Abortion in the United States: Identifying Populations That Perceive the Most Abortion-Related Stigma

by

Megan Layne Cheatham

Master of Science
in Psychology
Florida Institute of Technology
2017

Bachelor of Science
in Psychology
Old Dominion University
2013

A doctoral research project proposal submitted to Florida Institute of Technology in partial fulfillment of the requirement for the degree of

Doctor of Psychology

Melbourne, Florida
February 1, 2019
We the undersigned committee, having examined the submitted doctoral research project, “Abortion in the United States: Identifying Populations That Perceive the Most Abortion-Related Stigma” by Megan Layne Cheatham, M.S. hereby indicate its unanimous approval.

_______________________________________
P. Aragon, Psy.D., Committee Chair
Assistant Professor, School of Psychology

________________________________________
Vida L. Tyc, Ph.D., Committee Member
Professor, School of Psychology

________________________________________
Natalie M. Dorfeld, Ph.D., Committee Member
Associate Professor, School of Arts and Communication

________________________________________
Lisa A. Steelman, Ph.D.
Professor and Dean
College of Psychology and Liberal Arts
Abstract

Abortion in the United States: Identifying Populations That Perceive the Most Abortion-Related Stigma
by
Megan Layne Cheatham, M.S.
Committee Chair: Patrick J. Aragon, Psy.D.

Approximately three million pregnancies in the United States each year are unintended, and about half of the women who experience an unwanted, unintended pregnancy obtain an abortion to terminate their pregnancy. However, despite abortion being a common and safe gynecological procedure, it is publicly controversial and highly stigmatized. Available research is in agreement that abortion does not lead to long-term mental health problems; however, there is a strong and significant association between abortion-related stigma and pre-abortion depressive, anxiety, and stress symptoms. Furthermore, stigma is suspected to vary based on demographic factors, and understanding these differences may help further prevent and manage abortion-related stigma.

The present study sought to identify which groups of women were more prone to perceiving abortion-related stigma. This cross-sectional study utilized the Guttmacher Institute’s 2008 Abortion Patient Survey dataset, which in addition to demographic information, it included nine specific questions about abortion-related stigma ($n = 4724$). Results demonstrated there is an overall significant mean difference in the perception of stigma between Hispanic women and non-Hispanic women, $t(4314) = -2.4, p < .05$; specifically, Hispanic women perceived
significantly more abortion-related stigma when compared to both Black women and women who identified their ethnicity as Other, $F(5, 4310) = 22.2, \ p < .001$. Furthermore, it was discovered there was no significant difference in the level of perceived abortion-related stigma for married and non-married women, $t(761) = - .15, \ p = .88$. Results also demonstrated college educated women perceive more abortion-related stigma than non-college educated women, $F(3,4312) = 9.5, \ p < .01$. Lastly, it was discovered women who obtained an abortion in the first trimester have a significantly higher level of perceived abortion-related stigma than women who obtained an abortion in their second trimester, $t(4314) = 4.29, \ p < .001$. Findings from this study will be used to inform reproductive health providers which populations will benefit most from pre-abortion interventions or resources to prevent or decrease stigmatization in order to better protect these marginalized groups from the negative impact of stigma.
# Table of Contents

Acknowledgements .................................................................................. vii

Introduction ............................................................................................. 1

Review of the Literature ........................................................................... 4

Abortion in the United States ..................................................................... 4

Past and Present Abortion Regulations ..................................................... 6

Pre-Abortion Clinic Visit ........................................................................... 21

Preparation for the Abortion Procedure ..................................................... 24

Abortion Procedure .................................................................................. 29

Abortion and Mental Health ...................................................................... 38

Abortion-Related Stigma ........................................................................... 52

Study Purpose and Rationale ..................................................................... 63

Objectives and Hypotheses ....................................................................... 65

Method and Procedures ............................................................................ 69

Data Collection ......................................................................................... 69

Research Design and Analysis of Data ....................................................... 73

Results ........................................................................................................ 74

Participants ................................................................................................ 74

Statistical Analyses ................................................................................... 75

Discussion .................................................................................................. 79

Impact of Study ......................................................................................... 79
Limitations and Areas for Future Research………………………………84

Conclusion……………………………………………………………………85

References……………………………………………………………………….87

Tables……………………………………………………………………………107

Table 1……………………………………………………………………………107

Appendices………………………………………………………………………109

Appendix A……………………………………………………………………109

Appendix B……………………………………………………………………113
Acknowledgements

I feel so fortunate to have had an amazing support system throughout graduate school. I am grateful for the unconditional love and support from my sweet husband. I owe so much to my parents, my grandma, and family for always being my biggest fans and providing endless encouragement throughout my life.

I also appreciate the understanding and assistance from my doctoral research project committee, especially Dr. Aragon, whose guidance, positivity, and openness has kept me moving forward.

Lastly, I am appreciative of all of the social justice warriors who fight for reproductive freedom. I am especially thankful to Planned Parenthood for countering abortion-related stigma and empowering individuals to make their own informed personal healthcare decisions, and to the Guttmacher Institute for their dedication to reproductive health research and education.
Abortion in the United States: Identifying Populations That Perceive the Most Abortion-Related Stigma

Abortion is described as the loss of pregnancy, and it is medically defined as the removal of the products of conception, including the fetus, fetal membranes, and placenta, from the uterus, in the earlier months of pregnancy (Venes, Thomas, & Taber, 2001). Exploration of this topic by the researcher remained focused on induced abortion, which, as the name implies, is related to purposeful termination of pregnancy. Consequently, the implications of spontaneous abortion, or miscarriage, will not be discussed.

According to the most recent data from the U. S. Department of Health and Human Services (USDHHS; USDHHS, 2016), approximately half of the 6.1 million pregnancies in the United States in 2011 were unintended. Unintended pregnancies are considered to be pregnancies that are either unwanted or mistimed. An unwanted pregnancy is defined as a woman who became pregnant for whom did not have the desire to bear children during her lifetime, while a mistimed pregnancy is defined as a woman who became pregnant and did not wish to become pregnant at the time her pregnancy occurred, but was hopeful to become pregnant in the future (USDHHS, 2016). Although pregnancy may not have occurred at an optimal time, many unintended pregnancies evolve into a welcomed pregnancy (Henshaw, 2009). Furthermore, some women decide a pregnancy is wanted and welcomed only after delivering their baby and judging their personal
amount of social support and financial situation, among other reasons. However, a great deal of unintended pregnancies are unwanted. With that said, in 2001, 48% of women who experienced an unwanted unintended pregnancy obtained an induced abortion (Paul et al., 2005).

Unintended pregnancies occur indiscriminately across our population, as it affects women of all ages, ethnicities, income levels, and levels of educational attainment; however, certain demographic groups tend to experience higher rates of unintended pregnancy. Among those groups who experience higher rates of unintentional pregnancies are (a) women in the 18 to 24 age group, (b) Black women, (c) Hispanic women, (d) women whose income level falls below the national poverty line, (e) women who have not obtained a high school diploma, and (f) unmarried women who are cohabitating with their partner (Frost et al., 2015). Furthermore, Cohen (2008) reported among the lowest socioeconomic statuses, Hispanic women are the most likely to experience an unintended pregnancy, and are two times more likely to experience this than White women.

Similarly, access to family planning services in the United States is also not created equal. Unfortunately, groups who have been identified to have the highest number of unintended pregnancies are less likely to have access to family planning services (Chandra, Martinez, Mosher, Abna, & Jones, 2005). Due to the high rate of unintended pregnancies and subsequent increased abortion rate, it is a national public health goal of the USDHHS to increase the proportion of pregnancies that
are intended, versus unintended, by 10% between 2010 and 2020 (USDHHS, 2016). According to the World Health Organization (2018), decreasing the number of unintended pregnancies can be accomplished by access to adequate family planning services, such as providing access and education regarding contraceptive methods. Family planning services allows individuals to have their desired number of children, as well as decide the timing that works best for them, by using contraceptive methods. The USDHHS (2016) outlined that in addition to providing contraceptive methods, family planning services include pregnancy testing and counseling, infertility treatment, prevention and treatment of sexually transmitted diseases, patient education and counseling, breast and pelvic examinations, breast and cervical cancer screenings, sexually transmitted infection and human immunodeficiency virus (HIV) prevention education, counseling, testing, and referrals.

Despite abortion being a common and safe gynecological procedure, it is an action in the United States that is considered to be highly stigmatizing. Stigma, defined by Goffman (1963), is a label marking an individual or their behavior as deviant in the context of diverging from the normalcy of society, or social expectations, which in turn, often devalues the individual and impacts her identity development. Goffman (1936) referred to stigma as an “undesired differentness” and a “deeply discrediting” attribute. To aid in the understanding of stigma, the construct should be conceptualized on multiple levels: between individuals, in
ABORTION STIGMA AMONG VARYING POPULATIONS

communities, in institutions, in law and government structures, and in framing discourses (Kumar, Hessinia, & Mitchell, 2009). Specifically, stigma related to abortion is the discreditation of individuals due to his or her association with terminating a pregnancy (Norris et al., 2011). Three groups of individuals can be affected by abortion-related stigma: (a) women who obtain an abortion; (b) abortion care providers and staff; and (c) individuals who support women who have abortions, such as the abortion seeker’s partner, advocates for reproductive freedom, researchers, etc. This study will focus specifically on women who obtain abortions and the stigma they endure. An individual’s experience of abortion-related stigma varies by their personal characteristics, such as their cultural values, religious practices, and economic status (Kumar et al., 2009). In summation, Kumar et al. (2009) stated, “Ultimately, abortion stigma serves to erase and disguise a legitimate medical procedure, discredit those who would provide or procure it and undermine those who advocate for its legality and accessibility.”

Review of the Literature

Abortion in the United States

Prevalence and the decline in abortion rate. According to Jones & Jerman (2017b), abortion remains one of the more safe and common medical procedures in the United States; in 2014, there were 926,190 abortions performed. Previously, between 2008 and 2014 abortion rates were reported to be 25% less frequent, as the rate decreased from 19.4 to 14.6 abortions per 1,000 women aged
15 to 44 years of age. Jones and Jerman (2014) reported a stabilization of the abortion rate following the national decline, although the decrease has been less prominent in low-income women and in certain U.S. states. It was subsequently suggested there may be disparities in access to contraceptive methods or other social challenges unique to those populations, as a possible explanation for this change. In the U.S., states in the South and West demonstrated small declines from 2005 to 2008 while Northwestern and Midwestern states did not see any notable change during that time. Furthermore, Jones and Jerman (2017b) reported the abortion rates declined for all racial and ethnic groups. Among the races and ethnicities analyzed, white women accounted for the largest number of abortions (358,810), although they had the lowest abortion rate at 10.0 per 1,000. Black women were second in number of abortions in 2014 at 255,630 with an abortion rate of 27.7 per 1,000, while Hispanic women had 229,790 abortions in 2014, with a rate of 18.1 per 1,000.

**Reasons to elect for abortion.** Women have many valid reasons to decide not to carry a pregnancy to term, and the decision-making process is a profoundly personal medical decision between a woman and her doctor based on what is best for the individual. Chae, Desai, Crowell, and Sedgh (2017) reported the three most common reasons for women in the United States cite for deciding to obtain an abortion, related to age range. For women under 25, socioeconomic concerns were the leading reason for deciding to have an abortion (30%) and was followed closely
by wanting to postpone having children or wanted greater spacing between her children (28%). Additionally, for those under 25, the third most frequent reason given was that they were too young to be a parent, or their parent(s) objected to them giving birth (14%). For women 25 and older, socioeconomic concerns (25%) and not wanting any children or not wanting any more children (25%) were listed as the most common reasons to have an abortion, and they were followed by wanting to postpone having children or wanting greater spacing between her children (21%; Chae et al., 2017). Many women who terminate their pregnancies report multiple reasons for seeking an abortion. Biggs, Gould, and Foster (2013) elaborated that 36% of women note one main reason to have an abortion, while 29% of women delineate two reasons; however, 13% of women described four or more reasons they decided to have an abortion. Their results were commensurate with other studies in which women largely cited financial concerns (40%), timing of the pregnancy (36%), and partner-related concerns (31%) as their main reasons to obtain an abortion.

**Past and Present Abortion Regulations**

**1800s through the 1960s.** Until the latter part of the 19th century, abortion was legal in the United States prior to the point of *quickening,* in which the woman perceived to feel movements of the fetus, suggested to occur around the fourth to fifth month of pregnancy (Mohr, 1978). Women were “legally able” to attempt to put an end to the condition, that may or may not have been pregnancy, up until the
pregnancy was confirmed by the woman’s subjective perception of fetal movement. After quickening, the termination of the fetus was considered to be a crime and was punishable by law, although it was categorized as a common law misdemeanor offense, thus punished less harshly than homicide, as the fetus had no established personhood (Mohr, 1978). Home medical guide books provided abortion-inducing recipes, and in the mid-18th century, pregnancy-terminating drugs were widely available and advertised. Unfortunately, in the 1820s and 1830s, these drugs were often fatal to women, which engendered the first statutes regulating abortion practices; however, these statutes were related to poison control, and not the cessation of legal abortion.

Shortly after its founding in 1847, physicians of the American Medical Association, began to campaign against abortion. As it gained traction, the anti-abortion stance was propelled by nativism and anti-Catholicism (Reagan, 1998). By the 1880s, abortion became outlawed across most of the United States. Reagan (1998) described a desired effect from criminalizing abortion was to expose and humiliate women who were caught in abortion clinic raids or seeking medical treatment for abortion-related complications, which would reinforce gender norms and maintain male dominance in society. Reagan (1998) reported that in 1902, the Journal of the American Medical Association endorsed the then-common policy of denying a woman suffering from abortion-related complications proper medical care until she confessed to attempting an abortion, and named all of the individuals
associated with the woman, including the man responsible for the pregnancy and the abortion care provider. This fear tactic caused many women to delay or avoid seeking medical treatment, and often had a fatal ending, as over 15,000 women per year died from abortions in the late 1920s. The Great Depression also stimulated a rise in the rate of abortions, as some women feared losing their jobs if they became pregnant, or they could not afford to care for another child. During this time, there were abortion clinics with doctors and support staff who were generally able to provide safe abortion care, along with birth control clubs whose members would pay dues into a collective abortion fund to use, as needed.

However, through the 1940s and 1950s, these operations were forced out of business, which generated a spike in abortion-related complications and deaths due to botched “back alley abortions”, and even more dangerous self-abortion procedures. Women with privilege, specifically upper-class White women, maintained the ability to obtain legal “therapeutic abortions” during this time; although, this option was rarely available to non-White or socioeconomically disadvantaged women (Reagan, 1998). During the 1950s, safe access to abortion for all women was severely limited, due to abortion care providers fearing legal punishment. As a result of the changing of political and social ideologies in the 1960s, a wave of moderate abortion care reform began. States began to pass laws to permit abortion in the cases of rape, incest, fetal defect, or if the pregnancy posed a threat to the woman’s physical or mental health; however, this era still was unable
to attain full reproductive freedom for women who sought abortions for other reasons.

*Roe v. Wade (1973).* In 1970, Hawaii was the first state to legalize abortion, although it only applied to residents of Hawaii. Later that year, New York fully legalized abortion for all women, and Alaska and Washington soon followed suit. Immediately prior to the passing of *Roe v. Wade,* abortion was illegal in all circumstances in 30 states, while the remaining 16 states declared abortion as legal in certain circumstances, such as rape, incest, or if the pregnancy endangered the woman’s health. On January 22, 1973, the United States Supreme Court made a landmark decision on *Roe v. Wade* to legalize abortion nationwide. All previous state laws that limited reproductive freedom during the first trimester of pregnancy were invalidated, which affected legislation in 46 states (*Roe v. Wade,* 1973). The Supreme Court ruled a woman’s right to make her own personal medical decisions was protected by the Fourteenth Amendment’s constitutional right to privacy.

Before this monumental Supreme Court ruling, it was estimated 1.2 million women in the United States obtained illegal abortions each year, and unsafe abortion services caused as many as 5000 deaths per year; however, after the *Roe v. Wade* decision, maternal mortality due to abortion sharply decreased, which signifies the importance of easily accessible and safe abortion care for women’s health (Cates, Grimes, & Schulz, 2003).
Later, the Court ruling further defined different levels of state interest in abortion utilizing the trimester system. It declared that women have the freedom to make their own personal medical decisions regarding termination of pregnancy during the first trimester (*Roe v. Wade*, 1973). This ruling granted women the right to make their own personal medical decisions during the first trimester. During the second trimester, states are permitted to regulate abortions in order to protect the woman’s health. Regarding the third trimester, after the fetus is considered to be viable, state laws are permitted to restrict and prohibit abortion unless the health of the woman is at stake or in cases of severe fetal anomalies, which accounts for only 1.4% of abortions.

