <input type="checkbox"/> I value motherhood | 8 |
| <input type="checkbox"/> I value my goals for the future | 9 |
| <input type="checkbox"/> I value women's rights | 10 |
| <input type="checkbox"/> Other | 11 |
| <input type="checkbox"/> I don't know | 88 |

6. Do you think abortion should be:

Please check ONE box.

- | | |
|--|---|
| <input type="checkbox"/> Legal in All Cases | 1 |
| <input type="checkbox"/> Legal in Most Cases | 2 |
| <input type="checkbox"/> Illegal in Most Cases | 3 |
| <input type="checkbox"/> Illegal in All Cases | 4 |

I don't know 88

7. I need to hide my feelings about abortion from the people I'm close with.
Please check ONE box.

- Strongly Disagree 1
- Disagree 2
- Neither Agree nor Disagree 3
- Agree 4
- Strongly Agree 5

NEXT

Page Break

Page 12

[Comment Box]

The following questions are about the community you live in now.

How much of your community (city or town) hold the following beliefs?

1. Abortion is a woman's right.

- No one 1
- A few people 2
- By about half the people 3
- Many people 4
- Most people 5

2. Abortion is a sin.

- No one 5
- A few people 4
- By about half the people 3
- Many people 2
- Most people 1

3. Abortion should be legal and available.

- No one 1
- A few people 2
- By about half the people 3
- Many people 4
- Most people 5

4. Abortion is always wrong.

- No one 5
- A few people 4
- By about half the people 3
- Many people 2
- Most people 1

5. Abortion is a good option for an unplanned pregnancy.

- No one 1
- A few people 2
- By about half the people 3
- Many people 4
- Most people 5

6. Abortion can be a good thing for some women.

- No one 1
- A few people 2
- By about half the people 3
- Many people 4
- Most people 5

7. Abortion is the same as murder.

- No one 5
- A few people 4
- By about half the people 3
- Many people 2
- Most people 1

_____ Page Break _____

8. My attitudes and beliefs are the SAME as my community's attitudes and beliefs.

- Strongly Disagree 1
- Disagree 2
- Neither Agree nor Disagree 3
- Agree 4
- Strongly Agree 5

9. With respect to abortion, would you consider yourself to be pro-choice or pro-life?

- Pro-Choice 1
- Pro-Life 2
- Mixed or Neither 3
- I don't understand the question 88
- No Opinion 4

11. Of the people you know, who has had an abortion?

*Check ALL that apply. *Because subjects may check more than one response, each response is coded yes/no, or 1/0.*

- My mother 1 / 0
- My aunt 1 / 0
- My sister 1 / 0
- My friend 1 / 0
- A mentor/teacher/counselor 1 / 0
- An acquaintance 1 / 0
- I don't know 88
- No one I know has had an abortion 1 / 0

12. If you had an abortion, did you tell someone about it?

- Yes [skip to question 13] 1
- No [skip to PAGE 13] 0
- I have never had an abortion [skip to PAGE 13] 99

_____page break_____

13. If yes, who was that person/who were those people?

- Current sexual partner 1 / 0
- Family member(s) 1 / 0
- Friend(s) 1 / 0
- Counselor/therapist 1 / 0
- Support group member (internet, in-person) 1 / 0

NEXT

Page Break

Page 13

[Comment Box]

When people think about their identity, they often ask themselves the following questions:

- ▲ Who am I?
- ▲ What are my character/personality traits?

- ⤴ What are my talents?
- ⤴ What experiences have I had that shape who I am?
- ⤴ Am I different from or similar to people whom I know?

Please consider the parts of yourself that shape your identity.

0 = NOT AT ALL important to the sense of who I am

1 = NOT VERY important to the sense of who I am

2 = SOMEWHAT important to the sense of who I am

3 = IMPORTANT to the sense of who I am

4 = EXTREMELY IMPORTANT to the sense of who I am

Rate the following list with number 0-4

**Each response choice is coded 0-4.*

___ Being part of my family

___ Being a mother

___ Having the ability or desire to be a mother

___ NOT having the ability to be a mother

___ NOT having the desire to be a mother

___ Being a woman

___ My body: my physical appearance, weight, health

___ My sexual orientation

___ Belonging to my community

___ Forming close relationship(s) with a person / network of people I
feel close to & can trust unconditionally

___ My social class, the economic group I belong to

___ My age, belonging to my age group or being part of my generation

___ Other people's opinions of me, the beliefs they hold about the
choices I make

___ Feeling like a unique person, distinct from other people

___ Knowing that I adapt and change as life changes

___ Knowing that I continue to be the same person, even though life presents many transitions and changes

___ My personal values and moral standards

___ My goals and future plans

___ My occupational choice and career plans

___ My language

___ My political views

___ My religion

2. If you already had an abortion, did the experience become a part of your identity?

Select one box.