**Current restrictions to abortion access.** Although *Roe v. Wade* ruled to legalize abortion, it is often the topic of extensive debate on both the national and state levels. From January 2011 through December 2017, states enacted 401 abortion restrictions, which comprises 34% of the 1,193 abortion restrictions created since the 1793 *Roe v. Wade* decision (Nash, Gold, Mohammed, Ansari-Thomas, & Cappello, 2017). In 2017 alone, 19 states passed 63 new restrictions to abortion access. A categorization system was developed to classify each state’s support of reproductive freedom by summing how many of 10 major types of abortion restrictions the state has enacted (e.g., mandatory waiting periods, parental involvement with a minor’s abortion, restricting abortion coverage in private health plans, etc.) Nash et al. (2017) reported a state is considered *supportive* of abortion
rights if they have no more than one restriction, *middle-ground* if the state has two to three restrictions, *hostile* if it has four to five restrictions, and *extremely hostile* if it has six to 10. As of the beginning of 2018, there are 23 states classified as extremely hostile to abortion rights and six states classified as hostile, while there are 12 states classified as supportive; the remaining nine states are classified to be a middle-ground state. Only 30% of women of reproductive age live in a state considered supportive of abortion rights, while 58% of the same population of women live in a hostile or extremely hostile state (Nash et al., 2017). In fact, there are 17 states that have abortion laws that largely conflict with scientific evidence while 12 states have abortion restrictions that moderately conflict with scientific evidence; these 29 states have adopted many controversial abortion-related regulations. Several prevalent abortion restrictions, including targeted regulation of abortion providers, restrictions on public and private insurance coverage, pre-abortion counseling, and mandatory waiting periods, and the consequences of these regulations will be discussed.

**Targeted regulation of abortion providers.** Many of those states have passed regulations considered to be targeted regulation of abortion providers (TRAP) laws aimed to reduce the number of abortion providers and facilities, thus making abortion care less accessible (Gold & Nash, 2017). The American College of Obstetricians and Gynecologists (2014) reported that health abortion care providers face laws inappropriately unique to the provision of abortion, and some
procedure regulations and pre-abortion counseling are not evidenced-based or ethical. Examples of TRAP laws include establishing the requirement that abortion providers must have hospital admitting privileges, allowing only licensed physicians to perform abortions, holding reproductive health facilities to the same standards of ambulatory surgical centers (although surgical centers generally provide more risky and invasive procedures), and denial of the use of telemedicine to assist in ending a pregnancy. However, Weitz et al. (2013) found that surgical abortions performed by nurse practitioners, physician assistants, and certified nurse midwives were not significantly less safe than abortions performed by physicians in terms of the rate of abortion complications, as their rate of complications were 1.8% and 0.9%, respectively. The difference in risk between the two was largely the result of a higher incidence of minor complications, which were reported to be easily treated diagnoses without consequential sequelae (Weitz et al., 2013). This research supported generating policies to allow medical providers other than physicians to perform early vacuum aspirations in order to expand abortion care access.

Although some of these regulations may appear to be providing a higher standard of care for the abortion-seeking patient, the logistical burdens often placed on the patient have been reported to be a tactic to discourage and limit access to services (Jones & Jerman, 2016). For example, the majority of abortion providers are located in metropolitan areas, which demonstrates that rural women have an
already-limited access to abortion care. If TRAP laws mandate abortion care providers must have admitting privileges at a hospital, it can reduce abortion access to the estimated 20% of women ages 15 to 44 who live 50 or more miles from their nearest abortion clinic (Bearak, Burke, & Jones, 2017). As of 2014, 90% of counties in the United States did not have an abortion provider, and 39% of women of reproductive age reside in those counties (Jones & Jerman, 2014).

The Hyde Amendment. The Hyde Amendment was first passed in 1976 as an amendment to the Departments of Labor and Health, Education, and Welfare, Appropriation Act (1977). It is an annually reviewed provision and has been reenacted every year since its introduction. This amendment banned the use of federal Medicaid funding for abortion services with the exception of extreme circumstances, such as when the pregnancy is a result of rape or incest or if it endangers the woman’s life (Shimabukuro, 2018). Even if a woman’s health or well-being is at risk and her physician recommends an abortion, Medicaid will not cover the services (Planned Parenthood Action Fund, n.d.).

Medicaid is the main public health insurance program for low income individuals in the United States. Although Medicaid, which was established in 1965, did not originally cover abortions, under the Nixon Administration the Department of Health, Education and Welfare chose to reimburse states for abortions provided to low-income women, in an effort to legitimize abortion as a medical procedure (Shimabukuro, 2018). However, after the Roe v. Wade ruling,
anti-abortion advocates and members of Congress wanted to ban the use of federal dollars to fund abortions, and then most federally funded abortions were reimbursed under Medicaid; therefore, the effort to reduce federal funds as payment for abortions was focused on prohibiting Medicaid recipients from receiving federal funds to cover abortion services. Since *Roe v. Wade*, Congress has attached abortion funding restrictions to multiple appropriations bills; the Hyde Amendment currently falls under the annual appropriations for the USDHHS (Shimabukuro, 2018).

The Patient Protection and Affordable Care Act (ACA), colloquially known as “Obamacare”, was enacted on March 23, 2010 in an effort to reduce the number of uninsured citizens and restructure the private health insurance market (Shimabukuro, 2018). The ACA’s provisions on abortion have been controversial, especially in the context of using premium tax credits or cost-sharing subsidies to obtain health coverage that includes coverage for elective abortions. The ACA refers to the Hyde Amendment to distinguish between two types of abortions: (a) abortions for which federal funds appropriated for USDHHS may be used, and (b) abortions for which such funds may not be used (i.e., elective abortions). Shimabukuro (2018) summarized, to ensure funds attributable to a credit or subsidy are not used to pay for elective abortions, the ACA mandated payment and accounting requirements for plan issuers and enrollees. The issuer must determine whether to provide coverage for (a) elective abortions, and/or (b) abortions for
which federal funds appropriated for USDHHS are allowed, or (c) not provide coverage for any abortion care. The ACA permits states to prohibit abortion coverage in marketplace exchange plans by enacting a law stating so.

Guttmacher Institute (2018b) reported of October 2018, 26 states restrict abortion coverage in plans offered through the insurance exchanges, while 11 states have laws that restrict insurance coverage of abortion in all private health insurance plans written in the state, including the health insurance exchanges, with two of those states prohibiting any abortion coverage for any reason. Twenty-two states restrict abortion services coverage for public employees. They further reported 20 states have more than one of the restrictions named above.

When insurance covers all pregnancy-related healthcare services except abortion care, it attempts to stigmatize and invalidate abortion as a legitimate medical procedure and interferes with a woman’s private healthcare decisions, as well as significantly impacts an individual’s financial burden. About 75% of individuals obtaining an abortion pay for the procedure with their own funds (Henshaw & Finer, 2001). Confusion over what their insurance may or may not cover in combination with abortion-related stigma causes some women to pay out of pocket rather than seek out clarification of their coverage (Van Bebber, Phillips, Weitz, Gould, & Stewart, 2006). Additionally, some women self-pay for abortions due to privacy concerns. Some abortion clinics do not accept third party payers, such as insurance companies, requiring all patients to be self-pay (Van Bebber et
Planned Parenthood Action Fund (n.d.) highlighted that Medicaid provides healthcare coverage to 1 in 5 women of reproductive age (15-44), and women of color are disproportionately enrolled in Medicaid, as 30% of Black women and 24% of Hispanic women are enrolled in Medicaid, while only 14% of White women are enrolled. Sixty percent of women of reproductive age on Medicaid live in states that do not allow federal funding of abortions (Guttmacher, 2018b). Furthermore, often times not being able to use federal funding for abortion care either forces the individual to carry their pregnancy to term, or pay out of pocket, which may result in forgoing basic necessities to generate the needed funds, or places the individual at risk to attempt to self-induce an abortion, or obtain an abortion from an untrained or unlicensed practitioner (Planned Parenthood Action Fund, n.d.). In summation, restrictions on insurance coverage for abortion services increase the number of women without financial coverage for abortion care, and the cost of abortion has a detrimental impact on low-income women (Jones & Weitz, 2009).

State mandated pre-abortion counseling. Currently, it is established practice for all medical providers to communicate accurate and relevant information pertinent to their prospective medical procedure to aid in decision-making and to increase understanding of all potential risks of their chosen procedure (e.g., ensuring a patient's consent is informed). With that said, there have been questions about how (and what) information is given, as well as who regulates
this provided information. Since September 2018, there are eight states in the U.S. that require abortion care providers to give pre-abortion counseling to inform the patient that obtaining an abortion can have serious long-term mental health consequences (Guttmacher Institute, 2018). Some states have also enacted regulations regarding mandatory pre-abortion counseling; however, there exist a plethora of studies that have worked to show there is not a relationship between having an abortion and developing long-term mental health consequences specifically as a result of having an abortion.

The APA Task Force on Mental Health and Abortion (2008) stated, “The best scientific evidence published indicates that among adult women who have an unplanned pregnancy, the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion or deliver that pregnancy.” According to Charles, Polis, Sridhara, & Blum (2008), policies should be based on the most scientifically sound research available. States who are required to inform abortion-seeking patients about the mental health consequences should be modified to include empirically validated information, as their currently disseminated information is unwarranted based on current research (Charles et al., 2008). These findings, among others, suggest that informing patients that an abortion will lead to a long-term mental health consequences falls outside the realm of best practice, and is haphazard in informing a patient about the actual options available to them. Charles et al. (2008) summarized:
...making policy recommendations such as the enforcement of so-called “informed consent” laws (which often provide misinformation regarding mental health risks of abortion) is unwarranted based on the current state of the evidence. If the goal is to help women, we are obligated to base program and policy recommendations on the best science, rather than using science to advance political agenda. (p. 449)

*Mandatory waiting periods.* As of September 2018, there are currently 27 states that require mandatory waiting periods that begin after completing pre-abortion counseling before the patient can obtain an abortion procedure (Guttmacher, 2018a). These waiting periods require women to wait between 18 hours and three days, excluding weekends or holidays. While research shows 24-hour waiting periods do not tend to affect the abortion rate, a two-visit requirement is associated with a decrease in the state’s abortion rate; however, also noted is an increase in out of state travel for abortion, and an increase in the rate of abortions that are performed in the second trimester (Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009; Joyce, Henshaw, & Skatrud, 1997).

Many anti-abortion advocates are in favor of mandatory waiting periods, as they believe the regulations ensure women have sufficient time and opportunity to change their minds about terminating their pregnancy (Roberts, Turok, Belusa, Combellick, & Upadhyay, 2016). However, according to Moore, Frohwirth, and Blades (2011), 92% of women reported they have made up their mind to terminate
a pregnancy prior to making an appointment with an abortion provider. Additionally, a review by Joyce et al. (2009) suggested states requiring two clinic visits have negative consequences for the vulnerable populations with limited resources. That is, while time may not be a negative suggestion before electing to have a surgery, requiring multiple appointments, excessive travel, and related time commitments to already resource-limited population is suggestive of a restriction to access (Joyce et al., 2009). Similarly, Karasek, Roberts, and Weitz (2016) indicated that for the majority of women, a waiting period generates additional financial and logistical hardships, such as taking time off work or making childcare arrangements. Most women in their study reported one or more financial or logistical challenges in obtaining abortion care, while more than two-thirds of the women conveyed having difficulty paying for the abortion or appointment-related expenses; these costs prevented or delayed almost one-half of women from paying for other financial obligations, such as rent, bills, or food. Ninety percent \((n = 379)\) of women in the study reported the waiting period would lead to at least one hardship. Only 8% of women reported the waiting period would have a positive effect on their well-being, while over half of women reported it would have a negative effect on their well-being. Low income women were more likely to report the law may prevent them from accessing abortion care (Karasek et al., 2016).

This suggestion was also evidenced by Althaus and Henshaw (1994) in the first research study ever conducted on mandatory waiting periods. By studying the
case of the state of Mississippi, as their waiting period law mandating at least two in-clinic visits to obtain an abortion was enacted in 1992. The researchers performed a before-waiting period and after-waiting period analysis of abortions performed in Mississippi and its surrounding states. After the passing of the 1992 law, Mississippi’s number of abortions performed was 22% lower than expected based on data from previous years, and the decline in abortions was notably greater for women with less than 12 years of education compared to women with more than 12 years of education. Furthermore, along with an increase in the number of second trimester abortions in Mississippi, the number of abortions provided to non-residents fell 30%, as the number of Mississippi residents who elected to obtain an abortion in the neighboring states of Tennessee and Alabama increased by 17%. Althaus and Henshaw (1994) reported that overall, among women who would have obtained abortions, the mandatory waiting period law prevented an estimated 11-13% of those women from terminating their pregnancy.

In this context, a decrease in the number of abortions is not beneficial to women’s overall health or well-being. Timely access to abortion services is critical, as second trimester abortions are more expensive and invasive, and may be more difficult to obtain (Thomas, 2016). Nine percent of women in Karasek’s (2016) study reported mandatory multiple visits to the abortion facility would prevent them from obtaining their needed abortion or further delay them from obtaining the procedure (31%). Being delayed beyond the first trimester likely causes women to
seek services elsewhere, which is problematic, as second trimester abortion care services are becoming more scarce (Jones & Weitz, 2009; Karasel et al., 2016; Roberts, Gould, Kimport, Weitz, & Foster, 2014; Upadhyay, Weitz, Jones, Barar, & Foster, 2014); for example, in 2012, 95% of abortion facilities offered abortions at eight weeks gestation, a significantly reduced number of facilities (34%) offered abortion care at 20 weeks gestation (Jerman & Jones, 2014). Upadhyay et al. (2014) found the most common reason for women to delay obtaining an abortion is due to financial reasons (e.g., trouble raising money for travel expenses or cost of the procedure); moreover, women living in states with mandatory waiting periods were more likely than women living in states without waiting periods to experience a delay of more than two weeks (Jones & Jerman, 2016). It is estimated over 4000 women annually are denied an abortion because of a state’s gestational limits and must carry an unwanted pregnancy to term, thus mandatory waiting periods can be detrimental to obtaining a needed abortion (Upadhyay et al., 2014).

**Pre-Abortion Clinic Visit**

**Informed consent and patient education.** Prior to obtaining an abortion, it is legally and ethically imperative that women receive adequate education beforehand that will assist them in their decision-making process, as well as assist their medical provider in determining the best possible care for the patient. Preceding any medical procedure, informed consent must be obtained in order for the provider to avoid any civil or criminal liability, and to thoroughly inform the
patient about the procedure, risks, benefits, and alternatives to the medical procedure (Baker & Beresford, 2009). The three considerations necessary in order to gain informed consent are (a) the patient must have the capacity to make autonomous decisions about their healthcare, (b) decisions must be made without coercion or manipulation, and (c) patients must be given appropriate information relevant to making the specific decision. Baker and Beresford (2009) stated the process of informed consent for an abortion procedure should include, but not be limited to:

- providing the patient with the information she needs in order to make a voluntary, informed decision about her pregnancy options and, if she chooses abortion, about the methods of abortion available to her;
- answering the patient’s questions, such as those pertaining to how the procedure is performed, the length of time required, and issues of pain and safety;
- adhering to all state mandated protocols;
- in case of illiteracy or language barriers, helping the patient understand the information through audiovisuals, translators, and if possible, written materials in the patient’s language;
- postponing the procedure if drug or alcohol use or other conditions have impaired the patient’s comprehension and ability to consent;
obtaining the signature of the legal guardian/parent if the patient has mental or developmental disabilities that prevent comprehension; 

- requiring documentation of competency from a psychiatrist if the patient has a history of psychotic episodes; and 

- co-signing consent forms that include all the elements of informed consent.

During this process is when the patient should be informed of the gestational age of the pregnancy and advantages and potential complications to her chosen abortion method that is appropriate for the duration of her pregnancy (Baker & Beresford, 2009). Patient education is also imperative to provide during pre-abortion office visits. The patient should be educated about contraceptive options and if she consents, she should be provided help in choosing the option that best fits her, and she should be provided information regarding sexually transmitted diseases and infections (Baker & Beresford, 2009).

**Medical evaluation.** The pre-abortion medical evaluation is conducted in order to confirm the diagnosis of pregnancy, evaluate the status of the pregnancy, and estimate the gestational age, as solely patient history is not sufficient to establish a pregnancy diagnosis or duration of the pregnancy (Goldstein & Reeves, 2009). Reproductive healthcare providers typically date pregnancy from the first day of the patient’s last menstrual period, which comprises the gestational age, and is generally reported in number of weeks. It is typical for patients to seek abortion
services around or following the first missed menses, which is approximately four-weeks gestational age. Some women do not know the date of their last menstrual period, or some have not taken an at-home pregnancy test, so it is imperative to properly diagnose the pregnancy by collecting patient history, performing a biochemical test, and utilizing a physical exam and/or ultrasound, if medically indicated (Goldstein & Reeves, 2009).

**Preparation for the Abortion Procedure**

**Pre-abortion counseling.** Many patients who seek abortion care are confident about their decision, although some women seek to explore their options with reproductive health professionals while considering what is the best option for them. To assess a patient’s need for pre-abortion counseling, the medical professional will likely attempt to learn the patient’s degree of certainty and feelings regarding her decision, her beliefs about abortion, and her support system (Baker & Beresford, 2009). If necessary, the medical professional will call on a colleague who is trained with counseling skills to explore negative beliefs and fears about abortion, ascertain her expectations and coping strategies, and provide any necessary referrals (e.g., domestic violence counseling center or mental health counselor). Baker and Beresford (2009) reported that among other benefits, pre-abortion counseling can potentially decrease anxiety, provide emotional support, decrease stigma, increase the patient’s beliefs in their ability to use effective coping skills, and reduce distress provoked by anti-abortion protestors or influences.
During the informed consent session and pre-abortion counseling, abortion care providers strive to utilize basic counseling techniques to engender positive interactions with the patient and make a positive impact on their abortion experience. Motivational interviewing in healthcare involves skillful clinical techniques, in which the provider is collaborative, evocative, and respectful of patient autonomy (Rollnick, Miller, & Butler, 2008). For example, it is essential for the provider to demonstrate they are listening and understanding their patients; this is often conveyed through reflection, which is reflecting back to the patient a brief summary of what they just stated and asking open-ended questions of the patient. Abortion care providers attempt to normalize the patient’s experience, so the patient will understand she is not alone in her thoughts, feelings, and questions. Normalizing the abortion experience will help to decrease abortion-related stigma (Norris et al., 2011).

Reframing is also a useful tool to guide a negative perspective into a more encouraging or positive perspective (Rollnick, Miller, & Butler, 2008). The abortion care team attempts to validate positive feelings surrounding the abortion, as well as manageable feelings of sadness, guilt, and anger (Baker & Beresford, 2009). The team also works with the patient to identify healthy coping techniques that have been effective in coping with difficult situations in the past. Healthy coping skills include using encouraging self-talk, reaching out to her support system, using spiritual beliefs to comfort herself, meditation, physical activity, or
compliance with medication or treatment for a pre-existing mood disorder, if applicable.

Although not all patients necessitate special distress-lowering interventions before or after an abortion, all abortion-seeking patients would benefit from interventions in order to decrease stigma surrounding terminating their pregnancy (Baker & Beresford, 2009). Perceived stigma and subsequent secrecy often cause the suppression of feelings about the situation or engender negative intrusive thoughts; the more likely the patient feels the need to avoid stigma, the more likely she will be to experience intrusive thoughts and avoid acknowledging her feelings that hinders adequate psychological adjustment. Stigma should be combated by providing a safe space to disclose feelings and personal information; abortion care facility staff assist patients by (a) decreasing their perceived level of stress prior to the procedure, (b) increasing sense of empowerment, (c) bolster their personal expectations for coping with the abortion effectively, and (d) expand their knowledge of effective coping strategies (Baker & Beresford, 2009).

According to Norris et al. (2011), abortion-related stigma may cause women to feel less empowered to ask questions about the abortion procedure and its potential health consequences. With the aim of making the patient as comfortable as possible and in order to reduce stigma, the abortion care team aims to convey empathy and communicate in a non-judgmental manner. Certain patient behaviors may trigger critical judgments, such as recurrent abortions, abusive
relationships, or second trimester abortions (Baker & Beresford, 2009); therefore, it is imperative reproductive health providers are aware of and subsequently challenge their own biases and attitudes in order to foster an effective alliance with the patient and produce the best possible outcomes for the patient in order to decrease abortion-related stigma.

**Common feelings the day of the abortion.** Baker and Beresford (2009) reported on the day of the abortion procedure, it is common for most women to experience feelings of relief and confidence, as well as a manageable level of anxiety. Numerous fears are common, and can include but are not limited to: (a) fear of pain, needles, and medical settings; (b) fear of becoming sterile or death; (c) fear of breached confidentiality, such as being filmed by anti-abortion protesters; (d) fear of negative emotions following the abortion; and (e) fear of god’s disapproval or punishment (Baker & Beresford, 2009).

**Shame and guilt.** Some women may experience fear, shame or guilt, sadness, or negative effects stemming from abortion-related stigma on the day of the abortion (Baker & Beresford, 2009). Shame and guilt are two common expressions of internalized abortion-related stigma (Bleek, 1981). According to Tagney and Dearing (2002), “Shame and guilt are thus both ‘self-conscious’ and ‘moral’ emotions: self-conscious in that they involve the self evaluating the self, and moral in that they presumably play a key role in fostering moral behavior.” Although the two terms often are used interchangeably, there are key differences.
Guilt involves feeling badly regarding a specific behavior, while shame pertains to what Baker and Beresford (2009) refer to as “total condemnation of self.” Individuals who are prone to guilt have a higher propensity to emphasize with others and accept personal accountability, while being less disposed to anger (Tagney & Dearing, 2002). After normalizing and re-framing their negative thoughts in pre-abortion counseling, feelings of guilt are generally able to be ameliorated, especially if the patient has efficacious coping skills and a strong support system. Shame-prone individuals tend to blame themselves or others for negative events, and are more prone to hold resentfulness and display hostility, as well as being less likely to be able to emphasize with others (Tagney & Dearing, 2002). Patients who demonstrate or verbalize feelings of shame during pre-abortion counseling or the day of the abortion will be more likely to be sensitive to external judgment (Baker & Beresford, 2009), and according to Tagney and Dearing (2002), shame-prone individuals may withdraw, become aggressive, or feel out of control. With this knowledge, individuals who display signs of shame should be referred to psychological counseling before or after the abortion (Baker & Beresford, 2009).

**Reaction to ineligibility for an abortion.** Some women may be denied an abortion due to the advanced stage of pregnancy, or for other medical reasons. Understandably, this can lead to feelings of anger, grief, shock, and other intense emotions (Baker & Beresford, 2009). After expressing these emotions, when the patient is capable of engaging in conversation, other options, such as adoption and
prenatal care referrals, will assist her in decision-making regarding her next step. During this stage, some women threaten suicide, which would warrant a risk assessment and possible psychiatric stabilization. Research by Rocca, Kimport, Gould, and Foster (2013), used data from the Turnaway Study, a five-year longitudinal study that evaluated the consequences of either receiving or being denied an abortion in the United States. The study had three groups: (a) the turnaway group, including women who were denied an abortion because they presented at the abortion care clinic past the allowed gestational age limit; (b) the near-limit group, encompassing women who presented at the facility during the two weeks prior to the gestational age limit, thus were eligible to receive an abortion; and (c) the first trimester group, comprised of women who had received a first trimester abortion procedure. Their study demonstrated women in the turnaway group were “more likely” to have felt regret (50%) and anger (42%) than their near-limit counterparts (41% and 29%, respectively). They also showed a decreased likelihood of experiencing relief, happiness, and guilt (30-49%) than the near-limit group (56-90%). It was reported that 62% of women in the turnaway group still wished they had been able to obtain an abortion (Rocca et al., 2013).

**Abortion Procedure**

When women are presented with an informed choice regarding picking their method of abortion, post-abortion satisfaction is improved (Baker & Beresford, 2009). This is echoed in research by Fielding, Edmunds, and Schaff (2002), as they
found abortion-seeking women valued being able to select their type of abortion procedure. Abortion care providers attempt to confirm the patient is making her decision based on facts in order to obtain her desired outcome, and barring any medical reasons, patients are generally permitted to choose their abortion method. However, all medical abortion patients must be made aware they may need a surgical abortion if the medical abortion fails; therefore, consent to both procedures is generally required. Research by Raymond and Grimes (2012) compared the safety of legal induced abortions and childbirth in the United States. They found the risk of maternal death associated with childbirth is approximately 14 times higher than the risk of death due to an abortion. The pregnancy-associated mortality rate for women who gave birth was 8.8 deaths per 100,000 live child births, while the rate for women who obtained an abortion was 0.6 deaths per 100,000 abortions (Raymond & Grimes, 2012). Additionally, pregnancy-related complications were more common in childbirth than abortion.

**Medical abortion in early pregnancy.** Medical abortion is defined as the use of medications up to 70 days, or 10 weeks, after the first day of the patient’s last period to terminate pregnancy without a surgical procedure (Planned Parenthood, n.d.). According to Planned Parenthood (n.d.), the *abortion pill* is the common name for the two medicines that work together to end a pregnancy: mifepristone and misoprostol. The first pill, mifepristone (RU-486), is administered by the abortion care provider at the facility. Mifepristone blocks the action of and
prevents the synthesis of progesterone, a hormone that is critical to pregnancy (Creinin & Danielsson, 2009). To take at home as directed by the abortion care provider, the patient will take the second medication, misoprostol, effects of which generally occur approximately six to eight hours later (Planned Parenthood, n.d.). Misoprostol is integral to the reproductive health field due to its uterotonic and cervical priming actions, also known as dilating or softening the cervix, to prepare for the intervention (Fiala, Gemzell-Danielsson, Tang, & von Hertzen, 2007), as it causes cramping and bleeding to empty the uterus (Planned Parenthood, n.d.). Within one to four hours following ingestion of misoprostol, bleeding and cramping generally begin. The passing of blood clots and fetal issue lasts approximately four to five hours, prompting the cramping and bleeding to decrease; it may take up to 24 hours for the abortion to complete.

Planned Parenthood (n.d.) has advised it is imperative for the patient to precisely follow after-care instructions and follow up with the abortion care provider to confirm the pregnancy was terminated. High effectiveness rates for the abortion pill are reported: (a) for patients who are eight weeks pregnant or less, it is successful 98% of the time; (b) patients from eight to nine weeks pregnant, it is successful 96% of the time; and (c) from nine to 10 weeks pregnant, it is successful 91-93% of the time. In the relatively small chance that the abortion is not completed by the medical abortion regimen, the abortion is considered to have failed, and the diagnosis of continuing pregnancy is given. This diagnosis would be
given at a follow-up two weeks after the initiation of abortion treatment upon an ultrasound being positive for viable pregnancy (Spitz, Bardin, Benton, & Robbins, 1998). Conversely, if a patient experiences little to no bleeding in the first 24 hours following administration of misoprostol, the patient should be reassured that bleeding is likely to spontaneously begin within the following one to two weeks, or she can be offered a repeat dose of misoprostol. The patient should be re-evaluated by the abortion care provider at the two week follow up appointment, or sooner if necessary, to determine the status of the pregnancy. If a continuing pregnancy is indicated, a surgical abortion is necessary to complete the abortion.

Women who choose a medical abortion generally are early in their pregnancy, and prefer to be at home instead of in a medical setting, as it grants more autonomy and privacy (Fielding, Edmunds, & Schaff, 2002). Additionally, the patient likely prefers a non-invasive procedure that is seemingly a more natural process and is akin to having a heavy period or miscarriage. Lowenstein et al. (2006) reported women with a smaller number of past pregnancies or women who had fewer children at home are more likely to choose the medical abortion over the surgical abortion.

Fielding, Edmunds, and Schaff (2002) stated abortion care providers should assess whether the patient is both willing and able to comply with the demands of the medical abortion procedure at home. Abortion care providers must thoroughly explain each step of the process, and aid the patient in understanding what are
considered to be normal and abnormal symptoms (Baker & Beresford, 2009). Women must be instructed on how to assess their bleeding after taking misoprostol, and must agree to follow-up care in the clinic. Further instructions should include information on what each medication prescribed does and potential side effects, when and how to use the medications, how long the abortion should take, intensity of side effects from the procedure, pain-relief options, provide information regarding access to emergency medical care, and the risk of abortion failure (Baker & Beresford, 2009).

**Surgical abortion in first trimester.** According to Meckstroth and Paul (2009), nearly all surgical abortions, until the end of the 12th week of pregnancy, or the first-trimester, are accomplished by vacuum aspiration. Vacuum aspiration utilizes suction to empty the pregnancy from the uterus. Planned Parenthood (n.d.) reported the procedure begins with examination of the uterus and insertion of a speculum prior to injecting a numbing medication around the patient’s cervix. The opening of the cervix is stretched with dilating rods (unless cervical priming was initiated) and a thin tube is then inserted through the cervix into the uterus. A small suction machine is used to gently remove pregnancy tissue from the patient’s uterus, and if necessary, the abortion care provider will use a curette to remove any tissue left in the uterus. This process takes approximately five to 10 minutes, not including time spent in the recovery room following the procedure, which is normally close to an hour. Sedation is a topic discussed between the abortion care
provider and the patient prior to the procedure; sedation is optional, and the patient can speak to the provider regarding the different degrees of sedation available. Vacuum aspiration is an effective way to end pregnancy over 99% of the time, and it is rare to require a second procedure to end the pregnancy.

Surgical abortion is one of the safest surgical procedures for women, with only a small percentage of women experiencing a complication (Planned Parenthood, n.d.). Weitz et al. (2013) demonstrated out of 11,487 vacuum aspiration abortions, 152 of them, or 1.3%, resulted in a complication. Ninety-six percent of those complications were considered to be minor, thus could be treated at home or an outpatient setting; major complications indicate a hospital admission, surgery, or blood transfusion was required to treat the complication. Upadhyay et al. (2015) also found the complication rate for surgical abortion (1.3%) to be safer than medication abortions (5.2%) and second trimester or later procedures (1.5%), and noted that fewer than 0.3% of abortion patients experience a complication that requires hospitalization. Minor complications of surgical abortion include incomplete abortion, failed abortion, bleeding that did not require transfusion, hematometra, infection, endocervical injury, anesthesia-related reactions, and uncomplicated uterine perforation. Out of the 11,487 abortions performed, only six were major complications, which included uterine perforations, infection, and hemorrhage (Weitz et al., 2013).
There are several reasons why patients may be more inclined to choose surgical abortion over the abortion pill. First, the patient may not have the time to go through the multi-step process of the medical abortion, as it generally requires at least three visits (Baker & Beresford, 2009). Some women, especially those who are low income and do not have the resources to take additional time off work or obtain childcare, are essentially forced to choose surgical abortion option because it only necessitates one to two office visits: a pre-abortion counseling office visit (if it is a requirement of their state) and the appointment for the surgical procedure. Additionally, women may choose the surgical abortion because the termination of pregnancy is more brief with surgical abortion, as it takes one to several days to complete a medical abortion (Meckstroth & Paul, 2009). Some women prefer to be in a clinic with medical and support staff for the surgical abortion, compared to carrying out the abortion at home.

**Surgical abortion after the first trimester.** *Dilation and evacuation,* commonly referred to as D&E, is another method of an in-clinic, surgical abortion. It can be performed later in pregnancy, compared to the medical and vacuum aspiration surgical abortions previously described. Hammond and Chasen (2009) reported D&E procedures are generally utilized for abortions at or greater than 13 weeks gestation; therefore, they most often are used during the second trimester. Overall, the procedure is similar to a vacuum aspiration abortion, although it utilizes larger surgical instruments (Planned Parenthood, n.d.). First, the abortion
care provider will prepare, or open, the cervix with medication. Since the cervix must be opened larger than required for a vacuum aspiration, small dilator sticks called laminaria, are often be used to open the cervix, as they absorb bodily fluid to grow larger to stretch the cervix. For abortions after 20 weeks gestation, physicians generally initiate dilation at least one day prior to the procedure. Following receiving sedation and/or a medication injection to numb the cervix, a thin tube will be inserted through the dilated cervix into the uterus, where the abortion care provider can then use a combination of surgical instruments and a suction device to clear the pregnancy tissue from the uterus. This procedure takes approximately 20 minutes, not including time to prepare the cervix and recovery.