- | | |
|---|----|
| <input type="checkbox"/> I have never had an abortion. | 99 |
| <input type="checkbox"/> No, my previous abortion(s) did not become part of my identity. | 0 |
| <input type="checkbox"/> I don't know | 88 |
| <input type="checkbox"/> Yes, I had an abortion in past that became part of my identity. | 1 |
| <input type="checkbox"/> Yes, I had an abortion in the past that became part of my identity at first, but became less so over time. | 2 |

[If either “Yes” selected: “How much of your identity did the abortion become?”]

1 = NOT VERY important to the sense of who I am

2 = SOMEWHAT important to the sense of who I am

3 = IMPORTANT to the sense of who I am

4 = EXTREMELY IMPORTANT to the sense of who I am

[Comment Box]

Whether or not you have had an abortion before:

1. Can you imagine having an abortion for an unplanned pregnancy in the future?

- | | |
|---------------------------------------|----|
| <input type="checkbox"/> Yes | 1 |
| <input type="checkbox"/> No | 0 |
| <input type="checkbox"/> I don't know | 88 |

2. Can you imagine having an abortion if you had a fetal abnormality?

- Yes 1
- No 0
- I don't know 88

3. Can you imagine having an abortion to terminate a pregnancy that resulted from rape?

- Yes 1
- No 0
- I don't know 88

_____page Break_____

1. Do you believe abortion should be available to women for:
[table]
unplanned pregnancies?

- Yes 1
- No 0
- I don't know 88

2. fetal abnormalities?

- Yes 1
- No 0
- I don't know 88

3. rape or incest?

- Yes 1
- No 0
- I don't know 88

NEXT

_____Page Break_____

DEMOGRAPHIC INFORMATION

1. What is your race?

- American Indian or Alaska Native 1
- Asian 2
- Black or African American 3
- Native Hawaiian or Other Pacific Islander 4
- White 5
- Other 6

2. What is your ethnicity?

- Hispanic or Latina 1
- Non Hispanic or Latina 0

3. What is your yearly household income ?

- Less than or equal to \$10,000 per year 1
- Less than or equal to \$20,000 per year 2
- Less than or equal to \$50,000 per year 3
- Less than or equal to \$100,000 per year 4
- more than \$100,000 per year 5
- I don't know 88

4. What is your relationship status?

- Single 1
- Partnered 2
- Married 3
- Separated 4
- Divorced 5

5. How do you define your sexual identity?

- Heterosexual / straight 1
- Homosexual / lesbian 2
- Bisexual 3
- Other 4

6. Do you identify with one of the following religious communities?

- Baptist 1
- Buddhist 2
- Catholic 3
- Christian (general) 4
- Church of Christ 5
- Congregational 6
- Eastern Orthodox 7
- Episcopal 8
- Hindu 9
- Jehovah's Witness 10
- Jewish 11
- Lutheran 12
- Methodist 13
- Muslim 14
- Pentecostal 15
- Protestant 16
- Presbyterian 17
- Other 18
- No religion 0

7. What is your political affiliation?

- Democrat 1
- Republican 2
- Independent 3

- Other 4
- I am not political or “I don’t know” 0

8. Are you currently enrolled in school?

- Yes 1

[Pop-up question with drop-down menu of colleges and universities]

- No 0

If No, what is the highest level of education you have completed?

- Some high school 1
- High school graduate / GED 2
- Some college / associate degree 3
- \geq College degree 4

APPENDIX J

Recruitment Flyer

Research Study for Women

- Are you a woman between age 18 & 65?
- Do you speak and read English?

If so, you may qualify for a research study investigating how women feel about abortion.

What will you be asked to do?

- Spend 20 min. taking an **anonymous** and **confidential** survey:
www.surveymonkey.com/s/WSE
- Answer questions about your demographics and your social and emotional experiences with abortion.