Although abortion is considered to be a safe procedure, the medical risk increases with gestational age; Bartlett et al. (2004) reported increased access to surgical and medical abortion services may increase the proportion of early gestation abortions performed at lower-risk times to help decrease maternal complications and death. Additionally, Henshaw and Finer (2003) reported as the gestational age increases, there is a decline in providers to perform the abortion due to state regulations, which can also lead to delays in obtaining services. A study by Jerman and Jones (2014) found nearly all abortion facilities (95%) performed abortions at eight weeks gestation. That number of facilities declines to 72% at 12 weeks, then to 34% at 20 weeks, while only 16% of abortion facilities provide abortions at 24 weeks gestation.
Research has indicated the majority of women who obtained an abortion during the second trimester would have preferred it to be conducted earlier (Finer, Frohwirth, Dauphinee, & Moore, 2006). Characteristics that have shown to increase the probability of obtaining an abortion in the second trimester include (a) being Black, (b) having less than 12 years of education, (c) relying on financial assistance to pay for the procedure, (d) living over 25 miles from an abortion providing facility, and (e) late knowledge of pregnancy (Jones & Jerman, 2017a). Research showed that these overrepresented groups in the second trimester (i.e., women of color, low-income individuals, and young women) are in part due to being disproportionately impacted by abortion restrictions that force women to delay obtaining abortion care services (Jones & Finer, 2012). Furthermore, the cost of the abortion procedure is often seen to be restrictive to low-income individuals and studies show lack of funds for an abortion results in delays that push the procedure into the second trimester (Finer et al., 2006; Foster et al., 2008). The procedure increases in cost as the gestational age increases due to the procedure taking two or more days to complete, and utilizing greater surgical skill and resources; thus, they are substantially more expensive during the second trimester (Jerman & Jones, 2014; Jones & Weitz, 2009). The median charge for an abortion at 20 weeks gestation was $1350, with a range of $750 to $5000. Comparatively, the median cost for a surgical abortion at 10 weeks gestation was $495 (range = $10-$2908) and the median cost for a medical abortion at 10 weeks was $500
Jerman and Jones (2014) noted the minimum ranges were outliers performed by one facility that provides relatively few abortions annually, and it reflects a sliding scale or reduced fee. Considering the cost of later second trimester abortions especially, in combination with all of the expenses associated with having an abortion, including transportation, potentially overnight lodging (due to some second-trimester abortions requiring more than one day to perform), losing wages from work, or possibly paying for childcare, the cost of obtaining a second trimester abortion can be prohibitive for some individuals.

**Abortion and Mental Health**

Gilchrist, Hannaford, Frank, and Kay (1995) found rates of total reported psychiatric disorders were no higher after obtaining an abortion compared to childbirth. Moreover, research has demonstrated symptoms of depression, anxiety, and stress are higher immediately prior to obtaining an abortion, compared to any time following the abortion (Lowenstein et al., 2006; Major et al., 2000). Additionally, Steinberg, Tschann, Furgerson, and Harper (2016) indicated that the association between abortion-related stigma and pre-abortion depressive, anxiety, and stress symptoms was strong and significant. According to a comprehensive systematic review of the literature by Charles et al. (2008) the highest-quality research available does not support the hypothesis that abortion leads to long-term mental health problems.
Pre-abortio**n mental health.** It is imperative for abortion providers to be aware of their patient’s psychological and social functioning prior to obtaining an abortion in order to generate the best possible outcomes for the patient. Multiple studies have demonstrated pre-abortion mental health is the strongest predictor for post-abortion mental health, and that pre-existing mental health difficulties is the main predictor of mental health after pregnancy, regardless if the pregnancy is terminated or carried to term (Major et al. 2009; Major et al. 2000; Russo & Zierk, 1992). This finding echoes past research by Gilchrist et al. (1995), who indicated women with a previous history of psychiatric illness are most at risk for mental health problems at the end of their pregnancy, no matter if the individual terminated her pregnancy or gave birth. Furthermore, it was evidenced that women who have “better” mental health (i.e., less reported depression and higher reported self-esteem), report more positive emotions and evaluations regarding their abortion (Major et al., 2000). Furthermore, women who carry a higher social burden, such as those living in poverty or difficult conditions, or who are in abusive relationships, for example, generally have a poorer baseline of mental functioning pre-abortion (Major & Cozzarelli, 1992). It is also necessary to consider women of low socioeconomic status and women who have inadequate access to healthcare resources. Research has found that not only does this population have difficulty accessing contraceptives, but they also are at a higher risk of refusing unprotected
sex (Ashton, 1980), further contributing to poorer pre-abortion mental health, according to outcome measures.

According to Steinberg et al. (2016), women with the most pre-abortion depressive symptoms were (a) younger, (b) at least some college, (c) more childhood adversities (e.g., childhood psychological, physical, or sexual abuse, parental substance use, etc.), (d) more frequent instances of intimate partner violence, and (e) noted to have more perceived abortion stigma. Pre-abortion symptoms of anxiety and stress echoed the findings for depression, except more frequent instances of intimate partner violence was not associated. Furthermore, the more frequent the reproductive coercion was experienced in the past six months, the more pre-abortion anxiety and stress symptoms were experienced (Steinberg et al., 2016). Examples of reproductive coercion include birth control sabotage, such as a male partner removing his condom during sex, or partners threatening their significant other to become pregnant. Broen, Moum, Bodtker, and Ekeberg (2005) also indicated that a male partner’s pressure to obtain an abortion has a significant negative influence on the woman’s psychological responses at two years post-abortion. Additionally, Sternberg et al. (2016) noted perceiving a greater amount of abortion-related stigma was significantly associated with higher levels of depressive ($r = 0.43$), anxiety ($r = 0.39$), and stress symptoms ($r = 0.40; ps < 0.0005$).
**Emotional reactions to abortion.** Emotional reactions to unintended pregnancy are common, and women often experience a variety of emotions following an abortion. It’s not suggested that abortion comes without any potential negative emotional reactions. Although some women experience feelings of guilt and loss prior to and following an abortion, these feelings usually resolve spontaneously in most women within a few days or a week, and does not meet criteria to constitute a psychiatric disorder. Persistent feelings of sadness, guilt, and regret following an abortion appear to occur in only a minority of women (Charles et al., 2008). Major and Gramzow (1999) found the more abortion-related stigma a woman experiences, the more likely she is to have adverse emotional outcomes following the abortion.

Policy making and generation of anti-abortion legislation has partially rested on the ideology that women require protection from obtaining an abortion due to suggested negative psychological effects. However, the expectation that women who obtain an abortion will ultimately experience negative symptomatology, is often contraindicated to current research findings. Rocca et al. (2013) found three harmful problems with viewing an abortion as emotionally harmful. Firstly, it is implied that negative emotions experienced surrounding obtaining an abortion are attributable to the abortion, rather than the pregnancy itself or other potential sources of negative emotionality. Secondly, viewing abortions as emotionally harmful to women does not take into account for
simultaneous positive and negative emotions that the woman may be experiencing. Ambivalence, or mixed emotions, regarding obtaining an abortion speaks to the complexity of the situation (Kero & Lalos, 2000). Lastly, it is faulty to assume women with an unintended pregnancy would have less negative emotionality if they carried their pregnancy to term rather than if they obtained an abortion (Rocca et al., 2013).

Interestingly, the most common emotional response following an abortion tends to be relief (Adler et al., 1990; Kero & Lalos, 2000; Major et al., 2000). For most women, the decision to terminate a pregnancy is reached after a substantial amount of energy has been expended into decision making. Many times an abortion is seen as the resolution of a stressful situation, and although the woman may feel emotionally exhausted, it generally provides a sense of relief overall. Relief as a product of abortion was also cited by Paul et al. (2009), as their research indicated feelings of relief are common since women who obtain abortions generally feel a sense of overall confidence in their decision. Similarly, Rocca et al. (2013) reported women in two groups of their study (first trimester group and near-limit for gestational age group) reported the main emotions they experienced following their abortion were relief (37%) and sadness (20%). At both one month and two years post-abortion, Major et al. (2000) reported most women indicated they had benefited from their abortion more than they had been harmed by it.
American Psychological Association’s stance on abortion and mental health. The American Psychological Association (APA) created a Task Force on Mental Health and Abortion, whose focus was to determine the implications abortion has on an individual’s mental health, which includes their well-being, coping abilities, and experience of negative psychological reactions, which encompasses negative behaviors and emotions (APA, 2008). The researchers’ analysis of relevant literature only included peer-reviewed journal articles that were published after 1989 that compared the mental health status of women who obtained an abortion to women who were in control groups. The research completed overwhelmingly indicated that adult women living in the United States who had an unplanned pregnancy that resulted in abortion are not at any greater risk for mental health problems than those individuals who had an unplanned pregnancy that resulted in childbirth (APA, 2008). The APA (2008) reported a positive association between a woman obtaining multiple abortions and negative psychological reactions, which included negative emotionality and maladaptive coping mechanisms. However, it was noted there is difficulty in assessing this variable without the confounded influence of co-occurring risks that predisposed a woman obtaining multiple unwanted pregnancies and subsequent abortions, and mental health problems. This phenomenon may be attributable to low socioeconomic status, pre-existing mental health conditions, or harmful intimate partner relationships, among other variables.
It was reported that the prevalence of mental health problems in women who legally obtained a first trimester abortion is consistent with normed data for the general population of women in the United States. It is expected that some women will experience negative emotions, such as grief, sadness, guilt, and shame, or clinically significant disorders, such as anxiety or depression, following an abortion. However, there was not sufficient evidence for the APA (2008) to support claims that there is a strong positive correlation between past history of abortion and mental health problems. On the other hand, the study was able to identify factors that more accurately predict post-abortion mental health functioning, including: perceived stigma, lack of social support, need for secrecy regarding the abortion, personality factors (such as low self-esteem and pessimism), poor coping skills, and characteristics of the particular pregnancy were all identified as potential factors. Of the factors provided, the strongest predictor for negative psychological response was a prior history of mental health difficulties (APA, 2008; Gilchrist et al., 1995; Major et al. 2009; Major et al. 2000; Russo & Zierk, 1992).

Moreover, the APA (2008) reported perceived stigma can influence an individual’s level of comfort in disclosing personal information, which would have an effect on their decisions and behaviors surrounding disclosure, in addition to affecting their physical and mental health well-being. Perceived stigma has a propensity to create negative cognitions, emotions, and behaviors that can negatively impact an individual’s cognitive, biological, and psychological
functioning; it can cause deficits in cognition and performance, increased alcohol intake, avoidance, social withdrawal, and stress. The APA (2008) also described internalized stigma, which occurred when members of a marginalized group, such as a woman obtaining an abortion, accepted the negative stereotypes and societal beliefs about themselves. Individuals who manifest internalized abortion-related stigma, such as seeing themselves as having flawed morals or viewing themselves as tainted, have a higher likelihood of experiencing future psychological distress.

**Psychological sequelae of abortion.** Adler et al. (1990) found that autonomously-chosen legal abortion, especially if completed during the first trimester, is not associated with severe psychological trauma, despite it occurring in the stressful context of an unwanted pregnancy. However, a research limitation exists, as discussed by Rowlands and Guthrie (2009), as it is not truly ethically scientifically testable to determine if abortion legitimately generates detriment to a woman’s mental health, as women who are managing an unwanted pregnancy cannot be randomly assigned to a group to obtain an abortion nor a group that is denied an abortion and consequently forced to continue their pregnancy. However, despite that research limitation, the following studies have demonstrated that obtaining an abortion does not place an individual at greater risk for subsequent mental health problems.

The U. S. Preventive Services Task Force indicated unintended pregnancy is a risk factor for depression during pregnancy, as well as the postpartum period
A study by Hemmerling, Siedentopf, and Kentenich (2005) examined data collected from 219 women who chose to obtain either a surgical or medical abortion. The participants completed a self-administered questionnaire, as well as the Hospital Anxiety and Depression Scale (HADS), prior to their abortion and four weeks post-abortion. Their study determined 27.2% of women in the medical abortion group and 39.1% in the surgical abortion group showed clinically significant anxiety on the HADS prior to their procedure; four weeks after their abortion, those numbers decreased to 3.7% and 6.3%, respectively. Regarding depression, 21.3% of women in the medical abortion group and 21.9% in the surgical abortion group evidenced clinically significant levels of depression prior to obtaining an abortion, while the levels of depression declined to 2.2% and 4.7%, respectively, four weeks post-abortion (Hemmerling et al., 2005). Their study suggested there is a significant decrease in anxiety and depression following the abortion procedure. Four weeks post-abortion, none of the participants evidenced higher anxiety than their pre-abortion level. In five of the 219 participants, the participants’ post-abortion depression scores were higher than their pre-abortion score; however, Hemmerling et al. (2005) indicated mean scores of these participants were not higher than what is found in a normal population. A study by Schmiege and Russo (2005) found no evidence that termination of pregnancy changes an individual’s risk for subsequent depression when compared to delivering an unwanted first pregnancy. These findings were also comparable to
earlier research by Major et al. (2000), who conveyed the rate of depression for women two years post-abortion (20%) is equal to the national rate of depression among women aged 15 to 35, thus demonstrating mental health did not decline following an abortion. The results of the two aforementioned studies were commensurate with previous studies performed by Henshaw, Naji, Russell, and Templeton (1994), Gilchrist et al. (1995), and Slade, Heke, Fletcher, and Stewart (1998). Moreover, Russo and Zierk (1992) found no differences in self-esteem among women who obtained an abortion in comparison with women who delivered an unwanted pregnancy. In fact, having one abortion was positively associated with increased overall self-esteem, especially feelings of self-worth and capableness, and not feeling like a failure.

Certain characteristics were correlated with increased risk for mental health problems following an abortion. Ambivalence surrounding the pregnancy during the woman’s abortion decision-making process, and delayed decision-making, where the individual did not make a definite decision to terminate the pregnancy at an early point after discovering pregnancy, were correlated with higher levels of depression and anxiety (Hemmerling, Siedentopf, & Kentenich, 2005). Additionally, married women who had abortions were at an elevated risk for depression compared to their peers who did not terminate their unintended pregnancies, while unmarried women did not demonstrate a significant difference in their risk of their depression regardless of termination or delivery of pregnancy.
(Reardon & Cougle, 2002). Baker and Beresford (2009) reported that in addition to having a pre-existing mental health diagnosis and/or being sensitive to stigma, lingering troubled feelings following an abortion are usually due to (a) a woman’s relationship dissatisfaction with her partner, (b) conflicts with her parent(s), (c) unacknowledged sense of loss, (d) significant personal losses subsequent to the abortion, (d) later failed outcome of a wanted pregnancy, (e) joining a church that condemns abortion and emphasizes judgment, and/or (f) isolation or lack of social support.

Conversely, Cozzarelli (1993) and Major et al. (1998) indicated women with resilient personalities (e.g., higher self-esteem, having an internal locus of control, and an optimistic outlook) generally reported feeling more capable of coping with their abortion, and evaluated their situation in a more positive manner prior to the abortion procedure. It was indicated that their positive cognitive appraisals were associated with more acceptance of their situation, thus less avoidance, which led to overall increased adaptive coping skills that were associated with reduced psychological distress and increased positive well-being over time.

Effects of social support and perceived stigma on an individual’s well-being. A woman’s partner, parent, or any integral member of their support system, affects her emotional adjustment pre- and post-abortion (Major et al., 1990). If a woman perceives she has the support of her male partner surrounding obtaining an
abortion, she is more likely to have a better psychological adjustment following her abortion (Broen et al., 2004; Cozzarelli, Sumer, & Major, 1998; Major, Cooper, Zubek, Cozzarelli, & Richards, 1997). Conversely, when a male partner whom does not support a woman’s decision to carry her pregnancy to term, thus he coerces or pressures her to have an abortion, it likely also leads to negative emotionality following the abortion (Broen et al., 2004). Additionally, when a male partner had low expectations regarding the coping process after an abortion, it was found to negatively affect a woman’s coping ability only if her expectations were also low; having a strong expectation for effective coping allays a male partner’s negative expectation (Major, Cozzarelli, Testa, & Mueller, 1992). Furthermore, Cockrill and Nack (2013) concluded that women who choose to disclose their abortion history are better equipped to cope with instances of stigmatization if they have ongoing social support. In consideration of societal support, Kumar et al. (2009) reported women who perceived their community believed women have the right to reproductive freedom, were less likely to experience feelings of guilt and shame compared to women who do not share this perception.

Autonomy has also been evidenced to be integral to the abortion decision-making process. Women who believed their partner left the abortion decision-making up to them demonstrated more positive emotions than women who believed their partner did not want her to obtain an abortion, or if they were unsure of their partner’s wishes (Rocca et al., 2013). Similarly, in a study by Kimport, Foster, and
Weitz (2011), women conveyed experiencing negative emotionality following an abortion if they did not feel the decision was primarily their own, even if they would have made the same choice autonomously. Biggs et al. (2013) reported 5% ($n = 48$) of women in their study using Turnaway Study data cited the theme of influences from family or friends as a reason for obtaining the abortion. Twenty-two of the women stated it would have a negative impact on their family or friends, 19 women conveyed they did not want others to know about their pregnancy and/or feared they would be judged for it, while 11 women cited pressure by family or friends to have an abortion. Biggs et al. (2013) noted the majority of women (85%) who reported influences from family or friends as a reason for their abortion were ages 24 and younger.

Considering the quality of the relationship with a male partner and the potential support the woman will receive from him is also essential to the abortion decision-making process. According to Chibbler, Biggs, Roberts, and Foster (2014), approximately one third of women reported their partner as a reason for obtaining an abortion. The three most common partner-related reasons were (a) poor relationship quality, (b) partner was not able or not willing to support a child, and (c) partner had characteristics unfavorable for child raising. Furthermore, eight percent of the women who listed their partner as a reason for abortion indicated intimate partner violence was among their reasons to obtain an abortion.
A study by Cowan (2017) examined how individuals who disclosed abortions perceived others’ reactions to their news. They used the abortion subsample ($n = 179$) from the American Miscarriage and Abortion Communication Survey. Participants chose from one of eight possible choices to describe how the individual they disclosed their abortion status to reacted, and each disclosure fell into a cluster: negative reaction, supportive reaction, or sympathetic reaction. Cowan (2017) indicated the majority of abortion disclosures received largely positive reactions (32.6% supportive; 40.6% sympathetic); however, a lesser, yet still substantial, amount of disclosures were characterized as a negative reaction (26.8%). Across all of the individual's disclosures, the majority of participants perceived only positive reactions (58.3%) to their abortion disclosure. Thirty-four percent of individuals perceived a mixture of negative and positive reactions, while 7.6% of individuals perceived only negative reactions. The negative or positive reaction is predicted by the relationship between the participant and the listener, as well as why the disclosure was made. Overall, the individuals’ experienced disclosing their status was dependent upon their race, income, and the number of people they have told. Cowan (2017) stated Hispanic participants were especially likely to perceive negative reactions to disclosing their abortion history. Middle income respondents demonstrated a higher tendency to perceive positive responses to their disclosure than when compared to both the lowest and the highest income participants. Moreover, disclosures made due to a shared abortion experience never
received a negative response, and disclosures made to close friends were more likely to receive a sympathetic response as compared to disclosures made to close family members. Cowan (2017) emphasized that the minority who receive stigmatizing reactions is a significant consideration, as positive reactions and social support bolsters the individual’s health and functioning, while negative stigmatizing reactions can be harmful to health and psychological functioning.

**Abortion-Related Stigma**

Kumar et al. (2009) conceptualized abortion-related stigma in the context of Link and Phelan’s (2001) four-component framework for the general construct of stigma. The first component is that in society, people distinguish and label differences. Regarding abortion, Kumar et al. (2009) described stigma being created by “over-simplifying complex situations” and denying the frequency at which abortion truly occurs in a population, as it is often underreported. In the second component, dominant cultural or societal beliefs link a labeled person to undesirable characteristics, or negative stereotypes (Link & Phelan, 2001). Stereotypes are commonly held evaluations that are shared and well-known throughout members of a culture (Crocker et al., 1998). Thirdly, a universally-known category of women who have abortions is created to signify deviation from the societal norm (Kumar et al., 2009). In this component, labels and stereotypes are assigned; women who have abortions are often labeled as murderous, irresponsible, or sinful, etc. This component described labeled individuals being
ABORTION STIGMA AMONG VARYING POPULATIONS

placed into distinct categories to separate an “us” from “them” mentality (Link & Phelan, 2001); Kumar et al. (2009) described this component as fear of social exclusion and noted it prevents women and other individuals from publicly supporting women who have abortions, which perpetuates the negative stereotyping. The fourth component of Link and Phelan’s (2001) framework is that labeled individuals experience loss in their status, as well as discrimination, which generates inequality. Abortion-related inequalities can include the denial of receiving accurate medical information, unsafe conditions, public shaming, and excessive procedure costs, among many other things (Kumar et al., 2009).

**Manifestations of abortion stigma.** Following Herek’s (2008) sexual stigma framework, Cockrill and Nack (2013) created an adaptation to describe the three manifestations of abortion stigma among women: internalized, felt or perceived, and enacted abortion stigma. First, internalized stigma results from a woman’s acceptance of negative cultural valuations of abortion. Second, felt stigma encompasses her assessments of others’ abortion attitudes, as well as her expectations about how attitudes might result in actions. Then, enacted abortion stigma is a woman’s experiences of clear or subtle actions that reveal prejudice against those involved in abortion: for example, physical or emotional abuse, discrimination, hate speech, as well as verbal judgments/assumptions, avoidance, and displays of discomfort, anxiety, or even disgust. These three manifestations are
related, but distinguishable facets of individual-level abortion stigma (Cockrill & Nack, 2013).

The most significant amounts of internalized stigma, such as guilt and shame, are most often experienced around the immediate time of the abortion procedure. Felt stigma can also occur around the time of the procedure, as well as afterwards, but its salience is likely to decrease over time. Women in Cockrill and Nack’s (2013) sample described their experiences with enacted stigma to be surrounding the incidents of social interaction associated with their abortion, such as making an appointment, traveling to the clinic, interacting with abortion protestors at the clinic, and disclosing to their loved ones. Many women who have had an abortion avoid disclosing their status, which increases enacted stigma (Major & Gramzow, 1999; Cockrill & Nack, 2013). Cockrill and Nack (2013) cautioned that disclosing their abortion status, thus possibly generating stigma enactments, could decrease their chances of disclosing again in the future; therefore, the burden to de-stigmatize abortion should not lie on women coming forward when there is potential for them to experience enacted or felt stigma.

The impact of stigma on health. Abortion-related stigma is poorly understood and generally not measured in abortion research; therefore, there is a limited amount of research to indicate the negative impact that stigma may have on abortion patients (Kumar et al., 2009). Abortion-related stigma, harassment, and violence discourages access to and provision of abortions, and the stigma of both
obtaining and providing abortions has the propensity to produce secrecy, marginalization of abortion from other routine medical services, delays in service, and increased morbidity (Harris, 2012). Due to the low rate of abortion procedure-related complications and mortality in the United States, abortion-related stigma does not pose a significant threat to public health; however, due to its controversial nature in legislation and politics and increased stigmatization, stigma often leads to secrecy, which can cause lapses in care or treatment, and the rates of some serious complications may subsequently increase (Harris, 2012).

**Abortion-related stigma and psychological functioning.** Stigma has the propensity to negatively affect an individual’s social, psychological, and biological functioning (Major & O’Brien, 2005), and the more stigma an individual experiences, the more likely they are to have adverse emotional outcomes (Major & Gramzow, 1999). As summarized by Steinberg et al. (2016), perceived abortion-related stigma explained the most amount of variance in depressive, anxiety, and stress symptoms; there was a strong and significant association reported between stigma and pre-abortion depressive, anxiety, and stress symptoms. Steinberg et al. (2016) conveyed decreasing the stigma surrounding obtaining an abortion may lower pre-abortion psychological distress, and since pre-abortion psychological functioning is the strongest predictor of post-abortion psychological health, then decreasing stigma may in turn bolster post-abortion psychological health.
Major and Gramzow (1999) reported women who perceived abortion-related stigma were more likely to keep their abortion a secret from their family and friends, and further reported secrecy as positively related to suppressing abortion-related thoughts and negatively correlated to disclosing feelings about their abortion to others. Since suppression was found to be associated with an increased amount of intrusive thoughts about the abortion, it was also indicated to be related to increased psychological distress. However, emotional disclosure appeared to moderate the association between intrusive thoughts and distress, as disclosure was associated with decreased distress among women experiencing intrusive thoughts about their abortion (Major & Gramzow, 1999). Similarly, research by Cockrill and Nack (2013) indicated stigma generates negative self-evaluations, fear about one’s reputation, and negative social interactions, which can lead to secrecy, deception, and social isolation, which hinders women from utilizing an effective social support system.

“Why” abortion is stigmatized. Norris et al. (2011) indicated there is a prevalent notion that there are “good abortions” and “bad abortions” depending upon the reasoning behind the abortion, even among women who have previously had an abortion; stigma may be increased or decreased for an individual, contingent upon their personal reasons for the abortion. “Good abortions” are considered more socially acceptable and occur in situations of fetal abnormalities, pregnancy while using a reliable contraceptive method, abortion due to rape or incest, first-time
abortions, a very young woman obtaining the abortion, or a remorseful individual who is in a monogamous relationship. Comparatively, “bad abortions” occur at later gestational ages or they are obtained by “selfish” women who have had multiple previous abortions without using birth control methods (Norris et al., 2011). Women who have had abortions may use their “goodness” to distance themselves from individuals who have had “bad abortions”, thus evidencing women who have abortions may be both stigmatized and a stigmatizer of abortion.

Norris et al. (2011) described numerous reasons that contribute to the stigmatization of abortion. Based on earlier work by Kumar et al. (2009), Norris et al. (2011) described abortion to violate two of the fundamental ideals of womanhood: nurturing motherhood and sexual purity. This is based on the notion that the desire to be a mother is central to womanhood, as well as women should only engage in sexual activities with the goal of procreation; therefore, abortion as a product of non-procreative sex threatens gender norms and is consequently stigmatized. Attributing personhood to the embryo or fetus also resulted in stigmatization, as technological advances (e.g., ultrasound imaging, fetal surgery) have personified the fetus and made personhood boundaries less clear than in the past. Personhood measures seek to establish fertilized eggs as separate legal individuals that are subject to laws of the state; regulations that attempt to define personhood are likely to criminalize abortion, along with embryonic stem cell research, infertility treatments, certain cancer treatments, and some methods of
contraception (American College of Obstetricians and Gynecologists, 2014). Norris et al. (2011) described fetal images and shaming practices widely used by anti-abortion advocates in effort to attribute personhood to the embryo or fetus have equated termination of pregnancy with murder.

Additionally, legal restrictions on abortion also have the propensity to generate stigma. Waiting periods, parental consent, and gestational age limits, among other restrictions, make it more difficult for women to freely obtain abortions, which reinforces the notion that abortion is morally wrong. Abortion can also be stigmatized because it can be viewed as dirty or unhealthy, which was engendered by the U.S.’s history of back alley abortions, which often were harmful to women; however, anti-abortion advocates capitalize on the dated narrative that “abortion hurts women.” Unproven links between abortion and breast cancer, reduced future fertility, and psychological sequelae have been promoted to reinforce stigmatizing ideas that abortion is unhealthy for women. Even visiting a facility can reinforce stigma for some women, as the clinic is generally distanced from other medical facilities and frequented by anti-abortion protesters. Finally, Norris et al. (2011) reported that the anti-abortion movement seeks to not only create and maintain barriers to obtaining abortions, but also change cultural values and norms about abortions, so women will utilize abortion services less frequently overall. The anti-abortion advocates create stigma as a deliberate tactic to decrease societal support; therefore, it is not solely a byproduct of values or legislation.
Harassment at abortion facilities. Most abortion clinics report the harassment of the facility, providers, and patients. The Freedom of Access to Clinic Entrances Act (1994) was prompted due to violence at abortion facilities, and it authorizes the U.S. Attorney General to prosecute individuals or organizations who engage in conduct that violates the Act, which includes the use of force or threat of force and physical obstruction that injures, intimidates, or interferes with an individual seeking to obtain or provide reproductive health services. However, local law enforcement is required to uphold and implement the Act, and their enforcement of the prohibited conduct can be inconsistent (American College of Obstetricians and Gynecologists, 2014). Common types of harassment at abortion facilities include taking photographs or videos of patients, tampering with the facility’s garbage, placing glue in door locks or nails in the driveway, interfering with phone connections, and recording license plates. Jerman and Jones (2014) reported the majority of abortion clinics (84%) experienced at least one form of harassment in 2011 with the most common harassment being anti-abortion picketing (80%); almost all facilities with annual abortion patient caseloads of over 1000 experienced picketing (94%). An estimated 75,000 instances of anti-abortion picketing occurred in 2017 alone (National Abortion Federation, 2018). Furthermore, clinics located in the Midwest and South were exposed to greater levels of harassment than clinics located in the Northeast and West (Jerman & Jones, 2014).
Stigma experienced by abortion providers. Abortion-related stigma, incidents of harassment, and fear of violence can also discourage providers from performing abortions (Harris, 2012). Although stigma and fear of violence are less tangible than legislative restrictions, nevertheless, they remain powerful barriers to abortion provision. There were 62 reported death threats or threats of harm to abortion providers in 2017, which is a substantial increase from 33 instances in 2016 (National Abortion Federation, 2018); sadly, there have been 13 physicians and abortion clinic staff murdered or seriously harmed over the past 20 years (Harris, Martin, Debbink, & Hassinger, 2013). The National Abortion Federation (2018) reported that since they began collecting data in 1977 there have been 17 attempted murders, over 200 arsons or bombings at clinics, and approximately 100 butyric acid attacks. They also indicated an increase in online hate speech against abortion facilities and providers surrounding the time of the 2016 presidential election; these instances included online activities, such as falsely changing clinic phone numbers and addresses, claims that facilities had closed or relocated, and posting vulgar and misleading reviews on social media pages. Herek (1991) noted stigma can lead to violence because of the dehumanizing aspect of stigma, as dehumanization is a step on the path to violent acts. Similarly, since some individuals express their negative feelings towards others behaviorally, an individual disliking abortion can take the form of harassment. Russo, Schumacher,
and Creinin (2012) reported that the harassment of abortion providers in the U.S. has an association with increased restrictiveness of state laws.

Providers encounter stigma not only in legislation, political rhetoric, and harassment from anti-abortion radicals, they also face stigma in their own institutions (e.g., hospitals, churches, schools), and in their personal relationships with their family and friends (Harris et al., 2013). As a result of the stigma and targeting of abortion providers, many providers do not speak openly about their work, and if they do, they are cautious on who they disclose to. They are prone to experiencing conflict in their relationships and threats to their safety when they disclose their profession, and if they keep their work hidden, there is a chance of feeling isolated and disconnected due to their perceived need for secrecy.

Harris et al. (2013) hypothesized there is a paradoxical cycle of stigma and silence that inflicts abortion providers; when providers do not disclose their work in their daily encounters, their silence maintains the stereotype that working in abortion is deviant and legitimate, mainstream doctors do not perform abortions. This line of thinking increases the marginalization of abortion providers and influences the targeting of providers for harassment or violence; thus, providers’ reluctance to be open about their work is reinforced, and the cycle of stigma and silence continues. Harris et al. (2013) reasoned that many highly trained and legitimate physicians provide abortion care services, despite the stereotypes. Furthermore, abortion providers are consistently portrayed in a negative light in
popular culture, which may deter some physicians from providing services, which will contribute to provider shortages. Providers who perform abortions are often stereotyped as substandard, which may be damaging to their careers. Furthermore, some physicians convey feeling judged, and perceive to be seen as morally and technically deficient. One physician from Harris et al.’s study (2013) stated, “Patients think we’re bad people even though we’re doing what they want us to do.” Moreover, abortion patients may also hold the stereotype that abortion doctors are dangerous, which may contribute more to their own stigma or worry surrounding the procedure. However, Harris et al. (2013) reported that overall, abortion providers are proud of the care they provide to women, and are confident they are positively contributing to women, their families, and society.

Harris et al. (2013) noted certain TRAP laws, such as legislation mandating different malpractice insurance or surgical center requirements, are in place to protect women from so-called unsafe doctors, and implies that without legislative intervention, abortion providers would not provide the highest quality of care for their patients. They further noted malpractice requirements rely on the stereotype that abortion providers are dangerous, which maintains stereotypical thinking, as other types of physicians are not demeaned in the same way that abortion providers are.
Study Purpose and Rationale

As terminating a pregnancy is one of the most common and safe medical procedures in the United States, abortion care and its outcomes should be more widely studied. Unintended pregnancies occur broadly across our population, although certain groups experience higher rates of unintended pregnancies (Frost et al., 2015). Unfortunately, there is a discrepancy in the distribution of reproductive healthcare services, as the groups who have the highest number of unintended pregnancies quite often have the least amount of access to family planning resources. As a consequence, this generates inequalities not only in the ability to obtain services, but also in the experience of abortion-related stigma (Chandra et al., 2005). Often too, the greater the amount of stigma a woman experiences surrounding her abortion, the more likely she is to have negative emotional outcomes following an abortion (Major & Gramzow, 1999). The threat of negative emotional outcomes following a stigmatized experience demonstrates the gravity of the situation some women face and illustrates the importance of conducting more research on this topic. Due to the current limited understanding and relative lack of research on abortion-related stigma, more research on this topic is needed to aid in the understanding of potential negative consequences of abortion-related stigma.

Stigmatization of reproductive freedom has become the norm in our current climate. Abortion-related stigma is a phenomenon experienced beyond the individual level, as it is also prevalent in communities, institutions, public
discourse, and legislation (Kumar et al., 2009). Legislation has often leaned on the idea that regulations are necessary to protect women from obtaining an abortion due to the proposed negative psychological effect on women, although research has reported evidence to the contrary (Rocca et al., 2013). Unfortunately, this discrepancy has resulted in abortion-related inequalities that include the denial of receiving accurate medical information, unsafe conditions, public shaming, and excessive procedure costs, which all have the propensity to increase the amount of stigma a woman experiences (Kumar et al., 2013). Since abortion-related stigma has appeared to be less prevalent in regions with less restrictive abortion laws, it is suggested that stigma can be influenced by legislation (Cockrill & Nack, 2013). Therefore, decreasing abortion-related stigma at the community, state, and national level is likely to lower pre-abortion emotional distress, and bolster post-abortion psychological health.