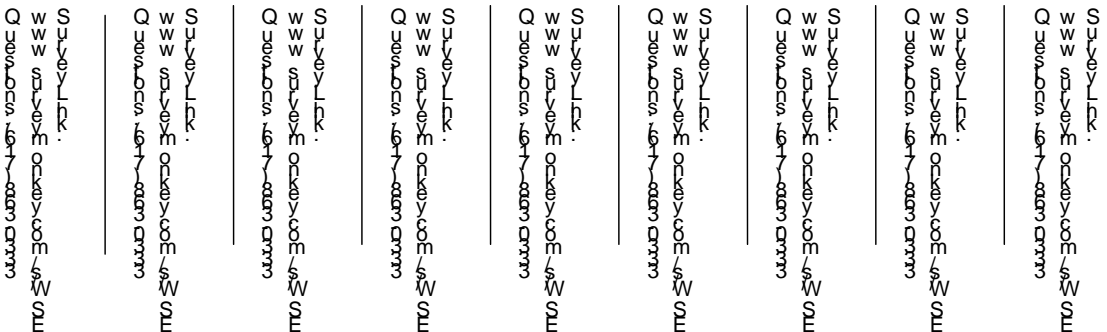
You do not have to provide your name & you may skip any question.

*You have the option to enter a pool to win a \$100 gift certificate.
Any contact information you give will not be connected to study data.*

How do you volunteer?

- Tear off a tab below and go to the website to learn more.

Questions? call - to reach Alicia Flanagan, MSW student at
Smith College School for Social Work *(You may give a fake name.)*



APPENDIX K

Script for calling quantitative questionnaire participants who volunteered to participate in the in-depth telephone interview:

If participant answers:

"Hi my name is Alicia Flanagan, and I'm a master's student from Smith College School for Social Work. I am contacting you because you recently provided your telephone number on a survey you took regarding women's social and emotional experiences with abortion. You gave your contact information, expressing interest in the second phase of the research study, which is a 30-45 minute in-depth interview. Did you intend to volunteer for the interview?"

If no: OK. Thank you for completing the survey. Good-bye.

If yes:

The reason I'm calling is that I would like to describe what participation involves and schedule a time to interview you. Would you be interested in hearing more about it now?

If no: OK. Would there be a better time, or would you prefer not to be contacted again about the research study?

If yes:

Participation in the in-depth interview involves having an open dialogue about the topics raised in the questionnaire. Throughout the interview, I will ask you 3 questions and I'll tell you what they are right now. However, I would not like you to answer these questions now. I'm sharing them with you ahead of time so that you know what the conversation will involve.

1. What was your experience taking the survey?
2. What are your views on abortion?
3. What are your community views on abortion?

I will ask follow-up questions in order to have a discussion about these topics, and you are welcome to raise questions throughout the interview. I may/may not be able to answer your questions, but I welcome you to share any thoughts you have. We'll probably talk for about 30-45 minutes.

Are you interested in participation?

If no: Thank you for your time. Good-bye.

If yes: Thank you; I appreciate your interest in the research study. (Obtain mailing address to send informed consent, schedule a mutually agreeable time for the telephone interview.)

The day before the interview, I will call you to make sure that you are still able to participate. If you have to cancel because you are no longer interested in participating or if you have to reschedule, you can call me at **(personal information deleted by Laura H. Wyman, 11/30/12)**

Thank you very much for volunteering to participate in another part of this research study. You will be mailed a \$5 gift certificate to Dunkin Donuts in appreciation for your participation.

If leaving a voice mail message:

"Hi my name is Alicia Flanagan, and I'm a master's student from Smith College School for Social Work. I am contacting you because you recently provided your telephone number on a survey you took. Please return my call at **(personal information deleted by Laura H. Wyman, 11/30/12)**. I will try to reach you once more. If I don't hear from you, I will assume that you are not interested in participating in an interview. Thank you.

APPENDIX L

FACESHEET

Participant Number _____

Date _____

Hello. Thank you for volunteering to participate in an in-depth interview about your social and emotional experiences about abortion. During the course of this interview, you will be asked questions similar to those on the survey you completed, and you will also be asked three questions about your demographics: you age, race & ethnicity, and your annual household income. I am also interested to hear about your experience taking the questionnaire.

This telephone interview will take approximately 45 minutes to 1 hour. You may withdraw from the interview at any point. You may choose not to respond to any question without penalty. Please feel free to ask questions and clarify any question you do not understand.