Critics of women who choose to have an abortion may question the need for resources to go towards decreasing the emotional distress these women face as a potential result of the procedure. However, as has been demonstrated in multiple research studies in the past few decades, that although the decision to terminate an unwanted pregnancy may be complicated, it does not, nor should not, be tied to significant negative emotional distress (Adler et al., 1990; APA, 2008; Charles et al., 2008; Gilchrist et al., 1995; Hemmerling et al., 2005; Henshaw et al., 1994; Kero & Lalos, 2000; Major et al., 2000; Slade et al., 1998). The impact of
protective factors cannot be overstated. Women who have support from their loved ones were less likely to experience shame and guilt, which are two common expressions of internalized abortion-related stigma (Bleek, 1981; Major et al., 1990). Moreover, women who perceive their community believes in the right to reproductive freedom were less likely to experience feelings of shame and guilt (Kumar et al., 2009).

Therefore, to further identify protective measures for women obtaining an abortion, it is first necessary to identify those most at risk. The following study will look to identify which groups of women are more prone to experiencing stigma. It will also assist in the effort to provide those women with support and additional resources as needed, in order to decrease the stigma surrounding abortion. In summation, abortion services in the United States remain significantly stigmatized, and it is imperative for women who seek abortion care services, as well as abortion care providers, staff, and supporters, to be aware of the effects of stigma and who it is most likely to impact to better protect these marginalized groups from the negative impact of stigma.

**Objectives and Hypotheses**

**Objective 1:** To examine racial and ethnic differences among women who obtain an abortion, as a possible predictor for groups who are at a higher risk of stigma-related to abortion. Hartnett (2012) found American Hispanic women, especially those who are foreign-born and very religious, tend to be happier about births, even
if they are unintended, compared to both White and Black women. Furthermore, Aiken, Dillaway, and Mevs-Korff (2015) reported Hispanic women, experience societal pressure to view all pregnancies, including unwanted pregnancies, as a blessing or gift which they should be thankful for. Considering this information, it is expected Hispanic women will perceive more abortion-related stigma than other racial and ethnic groups.

Hypothesis 1.

Hispanic women will perceive the highest level of abortion-related stigma, compared to other ethnic groups.

Objective 2: To determine if being in a committed relationship (i.e., marriage) is a contributing factor to the effects and expectations of abortion among women.

Recent literature reported about 14% of abortion patients are married, while the majority of abortion patients were never married (46%) or cohabitating (31%) (Jerman, Jones, & Onda, 2016). Furthermore, a significantly higher proportion of married women use a contraceptive method (77%) compared to never married women (42%); even among those populations who are at greater risk for unintended pregnancy who are married, contraceptive use is still higher among married women (93%) than never married women (83%) (Jones, Mosher, & Daniels, 2012). This research may suggest that married women who do not wish to become pregnant generally use contraceptives to actively avoid becoming pregnant, which may lead to increased perceived stigma if pregnancy is not avoided. This
information, in combination with data from Cowan (2017), which stated 10.5% of abortion patients who were married perceived only negative reactions upon disclosure of their abortion status, compared with only 2% of never married women who perceived only negative reactions following their disclosure, suggests married women may perceive more stigma than non-married women. Additionally, researchers examining abortion stigma in Kenya identified married women, as well as young unmarried women, to report higher stigma scores compared to non-married women (Yegon, Mwaniki, Echoka, & Osur, 2016). It is a goal of this study to determine if married women in the U.S. also experience higher perceived stigma akin to married women in Kenya.

Hypothesis 2.

Married women will perceive more abortion-related stigma than non-married women.

Objective 3: To identify if level of education contributes to increased perception of stigma in women who obtain an abortion. Women with lower education were less likely to use a method of contraception at last reported intercourse (Chandra et al., 2005); thus it is the supposition of this researcher that women with higher educational attainment (i.e., college-educated women) tend to have greater access to family planning services, including contraceptives; therefore, they may perceive more stigma surrounding their abortion, compared to individuals with less access to contraceptive services. Furthermore, compared with women who completed some
college, women whose educational attainment extends only to completion of high school scored lower on an isolation index on a measure of abortion stigma, which indicated a greater extent to which women spoke with close friends and relatives about their abortion and felt supported in their decision (Cockrill, Upadhyay, Turan, & Foster, 2013). A recent study found women in Nigeria with higher educational status were more likely to express higher individual-level abortion stigma compared to individuals with less education (Oginni, Ahmadu, Okwesa, Adejo, & Shekerau, 2016), and it is an aim to see if this is commensurate with the U.S. population.

**Hypothesis 3.**

College-educated women will perceive more abortion-related stigma than non-college educated women.

**Objective 4:** To determine if gestational age is a contributing factor to being higher risk for abortion-related stigma. Certain characteristics that increase the probability of having a second trimester abortion (i.e., Black women, having less than 12 years of education, and being low-income) are associated with lower levels of abortion-related stigma (Jones & Jerman, 2017a); therefore, an aim of this study is to determine if those characteristics remain consistent despite obtaining an abortion in the second trimester, taking into account the propensity of our society to stigmatize the practice of second trimester abortion (Cockrill & Nack, 2013).
Hypothesis 4.

Women in their first trimester will experience more perceived abortion-related stigma than women who are in their second trimester of pregnancy.

Method and Procedures

Data Collection

This study utilized the 2008 Abortion Patient Survey (APS) dataset from the Guttmacher Institute, which is the fourth survey in a series (previous data collected in 1987, 1994-1995, and 2000-2001, respectively). The 2008 APS is a four-page questionnaire that collected information about demographic items (i.e., age, race and ethnicity, marital status, etc.) and information related to contraceptive use in the month the woman became pregnant. The 2008 APS added new issues to examine, such as health insurance coverage, foreign-born status, and how women were paying for their abortion. The 2008 APS creators used a module design to create two versions of the questionnaire: Module A and Module B, in order to keep the survey relatively brief and limited to four pages (see Modules A and B of the 2008 APS in Appendices A and B, respectively.) All core demographic questions and contraceptive methods items were asked of all respondents. Half of the respondents received Module A, which included questions regarding their happiness about the current pregnancy, and knowledge about the pregnancy and about the abortion by the man who got the respondent pregnant. The other half of respondents completed Module B, which included nine specific questions about
abortion-related stigma. Within each abortion facility, Module A and B were distributed alternately to every other woman.

The facilities in the survey were sampled from hospitals, clinics, and physician medical offices where abortions were performed in 2005. Using information from the Guttmacher Institute’s 2006 Abortion Provider Census, the survey creators stratified the facilities by provider type (hospital or non-hospital), and caseload (30-390, 400-1,990, 2,000-4,990, and 5,000 or greater patients, respectively), then they were sorted by region and state in each stratum. Facilities who performed less than 25 abortions in 2005 were excluded due to their relatively small number of abortions performed; it is not expected their exclusion generates bias, as these facilities only accounted for one percent of all reported abortions in 2005. Every nth facility was sampled, and clinics with large caseloads were oversampled. For example, researchers took every fourth facility that reported 5,000 or more abortions in 2005, while they took every 21st facility that reported 30-390 abortions in 2005. Each facility was assigned a sampling period inversely proportional to the probability of being selected. The facilities were asked to administer the questionnaire to all women who had an abortion during a specific period; the periods ranged from two weeks in the largest facilities to 12 weeks in the smallest facilities. If a facility did not wish to participate in the study or no usable surveys were gathered from at least half of the respondents, then the facility was replaced by the next facility listed in its stratum, usually located in the same
The final sample is comprised from participants at 95 total facilities (10 hospitals and 85 non-hospital facilities). The questionnaire was available in English and Spanish at all locations and was additionally available in Portuguese at one facility. The facility staff administered the surveys and decided when during the patient’s visit to distribute the questionnaire; most facilities asked women to complete it while filling out other paperwork prior to their visit. The 2008 APS includes an introduction that explains the purpose of the survey and informed respondents that their participation was voluntary and anonymous. The questionnaire and procedures were approved by the Guttmacher Institute’s federally registered Institutional Review Board.

The 95 participating facilities reported performing 12,866 abortions during the sampling period. Usable questionnaires were obtained from 9,493 patients (74% response rate); 73% of the women obtained an abortion during the second half of 2008, while 27% obtained an abortion during the first half of 2009. Of the 3,373 respondents who did not complete the questionnaire, facility staff supplied information about age, race, ethnicity, insurance coverage, and method of payment for 1,162 women, while no information was available for the remaining 2,210 women. The researchers stated reasons women did not complete the questionnaire included refusal to participate, failure of the clinic to distribute the questionnaire, and lack of time to complete the questionnaire prior to the procedure.
The Guttmacher Institute utilized a three-stage weighting process in order to correct for any bias produced by deviation from the original sampling plan and non-response. Individual weights were developed to adjust for the demographic characteristics of the 1,162 non-respondents for which facility staff provided information. Then, facility-level weights adjusted for the other 2,210 non-respondents who did not have any demographic information available. Lastly, stratum weights were used to correct for departures from the number of facilities to be sampled in each grouping by caseload and provider type. The final weight was adjusted to a mean of 1.0, thus the standard deviation is 0.21 and the range is 0.42 to 2.95. Non-response on individual survey items was around two percent for most questions, but non-response ranged from 0.2% for age to 15% for family income. The Guttmacher Institute reported missing information on core demographic were imputed on the basis of the responses of other women with similar characteristics using a hotdeck procedure, which used cross-tabulations to identify the variables most strongly associated with each item requiring imputation. Respondents were sorted according to these variables in the order of the strength of the item’s association with the variable to be imputed; therefore, similar cases were adjacent to one another in the file. A missing value was then replaced by the value of the preceding case in the file.
Research Design and Analysis of Data

Permission was granted to the researcher by the Guttmacher Institute on January 26, 2018, to utilize their archival data. Prior to analyzing data, approval from the Florida Institute of Technology Institutional Review Board (IRB) was obtained by the researcher. The study utilized a cross-sectional design. Data originated from the 2008 Abortion Patient Survey (APS) dataset from the Guttmacher Institute, and data were specifically derived from Module B. Informed consent was obtained by each participant who completed the survey as deemed acceptable by the Guttmacher Institute and related researchers involved. Certain items from the Module B stigma questions were reverse coded, so that items that are negatively worded would have a higher value to indicate the same type of response on every item; for example, answering affirmatively to “I would be looked down on by some people if they knew I’d had this abortion” was reverse coded and given a higher numerical value, which totaled to form a score for perceived abortion-related stigma.

Descriptive statistics including assessment of means, standard deviations, and frequencies, and were calculated for participant demographic variables for the primary outcomes. Analyses of variance (ANOVA) were used to examine the relationship between multiple variables. Independent-samples $t$-tests were conducted to determine the relationship between two conditions. Data were analyzed using the Statistical Package for the Social Sciences (SPSS) – Version 25.
Results

Participants

A total of 9,493 participants completed the 2008 APS; however, this study is researching abortion-related stigma, which was only assessed on Module B, thus only Module B data ($n = 4724$) were examined. Participants were aged 12 to 49 ($M = 25, SD = 6.3$), and were 36.8% White ($n = 1740$), 30.6% Black ($n = 1447$), 23.2% Hispanic ($n = 1095$), 6.6% Asian/South Asian/Asian Pacific Islander ($n = 314$), 1.6% Other ethnicity ($n = 76$), and 1.1% American Indian ($n = 52$). The highest level of education that was most frequently obtained was some college or associate degree ($n = 1746 : 37\%$), followed by completed high school or GED ($n = 1365 : 28.9\%$), 0 through 11th grade ($n = 835 : 17.7\%$), and college graduate and more ($n = 778 : 16.5\%$). The participants were largely never married ($n = 3312, 70.1\%$), followed by married ($n = 698, 14.8\%$), separated ($n = 377, 8.0\%$), divorced ($n = 306, 6.5\%$), and widowed ($n = 31, 0.7\%$). Additionally, the vast majority of women obtained an abortion in their first trimester ($n = 4223, 89.4\%$), while 6.4% ($n = 302$) of women in the sample obtained an abortion between 13 and 15 weeks of gestation, followed by 3.3% ($n = 157$) women who were between 16 and 20 weeks pregnant. Less than one percent of the sample of women were between 21 and 24 weeks of gestation ($n = 42$). See Table 1 for further participant demographic information. Furthermore, the abortion-related stigma total score had a range of zero to a maximum score of 36, with lower scores signifying lower perceived
stigma and higher scores signifying higher stigma. The total score had a mean of 18.5, and a standard deviation of 6.0, while the mode was a score of 21.

**Statistical Analyses**

**Racial and ethnic differences.** An independent-samples t-test was conducted to examine whether Hispanic women perceive more abortion-related stigma in comparison to other ethnic groups. Levene’s test showed the variances for perceived stigma for both groups were statistically equivalent, $F(4314) = 3.23$, $p = .07$. Results demonstrated there is an overall significant mean difference between Hispanic women ($M = 18.93$, $SD = 6.34$) and non-Hispanic women ($M = 18.39$, $SD = 5.95$); $t(4314) = -2.4$, $p < .05$, two-tailed. The magnitude of the differences in the means ($M$ difference $= -.53$, 95% CI $[-.97, -.10]$) was moderately large (Cohen’s $d = 0.09$). Furthermore, a one-way analysis of variance (ANOVA) was conducted to assess the differences in the level of perceived abortion-related stigma between racial groups. Results showed that there is an overall significant mean difference among Hispanic women when compared to both Black women and women who identified their ethnicity as Other, $F(5, 4310) = 22.2$, $p < .001$. A Bonferroni post-hoc test demonstrated Hispanic women ($M = 18.9$, $SD = 6.3$) perceived significantly more abortion-related stigma than Black women ($M = 17.2$, $SD = 5.8$) and women who identified their ethnicity as Other ($M = 16.6$, $SD = 7.2$). Additionally, there were no significant differences in the level of perceived abortion-related stigma for Hispanic women when compared to the following
ABORTION STIGMA AMONG VARYING POPULATIONS

groups: American Indian ($M = 18.08, SD = 7.88$), Asian ($M = 19.0, SD = 6.34$), and White ($M = 19.35, SD = 5.74$).

**Marital status.** An independent-samples $t$-test was conducted to compare the amount of perceived abortion-related stigma experienced by married and non-married women. Levene’s test showed the variances for perceived stigma for both groups were not equal, which violated the assumption of equal variance, $F(4314) = 18.04, p < .001$, thus a correction to $F(761) = 18.04, p < .001$ was made. There was no significant difference in the level of perceived abortion-related stigma for married ($M = 18.47, SD = 6.75$) and non-married ($M = 18.52, SD = 5.92$) women; $t(761) = -.15, p = .88$, two-tailed. The magnitude of the differences in the means ($M$ difference $= -.04, 95\% CI [-.62, .53]$) was very small (Cohen’s $d = 0.008$). The hypothesis that married women perceive a greater amount of abortion-related stigma than non-married women was not supported. Due to the unequal variance between groups, a non-parametric test was conducted in order to not make assumptions regarding the underlying population distribution. A Mann-Whitney $U$ Test was conducted and the medians of the group of married women and non-married women both had a value of 19, and distributions of the two groups did not significantly differ (Mann-Whitney $U = 1111600.5, p = .74$), which confirmed the hypothesis was not supported.

In order to seek specific differences in perceived stigma among differences in marital status (*married, divorced, widowed, separated, and never married*), a
one-way ANOVA was conducted. It was concluded that there are no significant differences in the level of perceived abortion-related stigma between groups, $F(4,4311) = 1.49, p = .20$.

Educational differences. A one-way ANOVA sought to determine if college-educated women perceive more abortion-related stigma than non-college educated women. Results demonstrated there is an overall significant mean difference among college graduates and above, as compared to both women educated through the 11th grade and women who have graduated high school or obtained a GED, as well as a significant difference between women who have received some college or obtained their associate degree and women who have graduated high school or obtained their GED, $F(3,4312) = 9.5, p < .01$. Bonferroni post-hoc tests demonstrated college graduates and above ($M = 19.3, SD = 6.2$) perceived significantly more stigma than women educated through the 11th grade ($M = 18.2, SD = 6.0$), as well as perceived more stigma when compared to women who have graduated high school or obtained a GED ($M = 17.9, SD = 6.0$). Additionally, the data demonstrated women who have received some college education or obtained their associate degree ($M = 18.73, SD = 5.99$) perceive significantly more abortion-related stigma than women who have graduated high school or obtained their GED ($M = 17.9, SD = 6.0$). Thus, the hypothesis that college educated women perceive more abortion-related stigma than non-college educated women was supported.
**Gestational age.** An independent-samples *t*-test was conducted to compare the amount of perceived stigma experienced by women who obtain an abortion in the *first trimester* (the initiation of pregnancy up until the end of week 12 of gestation) versus the *second trimester* (week 13 until the end of week 27). Assumption tests suggested there were no outliers in the perceived stigma scores for the first and second trimester, and perceived stigma was normally distributed across both groups. Levene’s test suggested that variances in perceived stigma for the first and second trimester abortions were statistically equivalent, *F*(4314) = .000, *p* < .001. Results of the independent-samples *t*-test demonstrated women who obtained an abortion in the first trimester (*M* = 18.64, *SD* = 6.03) have a significantly higher level of perceived abortion-related stigma than women who obtained an abortion in their second trimester (*M* = 17.36, *SD* = 5.98), *t*(4314) = 4.29, *p* < .001, two-tailed, with the difference to have a 95% confidence interval [0.70, 1.87]. The difference presented a small-sized effect, Cohen’s *d* = 0.13. The hypothesis that women in the first trimester perceived more abortion-related stigma than women who obtained an abortion in the second semester was supported.

In order to understand specific differences in perceived stigma among women who obtained first and second trimester abortions, a one-way ANOVA was conducted. There was an overall significant mean difference among women in their first trimester (*M* = 18.64, *SD* = 6.03) compared to women in weeks 13 through 15 of their second trimester (*M* = 17.3, *SD* = 6.0), *F*(3, 4312) = 6.2, *p* < .001.
However, results were not significant when perceived abortion-related stigma during the first trimester was compared to an abortion obtained in weeks 16 through 20 or 21 weeks and greater.

Finally, a multiple regression was conducted to examine if the variables race and ethnicity, marital status, educational attainment, and gestational age predicted the total amount of abortion stigma. When all four predictors were accounted for, a significant amount of the variance in stigma was found \( R^2 = .01, F(4, 4311) = 15.07, p < .001 \). Only one percent of the variance in abortion stigma was accounted for by all four variables accounted for together. Gestational age \( (\beta = -.06, p < .001) \), educational attainment \( (\beta = .07, p < .001) \), and race and ethnicity \( (\beta = .07, p < .001) \) were a significant predictor of perceived abortion stigma. Marital status \( (\beta = .02, n.s.) \) was not a significant predictor of perceived abortion stigma.

**Discussion**

**Impact of Study**

As previously suggested, it is imperative to conduct further research to better understand the stigma surrounding abortion care services in order to work towards decreasing the stigma associated with terminating a pregnancy. Kumar et al. (2009) indicated an individual’s experience of stigma varies by their personal characteristics; therefore, identifying certain groups who have a higher propensity to experience stigma surrounding their abortion may help to better predict which women will experience post-abortion negative emotional outcomes, as well as
know which populations will benefit most from pre-abortion interventions or resources to prevent or attenuate stigmatization.

This study examined ethnic differences among women who obtain an abortion, and specifically supposed Hispanic women have a higher likelihood of perceiving stigma regarding terminating pregnancy. This study’s finding that Hispanic women are more likely to perceive a higher amount of overall abortion-related stigma than non-Hispanics is commensurate with a previous study by Shellenberg and Tsui (2012), who stated Hispanic women were more likely to perceive stigma from their friends and family, and feel more urgency to keep their abortion a secret. From a cultural perspective, Cockrill et al. (2013) discussed the increased religiosity of Hispanic women, and reported Catholic and Protestant women reported more stigma than non-religious women. Furthermore, Hispanic Catholics have demonstrated a stronger tendency to hold negative attitudes toward abortion. Over half of Hispanic individuals in America identify as Catholic, while 22% identify as Protestant (Pew Research Center, 2013). Therefore, it is supposed that religiosity and a greater sense of family unity may be just a few of the reasons why Hispanic women feel the need to keep their abortion status private, thus increasing the amount of perceived abortion-related stigma as compared to non-Hispanic women.

Contrary to our hypothesis, a significant relationship between marriage and increased levels of perceived abortion stigma was not found. Additionally, this
study found there is no observed relationship between marital status and perceived stigma, as there are no significant differences between the level of perceived abortion-related stigma and *married, divorced, widowed, separated, or never married* individuals. Research by Cowan (2017) suggested a greater amount of abortion patients who were married perceived only negative reactions when disclosing their abortion history, while fewer non-married women perceived only negative reactions. However, results from the current study were unable to support Cowan’s data. It is possible that stigma exists in varying ways for both married and non-married women, and therefore is not able to be identified specifically in this study. It is also probable that marital status does not necessarily speak to an individual’s level of social support; for which we know to be a protective factor of stigma (Cockrill & Nack, 2013; Kumar et al., 2009; Major et al., 1990). That is, being married suggests a minimum of one support (i.e., spouse), whereas a non-married woman may have as little as no primary support systems; conversely, she may also lean more frequently on her family, thus increasing social support substantially in some cases.

These results also demonstrated that the Kenyan and U.S. populations are not commensurate regarding perceived stigma, as results of this study did not parallel results found in Kenya, which suggested married women reported higher stigma scores than non-married women. Overall, there is a scarcity of research conducted on the relationship between marital status and abortion-related stigma,
and results from this study suggested perceived abortion-related stigma transcends all marital statuses equally.

In support of our hypothesis, our results demonstrated that higher educational attainment is associated with increased perceived stigma in women who obtain an abortion. Specifically, women with at least some college education and beyond experience more stigma than women without any college education. This finding is consistent with current research by Cockrill et al. (2013) who found women who have completed only high school are less isolated in their abortion experience, meaning they are more likely to feel supported by close friends and relatives, as compared to women who completed some college who perceived more stigmatization. This finding also aligns with Oginni et al.’s (2016) study which found women in Nigeria with a higher educational attainment were more likely to express increased levels of abortion stigma, which also suggests U.S. women and Nigerian women have similar experiences in this domain. It is supposed that although more educated women may view obtaining an abortion as less stigmatizing than carrying a mistimed or unintended pregnancy to term, this does not negate their high amount of perceived stigma from obtaining an abortion. In general, educated women would likely be more attuned to the amount of stigma society places on individuals who make the personal decision to terminate their pregnancy. Higher education likely lends an individual insight into stigma that is broadly experienced on multiple levels, including awareness of individual-level
stigmatization and stereotypes pervasive in communities, as well as stigma on a grander scheme that is generated from our current political climate and anti-abortion laws and regulations.

Lastly, we sought to determine if gestational age is a factor of increased risk for perceived abortion-related stigma. Although our society tends to greatly stigmatize second trimester abortion procedures, the demographics who are most likely to obtain a second trimester abortion (i.e., Black women, women with less than 12 years of education, and low-income women) generally reported lower levels of abortion-related stigma (Jones & Jerman, 2017a). Our hypothesis that women in their first trimester will perceive more abortion-related stigma than women in their second trimester was supported, and more specifically, women in their first trimester perceive more stigma than women in weeks 13 through 15. As Yanow (2009) stated, 58% of women who obtain second trimester abortion services have faced barriers or delays in obtaining their procedure, which contributes to a later gestational age. Some women require more time to arrive at a decision about their pregnancy, while other women have desired pregnancies and find their situation changed in a manner that precludes them from carrying their pregnancy to term or raising a child. The extra time spent on decision-making or facing new barriers may mitigate the amount of stigmatization perceived. Therefore, it may have been necessary to understand the reasons why the women in question elected for a second trimester abortion (e.g., delayed access to healthcare
services, financial barriers, etc.), and if they would have elected instead for a first-trimester abortion, in order to better assess the possibility and experience of stigma.

Subsequently, it is hoped that this may be an area for future research.

**Limitations and Areas for Future Research**

**Guttmacher Institute.** Guttmacher Institute noted several limitations with their 2008 Abortion Patient Survey dataset. They reported their measure of poverty was imprecise, and poverty levels may be somewhat overestimated in the data; thus, this researcher did not utilize income-related data in the formulation of hypotheses. Future research may want to more closely examine a possible link between low socioeconomic status and experience of abortion-related stigma. The researchers also noted their measures of health insurance coverage are also imperfect, largely due to the complexity of the current healthcare system and women’s uncertainty about what kind of insurance coverage they have.

Furthermore, as the APS questionnaire was only typically available in English and Spanish, foreign-born women who spoke other languages may have been unable to participate and underrepresented in the study. This researcher notes that an additional limitation is the self-report nature of the questionnaire may lead to inaccuracies.

**Researcher.** Furthermore, a limitation of our study is the dataset is from 2008; therefore, current demographics and abortion rates may differ slightly from the information presented in this study. During the course of the research, it was
ABORTION STIGMA AMONG VARYING POPULATIONS

apparent the disparity between state legislature and related management of abortions, and abortion-related facilities. Consequently, it is felt that conducting research at the national level did not account for the state-by-state differences. This may be most observed regarding the number of abortion clinics allowed within a state ordinance, impacting access to healthcare, increasing concentration of protests, etc. Whereas it is hoped that the sample size counteracted some of this disparity, it remains an area for future research. Furthermore, as a consequence of the current presidential administration’s anti-abortion stance and their at times hateful rhetoric, this researcher supposes abortion procedures are currently more highly stigmatized than the 2008 demonstrates. Lastly, stigma is a difficult variable to assess, and thus, abortion stigma overall is not frequently researched and is under-theorized, and there would be great public benefit in this area for future research.

**Conclusion**

Although this data can be used by medical providers who work in abortion care, this information can also be used by mental health providers that do not work directly in abortion care, but have patients who disclose their previous or intended abortions. It may be of some benefit for these providers to have knowledge of populations who are more prone to experience stigma, so they can more proactively assist with interventions to combat potential negative emotional reactions due to abortion-related stigma. For example, mental health clinicians may use the
opportunity to bolster the individual’s coping skills by teaching effective coping and relaxation methods, reinforce the importance of self-care, and use the therapeutic relationship to foster a safe space to speak about the individual’s abortion experience and perceived stigmatization. Furthermore, not only knowledge about abortion stigma, but also general knowledge of abortion practices is imperative for mental health providers, since abortion is a common medical procedure and is a part of many women’s narratives. It is essential mental health providers know how to provide care and process an abortion story with an individual without further stigmatizing it or imparting their own personal biases towards abortion into the conversation. Women who seek mental health services, whether it is immediately following their abortion or years later, require a safe and nonjudgmental space to find support from their mental health provider.
References

Academy of Medical Royal Colleges (AOMRC). (2011). *Induced abortion and mental health: A systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors.* London: Academy of Medical Royal Colleges.


ABORTION STIGMA AMONG VARYING POPULATIONS


Lichtenberg, L. Borgatta, D. A. Grimes, P. G. Stubblefield, & M. D. Creinin
(Eds.), Management of unintended and abnormal pregnancy:
Comprehensive abortion care (pp. 157-177). West Sussex, UK: Wiley-
Blackwell.

Obstetrics & Gynecology, 120(6), 1472-1474. doi:
10.1097/aog.0b013e3182723d82

 provision and the legitimacy paradox. Contraception, 87(1), 11-16. doi:
j.contraception.2012.08.031

Hartnett, C. S. (2012). Are Hispanic women happier about unintended births?
Population Research and Policy Review, 31(5), 683-701. doi:
10.1007/s11113-012-9252-7

acceptability of medical abortion with mifepristone: A German experience.

Henshaw, R. C., Naji, S. A., Russell, I. T., & Templeton, A. (1994). Comparison of
medical abortion with surgical vacuum aspiration: Women’s preferences
and acceptability of treatment. British Medical Journal, 307(6906), 714-
717.


ABORTION STIGMA AMONG VARYING POPULATIONS


ABORTION STIGMA AMONG VARYING POPULATIONS


Table 1

Descriptive Statistics of Participant Demographic Information

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race and Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td>52</td>
<td>1.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>314</td>
<td>6.6%</td>
</tr>
<tr>
<td>Black</td>
<td>1447</td>
<td>30.6%</td>
</tr>
<tr>
<td>White</td>
<td>1740</td>
<td>36.8%</td>
</tr>
<tr>
<td>Other</td>
<td>76</td>
<td>1.6%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1095</td>
<td>23.2%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-14</td>
<td>16</td>
<td>0.3%</td>
</tr>
<tr>
<td>15-17</td>
<td>280</td>
<td>5.9%</td>
</tr>
<tr>
<td>18-24</td>
<td>2110</td>
<td>44.7%</td>
</tr>
<tr>
<td>25-29</td>
<td>1177</td>
<td>24.9%</td>
</tr>
<tr>
<td>30-34</td>
<td>642</td>
<td>13.6%</td>
</tr>
<tr>
<td>35-39</td>
<td>371</td>
<td>7.9%</td>
</tr>
<tr>
<td>40-44</td>
<td>118</td>
<td>2.5%</td>
</tr>
<tr>
<td>45-49</td>
<td>10</td>
<td>0.2%</td>
</tr>
<tr>
<td>Educational Attainment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 through 11th grade</td>
<td>835</td>
<td>17.7%</td>
</tr>
<tr>
<td>High school graduate or GED</td>
<td>1365</td>
<td>28.9%</td>
</tr>
<tr>
<td>Some college or associate degree</td>
<td>1746</td>
<td>37.0%</td>
</tr>
<tr>
<td>College graduate or more</td>
<td>778</td>
<td>16.5%</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>698</td>
<td>14.8%</td>
</tr>
<tr>
<td>Divorced</td>
<td>306</td>
<td>6.5%</td>
</tr>
<tr>
<td>Widowed</td>
<td>31</td>
<td>0.7%</td>
</tr>
<tr>
<td>Separated</td>
<td>377</td>
<td>8.0%</td>
</tr>
<tr>
<td>Never married</td>
<td>3312</td>
<td>70.1%</td>
</tr>
<tr>
<td>Gestational Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First trimester</td>
<td>4223</td>
<td>89.4%</td>
</tr>
<tr>
<td>4-6 weeks</td>
<td>1381</td>
<td>29.2%</td>
</tr>
<tr>
<td>7-9 weeks</td>
<td>2000</td>
<td>42.3%</td>
</tr>
<tr>
<td>10-12 weeks</td>
<td>842</td>
<td>17.8%</td>
</tr>
<tr>
<td>Second trimester</td>
<td>501</td>
<td>10.6%</td>
</tr>
<tr>
<td>13-15 weeks</td>
<td>302</td>
<td>6.4%</td>
</tr>
<tr>
<td>16-18 weeks</td>
<td>126</td>
<td>2.7%</td>
</tr>
<tr>
<td>19-21 weeks</td>
<td>48</td>
<td>1.0%</td>
</tr>
<tr>
<td>Number of Previous Abortions</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>None</td>
<td>2376</td>
<td>50.3%</td>
</tr>
<tr>
<td>One</td>
<td>1342</td>
<td>28.4%</td>
</tr>
<tr>
<td>Two</td>
<td>600</td>
<td>12.7%</td>
</tr>
<tr>
<td>Three</td>
<td>243</td>
<td>5.1%</td>
</tr>
<tr>
<td>Four or more</td>
<td>163</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Previous Births</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1865</td>
<td>39.5%</td>
</tr>
<tr>
<td>One</td>
<td>1233</td>
<td>26.1%</td>
</tr>
<tr>
<td>Two</td>
<td>935</td>
<td>19.8%</td>
</tr>
<tr>
<td>Three</td>
<td>417</td>
<td>8.8%</td>
</tr>
<tr>
<td>Four</td>
<td>172</td>
<td>3.6%</td>
</tr>
<tr>
<td>Five</td>
<td>57</td>
<td>1.2%</td>
</tr>
<tr>
<td>Six or more (range = 6-13)</td>
<td>45</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $9,999</td>
<td>1075</td>
<td>22.8%</td>
</tr>
<tr>
<td>$10,000 – 19,999</td>
<td>1102</td>
<td>23.3%</td>
</tr>
<tr>
<td>$20,000 – 29,999</td>
<td>802</td>
<td>17.0%</td>
</tr>
<tr>
<td>$30,000 – 39,999</td>
<td>518</td>
<td>11.0%</td>
</tr>
<tr>
<td>$40,000 – 49,000</td>
<td>363</td>
<td>7.7%</td>
</tr>
<tr>
<td>$50,000 – 59,000</td>
<td>225</td>
<td>4.8%</td>
</tr>
<tr>
<td>$60,000 – 74,999</td>
<td>230</td>
<td>4.9%</td>
</tr>
<tr>
<td>$75,000 or more</td>
<td>409</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>1809</td>
<td>38.3%</td>
</tr>
<tr>
<td>Catholic</td>
<td>1268</td>
<td>26.8%</td>
</tr>
<tr>
<td>Jewish</td>
<td>36</td>
<td>0.8%</td>
</tr>
<tr>
<td>No religion</td>
<td>1301</td>
<td>27.5%</td>
</tr>
<tr>
<td>Other</td>
<td>310</td>
<td>6.6%</td>
</tr>
<tr>
<td>Muslim</td>
<td>36</td>
<td>0.8%</td>
</tr>
<tr>
<td>Hindu</td>
<td>45</td>
<td>1.0%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>16</td>
<td>0.3%</td>
</tr>
<tr>
<td>Christian (non-denominational)</td>
<td>384</td>
<td>8.1%</td>
</tr>
<tr>
<td>Christian (other)</td>
<td>35</td>
<td>0.7%</td>
</tr>
<tr>
<td>Christian Scientist</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>General (religious)</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other or multiple religions</td>
<td>45</td>
<td>0.9%</td>
</tr>
</tbody>
</table>
Appendix A

**NATIONAL PATIENT SURVEY**

The Guttmacher Institute, a non-profit research organization, is asking abortion patients across the country to provide us with information in order to improve health programs and policies in the United States. Please help by answering the below questions about yourself, your decision to have an abortion and other aspects of your life.