This interview will be audio-recorded and then transcribed by me. All data will remain confidential, and it will be stored in a locked environment. If you have any questions regarding your rights as a research subject you may contact the Smith College School for Social Work Human Subjects Review Committee: (413) 585-7974.

Do you have any questions at this time?

Does you consent to be audio-recorded?

YES NO

Time Interview Recording Begins _____ : _____ AM / PM

[audio recorder turned on]

Participant's Age _____

Participant's Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other

Participant's Ethnicity:

- Hispanic or Latina
- Non Hispanic or Latina

Participant's Household Income:

- Less than or equal to \$10,000 per year
- Less than or equal to \$20,000 per year
- Less than or equal to \$50,000 per year
- Less than or equal to \$100,000 per year
- more than \$100,000 per year
- I don't know

1 What was your experience taking the survey?

1.1 Are there any questions that stand out in your memory? (Which ones? Why?)

1.2 Were there any questions that were difficult to answer? (Which ones? Why?)

Notes

2 What are your views on abortion?

Notes

2.1 Do you think a woman should be able to have an abortion for an...unwanted pregnancy...rape...incest...fetal abnormalities?

2.2 What/who informs your views?

3 What are your community's views on abortion?

3.1 Have you always lived in a community with these views? (What other communities have you lived in? What other views has your community had?)

4 Is there a question that I have not asked you that you thought I might ask?

4.1 What is it? (Would you like to answer it?)

4.2 Why did you think I would ask that question?

4.3 Are there any other questions you anticipated?

[If not mentioned: Does she see herself as a parent? As a mother? As someone who will/will not be a mother in the future? Does she have thoughts regarding parenthood when she thinks about having an abortion, or when she thinks about others having an abortion? How does she define her her identity? How does she compare her attitudes about abortion to her conceptualization of her community's attitudes' re: abortion? Her attitudes regarding self?]

Time Interview Recording Ends ____ : ____ AM / PM

[audio recording turned off, participant and interviewer hang up]

Participant Number _____

Date _____

NOTES:

APPENDIX M

Letters of Professional Assurance of Research Confidentiality

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December 12, 2011

Advancing New Standards in
Reproductive Health (ANSIRH)
1330 Broadway, Suite 1100
Oakland, CA 94612
Phone: 510-986-8000
Fax: 510-986-0660
www.ansirh.org


Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

Re: Alicia Flanagan

To whom it may concern,

I'm writing to verify that I have been in communication with Alicia Flanagan since August of 2011. Alicia contacted me to discuss conducting research about abortion stigma for her master's thesis. I provided Alicia with a copy of ANSIRH's stigma scale to use for her to use confidentially as she developed her project ideas. In addition, I have given her feedback on her project and shared with her my bibliography of stigma related research. She has my permission to use elements of ANSIRH's abortion stigma scale in her surveys for graduate project.

Best,



Kate Cockrill, MPH
Program Director
Social and Emotional Aspects of Abortion

Advancing New Standards in Reproductive Health
University of California, San Francisco
1330 Broadway, Suite 1100
Oakland, CA 94612
Phone: (510) 986-8953 | Fax: (510) 986-8960

Volunteer or Professional Assurance of Research Confidentiality

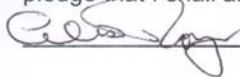
Smith College School for Social Work Master's Thesis

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 reviewers, transcribers, statisticians, co-investigators, and survey disseminators for this project shall sign this assurance of confidentiality.
- ^ All volunteers or professionals 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, Alicia Flanagan, shall be responsible for ensuring that all volunteer s and professionals 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 the research with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Alicia Flanagan 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.



Signature

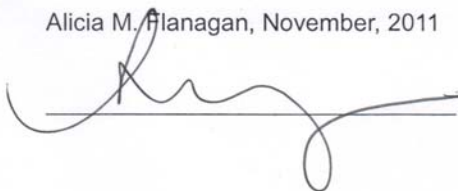
Celeste Zagon

Print Name

12/8/11

Date

Alicia M. Flanagan, November, 2011



Volunteer or Professional Assurance of Research Confidentiality

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Tim Creedan Signature

Timothy Creedan Print Name

12/12/11 Date

Alicia M. Flanagan, November, 2011

[Signature]

Volunteer or Professional Assurance of Research Confidentiality

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Nina Douglas Signature

Nina Douglas Print Name

12/7/11 Date

Alicia M. Flanagan, November, 2011

[Signature]