Your participation is voluntary and will not affect the services you receive. There are no direct benefits to participating in this study. While the risks are minimal some of the items are about sensitive issues such as sexual assault and may make you uncomfortable; you can skip these questions as well as any that you are unable to answer. The survey should take 5 to 10 minutes to complete. When you are done with it, place it in the attached envelope and return it to a staff member. Your name is not requested here. This survey is confidential and anonymous. The information you provide will be used for research purposes only.

If you would like a copy of the results, ask the clinic for a Guttmacher postcard. You can also contact Dr. Rachel Jones, the survey director, via email (rjones@guttmacher.org) or at the above address and phone number to find out more about the study.

<table>
<thead>
<tr>
<th>Today’s date: / /</th>
<th>(11-16)</th>
</tr>
</thead>
</table>

1. What is your age? ____ (17-69)

2. Are you Hispanic or Latina or of Spanish origin?
   - Yes
   - No (10)

3. Which of these groups best describes your racial background?
   - American Indian
   - Asian or South Asian
   - Native Hawaiian or other Pacific Islander
   - Black or African American
   - White
   - Other: ________________ (20)

4. Which of the following types of health insurance do you currently have? (check all that apply)
   - Temporary Medicaid coverage (does not cover regular health care) (32)
   - Medicaid or another state-run health insurance program (33)
   - Private or employee-sponsored health insurance (34)
   - Some other type of health insurance: ________________ (35)
   - I do not have health insurance (36)

5. How are you paying for this abortion? (check all that apply)
   - I am paying for it out of pocket, but will be reimbursed by my insurance company (39)
   - The clinic accepts my private health insurance (39)
   - I am using Medicaid (state-sponsored health insurance) (40)
   - I am paying for all or part of it out of pocket (includes cash and credit cards) (41)
   - I received financial assistance from an outside organization (42)
   - I qualified for a price reduction (43)
   - Other: ________________ (44)
ABORTION STIGMA AMONG VARYING POPULATIONS

8. Indicate if you experienced any of the following in the LAST 12 MONTHS (check all that apply):
   - A close friend died
   - I fell behind on my rent or mortgage
   - I separated from my husband/partner
   - I was unemployed and looking for work for a month or more
   - I had a serious medical problem
   - A dependent or close family member had a serious medical problem
   - I had a baby
   - I was the victim of a robbery (mugging or stick-up) or personal assault
   - My home was burglarized or broken into
   - I had a partner who was arrested or incarcerated
   - I moved 2 or more times

7. When you made this appointment, had you already made up your mind to have an abortion?
   - Yes
   - No

8. What was the first day of your last menstrual period?

9. About how many weeks pregnant are you?

10. Before you became pregnant this time, had you stopped using all methods of pregnancy prevention, including condoms, withdrawal, rhythm, etc.?
   - Yes
   - No
   - Never used any pregnancy prevention

11. What was the LAST method of pregnancy prevention you used before you found out you were pregnant? (check all that apply)
   - Pill
   - Condom, rubber (for males)
   - Depo-Provera, the shot, injectables
   - The patch, Ortho Evra
   - NuvaRing, vaginal ring
   - Implants in arm
   - Spermicides (foam/cream/jelly/film/suppositories/inserts)
   - Rhythm, natural family planning
   - Withdrawal, pulling out
   - Other method (specify):
   - I never used a method

12. In what month and year did you stop using that method? (check only one box)
   - Less than 1 month
   - 1-3 months
   - 4-6 months
   - 7-9 months
   - 10-12 months

13. For about how many months in a row had you been using that method? Please check only one box.
   - Less than 1 month
   - 1-3 months
   - 4-6 months
   - 7-9 months
   - 10-12 months

14. In the month you became pregnant, what was your formal marital status?
   - Married
   - Divorced
   - Widowed
   - Separated
   - Never married

15. In the month you became pregnant, were you living with your husband or boyfriend?
   - Yes
   - No

16. What is the highest grade of school you have completed?
   - 0-11th grade
   - High school graduate or GED
   - Some college or Associate degree
   - College graduate or more

17. What religion are you?
   - Protestant (for example, Baptist, Methodist, Lutheran, Pentecostal, etc.)
   - Catholic
   - Jewish
   - Other (specify)
   - None
18. Which of these do you consider yourself to be, if any?
- Born-again Christian
- Charismatic
- Evangelical
- Fundamentalist
- None of the above

19. About how often do you attend religious services?
- More than once a week
- Once a week
- 1-3 times a month
- Less than once a month
- Never

20. Including your children, how many family members do you currently live with?
Myself + ______ family members
(This includes your husband or boyfriend if you live with him, and any of his family members that live with you.)

21. What was the total household income last year (2007), before taxes, of yourself and all the family members counted in Q.20? Please provide your best estimate if you do not know the exact amount.
- $0.00 - $4,999 (less than $102/week)
- $5,000 - $14,999 ($102-$257/week)
- $15,000 - $19,999 ($258-$334/week)
- $20,000 - $24,999 ($335-$480/week)
- $25,000 - $29,999 ($481-$578/week)
- $30,000 - $34,999 ($579-$727/week)
- $35,000 - $39,999 ($728-$978/week)
- $40,000 - $44,999 ($790-$864/week)
- $45,000 - $49,999 ($805-$901/week)
- $50,000 - $59,999 ($902-$1153/week)
- $60,000 - $74,999 ($1154-$1441/week)
- $75,000 or more/year ($1442 or more/week)

22. Were you born in the United States?
- Yes  \( \rightarrow \) SKIP TO Q.24
- No, I was born in ______ (country) ________

23. When did you come to live in the United States?

24. Where do you currently live?
State ____________
ZIP ____________

25. How many births have you had?

26. How many abortions have you had before this one? ________

27. Right before you became pregnant, did you want to have another baby at any time in the future?
- Yes
- No  \( \rightarrow \) SKIP TO Q.28
- Not sure, don’t know
- Didn’t care

28. So would you say you became pregnant:
- Too soon
- At the right time
- Later than I wanted
- Didn’t care

29. On a scale of 1 to 10, circle the number that best describes how you felt when you found out you were pregnant.
1 2 3 4 5 6 7 8 9 10

30. At the time you became pregnant, how long had you been in a relationship with the man with whom you got pregnant?

31. Does he know that you are pregnant?
- Yes
- No
- I don’t know if he knows

32. Does he know that you are choosing to have an abortion?
- Yes
- No
- I don’t know if he knows
33. How supportive is he of your decision to have an abortion?
   - ☐ 1. He doesn’t know I’m having an abortion
   - ☐ 2. Very supportive
   - ☐ 3. Somewhat supportive
   - ☐ 4. Neither
   - ☐ 5. Somewhat unsupportive
   - ☐ 6. Very unsupportive
   - ☐ 7. I’m not sure how supportive he is

34. Has he ever hit, slapped, kicked or otherwise physically hurt you?
   - ☐ 1. Yes
   - ☐ 2. No

35. Has he ever forced you to do anything sexual when you didn’t want to?
   - ☐ 1. Yes
   - ☐ 2. No

36. Is this pregnancy the result of a partner forcing you to have sex when you didn’t want to have sex?
   - ☐ 1. Yes
   - ☐ 2. No
   - ☐ 3. Don’t know

37. Do you think abortion should be:
   - ☐ 1. Legal in all cases
   - ☐ 2. Legal in most cases
   - ☐ 3. Illegal in most cases
   - ☐ 4. Illegal in all cases

38. Did you take any of the following to try to bring back your period or end the CURRENT pregnancy BEFORE you came here? (check all that apply)
   - ☐ 1. Cytotec, or misoprostol
   - ☐ 2. Emergency contraception, also known as EC or the morning-after pill
   - ☐ 3. Other: ____________________________
   - ☐ 4. None of the above

39. Have you EVER taken anything ON YOUR OWN to try to bring back your period or end a pregnancy? (check all that apply)
   - ☐ 1. Yes, I have taken cytotec, or misoprostol
   - ☐ 2. Yes, I have taken emergency contraception, also known as EC or the morning-after pill
   - ☐ 3. Yes, I have taken another drug:
   - ☐ 4. None of the above

Thank you very much for your help.
Appendix B

NATIONAL PATIENT SURVEY

The Guttmacher Institute
A not-for-profit organization for reproductive health research, policy analysis and public education
125 Maiden Lane, New York, NY 10038  Phone: (800) 366-0244  Fax: (212) 248-1951  Web: www.guttmacher.org

The Guttmacher Institute, a non-profit research organization, is asking abortion patients across the country to provide us with information in order to improve health programs and policies in the United States. Please help by answering the below questions about yourself, your decision to have an abortion and other aspects of your life.

Your participation is voluntary and will not affect the services you receive. There are no direct benefits to participating in this study. While the risks are minimal some of the items are about sensitive issues such as sexual assault and may make you uncomfortable if you are unable to answer. The survey should take 5 to 10 minutes to complete. When you are done with it, please put it in the attached envelope and return it to a staff member. Your name is not requested here. This survey is confidential and anonymous. The information you provide will be used for research purposes only.

If you would like a copy of the results, ask the clinic for a Guttmacher postcard. You can also contact Dr. Rachel Jones, the survey director, via email (rjones@guttmacher.org) or at the above address and phone number to find out more about the study.

4. Which of the following types of health insurance do you currently have? (check all that apply)
   1. Temporary Medicaid coverage (does not cover regular health care) (2)
   2. Medicaid or another state-run health insurance program (2)
   3. Private or employer-sponsored health insurance (2)
   4. Some other type of health insurance: __________________________ (2)
   5. I do not have health insurance (2)

5. How are you paying for this abortion? (check all that apply)
   1. I am paying for it out of pocket, but will be reimbursed by my insurance company (2)
   2. The clinic accepts my private health insurance (2)
   3. I am using Medicaid (state-sponsored health insurance) (2)
   4. I am paying for all or part of it out of pocket (includes cash and credit cards) (2)
   5. I received financial assistance from an outside organization (2)
   6. I qualified for a price reduction (2)
   7. Other: __________________________ (2)
6. Indicate if you experienced any of the following in the LAST 12 MONTHS (check all that apply):

- A close friend died
- I fell behind on my rent or mortgage
- I separated from my husband/partner
- I was unemployed and looking for work for a month or more
- I had a serious medical problem
- A dependent or close family member had a serious medical problem
- I had a baby
- I was the victim of a robbery (mugging or stick-up) or personal assault
- My home was burglarized or broken into
- I had a partner who was arrested or incarcerated
- I moved 2 or more times

7. When you made this appointment, had you already made up your mind to have an abortion?

- Yes
- No

8. What was the first day of your last menstrual period?

- / / 

9. About how many weeks pregnant are you?

- weeks

10. Before you became pregnant this time, had you stopped using all methods of pregnancy prevention, including condoms, withdrawal, rhythm, etc.?____

- Yes
- No
- Never used any pregnancy prevention

11. What was the LAST method of pregnancy prevention you used before you found out you were pregnant? (check all that apply)

- Pill
- Condom, rubber (for males)
- Depo-Provera, the shot, injectables
- The patch, Ortho Evra
- NuvaRing, vaginal ring
- Implants in arm
- Spermicides (foam/cream/jelly/film/suppositories/inserts)
- Rhythm, natural family planning
- Withdrawal, pulling out
- Other method (specify)

12. In what month and year did you stop using that method? ___/___/___

- Still using method

13. For about how many months in a row had you been using that method? Please check only one box.

- Less than 1 month
- 1 month
- 2 months
- 3 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months
- 10 months
- 11 months

14. In the month you became pregnant, what was your formal marital status?

- Married
- Divorced
- Widowed
- Separated
- Never married

15. In the month you became pregnant, were you living with your husband or boyfriend?

- Yes
- No

16. What is the highest grade of school you have completed?

- 0-11th grade
- High school graduate or GED
- Some college or Associate degree
- College graduate or more

17. What religion are you?

- Protestant (for example: Baptist, Methodist, Lutheran, Pentecostal, etc.)
- Catholic
- Jewish
- Other (specify) 
- None
18. Which of these do you consider yourself to be, if any?  
☐-1 Born-again Christian  
☐-2 Charismatic  
☐-3 Evangelical  
☐-4 Fundamentalist  
☐-5 None of the above  

19. About how often do you attend religious services?  
☐-1 More than once a week  
☐-2 Once a week  
☐-3 1-3 times a month  
☐-4 Less than once a month  
☐-5 Never  

20. Including your children, how many family members do you currently live with?  
Myself + _______ family members  
(This includes your husband or boyfriend if you live with him, and any of his family members that live with you.)  

21. What was the total household income last year (2007), before taxes, of yourself and all the family members counted in Q.20? Please provide your best estimate if you do not know the exact amount.  
☐-1 Under $9,999 (less than $192/week)  
☐-2 $10,000-$14,999 ($192-$280/week)  
☐-3 $15,000-$19,999 ($280-$354/week)  
☐-4 $20,000-$24,999 ($354-$450/week)  
☐-5 $25,000-$29,999 ($450-$567/week)  
☐-6 $30,000-$34,999 ($567-$672/week)  
☐-7 $35,000-$39,999 ($672-$780/week)  
☐-8 $40,000-$44,999 ($780-$894/week)  
☐-9 $45,000-$49,999 ($894-$1011/week)  
☐-10 $50,000-$59,999 ($957-$1153/week)  
☐-11 $60,000-$74,999 ($1153-$1441/week)  
☐-12 $75,000 or more/year ($1441 or more/week)  

22. Were you born in the United States?  
☐-1 Yes ➔ SKIP TO Q.24  
☐-2 No, I was born in __________ (country)  

23. When did you come to live in the United States?  
_______ Year  

24. Where do you currently live?  
State ___________  
ZIP ___________

25. How many births have you had? ________  

26. How many abortions have you had before this one? ________  

27. Right before you became pregnant, did you want to have another baby at any time in the future?  
☐-1 Yes  
☐-2 No ➔ SKIP TO Q.29  
☐-3 Not sure, don’t know  
☐-4 Didn’t care  

28. So would you say you became pregnant:  
☐-1 Too soon  
☐-2 At the right time  
☐-3 Later than I wanted  
☐-4 Didn’t care  

29. At the time you became pregnant, how long had you been in a relationship with the man with whom you got pregnant?  
☐-1 _______ Months ☐-2 _______ Years  
☐-3 I was not in a relationship with him  

30. How supportive is he of your decision to have an abortion?  
☐-1 He doesn’t know I’m having an abortion  
☐-2 Very supportive  
☐-3 Somewhat supportive  
☐-4 Neither  
☐-5 Somewhat unsupportive  
☐-6 Very unsupportive  
☐-7 I’m not sure how supportive he is  

31. Has he ever hit, slapped, kicked or otherwise physically hurt you?  
☐-1 Yes ☐-2 No  

32. Has he ever forced you to do anything sexual when you didn’t want to?  
☐-1 Yes ☐-2 No  

33. Is this pregnancy the result of a partner forcing you to have sex when you didn’t want to have sex?  
☐-1 Yes  
☐-2 No  
☐-3 Don’t know
34. Did you take any of the following to try to bring back your period or end the CURRENT pregnancy BEFORE you came here? (check all that apply)

- [ ] Mifepristone or misoprostol (22)
- [ ] Emergency contraception, also known as EC or the morning-after pill (23)
- [ ] Other: __________________________ (24)
- [ ] None of the above (25)

35. Have you EVER taken anything ON YOUR OWN to try to bring back your period or end a pregnancy? (check all that apply)

- [ ] Yes, I have taken mifepristone or misoprostol (22)
- [ ] Yes, I have taken emergency contraception, also known as EC or the morning-after pill (23)
- [ ] Yes, I have taken another drug: __________________________ (24)
- [ ] None of the above (25)

36. The following questions are about how other people's opinions and feelings about abortion may affect you.

<table>
<thead>
<tr>
<th>Please indicate how much you agree or disagree with the following statements.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I would be looked down on by some people if they knew I'd had this abortion.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. I need to keep this abortion a secret from my close friends and family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. I can talk openly with people about this abortion.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. My friends and family would think less of me if they knew about this abortion.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Having this abortion will not cause problems in my relationship with my current partner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Telling my close friends and family about this abortion would not cause problems in our relationships.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. My regular health care provider(s) would treat me differently if they knew I'd had this abortion.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. I'd be at risk of physical abuse (e.g., being hit, punched or slapped) if I told my current partner or certain family members about this abortion.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>i. What other people think or feel about my decision to have an abortion doesn't matter to me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Thank you very much for your help.